Editorial

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Editor

A socialist, capitalist or pipe-and-slippers approach to diabetes research?

'The future, according to scientists, will be much like the past only far more expensive' – John Sladek

I work in a district general hospital where 10 years ago there were two consultant cardiologists; in a few months, we will be appointing a seventh. Yesterday morning, an email popped into my inbox informing me (and everyone else) that the trust had approved the purchase of new state-of-the-art echocardiogram machines costing zillions of pounds. Last night, at our regular medical directorate meeting for consultants and managers, we were told that a fourth cardiac catheter laboratory would soon be operational (there had been no discussion on this!). These developments were taking place despite growing evidence that perhaps the brakes should be gently applied to invasive procedures in that speciality (Griffin et al, 2007).

The costs of technological advances in diabetes pale into insignificance compared with this. I suspect that here we are more into gadgets and gizmos than other units with our self-proclaimed enthusiasm for insulin pump therapy and continuous glucose monitoring (Deiss et al, 2006), all of which costs a fraction of what a cardiologist can spend in a year! Nevertheless, procedure-driven specialities are getting most of the NHS gravy as diabetes is gradually being consumed by primary care. While some may see this as progress, if one judges it by the level of career interest shown by trainees in the subject, specialist diabetes care is now on the endangered species list.

The decline in UK specialist diabetes services is progressing against a background of rising numbers of people with the condition, recognition of the prognostic importance that hyperglycaemia has for people admitted to hospital (ACE/ADA Task Force on Inpatient Diabetes, 2006) and a strong media interest in potential 'cures' (such as that described by Voltarelli et al, 2007). So why have specialist services allowed this to happen? One reason might be that the people involved are in it for all the right and altruistic reasons and are more pipe-and-slippers (metaphorically speaking, of course!) than new-order market capitalists. Many are probably closet socialists and almost certainly prefer football to rugby. In recent years, one self-inflicted wound has come about, perhaps owing to our close relationship with industry. This is not about junkets and educational meetings in exotic places, but clinical research agendas. Most developments in clinical diabetes research in recent years have focused on randomised trials of drugs. For example, it is now predictable that the latest megatrial will almost certainly be guaranteed pride of place at the EASD or ADA conference, even though many have used composite end points to beef up their findings in favour of the new drug (described in more detail by Freemantle and Calvert, 2007). Ideally, the process of acceptance onto a programme should be completely transparent.

It feels like clinical (as opposed to basic or pharmaceutical) research in diabetes is in the doldrums. This does not have to be the case and it *should* not be. It is hoped that the new Diabetes Research Network will deliver more than just a greater opportunity for big pharmaceutical companies to access participants for trials of their new pills (visit http://www.ukdrn.org/index.html [accessed 30.04.07] for more information). Maybe the physiology, psychology and philosophy of diabetes care will reap huge benefits. We at *Diabetes Digest* are optimistic for the moment, but we will soon make our readers aware if it fails to live up to its promise.

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