Reflections on 'Tackling type 2 diabetes and coexisting conditions'

These letters are in response to the reports contained in the 2012 *Practical Diabetes* supplement 'Tackling type 2 diabetes and coexisting conditions'.

The supplement is available free to view at: www.practicaldiabetes.com/SpringboardWebApp/userfiles/espdi/file/Supplements/Pr%201278%20Final2.pdf.

Sir/Madam, In the context of my own County Council in Sweden, our studies indicate that diabetes specialist nurses (DSNs) in primary health care focus mostly upon biomedical issues or use what the supplement reports mention as a glucocentric approach but only a little on how it is to live with a chronic illness such as diabetes. Guidelines recommend annual appointments to both DSNs and physicians. Many diabetes patients in Sweden only meet DSNs, thus saving money and taking the burden off physicians.

There are many people living with diabetes who also have coexisting conditions and DSNs frequently meet these individuals. In order to better support these people, DSNs can focus more on those with high HbA_{1c} levels, obesity and other cardiovascular problems, and, as the supplement mentions, also depression. This means contacting them more often than usual, and leaving many of the biomedical issues to the physicians. Unfortunately, my study showed that people with coexisting conditions and high A_{1c} levels barely got their regular checkups because they were so difficult to handle and the DSNs did not have the tools to deal with their problems.[1]

There is inconsistency in the relationship between knowledge and health outcomes. Knowledge and education do not necessarily lead to changed behaviour. In order to provide most people with the necessary knowledge, it is important that the education or support is individualised and patient-centred (or what the report labels as 'user-centred'). However, groups of patients may have the same information gaps or problems and could preferably be provided with group education on these issues. Nevertheless, evaluation in the longer term is lacking and should be emphasised, which is not mentioned in the reports.

It is difficult for all of us to change behaviour. DSNs can support people in need of behavioural change by exploring what it is possible for them to change in their lives and investigating how to increase their motivation for a changed behaviour.[2,3]

Diabetes is an invisible illness for most patients. It is difficult to be motivated to perform self-management activities if you do not feel any physical differences or changes, whether or not you perform self-management activities. It is therefore important to discuss the seriousness of diabetes with patients to explore their views about its severity and discuss both emotional and existential aspects of living with diabetes in order to motivate them to change their lifestyle.[2,3] The report says that information should be positive and not focus on aspects of disease severity. I don't agree; and, for example, the Health Belief Model highlights that perceived susceptibility and severity are triggers for lifestyle change. Instead, our interventions focus on discussing these issues with patients, and we have shown positive effects on metabolic outcomes.[4]

It is important that nurses focus on people's illness integration of diabetes and not solely on self-management practice. The integration of illness and self-management is not highlighted in the report. I suggest that patient education should primarily focus on supporting people to integrate the illness into their lives, thus developing the necessary self-care activities in parallel.[3]

To talk about an individual's personal understanding of living with diabetes entails having a perspective about the future. Without scaring patients, it is possible to talk about the future and what they could attain by improving self-management. Talking about the seriousness of diabetes is an important way of integrating the illness, and the future must be discussed with patients since all behaviour changes that can be done today in self-management activities are important for the future when it comes to living with diabetes.[2,3,5]

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References

1. Jutterström L, *et al.* Ideal versus real conditions for type 2 diabetes care: diabetes specialty nurses' perspectives. *Internet J Advanced Nurs Pract* 2012;11(2).
2. Jutterström L, *et al.* Turning points in self-management of type 2 diabetes. *Eur Diabetes Nurs* 2012;9(2):46–50.
3. Hörnsten Å, *et al.* A model of integration of illness and self-management in type 2 diabetes. *J Nurs Healthcare Chronic Illness* 2011;3:41–51.
4. Hörnsten Å, *et al.* Metabolic improvement after intervention focusing on personal understanding in type 2 diabetes. *Diabetes Res Clin Pract* 2005;68:65–74.
5. Hörnsten Å. Experiences of diabetes care – Patients' and nurses' perspectives [Medical dissertation]. New series No 882. Umeå University, 2004.

