SCREEN OR NOT TO SCREEN?

Professor Kamlesh Khunti, Leicester

The prevalence of type 2 diabetes mellitus (T2DM) and pre-diabetes is increasing globally and many cases remain undiagnosed. Modelling studies have suggested that screening for T2DM and impaired glucose regulation followed by interventions is cost-effective. Although intervention studies have demonstrated the efficacy of lifestyle behaviour change programmes at slowing the progression to T2DM in high-risk populations, there are important gaps in the evidence when it comes to translating diabetes prevention research into practice.

A number of criteria need to be justified prior to implementation of a programme to prevent a disease. One key element of a screening programme is that a safe, acceptable and predictive test should be available to detect the pre-disease state. For every person with diabetes, there will be three to four people who will be at risk of diabetes. A good response rate is necessary for a screening programme to achieve a high diagnostic yield. To avoid unnecessary costs and inconvenience, it is important to identify high-risk people more likely to benefit from a screening programme. Non-invasive pre-screening tools are more cost-effective than an initial blood test. Simple self-assessment or practice-based computer strategies are most cost-efficient at identifying those with T2DM and those with impaired glucose regulation. The gold standard method of detecting undiagnosed T2DM and impaired glucose regulation is an oral glucose tolerance test (OGTT). This test is resource-intensive and appears to have limited use in a routine healthcare setting. Currently there are moves to simplify the diagnosis of diabetes and impaired glucose regulation using haemoglobin (HbA_{1c}), which will have an impact on any screening programme being implemented. However, there are still uncertainties, including how often people with a normal test or with impaired glucose regulation should be rescreened.

Further reading

- Gan D, editor. *Diabetes atlas*. 3rd ed. Brussels: International Diabetes Federation; 2006.
- Gillies CL, Lambert PC, Abrams KR et al. Different strategies for screening and prevention of type 2 diabetes in adults: cost effectiveness analysis. *BMJ* 2008; 336:1180–5. doi:10.1136/bmj.39545.585289.25
- Department of Health. *Putting prevention first. Vascular checks: risk assessment and management*. London: Department of Health; 2008.
- Lindström J, Tuomilehto J. The diabetes risk score: a practical tool to predict type 2 diabetes risk. *Diabetes Care* 2003; 26:725–31. doi:10.2337/diacare.26.3.725

LIFESTYLE CHANGE: WHO CAN MAKE IT WORK?

Professor Raj Bhopal, Edinburgh

Lifestyle change is, arguably, the vital ingredient in both the prevention and control of type 2 diabetes mellitus (T2DM). Lifestyle changes that prevent or control adiposity and maintain a modest amount of regular physical activity would dramatically reduce the incidence of new T2DM and improve its control in those already afflicted.

Two surprising, fundamental and opposing insights have emerged in research on lifestyle change in the past 50 years. The first is that, contrary to common sense, members of the public, mostly, do not act on lifestyle advice given by health professionals, even when they accept the case is sound. We need to reflect deeply on why this is so. The second is that if lifestyle advice is acted upon, the benefits for diabetes prevention are spectacular.

This presentation will start with a brief scan of diabetes prevention trials, and the rationale for the Prevention of Diabetes and Obesity in South Asians (PODOSA) trial. In particular, I will explain why a 15-session, family-orientated, home-based intervention was chosen, despite its high cost.

From there, I will tackle the question in the title on first principles. The answer will echo one of the earliest UK public health strategies, and state that lifestyle change is 'everybody's business'. Lifestyle change that relies on interactions between the public, patients and health professionals (including, of course, health promoters) is expensive but both feasible and cost-effective. However, it is probably not sustainable, especially in financially tough times. Making lifestyle change work in a sustainable way, it appears, requires a redesign of our style of life. It will require a reduction in personal choice and ostensibly radical actions, for example dramatic rises in the price of high-calorie, low-nutrition foods and for personal transport and paying for services such as a lift or escalator (excepting the disabled). Rather than counting calories, we need to make calories count in terms of nutritional value. Rather than seeing labour-saving devices as beneficial, we need to see each opportunity to take exercise as a boon. Pending such social and environmental changes that need political leadership, doctors, nurses, dietitians and other health promoters will need to battle against the consequences of obesity and physical inactivity.

