Take someone under your wing and inspire the next generation

Partha Kar

It was 1998 when I first came across him, one of the few who inspired me to take up diabetes and endocrinology as a profession. I was a clinical attaché, not even a bona fide recognised doctor in this country, but he always seemed to find time for me as he did for all juniors within his firm. He took time to explain what the subject was about, took time to share his passion, showed me interesting cases and thus the seeds for choosing this subspecialty were sown. His name was Dr Tony Zalin, and he was Diabetes Consultant based at Wordsley Hospital in Dudley.

Fast forward to the year 2000 and I was a Senior House Officer in Worcester when I started working with the second individual who nurtured that initial interest. He was Dr David Jenkins and, simply put, an individual who inspired and show-cased the benefits of this specialty. He encouraged me and sometimes even insisted that I do clinics in diabetes and endocrinology, see the patients who were being provided with antenatal diabetes care, understand the concept of multidisciplinary care, grow to respect the roles specialist nurses play – at the end of my tenure, I was sold. This was the specialty I wanted to do.

Finding the time – and a warning sign

Time has moved on and the drive to involve primary care has evoked differing responses from the specialist diabetes community. In some ways, it has been like going through the six stages of grief: shock, anger, denial, bargaining, grieving and acceptance. Existing specialists, as well as those just coming through, have felt insecure about their roles which understandably has led to a lessening of their pastoral roles. If you spend more of your time worrying about your present job, where exactly is the time to inspire the next generation? Perhaps in some quarters, this would cause indignation but the fact is that, bar a few specific individuals, there are not many who have the time to inspire the next generation. The Royal College of Physicians vacancy data published in August 2011 highlight 43 NTN (national training number) and LAT (locum appointment, training) posts vacant around the country, which has to serve as a warning sign.

The crux of the problem

As things stand in most centres, working for a diabetes firm involves, at least at a foundation year and core medical training level, simply doing a ward-based job. That could be a potentially interesting job if one could fantasise about a patient cohort with metabolic problems – for example, a ward base of patients recovering from diabetic ketoacidosis, hypercalcaemia, hypokalaemia, recovering diabetic foot ulcers – but, alas, the reality has been very different. Indeed, we have become the last bastions of a general physician and for most specialists that would not be an issue either. The crux of the problem has been that, with our fellow brethren in other areas of medicine picking and choosing their cohort of patients, we have been left with a group of patients who do not fit in perfectly to any agreed criteria.

An ever increasing elderly population continues to put huge pressure on elderly care teams and, with respiratory, gastroenterology and cardiology colleagues being insistent on being specialists, the inevitable fallout has been a diabetes team looking after elderly patients whose needs are not only restricted to their in-hospital stay but also to ensuring that they have adequate care at home. The seniors of the team, in most cases, feel their interest waning once the acute phase is over, not to mention that this is not their 'specialised' area, with an inevitable downward cascade of morale to the junior staff. The specialist trainees, again quite rightly, look forward to their outpatient clinical commitment, thereby once again leaving the juniors on the firm looking after patients whose acute needs are perhaps low and not specialty specific.

From a junior doctor's perspective

If one looks at it from a junior doctor's perspective, then a four- or six-month tenure involves being on the wards from 9 to 5 looking after patients who have perhaps little to do with inspiring them to pick diabetes as a specialty for their future. Very few centres actually have clinics earmarked for juniors to sit in or even hold a list of their own. So where do these folk actually get to see the patient cohort that would whet their appetite? Where do they see the type 1 adolescent challenges, see a patient on an insulin pump, the patient recovering from pituitary surgery? Due to ever-improving work patterns and system changes, admission of these patients, thankfully, is dropping – the irony being that, without any clinic exposure, the junior never even sees them. It may inspire a few to take up elderly medicine (and this country desperately needs more of them) but this is unlikely with regard to diabetes.

Contrast that with cardiology, respiratory and gastroenterology. Ward cases have their acute specialty mix: for example, the thrombolysed patient, the liver failure patient and so on. In short, due to a combination of hand-picking the patient cohort which they choose to look after, coupled with the inherent nature of the pathology, tenure in those firms for a junior doctor is, to put it simply, exciting.

Combine that with the inherent depression into which we have allowed ourselves to be sucked as a specialty … and you have a powerful cocktail. Other specialists have the belief that diabetes is a 'primary care specialty', thus any such budding ideas among juniors are openly derided while we, as a specialty, are starting to

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wonder whether we would encourage our juniors to pick up this subspecialty at all. As Royal College tutor, I regularly view requests from juniors concerning firms in which they want to work. Similarly, at their annual review, I specifically ask about their future ambitions. In both cases, the word 'diabetes' rarely, if ever, escapes their lips.

Where do we go from here?

So what now? Do we as professionals believe our specialty has a future and, if we do believe it, should we start planning to ensure that our future generation is recruited? As might be gathered from this article, I passionately believe in our specialty: we should start planning and this area is crying out for new leaders. As I have gone through my training years and my fledgling years as a consultant, I have continued to be fortunate in being around individuals such as Ken Shaw, Gerry Rayman and Jiten Vora, all of whom continue to inspire. What prevents the new cohort of consultants from being such figures?

Avenues to explore

How can we look at making our specialty more attractive or, for want of a better word, more 'sexy'? Some simple ideas may involve tried and tested methods such as ensuring juniors attend clinics on a rotational basis. Pessimists will point to the difficulty in getting hold of them due to the dreaded European Working Time Directive, but every problem, at least in my book, has a solution. Novel ideas may involve placing the onus on the junior team to have a designated person to come to some earmarked clinics – perhaps the one which will whet the appetite for the pituitary clinic, thyroid clinic, antenatal diabetes clinic etc. Locally, as the departmental educational lead, Ken Shaw had this as mandatory and this theme has been continued. That has translated into several trainees choosing this as a specialty over the last seven to eight years. Difficult to do? Yes. Impossible? No. Other ideas include setting up regular teaching sessions for the juniors when they are on the firm, in addition to seniors having a pastoral role trying to encourage the good trainees to look at this as a specialty.

