
GUEST EDITORIAL

Diabetes and the Family Practitioner

The past decade has witnessed an exponential increase in the number of diabetics in this country, but there has been no evidence of an increase in the number of physicians with a primary interest in the disorder. This is not surprising. The whole medical aid system is weighted in favour of the more invasive and procedurally-oriented of our brethren; witness the number who profess an expertise in gastro-enterology, based on a passing acquaintance with endoscopy, often of the 'watch one, do one and then teach one' variety. Those physicians of the (very) old school who earn their keep by their cognitive skills, constitute a dwindling and ever more poverty-stricken minority.

And so, until percutaneous islet-cell biopsy becomes a reality, an ever-expanding diabetic population will continue to overcrowd already hard-pressed hospital diabetes clinics. And general practitioners will continue to refer diabetics who need insulin to specialist physicians whose knowledge of modern diabetes management matches their own.

The skills required for adequate management of both Type I and Type II diabetes are well within the compass of our primary-care practitioner. After all, the main responsibility for the control of the insulin-dependent diabetic falls on the patient or the parents, and the doctor's or diabetes care sister's main task is an educational one.

Here is a gap which the South African general practitioner should rush to fill. It remains for us to acquire a reasonable knowledge of the disease and its complications, and, starting in this edition, your own journal will attempt to provide that knowledge, with a problem-oriented approach. As many general practitioners, particularly in rural areas, are doing their own surgery and anaesthetics, it is appropriate that we begin with a simple, well-tried and effective plan of action for the diabetic requiring surgery.

LI Robertson