J R Coll Physicians Edinb 2010; 40(Suppl 17):40–6

BARIATRIC SURGERY: WHO BENEFITS MOST?

Mr David Galloway, Glasgow

The recent steady increase in the prominence of bariatric surgery has given rise to a range of observations which relate to both the metabolic effects of weight reduction and the incidence and effects of numerous co-morbid conditions. One result has been the recognition of the specific metabolic consequences of certain gastrointestinal reconfigurations and hence the definition and development of 'metabolic surgery'.

The prevalence of obesity in the adult population of most Western countries has risen inexorably over the past three decades. The figures for Scotland[1] indicate that for 2008 the prevalence of a body mass index (BMI) in excess of 25 kg/m^2 had reached 66.3% for men and 59.6% for women aged 16–64. More alarming still is the prediction that while obesity (BMI in excess of 30 kg/m^2) affects slightly more than one in four adults that figure is expected to rise to 40% in the next 20 years.[1]

Bariatric surgery is now established as an effective treatment for selected, severely obese patients and the effects on weight control, quality of life, mortality and related conditions such as type 2 diabetes mellitus (T2DM) are well known.[2,3] There is a developing consensus with respect to the most appropriate indications for surgery in this group.

The effect of both restrictive and mixed restrictive and malabsorptive procedures in effectively reversing the metabolic sequelae of T2DM have also been consistently described. There is a great deal of active research interest in seeking to understand and exploit the mechanisms of this effect. The various roles of incretins and other signalling hormones are not only inter-related but are both diverse and complex.

It seems likely that new, minimally invasive (endoscopic and not necessarily surgical) procedures will become real options with a predominant indication for managing T2DM in a definitive and durable manner. The additional benefit to those who can benefit from weight reduction will be an added advantage. As the relative characteristics of the benefit from the several procedure-related approaches to T2DM management become clear there is little doubt that many patients with weight-related metabolic problems can expect much more effective management.

References

1 Bromley C, Bradshaw P, Given L, editors. *The Scottish health survey 2008*. Vol. 1. Edinburgh: Scottish Government; 2009. Available from: http://www.scotland.gov.uk/Resource/Doc/286063/0087158.pdf

2 Buchwald H, Estok R, Fahrbach K et al. Weight and type 2 diabetes after bariatric surgery: systematic review and meta-analysis (provisional abstract). *Am J Med* 2009; 122:248–56. doi:10.1016/j.amjmed.2008.09.041

3 Cunneen SA, Phillips E, Fielding G et al. Studies of Swedish adjustable gastric band and lap-band: systematic review and meta-analysis. *Surg Obes Relat Dis* 2008; 4:174–85. doi:10.1016/j.soard.2007.10.016

ARE WE GENOTYPING ENOUGH?

Dr Anna L Gloyn, Oxford

An estimated 2% of diabetes in the UK is caused by monogenic disorders of the β-cell (maturity onset diabetes of the young, MODY). The two most common subtypes of MODY seen in clinical practice are caused by mutations in the genes encoding hepatocyte nuclear factor 1-alpha (HNF1α) and glucokinase (GCK). The assignment of the correct molecular diagnosis is important for informed decisions regarding both treatment and prognosis. The use of low-dose sulphonylureas should be the first-line treatment in MODY due to HNF1α mutations (HNF1α-MODY), while patients with MODY due to GCK mutations (GCK-MODY) can often be managed by diet alone. Despite these clear advantages, individuals with MODY are frequently misdiagnosed as either having type 1 or type 2 diabetes or, even when MODY is suspected, do not undergo molecular genetic testing.