Sir/Madam, Care of patients with type 2 diabetes should exceed the limits of routine treatment, and include not only health, but also the emotional, physical and social development of the patient. Performing these tasks in primary care is so much easier when medical staff know the social situation of their patients. However, the programme of care can only be achieved with teamwork which includes a nurse, a doctor, nutritionist, psychologist, therapist and, of course, the patient. There are three core elements to improving care:

- **Education.** Learning by discovery is a great way to educate patients. It is affiliated with both the motivational interview and counselling model, which is the empowerment of the patient, i.e. strengthening/empowerment. Therefore, it would be appropriate to organise education centres in local communities that have achieved these goals in collaboration with the therapeutic team.
- **Policy and politics.** We know that primary prevention is the only way to stop the epidemic of diabetes and secondary prevention is essential to stop the development of diabetic complications. Therefore, local authorities should be made aware that the money spent on prevention will save long-term expenditure.
- **Communication.** For example:
  - To train the medical personnel in the field of communication and assertiveness.
  - To create an information system to enhance information exchange relating to the decisions made among the therapeutic team.

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Further reading

– Williams R, *et al. The Economics of Diabetes Care. An international perspective.* Blackwell Science, 2000.
– Fleming B, *et al.* The Diabetes Quality Improvement Project. Moving science into health policy to gain an edge on the diabetes epidemic. *Diabetes Care* 2001;24:1815–20.

Sir/Madam, Diabetes is a disease that can be largely controlled through good self-management and education. To become a good diabetes self-manager, there is more to learn. For patients, it is as important to talk to their diabetes educator as it is to talk to their doctor about all their questions, problems and concerns that they might have. It is essential that the educator is trustworthy and emotionally supportive in a manner that motivates the patient's understanding of their active role in managing their diabetes.

The education of all diabetes patients must be done gradually so that they can succeed in covering all the necessary stages of the learning process. The first responsibility of any chronic disease self-manager is to understand the disease. A disease is different for each person: with experience they and their family can, and will, become experts in determining the effects of the disease and its treatment since the patient lives with his/her disease every day. For patients, observing the disease and making accurate reports to their health care providers are essential parts of being good self-managers.

Education must be perceived as an ongoing learning process that permits each patient to live his/her life normally. Educational programmes should be structured according to the type of diabetes, medication, comorbidities and other factors. Educators should act as negotiators in their relationship with their patients; goals and steps taken in achieving balanced self-management should be agreed upon from the start.

I believe that psychological support for each patient is also very important; educators should state this from the first meetings, urging patients to take this into consideration thus preventing depression which is common in diabetes. Each education programme should provide basic information not only on monitoring blood glucose levels but also on other areas for managing the disease, such as healthy eating, reducing risk factors, taking proper medication etc.

Education in diabetes should not be done lightly: every person involved in the educational process plays an essential part in helping the patient lead a normal life. Educational programmes should involve active participation from all parts; e.g. in Romania the GPs follow only the instructions received from the DSN – they are not involved in the patient treatment or education programme.

When evaluating ongoing educational programmes, it is essential to get feedback from the patients in an effort to improve the educational process. The feedback will also provide educators with answers regarding each patient's level of understanding the disease and coping with it.

Politicians and policy makers play an essential role in effective diabetes management. Communications between them should be improved to a level where new strategies in education and prevention programmes are also created at local and national level. Long-term actions include distributing information ads on the online social network sites for a greater impact, or publishing booklets and flyers that can be handed out to any number of patients by GPs. Patients with type 2 diabetes who frequently meet with their GPs should be strongly motivated by them to take active part in ongoing education programmes.

Managing diabetes is a complex undertaking. There are many twists and turns, and mid-course corrections. Learning self-management is essential but not enough. Self-management does not mean going it alone. The message is: 'Get help or advice when you are concerned or uncertain'; this is very important for all patients.

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