

Diabetes Today

Diabetes afflicts large numbers of people of all social conditions throughout the world. The personal and public health problem of diabetes, already of vast proportions, continues to grow despite exciting advances in the past few years in virtually every field of diabetes research and in patient care (*eg* improved treatment, protection against complications, increased self-care, and even primary prevention of some forms of diabetes.)¹

The identification and mapping of the gene in man which codes for insulin production represents a gigantic step forward in our scientific knowledge. The human insulin gene can now be synthesised in the laboratory and, by inserting it into a bacterial host, limitless quantities of the hormone can be produced, freeing us from our dependance on animal pancreas. Yet, despite this new source of supply, diabetics still die from lack of insulin in many parts of the world.

Research into the immunological aspects of diabetes has reinforced the view that "diabetes mellitus" is merely a convenient label for a diverse spectrum of conditions with the common factors of hyperglycaemia and the micro- and macro-vascular complications resulting therefrom. Certainly there are sufficient differences in genetic background, clinical course and prognosis to warrant regarding the two main types of primary diabetes as distinct and different disorders, a distinction which will facilitate our understanding of the difference in management and prognosis to the insulin dependent and non-insulin requiring forms of the disease.

The current economic squeeze has caused the Provincial Administrations to revise their criteria for allowing patients to be treated at reduced rates in Provincial hospitals. As a result hundreds of Type 1 diabetics are not only being forced to purchase their own insulin, but have to be

managed in the private sector so that, inevitably, more and more private family practitioners are being called upon to manage diabetics in varying states of control. The initial impulse of the anxious young general practitioner is to refer these patients to his specialist physician colleagues. Unfortunately, even in these days of super-specialisation for physicians (and even paediatricians), very few have made a special study of this important area of endocrinology. The result is that there are, countrywide, but a few of our specialist colleagues who handle, on a day-to-day basis, a large enough number of Type 1 diabetics to acquire the skills and confidence to tread the narrow divide between good diabetic control and potentially catastrophic hypoglycaemia which is a necessary path to traverse if the dreaded long-term micro-angiopathic complications are to be avoided.

Furthermore, few consultants have the time to provide the basic education so necessary for the well-being of the patient and peace of mind of the family.

Patient education comes easily to the well-trained family practitioner.

The relationship between doctor and diabetic patient is an interesting and unique one. Not the usual patriarchal/child one ("just take these blood-pressure tablets, eat less salt and attend regularly for your blood pressure checks and you will be fine"), but an equal-adult relationship, irrespective of whether the patient is 8 or 80, a relationship in which doctor and patient accept equal responsibility for the latter's wellbeing, and in which the patient gets to know almost as much about the disease as the doctor does.

In other words, the ideal model for many family-practitioner/patient relationships.

REFERENCE

1. WHO Technical Report Series, No 727, 1985 (Report of a WHO Study Group.)