The hurdles that need to be overcome before systematic diagnostics for monogenic diabetes are in place include the development of improved protocols for case identification, increasing the awareness of monogenic diabetes among clinicians and reducing the cost of genetic testing. At present, the prevalence of monogenic diabetes varies greatly across the UK, reflecting differences in referral rates from different centres. Currently, patients are typically selected for molecular genetic testing on the basis of non-specific clinical features (age of onset, parental history of diabetes) and/or a clinical presentation, which is otherwise atypical for the assumed aetiology. There is a genuine need for both novel biochemical screening tools to identify and direct efficient genetic analysis in those for whom a probably monogenic diagnosis of diabetes exists and for prospective studies to evaluate the use of extended clinical and biochemical criteria for diagnostic referrals. With the advent of new sequencing technologies, which will decrease the cost of genetic testing, health economics should support increased molecular diagnostic referrals.

Further reading

- Gloyn AL, Ellard S. Defining the genetic aetiology of monogenic diabetes can improve treatment. *Expert Opin Pharmacother* 2006; 7:1759–67. doi:10.1517/14656566.7.13.1759
- Ellard S, Bellanné-Chantelot C, Hattersley AT et al. Best practice guidelines for the molecular genetic diagnosis of maturity-onset diabetes of the young. *Diabetologia* 2008; 51:546–53. doi:10.1007/s00125-008-0942-y
- Pearson ER, Starkey BJ, Powell RJ et al. Genetic cause of hyperglycaemia and response to treatment in diabetes. *Lancet* 2003; 362:1275–81. doi:10.1016/S0140-6736(03)14571-0
- Shepherd M, Shields B, Ellard S et al. A genetic diagnosis of HNF1A diabetes alters treatment and improves glycaemic control in the majority of insulin-treated patients. *Diabet Med* 2009; 26:437–41. doi:10.1111/j.1464-5491.2009.02690.x
- Pal A, Farmer AJ, Dudley C et al. Evaluation of serum 1,5 anhydroglucitol levels as a clinical test to differentiate subtypes of diabetes. *Diabetes Care* 2009 Nov 23 [Epub ahead of print].

USING GENETICS TO MANAGE THE DIABETES EPIDEMIC

Professor Tim Frayling, University of Exeter

There have been major advances in understanding the genetic component to type 2 diabetes over the past three years. Advances in technology have allowed researchers to test the majority of common variation in the human genome in large numbers of patients and non-diabetic controls. These genome-wide association studies (GWAS) have identified more than 30 gene variants associated with type 2 diabetes. Many more variants are associated with related traits, including obesity, lipid levels and glucose levels.

Two main conclusions have emerged from these findings. First, the effects of the known genetic variants are too small to offer useful predictive value. Even when combining information from all variants, there is currently limited clinical value in testing these variants. This may change as we move to sequencing the whole genome in patients and identify a fuller spectrum of variation involved in the condition. Second, the GWAS findings have provided many important insights into the aetiology of diabetes. These insights include:

a) the implication of novel mechanisms involved in diabetes risk – most of the associated variants are not near obvious candidate genes;
b) the prominence of reduced β-cell function ahead of increased insulin resistance as a primary cause of diabetes in today's environment;
c) a difference between physiological and patho-physiological glucose levels – the gene variants influencing fasting glucose levels in the non-diabetic population are often different to those predisposing to type 2 diabetes;
d) a link between circadian rhythm and diabetes – most notably variants in the melatonin receptor gene influence insulin secretion;
e) a genetic link between prostate cancer and type 2 diabetes;
f) an aetiological link between reduced circulating sex hormone-binding globulin (SHBG) and increased risk of type 2 diabetes – an association previously thought to be secondary to insulin resistance;
g) a genetic link between growth in utero and type 2 diabetes.

These findings offer a chance to make real progress in understanding why many obese and overweight people do not get type 2 diabetes, while many non-obese individuals do get the condition. Understanding the biology behind the disease will eventually lead to improved management for patients.

