<table>
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<th><strong>Title</strong></th>
<th>Shared care in diabetes [12]</th>
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<tr>
<td><strong>Author(s)</strong></td>
<td>McGhee, SM; Hedley, AJ</td>
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Women with positive results of stepwise screening. To dismiss their anxiety by saying that "this dissipated after receiving a negative result for their partners" is unreasonable.

The paper concludes that stepwise screening programs should be "cautious and careful." Providing information is an advantage only if it leads to specific action that would not otherwise have been taken. Providing excess information can invite unsolicited interventions, such as tracking of relatives to determine their carrier status, with unpredictable medical and financial implications. It could be costly and upsetting while conflicting little or no practical health benefit. Screening programs should be as simple and economical as necessary to achieve their intended aim in the population that has explicitly accepted the invitation for screening. Additional advantages should not be presumed. They should be made explicit and qualitatively assessed in both medical and financial terms.

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Short stature and diabetic nephropathy

EDITOR,—Rosing and colleagues conclude that short stature is related to the development of diabetic nephropathy in men and speculate that influences in early life could account for their findings. This interpretation is based on the assumption that adult height is determined solely by factors operating in utero and early life. But height is also related to parental social class and has been used as a proxy for adult socioeconomic status.

We have also found a relation between height and albuminuric status in a European study of the complications of insulin dependent diabetes but place a different interpretation on these findings. Patients aged 15-60 with insulin dependent diabetes were recruited from 31 European centres. Age at completion of education defined socioeconomic status in three groups: ≤ 14, 15-18, and >19. These analyses are restricted to people aged ≥25 to ensure that all those who would receive higher education had had an opportunity to do so. Adult albumin excretion rate was calculated from a timed 24 hour urine collection. Macroalbuminuria was defined as a rate of ≥ 200 µg/ml/min and microalbuminuria as a rate ≥ 20 µg/ml/min but <200 µg/ml/min.

Men with macroalbuminuria were significantly shorter than those without (table). This relation was present, but not significant, in women. The most educated men were also the tallest (171, 175, and 176 cm respectively, P=0.0001 for trend). This trend was not found in women (161, 164, and 163 cm respectively, P=0.2 for trend). When a term for educational status was included in the model the relation between height and albuminuric status was considerably attenuated in men (table). Adjustment for centre did not alter these relations.

We showed that height was related to nephropathy in men and confirmed that height was also related to educational status, a proxy for social class in adults. Educational status accounted for much of the relation between nephropathy and height. Longitudinal data are required before we can jump to hasty conclusions about influences in early life and diabetic nephropathy.

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JUDITH STEPHENSON Senior lecturer Academic Department of Genito-Urinary Medicine, University College London Medical School, London WC1E 6AU

4 Parekh N, Souter M. Early entry of coronary heart disease (the "Burke hypothesis"). BMJ 1995;305:411-2. (18 February.)

Shared care in diabetes

EDITOR,—We agree with Amanda J Soviden and colleagues' conclusion that evaluation of shared care must take into account many factors that influence effectiveness and efficiency, but the authors do not address the reasons why current systems of care fail. The main problem with traditional management of care is that it is likely to be an important determinant of continuity of care. Some patients receive a lot of care, a lot of patients receive some care, while other patients receive little or no care. Many patients are lost to follow up. A good system of shared care should rectify this imbalance by providing, efficiently, the best possible care with maximum coverage of the population at risk. Without such long term follow up schemes, determining what is best is not possible since data on outcomes are usually not available. In addition, to focus only on the clinical outcomes of those who are receiving care is to confuse assessment of the effectiveness of the delivery of care with that of the clinical care itself.

Cost effective trials of similar models of shared care for diabetes showed that shared care was associated with lower drop out rates and was more cost effective for the patient. Cost to the health service is likely to be an important determinant of continuity of care. The hypothesis that patients have lower costs for diabetes showed that the cost of the diabetes service was lower for patients in the shared care group compared with the traditional service group. This trial confirmed the findings of the current study and showed that shared care is a more cost effective way of delivering diabetes care.
review was maintained. Far from being "black boxes," the components of these approaches are clearly discernible and essential for any successful system: shared records; improved communication between doctors and with patients; a clear role for the patient; and specialist input (for example, screening of results from general practitioners). Finally, annual consultation; agreed management plans (which can be flexible to accommodate preferences); and the possibility of patients moving up and down the levels of care and a fail-safe system for coordination.

In the management of chronic disease a structured approach to matching levels of care to need and ensuring long term follow up has already been shown to be cost effective. We believe that these findings are widely applicable in the health care services. The next generation of trials should be concerned with identifying the best approaches to shared care, not comparison with traditional methods. Furthermore, all shared care should incorporate routine evaluation, including, in the longer term, assessment of clinical outcomes.

