Comment

Driving advice should come from the whole diabetes team

Simon Heller
Senior Lecturer in Medicine and Honorary Consultant Physician, University of Sheffield, Northern General Hospital, Sheffield

David Kerr and Joan Everett make many important points in their timely article on managing the hypoglycaemic driver (Vol 1, No 4, p108). However, although they suggest that a formal dietetic review can prevent further episodes, the importance of regular eating when driving is advice that should come from all members of the diabetes team. The limitations of current regimens produce insulin levels that are inappropriately high between meals. This results in rapid falls in glucose concentration as the effects of the previous meal wear off. By the time symptoms of hypoglycaemia appear, cognitive ability is often already impaired, so the emphasis should be on prevention with carbohydrate snacks taken every 2 hours if driving long journeys.

The restrictions that surround the driving licence are particularly irksome to patients who are urged to live as normal a life as possible. The limited research concerning the safety of drivers with diabetes is reassuring, although, as the authors point out, somewhat unreliable. Indeed, considering the potentially lethal threat that a person with diabetes poses when incapacitated by hypoglycaemia, the attitude of the DVLA is generally sympathetic. Even an episode of hypoglycaemia unawareness causing an accident does not mandate withdrawal of a driving licence. My own experience is that the licensing authorities are prepared to judge each case sympathetically according to its merits. Until advances in treatment remove the risk of hypoglycaemia, those with diabetes will always face some limits to their activities, particularly those that may affect others. Professional carers have a duty to explain the reasons for these limitations but be prepared to argue their patient's case when dealing with regulatory authorities.

Patients face thin end of the wedge over driving

Debbie Hicks
Centre Manager/ Senior Nurse, Michael White Centre for Diabetes and Endocrinology, Hull Royal Infirmary

I am writing in response to your article 'Managing the hypoglycaemic driver' (Vol 1, No 4, p108) which I thought was excellent. The article stressed the lack of conclusive evidence to support the fact that insulin-treated diabetics are at a greater risk from road traffic accidents. However, here we are now faced with informing our patients about the new legislation — the Second EC Directive on the Driving Licence which came into effect recently. This new directive, which allows no exceptions, further restricts those taking insulin to what motor vehicles they are allowed to drive.

On discussion with some patients who have been made aware of the changes in the driving regulations, there is a real sense of anxiety. These patients are worried that this is the thin end of the wedge and that they may eventually lose the right to drive at all just because they require insulin injections to treat their medical condition.

I think that all health care professionals in diabetes care should actively support the British Diabetic Association (see The LINK, p16) in trying to ensure that this never happens, unless of course research shows that there is conclusive evidence to prove otherwise.

Nurses should be able to prescribe non-drug items

Jill Rodgers
Diabetes Specialist Nurse (Primary Care), Queen Alexandra Hospital, Portsmouth

I write in response to the article 'Advantages and disadvantages of nurse prescribing' (Vol 1, No 4, p113). While I welcome the fact that the debate around nurse prescribing in diabetes is being raised in the journal, I would like to make the following comments:

1. Nurse prescribing in diabetes care is likely to be linked to a small number of specific treatments and home monitoring equipment, which means that much of the debate around broad pharmaceutical knowledge and current routes to nurse prescribing may not apply.

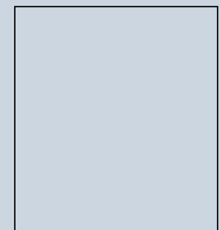
2. The article suggests that nurse prescribing is an 'added responsibility' — what responsibility could be greater than carrying out an illegal act on a daily basis, which is the current scenario?

3. The comment that DSNs prescribing will obviate the need to see a doctor suggests that the doctor's only role in diabetes care is the issuing of prescriptions, whereas their medical expertise is a valuable contribution to care.

4. There may be a way forward in prescribing under group protocols, a concept already agreed in principle by the UKCC.

The future development of a DSN qualification, which I would argue is likely to be at a minimum of first degree level if it is to be valued and respected, could be linked to DSN prescribing within that specialist area. At the end of the day, we need to put a stop to what is currently a paper exercise of prescribing, and seek ways to gain recognition and legitimisation for what has become an integral part of the DSN role in patient care.

Prescribing is an integral part of the DSN role



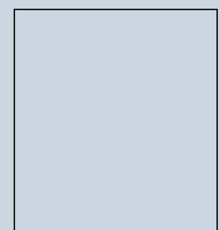
Andrea Taylor
Diabetes Specialist Nurse, Michael White Centre for Diabetes and Endocrinology, Hull Royal Infirmary

In response to the article 'Advantages and disadvantages of nurse prescribing' (Vol 1, No 4, p113), I would like to reply on behalf of our diabetes specialist nurse team in Hull. Our current practice includes the alteration of drugs, i.e. insulin or oral hypoglycaemic agents already prescribed in accordance with our job descriptions and agreed protocols, which are signed by our consultant diabetologist colleagues. However, we appreciate that the legality of this is still questionable under the Medicines Act 1968 and highlighted by Cradock (1998). Although I do not feel it is appropriate for DSNs to be involved in general prescribing, I do however believe that the ability to prescribe non-drug items, such as monitoring equipment and other self-care items, would save time for both the patients and ourselves as not all GPs are familiar with diabetes care equipment.

Within our team, we would welcome further training and education to support the role of the DSN to prescribe a limited list of medicines in accordance with recommendations from the 1989 Crown Report (Department of Health, 1989). None of the DSNs in Hull have a community qualification. Does this mean we would be excluded from being able to prescribe?

Cradock S, Avery L (1998) Nurse prescribing in diabetes. *Professional Nurse* **13**(5):315–9
Department of Health (1989) *Report of the Advisory Group on Nurse Prescribing* (Crown Report). HMSO, London

Experience should count for something



Joan James
Diabetes Specialist Nurse, Nantwich Health Centre, Cheshire

I read with interest the doctor's comment outlined in 'Is nurse prescribing a bad idea?' (Vol 1, No 4, p102), in which 'disappointment' was expressed at the move to allow nurses to prescribe insulin. I recently had cause to visit a patient in a nursing home who was on twice-daily fixed mixture insulin injections and Peg feeds. His feeding regime had been changed several times and the nursing staff were concerned that his diabetes was not being well controlled. Knowing that the GP was visiting later that day, I left a note asking if the man could be changed to a basal/bolus regimen suggesting which insulins might be used and the doses I thought he would need.

On follow up a few days later I discovered that the soluble insulin had been prescribed but the intermediate night insulin had been changed to a fixed mixture which was totally inappropriate. The patient was put at risk of hypoglycaemia due to a double dose of soluble insulin being given in a short period of time. Two days later I received a telephone call to say that the patient had died. Did he have another CVA or was it a hypoglycaemic coma?

I feel angry on two counts, one that the patient was put at risk and the other because I cannot openly question the competence of a GP. So when the question is asked 'Is nurse prescribing a bad idea?' you know what my answer would be.

I acknowledge that nurses need training in pharmacology and the legal aspects of prescribing, but experience should count for something as well.