THE IMPORTANCE OF HEALTH BELIEFS IN PEOPLE WITH DIABETES

Dr John Harvey, Wales College of Medicine

Effective management of diabetes requires advice from professionals but also a significant input from the patient in terms of self-management. We ask our patients to undertake a large amount of self-care, probably more than in any other chronic disease. The degree to which they achieve the goals we set has a major influence on the glycaemic control and outcome achieved. Historically we have relied on 'education' to influence patients' behaviour but with only modest success. More important than knowledge are patients' beliefs about diabetes, their own 'personal models' of the condition.[1] We have shown the impact these have on behaviours such as clinic attendance.[2] Patients' personal models do relate to glycaemic control. The development of personal models in the newly diagnosed is related to aspects of the way in which education is delivered to patients and to personality.[3] The perceptions generated mediate the approach patients take in dealing with their diabetes.[4]

Psychological factors are a major influence on patient self-care behaviour and hence glycaemic control, medical outcome and quality of life. In the majority of patients this is not psychiatric disease but the influences on normal behaviour. This analysis suggests an approach in which we assess health beliefs at the individual level and try to influence those which are unhelpful. In the future, clinical practice in diabetes will need to make more use of this body of psychological theory.

References

1 Harvey JN, Lawson VL. The importance of health belief models in determining self-care behaviour in diabetes. *Diabet Med* 2009; 26:5–13. doi:10.1111/j.1464-5491.2008.02628.x
2 Lawson VL, Bundy C, Lyne PA et al. Using the IPQ and PMDI to predict regular diabetes care-seeking among patients with type 1 diabetes. *Br J Health Psychol* 2004; 9:241–52. doi:10.1348/135910704773891078
3 Lawson VL, Bundy C, Harvey JN. The development of personal models of diabetes in the first 2 years after diagnosis: a prospective longitudinal study. *Diabet Med* 2008; 25:482–90. doi:10.1111/j.1464-5491.2008.02394.x
4 Lawson VL, Bundy C, Belcher J et al. Mediation by illness perceptions of the effect of personality and health threat communication on coping with the diagnosis of diabetes. *Br J Health Psychol* 2009 Nov 17. [Epub ahead of print]

WHAT PSYCHOLOGICAL INTERVENTIONS SHOULD BE USED AND WHEN?

Dr Vivien Swanson, Stirling

Health professionals cannot fail to appreciate the 'psychological burden' of diabetes.[1] People with diabetes are required to constantly manage health behaviours, including medication adherence and lifestyle factors in the context of day-to-day demands and stressors, which can lead to psychological distress, anxiety or depression. Clinical standards and guidelines for diabetes care are unanimous in their conclusions that tackling psychological issues are key to good clinical and self-management (for example, the American Diabetes Association guidelines[2]). However, a recent Scottish Intercollegiate Guidelines Network (SIGN) update for diabetes lifestyle factors suggested that 'research on the efficacy of psychological interventions in diabetes is in its infancy'.[3] Where interventions have been shown to be effective, adequate mechanisms for integrating psychological approaches as part of day-to-day diabetes care are not always in place, and health professionals may lack information as to 'which approaches are most appropriate for what types of improvement, in what settings'.[4]

This presentation will summarise some of the psychological challenges facing people with type 1 and type 2 diabetes, including behavioural issues, depression and anxiety and relate these to diabetes self-management. The evidence for the efficacy of different psychosocial interventions to improve diabetes self-management, including behaviour change, goal setting, patient empowerment, motivational interviewing, cognitive behaviour therapy and coping skills, will also be evaluated based on the recent SIGN guideline update.[3]

References

1 Peyrot M, Rubin RR. Behavioural and psychosocial interventions in diabetes: a conceptual review. *Diabetes Care* 2007; 30:2433–40. doi:10.2337/dc07-1222

2 American Diabetes Association. Standards of medical care in diabetes, 2009. *Diabetes Care* 2009; 32:S13–S61. doi:10.2337/dc09-S013

3 Scottish Intercollegiate Guidelines Network. *Management of diabetes: a national clinical guideline*. Edinburgh: SIGN; 2010.

