Diabetes care in Canadian family practice

A newcomer's perspective

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Diabetes is not a new condition but is indeed one that has plagued us since the earliest descriptions of "madhu-meh" (sweet urine) in the Sanskrit texts of the Susruta Samhita,[1] dated 400 bc by the Indian physician Susruta. The term diabetes mellitus was later coined by Aretaeus, a Greek physician.

Thousands of years and many new treatments later, I looked after people with diabetes in my family practice in London, England, and more recently in Ontario. Hailing from across the Atlantic, I can see that diabetes care in Ontario differs little from the care I used to offer in London. General practitioners face the same problems with and barriers to the care they provide. Though it can and should be fulfilling, caring for people with diabetes can also be extremely frustrating and chaotic.

In the United Kingdom, GPs were feeling burdened with increasing secondary care duties: more care for the sick in the community, earlier discharges, and ever-greater social problems. Patients were too poor to eat healthy food, and others were just too busy with emotional problems, depression, or unemployment. Sounds familiar, doesn't it?

Praise for family doctors

In the UK, the National Primary Care diabetes survey[2] shows that most people with diabetes are looked after by their family doctors only. In this issue of *Canadian Family Physician*, Harris and associates (page 778) show that, in Canada, 77% of diabetic patients are cared for by family doctors. Essentially, physicians look after all patients with type 2 diabetes and most with type 1, too, reserving referral to internists for difficult cases or sometimes new diagnoses. Harris and associates also show that the rate of documentation of HbA_{1C} for diabetic patients per annum in both the UK and Canada is comparable. In the UK, research[2] shows that most diabetes care is actually done by nursing staff (practice nurses) under the supervision of family doctors and that specific clinics or a specific number of sessions have been set up for this purpose. Family doctors have been shown to be very good at monitoring blood pressure (and macrovascular factors).

Family doctors are often criticized for not doing enough. I think it is time we realized how much family doctors actually do and how good they are at looking after people with diabetes.

Room for improvement

There is, however, always room for improvement. Family physicians are not as good at treating microvascular complications: microalbuminuria, retinopathy, and neuropathies. They are taught extensively about these pathologies. The problem is that they do not have the time, the resources, or the facilities to cover everything. In the UK, GPs have said the same thing.[3] Family doctors in the UK also want more information on diabetes to give to their patients and their staff and more educational forums and facilities to talk about diabetes.

Certain issues related to diabetes care remain unclear: what preconception counseling to offer women with diabetes (page 769), screening and care of women with gestational diabetes (page 761), concurrent use of insulin and oral hypoglycemics for the elderly, and whether to screen and how to screen for impaired glucose tolerance (an issue just about to hit family doctors). The problem is that, even if guidelines on these subjects were available, would family doctors actually follow them? Harris and associates say no. The problem, however, combines several complex issues involving both physicians and patients.

From patients' perspective, behavioural change depends on social and economic priorities. Some patients might understand that they need to make the changes their family doctors recommend (following clinical practice guidelines) but cannot make them because they are unemployed, have no benefits, or eat food culturally different from that discussed with the dietitian. A hassled physician, having dealt with a suicidal patient, a person

with chest pain, and an angry father demanding antibiotics for his 2-year-old's fifth viral infection of the season, all in the past half hour, will be less likely to counsel about microvascular risk factors and recommended changes.

Beyond the control of family doctors

Solving certain difficulties remains beyond the realm of an average family doctor. In Canada, I am often caught between knowing that I should prescribe a medication for a patient and knowing that the patient will not buy it because it is too expensive. Sometimes the really needy patients, the working poor who are younger than 65 and ineligible for other benefits, end up doing without. Perhaps Canada can learn a few things from the UK. Medications are free there for diabetic patients. Even the customary prescription charge is dropped for people with diabetes. Pregnant women also receive their medications free. If we want to improve diabetes care for everybody, our social welfare policy should be targeted at those who really need medications.

Sometimes clinical improvements have to be forced. In the UK, practices started to keep diabetes registers only when they were given a stipend for doing so. Mass computerization helped as well, because government subsidies enabled most practices to have computers and hence a computerized register. I can see that Canada is actively trying to follow suit with primary care reform policies, and many practices are now becoming computerized.

Communication between primary and secondary care has been very good in the UK. Canada has found it more difficult to maintain this type of communication because records are more scattered. The UK has a universal system (the Lloyd George files) in which patients' primary care records stay at the place of main primary care provision, moving only when patients register elsewhere.

Addressing issues as a whole

Social determinants of health seem to affect diabetes more than we think. The Health Determinants Model of Health[4] suggests they affect whether people actually develop diabetes (by virtue of lifestyle, culture, and genetic and social environment), how diabetes progresses (individual responses of biology and behaviour), whether they can access care and medication (physical environment), whether their neighbourhood can provide suitable care (health care system), and so on. Family doctors' different situations are affected by much the same factors as their patients' health determinants. Their care for diabetic patients is affected by patients' attitudes. These factors that affect our practice are almost "the social determinants of primary care providers." In some deprived areas, where diabetes prevalence is high, we are not even able to diagnose it, let alone treat and monitor it.

I believe our social and environmental policies should be more health-friendly and that family doctors should be involved when decisions are being made that can affect their ability to help their patients and their patients' ability to help themselves. When are we going to address these issues as a whole and ultimately improve diabetes care?

Possible long-term solution

Policy makers are rarely family doctors, and yet we are the ones on the front lines, the "bread and butter" practitioners. So much of what we do depends on public policy. Indeed public health seems to be moving away from family medicine these days. Although community medicine is a separate entity, it is allied to family medicine. Perhaps we need to create a new semigovernmental position (supported by a team of researchers and funding) dedicated to showing how social determinants are so important. The position would be similar to a Medical Officer of Health. The incumbent would establish liaisons with policy-making groups at the Ministry of Health and explain to them some of the real issues in family practice and public health. Someone needs to tell the government passionately and knowledgeably about these issues and offer practical solutions, such as free prescriptions for all diabetic patients and stipends for family doctors for keeping diabetic registers. We need champions for this school of thought. I suppose I could give it a go myself!

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