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Improving the quality of diabetic care

In South Africa and throughout the world the vast majority of people with diabetes, particularly type 2 diabetes, receive their routine care from family practitioners. Providing quality diabetes care is not a simple matter as it requires attention not only to glycaemic control, but also to lipids and blood pressure, screening for and appropriate management of micro- and macrovascular complications and addressing the psychosocial needs of the patient. Yet quality diabetes care is critical to ensuring optimal patient outcome. It has been suggested that the quality of care in family practice for patients with diabetes can act as a surrogate marker for the care of many other chronic disorders.¹ In other words, if you are 'getting it right' with your diabetic patients it is likely that you are also doing well with many other chronic conditions. Unfortunately many published South African studies demonstrate that the quality of diabetic care in the public sector is inadequate, which reflects negatively on the whole approach to chronic care in family practice.²⁻⁴

In *Innovative Care for Chronic Conditions: Building Blocks for Action* the World Health Organisation (WHO)⁵ emphasises the need for health systems to take chronic care much more seriously. They evaluate the current situation at the level of the health provider, the health organisation and national policy. At the level of the doctor-patient relationship they highlight the need to nurture quality interactions that promote behaviour change and adherence through a model of shared decision making and partnership. Patients should be empowered to be active role players in the management of their condition and not just passive recipients of care. In this edition of *CME* Professor Bob Mash in his article 'Motivating behaviour change in the diabetic patients' discusses some of the skills involved in realising this idea. At the organisational

level the WHO argues that the health system has historically supported an acute episodic approach to the delivery of care and is structurally inappropriate to deliver chronic care. Patients with chronic conditions are often seen by a series of different doctors or nurses, as if each consultation deals with an unconnected complaint. Continuity of care, especially in the public sector, is not valued or planned. Information systems are reactive and do not proactively promote care by keeping disease registers and call-recall systems. Family practitioners do not systematically evaluate or plan their care around the latest guidelines or evidence and are not encouraged to deliver opportunistic health promotion and disease prevention. General practitioners often fail to know or relate to the community-based resources that can assist with supporting and empowering patients. Dr Maryam Navsa in her article 'Organising and evaluating diabetic care in general practice' outlines an approach to improving the organisation of care for diabetic patients. Dr Penny Love provides information on the current nutritional recommendations for such patients. The early detection and prevention of microvascular complications is covered comprehensively in Professor Mollentze's article. Professor MAK Omar provides insight into how to approach patients in whom the type of diabetes is not clear at initial presentation, and Dr Wayne May and Professor Dinky Levitt in their article 'Prevention of type 2 diabetes — evidence from recent trials' discuss the latest evidence on interventions to delay or prevent diabetes.

The care of the diabetic patient is a test of the general practitioner's expertise in that it requires an integration of all the principles of family medicine,⁶ which dovetail remarkably with the recommendations of the WHO. There is also particular emphasis on a doctor-patient interaction

that values the perspective of the patient, understands the family and socioeconomic context and sees every contact as an opportunity for prevention or health education. The world body for family medicine, WONCA, has recently published a book that describes the family doctor's journey to quality⁷ and, together with the WHO, the following book: *Improving Health Systems: The Contribution of Family Medicine*.⁸ A country such as South Africa, which is failing to provide quality care to its diabetic patients, should take cognisance of the important role that can be played by well-trained family physicians and actively address the organisation of care to support a model of chronic care. We hope that this edition of *CME* will go some way towards this goal.

SINGLE SUTURE

Heat, death and political conflict

An astonishing number of people died in France during the recent heat waves – and there are still reports of mortuaries overflowing with unclaimed bodies. The heat wave lasted for two weeks in August and

was

predicted by weather forecasters. In that period the number of deaths doubled over a similar period in 2002. Leaping onto the bandwagon, opposition parties in France joined forces over what was called 'government inaction' and the president of the Union of Hospital Emergency Doctors called for a parliamentary investigation.

(Editor's note: Looking at all the reports in the lay press and medical journals, one is forced to ask – what exactly could government have done? Nowhere have I seen any concrete suggestions as to how these deaths could have been prevented.)

(Dorozynski A. *BMJ* 2003; **327**: 411.)