4 Grol R. Improving the quality of medical care: building bridges among professional pride, payer profit, and patient satisfaction. *JAMA* 2001; 286:2578–85. doi:10.1001/jama.286.20.2578

WHAT PSYCHOLOGICAL SUPPORT I NEEDED

Susan Morrow, Edinburgh

I have had type 1 diabetes since 1986. Since then I have received no formal psychological support. During my talk I will discuss what kind of support I have needed and at what points during my life support would have been useful. I will explore if my life and diabetic control would be any different if I had been offered support.

AFTER METFORMIN: WHO DECIDES?

Dr Amanda Adler

Metformin, or glucophage ('glucose eater'), is the drug of choice as first-line treatment for type 2 diabetes in all but the most hyperglycaemic patients. Its attributes include its price (cheap), relatively infrequent hypoglycaemia and weight neutrality, and it remains the only drug in diabetes shown in clinical trials to lower the risk of myocardial infarction. As such, metformin firmly holds place as first-line treatment. Yet, metformin rarely succeeds in controlling glycaemia as monotherapy. For treatment options after metformin, a number of choices exist at the second- and third-line. These include sulphonylureas, DPP-4 inhibitors, acarbose, incretins, thiazolidinediones and insulin, among others.

This talk will discuss the role of the regulator, the payer, patient, carer and manufacturer in the choice of these subsequent therapies, as well as the role of increasingly pragmatic ongoing trials, notably those designed to address cardiovascular safety. The development of both guidelines and quality standards strive to achieve quality, uniform, cost-effective care. This talk will highlight important gaps in the evidence required by those who make decisions about reimbursement of anti-diabetic therapies and the importance of valuing health-related quality of life, specifically those associated with hypoglycaemia and weight gain.

LESSONS FROM SCOTLAND

Dr Stephen Greene, Dundee

A 'model of care' is a multifaceted concept, broadly defining how health services are delivered. However, the definition of 'success' is problematic, particularly in a condition such as type 1 diabetes (T1D) that is predominantly self-managed. The service may be delivered effectively, but the primary health outcome is not achieved.

NHS Scotland appears to deliver a successful health service for young people with T1D and their families. In a part of the world with a high incidence, which is likely to rise significantly in the next 20 years, all children are referred to and managed by a multidisciplinary team of health professionals that delivers treatment at onset, early education and support, continuing education and immediate care of diabetes emergencies, some of which require hospital therapy. The service is underpinned by peer-reviewed guidelines and quality control through clinical networks. A 'standard' clinic system has been established with children and their families being offered outpatient appointments three to four times per year, supported by local parents' and patients' organisations and national support groups. Children appear to be well integrated into society, with the vast majority growing and developing appropriately, attending school and higher education normally and gaining employment.

Disappointingly, however, despite this effort, the outcome of the self-management of diabetes in Scotland continues to remain unacceptable by medical standards. The majority of children and adolescents have poor metabolic control, mostly related to difficulties in adherence to the intensive management regimens; this predicts poor long-term health for adults with diabetes, with a high risk of vascular disease and early mortality from heart attacks, stroke and renal failure.

New approaches to the models of care are required to support and motivate young people and their families with T1D. Recent evidence suggests prospective studies of social networks and increased 'social capital' predict health outcome. What is needed is a network that improves for individuals and their families 'diabetes social capital'. A radical rethink on the components of Scottish models of care is required.

