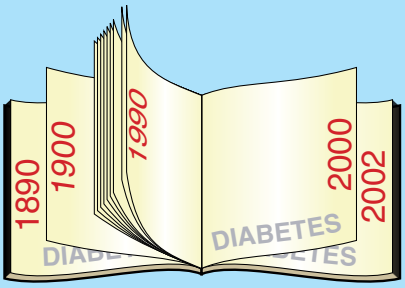
Management of diabetes in hospitals

Professor Robert Tattersall

Today's diabetes world is fast-moving and exciting; knowledge is accumulating at an astonishing rate, new discoveries and understanding lead to new ideas and innovations in treating, managing and preventing diabetes. However, there's nothing new under the sun. To help understand the present, it sometimes helps to examine the past.



Tattersall's Tales will enable readers to do just that. In every issue, Robert Tattersall, renowned diabetes sage and guru, will consider an aspect of diabetes and place it in a suitable historical context. Research, treatment, people and products will all feature. In this instalment, Robert Tattersall reflects on the problems of hospital management of people with diabetes, and compares this to the situation 90 years ago.

As many as one in ten patients in any hospital have diabetes; however, their management is often shambolic. This problem was recognised nearly 90 years ago by the Boston diabetes specialist, Elliott Joslin (1869–1962). In the first edition of his textbook The Treatment of Diabetes Mellitus: with observations based upon one thousand cases (Joslin, 1916), Joslin wrote:

'The management of diabetic patients in many large hospitals is an example of inefficiency. Instead of having the diabetic patients grouped together where the diets could be easily supervised, they are usually scattered throughout many wards. If the patients were assembled, labour in the kitchen, labour in nursing, and labour on the part of house officers and attending physicians would be saved. Furthermore, the patients would get far better treatment if they could be under the charge of a head nurse thoroughly skilled in their care, instead of having a nurse who had had only a few diabetic patients in her two or three years of training.'

Failure to concentrate patients on a diabetes ward is still the number one problem in most hospitals today. With the introduction of admission wards, shifts and the lack of continuity of care by a single physician, things have got worse in a way that Joslin could never have foreseen.

In one large hospital where Joslin was asked to prepare a patient for surgery, he noted despairingly that, 'nine different nurses cared for the patient during the 24 hours preceding, during and after the operation'. He suggested that the fewer nurses involved in the care of any particular hospital patient, the better. The 'named nurse' initiative introduced by the government in the 1980s was an acknowledgement that this a favourable scenario, but the initiative has turned out to be more of a paper exercise than a solution. Most nurses on general medical or surgical wards have only a sketchy idea of diabetes management and one solution, which will probably become more common in the future, is a diabetes specialist nurse who roams the hospital giving advice (Cavan et al, 2001).

No-one would doubt that the person who should be in charge of managing their diabetes is the patient or, if a child, the parent. As Joslin wrote:

'The patient has the diabetes – not the nurse – and is consequently the one most interested. Furthermore, the patient is aided in the treatment by his own feelings and can communicate these to the physician. In the hospital he often neglects to do this because he trusts to the nurse and often believes that whatever is done is all right, and thus neglects to discuss questions which come up.'

Bhattacharyya et al (2002) have recently produced a useful review of managing diabetes in hospitals, suggesting:

- Remember that your patient is the greatest expert on their diabetes; listen to their views and be ready to take their advice.
- There is no science to calculating insulin doses; apply simple rules of thumb, pay close attention to how patients respond to your regimens, be unafraid of making mistakes, and learn from experience.
- If you do not give insulin to patients with normal blood glucose levels, they will not stay normal for long.
- More instability is caused by fear of hypoglycaemia than by excessive insulin doses.

To these I would add beware sliding scales, which are probably the main cause of bad glucose control in hospitalised patients (Sawin, 1997). Their most obvious flaw is, as someone once said to me, you can't manage diabetes backwards.

Bhattacharyya A, Kaushal K, Dornan TL (2002) Glucose control in in-patients. *Diabetic Medicine* 19(Suppl. 1): 4

Cavan DA, Hamilton P, Everett J, Kerr D (2001) Reducing hospital inpatient length of stay for patients with diabetes. *Diabetic Medicine* 18: 162

Joslin EP (1916) *The Treatment of Diabetes Mellitus: with observations based upon one thousand cases.* 1st edn. Lea and Febiger, Philadelphia and New York

Sawin CT (1997) Action without benefit. The sliding scale of insulin use. *Archives of Internal Medicine* 157: 489