Further ideas revolve around setting up educational funds dedicated to enabling junior trainees to attend the annual professional conferences of, for example, the American Diabetes Association, and Diabetes UK – give juniors the opportunity to meet the Edwin Gales and Stephanie Amiels, simply to be inspired. The Society for Endocrinology already does this, so why should we not do so as well? One regularly hears about the commitment of pharmaceutical companies to 'enhance the future of the specialty' – so why not explore that avenue?

On a 'political' level, maybe it is time to have discussions about the cohort of patients we look after rather than simply accepting that we take patients whom no-one else will. Some centres have already done so and we may as well take their lead. As specialists, we chase the El Dorado of optimal inpatient diabetes care, so why not use this as a strong argument for the team's time to be involved in looking after those diabetic patients languishing on an orthopaedic ward? How about creating a metabolic medicine team, perhaps even working closely with neurologists, thus helping to create an attractive patient cohort? Surely, if it is patient care we are after, then serving these patients' needs is better than accepting that we are a subgroup of elderly medicine.

Finally, we need to come across, at least to our juniors, as people who believe in our specialty. We need to be those inspiring figures whom our juniors would want to be. I have miles to go before I can even be a fraction of what Dr Zalin or Dr Jenkins was, but at least I go to work every day knowing I chose well. If I can inspire even one person to pick this fascinating subject as a specialty, I will know that I have contributed to the next generation.

In Wessex, under the leadership of Professor Mike Cummings, a generic email has recently gone out to all junior trainees highlighting the benefits of this specialty, encouraging them to take up this fascinating and challenging subject (a copy of the email is available online at www.practicaldiabetes.com). There continue to be centres which do just this, but such events need to happen as a regular occurrence – not based on the passionate commitment of a few.

Now is the time to secure the future

We are now in a crisis of confidence as a specialty and we need to shake ourselves out of it. It has to be the responsibility of the current generation to ensure we have a next generation. We must not shirk from ensuring that the future is secure – if not for anyone else, then at least for the patients. It is easy to say that the responsibility for this lies with organisations such as the Association of British Clinical Diabetologists, the Young Diabetologists Forum or Diabetes UK; I would suggest it is actually an individual responsibility, rather than one which might simply be handed over to organisations.

As Jedi Master Yoda said: 'Do. Or do not. There is no try.' And 'Do' we must – before it is too late.

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Declaration of interests

There are no conflicts of interest declared.

NOTICE

Diabetes/endocrinology taster evening

14 March 2012, 6.30pm drinks and dinner Chilworth Manor Hotel, Southampton

The Portsmouth Diabetes team are organising a taster evening in Diabetes/Endocrinology for Foundation and Core Medical Trainees.

Speakers include Professor Michael Cummings, Dr Derek Sandeman, Dr Mike Masding and Professor Chris Byrne. After the presentations junior doctors will have the opportunity to interact and quiz the experts on this specialty.

Please contact Partha Kar (email: partha.kar@porthosp.nhs.uk) or Lina Chong (lina.chong@porthosp.nhs.uk) for further details.

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Have you ever considered a career in Diabetes and Endocrinology?

This letter is relevant to those doctors who are training who would have an interest in a career in Diabetes and Endocrinology. As trainers in Diabetes and Endocrinology, we recognise that there is limited exposure to this specialty for trainee doctors during Acute Medical training at FT1/2 and CT1/2 level. Your exposure at this point is likely to be limited to a handful of acute metabolic emergencies, the tip of the iceberg.

In considering a career in Diabetes and Endocrinology, the following points maybe helpful:

If you are somebody who enjoys developing a good rapport with your patient and multi-disciplinary team, diabetes care provision fulfills these criteria. Building a rapport with your patients helps to guide them through many different aspects of their disease ensuring they are well motivated to tackle the many challenges ahead.

Diabetes is not simply a disorder of glucose metabolism. It represents a multi-system disorder with probably the most varied experiences in healthcare provision for any disease process. Training in diabetes offers an opportunity to gain experience in optimising glycaemic control with a huge array of glycaemic lowering agents including novel GLP-1 agonists and novel insulin analogues with the use of subcutaneous therapy or insulin pumps. Experience is provided in management of young type 1 patients with diabetes through to the management of diabetes in pregnancy as well as management strategies in the elderly population. Complication managements training is provided in diabetes and renal disease, foot disease, eye disease, cardiovascular disease, autonomic care and neuropathy, sexual health and psychological aspects of diabetes.

National audits have demonstrated that approximately 20% of in-patients at any stage have underlying diabetes. An essential part of diabetes training is how to optimise in-patient care resulting in morbidity mortality approaching that of a non-diabetic population.

Although there have been some changes in the landscape of diabetes provision between primary and specialist care, there is still an absolute need for specialist diabetes care. In consequence there will be a continued thriving requirement for career diabetes specialists at consultant level.

Endocrinology includes a huge varied opportunity to train in management of a heterogeneous satisfying subject with many sub-specialty areas of interest. In consequence many centres now offer specific specialty training in areas such as thyrotoxicosis clinics, thyroid lump clinics, parathyroid clinics, adrenal lump clinics, lipid clinics, endocrine fertility clinics, pituitary clinics and many more.

The research opportunities in Diabetes and Endocrinology are endless with many examples of specialist registrars taking advantage of these opportunities within the Wessex region as well as other out-of-training experiences.

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