LESSONS FROM ITALY

Roberto Trevisan, Ospedali Riuniti di Bergamo, Italy

The transition to adult care is inevitable for children and adolescents with diabetes. This transition occurs in differing care settings, and there is no age when transition is smoothest. This transition is difficult for many youths, and lack of consistent care may follow transition in 30–40% of patients. Even in those who remain in care, reports of metabolic control in the two years after transition vary. Several guidelines indicate that a planned transition to adult diabetes care improves outcomes and there is some evidence that a combined adolescent/adult clinic with both paediatric and adult diabetes specialists may be the optimal model of transition to adult care. We aim to present a different care model where there is no transition to adult care, since children and adolescents with diabetes are followed up by the same diabetes specialist team from the diabetes onset throughout all diabetes duration.

In Bergamo's hospital, the Paediatric Unit is deeply involved in oncology and organ transplantation. This is the reason why ten years ago it was agreed to implement a specific new approach for the care of children with type 1 diabetes. At diabetes onset, children and adolescents are admitted in the Paediatric Unit, where the diabetes team together with paediatricians treat acidosis and dehydration. During this admission, which is as short as possible, the diabetes team provides proper education for patients and their families.

After this initial period of diagnosis and education (when frequent contact is required), the child is regularly reviewed throughout the year in the diabetic clinic on a specific day. This is to allow families to meet and discuss common problems related to diabetes. This occurs no less than three or four times per year, including one major annual review (paying particular attention to the review of regular growth data, blood pressure, puberty, associated conditions, nutrition and complications) with a multidisciplinary team (including a psychologist). Continuous subcutaneous insulin infusion and continuous glucose monitoring are also provided to those children with special needs or difficulties in getting a good metabolic control. As a result of this model, transition to adult care is absent in our care setting.

Further reading

- Court JM. Issues of transition to adultcare. *J Paediatr Child Health* 1993; 29(Suppl 1):S53–S55. doi:10.1111/j.1440-1754.1993.tb02263.x
- Dovey-Pearce G, Hurrell R, May C et al. Young adults' (16–25 years) suggestions for providing developmentally appropriate diabetes services: a qualitative study. *Health Soc Care Community* 2005; 13:409–19. doi:10.1111/j.1365-2524.2005.00577.x
- Weissberg-Benchell J, Wolpert H, Anderson BJ. Transitioning from pediatric to adult care: a new approach to the post-adolescent young person with type 1 diabetes. *Diabetes Care* 2007; 30:2441–6. doi:10.2337/dc07-1249
- Kipps S, Bahu T, Ong K et al. Current methods of transfer of young people with Type 1 diabetes to adult services. *Diabet Med* 2002; 19: 649–54. doi:10.1046/j.1464-5491.2002.00757.x
- Freed GL, Hudson EJ. Transitioning children with chronic diseases to adult care: current knowledge, practices, and directions. *J Pediatr* 2006; 148:824–7. doi:10.1016/j.jpeds.2006.02.010

LESSONS FROM LIVING WITH DIABETES

Maggie Smith, Edinburgh

Brief histology I have been a diabetic for 37 years. I was diagnosed eventually, after 18 months of investigations and being on antibiotics for urinary infections on and off, in April 1973, aged 3¾ years, following an abortive episode of measles. I was given x 2 injections daily of isophane. Urine testing was socially challenging and not very accurate. I was on a set amount of exchanges at each meal time.

Transition In 1981, aged 12 years, I was put onto pork insulin. By 1983, aged 14 years, I had been to the hospital to learn how to do my own injections and got my first blood glucose testing machine. It was a very difficult period in my life and took a lot of adjusting to. I fell pregnant when I was 35 years old. Due to it being unplanned I needed to take control almost immediately. This I did with great enthusiasm and dedication.

How accessible/didactic diabetes care is I believe that diabetes care is fairly accessible for those patients living in the UK. There are numerous websites for people willing to access information online and Balance is a good source of information.

D-day + histology This year, on 18 February, my son was diagnosed with type I diabetes. He will be five years old on 27 May. It is still very raw for me, as I know what he will have to go through in life being a diabetic. We were out for family meal (pizza) and he went to the toilet four times. Once home, I checked his blood glucose and it was 32.5. It rose to >33.3 mmol/l an hour later so I phoned the Royal Hospital for Sick Children (RHSC) and took him in. By 11pm I was being told my son had type I diabetes.