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Interpreting hospital death rates

EDITOR,—N W Harry raises several issues related to the indicators of clinical outcome published by the Clinical Resources Advisory Group.1 As he rightly points out, the intention was to promote discussion about variations, and if the information is to be used in league tables it is essential to the specific advice repeatedly given in the report and in related briefings. Copy of the report and briefing for handling inquiries were sent one week before publication to all chief executives and medical directors of trusts in Scotland. Several, including Harry, discussed these with central information services, but, clearly, misunderstandings persist.

Elderly people were not included by mistake. The specific intention was to include all patients with acute myocardial infarction because all should receive optimal care regardless of age and the hospital to which they are admitted. The tables are standardised for age and sex and consequently draw attention to variations that should be examined.

Harry questions the assignment of patients to his trust. All trusts were treated in the same way—namely, by all hospitals constituting a trust on 1 August 1993. The table does not include results for Fife Healthcare NHS Trust. They include Milesmark Hospital (now closed), but it is clear that, during the period analysed, mortality for Fife Healthcare arose largely from admissions to the smaller community hospitals and the geriatric specialties in the Victoria Hospital. Particular care should be taken in interpreting results when any hospital is divided between trusts according to specialties. Thus reference to Queen Margaret Hospital NHS Trust is inappropriate.

Some medical directors continue to express anxiety about the exercise, but it was agreed, after detailed consultation with the Medical Directors’ Group and other professional groups in Scotland, that professional practice and improved care would be best served by openness. The Scottish Association of Local Health Councils has reported no public disquiet about the report. Unnecessary anxiety seems to have been restricted to Fife Healthcare Trust’s sphere of influence enterprises. Professional staff and the media have, overall, received the report seriously and constructively. Health boards have been asked to initiate local discussions about the variations, and my professional colleagues and I are considering the implications of the report before finalising study design and continuing to work on refining the existing indicators and developing new ones.

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Lanarkshire Health Board
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Applicants for senior medical positions in New Zealand

EDITOR,—The New Zealand public health service is going through a process of rapid restructuring, and the employers of salaried senior medical staff are known as crown health enterprises. Coupled with this change is New Zealand’s unique industrial law. For example, there is no longer the lawful ability to negotiate national terms and conditions of employment, and what right employer will be sure that autonomous, non-lodging effective procedures or obligations. Negotiations now have to be conducted with each separate crown health enterprise (there are 23). The Association of Salaried Medical Specialists, affiliated to the New Zealand Medical Association, is responsible for the negotiation of collective contracts with these crown health enterprises. If readers of the BMJ are considering applying for, or having offered, positions in a New Zealand crown health enterprise they are strongly advised to seek the advice of the association. We can be contacted at PO Box 5251, Wellington, New Zealand. Tel 04 499 1271; fax 0604 499 4500. As the conditions of employment vary and there are different perspectives on the employment of senior medical staff among (in fact sometimes within) different crown health enterprises, professional advice is strongly recommended. You can be materially disadvantaged by taking either employment or profit

There are at least two crown health enterprises with which particular care should be taken. Firstly, contrary to the wishes of currently employed staff, it is seeking to employ new senior medical staff on significantly different, inferior, and deceptive individual contracts. The other is refusing point blank to negotiate a collective contract and instead is offering disadvantageous individual contracts in opposition to senior medical staff. In all cases applicants and those offered positions are encouraged to seek the advice of the association.

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Association of Salaried Medical Specialists, PO Box 5251, Wellington, New Zealand

Deaths occurring within 30 days of admission as percentage of all admissions with acute myocardial infarction, Fife Healthcare Trust and Scotland overall, October 1990 to September 1993

Deaths occurring within 30 days of admission as percentage of all admissions with acute myocardial infarction, Fife Healthcare Trust and Scotland overall, October 1990 to September 1993

<table>
<thead>
<tr>
<th>Patients admitted</th>
<th>Died within 30 days (%)</th>
<th>Mortality (standardised rate and confidence interval)</th>
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</thead>
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<tr>
<td>Victoria Hospital, Kirkcaldy (geriatric specialties)</td>
<td>885</td>
<td>292/66 6492/29 32/39 25/29 (25-29/33)</td>
</tr>
<tr>
<td>Queens Medical Hospital (geriatric specialties)</td>
<td>2</td>
<td>0/0</td>
</tr>
<tr>
<td>Milesmark Hospital</td>
<td>552</td>
<td>15/15 32/68 9/9 7/11 (7-11/7-11)</td>
</tr>
<tr>
<td>Firth Park Hospital</td>
<td>3</td>
<td>0/0</td>
</tr>
<tr>
<td>Other hospitals in trust</td>
<td>57</td>
<td>15/15 32/68 9/9 7/11 (7-11/7-11)</td>
</tr>
<tr>
<td>Rest of Scotland</td>
<td>39 305</td>
<td>8240</td>
</tr>
<tr>
<td>Scotland</td>
<td>40 190</td>
<td>8532</td>
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NA=Not applicable.