Comparisons of models of care What I've done here is to look at my son's diagnosis in 2010 and what happened with him in regards to the care he has received and is receiving from the RHSC and compare it with the care I received back in 1973.

Suggestions for better models of care I have put forward suggestions for how, as a parent of a newly diagnosed diabetic child, I envisage this model of care could change and become more in tune with a patient's needs and requirements, thus improving the overall service that the NHS provides.

MY LIFE WITH DIABETES

Ross Finnie, Glasgow

I have been a type I diabetic for 45 years. My wife, Phyl, has developed an almost telepathic understanding of my condition and it is doubtful if I would have survived without her support. A few key friends in my personal, professional and public life have also provided essential support. On the medical front, only three excellent diabetic consultants and three GPs have provided a remarkable continuity of outstanding medical support.

I qualified as a chartered accountant and moved into corporate finance, specialising in mergers, acquisitions and reconstructions of small to medium-sized companies. These type of transactions involve long and irregular hours, not wholly consonant with diabetes. I played rugby football until I was 30 and have always enjoyed a very active social life.

I was first elected as a local councillor in 1977 and managed to juggle council meetings and my professional career for the next 22 years until I stood down in 1999. I was then elected to the first Scottish Parliament and was re-elected in 2003 and 2007. I was appointed as a Cabinet Minister in the Liberal Democrat/Labour coalition government and served throughout the first eight years with the environment and rural development portfolio. I am currently my party's Shadow Secretary for Health and Wellbeing.

My first insulin regime was on single-dose lente and that lasted for 19 years. I was moved on to a three-dose regime of Human Actrapid and Human Ultratard and now Humalog and Lantus. My only prolonged period of poor balance and control was followed by diabetic retinopathy requiring laser treatment in 1980. I had to take three months off in 2004 for a double heart bypass operation, but I returned to full cabinet duties and have not looked back.

I am very far from being a perfect diabetic patient, but I have lived my life to the full and I have no regrets.

Speaker abstracts

ACHIEVING CONSENSUS

Dr Ken McHardy, NHS Grampian

The Royal College of Physicians of Edinburgh has hosted a number of consensus conferences since 1995. Each conference has been constructed around a broadly common basic methodology, whereby contemporary issues in clinical practice are presented by invited experts, then considered and discussed by a mixed, and substantially voluntary, gathering of interested parties. A second group of invited experts sit as a consensus panel considering the presented evidence and audience reaction to it, leading to the production of an agreed draft or 'consensus' statement. All participants have a further opportunity to comment on, and potentially amend, this statement before it is finalised at the end of the conference.

Previous conferences have covered issues ranging from management of long-term clinical conditions (e.g. chronic obstructive pulmonary disease and chronic kidney disease), through service reconfiguration (e.g. stroke management, epilepsy services and the emergence of acute medicine) to rationalisation of established treatments (e.g. lipid-lowering drugs and hormone replacement therapy).

The principle behind these conferences and their attempts to achieve consensus are noble in that they aim to involve partnership working with a sizeable group of interested professionals, who are empowered to contribute their opinions in an attempt to achieve inclusive agreement on actions or change promoted by the group. However, while much of the currency of the interaction is centred on relevant knowledge and measured evidence, one may legitimately ask about the completeness with which the recommendations of the so-called consensus will be adopted by those who 'consented', let alone by their wider professional peer groups beyond.

As diabetes now makes its debut under the RCPE Consensus Conference spotlight, this presentation will take a light-hearted look at how the attitudes, values and beliefs of experienced practitioners (and patients!) may challenge the idealised view that consensus can ever be truly achieved or wholeheartedly implemented.

J R Coll Physicians Edinb 2010; 40 (Suppl 17):40–6