Strong solutions for vulnerable issues


Within the last decade there has been a shift from generalised health goals for people with diabetes, toward individual health plans or personalised medicine. This shift is reflected in the current ADA guideline for diabetes care management, which states that: 'The management plan should be formulated as a collaborative therapeutic alliance among the patient and family, the physician, and other members of the health care team.'[1] There would seem to be three key drivers behind this shift: the first was the realisation that 'one size fits all' targets may in fact be detrimental to some patients; the second is the fact that many people with diabetes have multiple, complex and sometimes competing problems; and the third was the growing recognition that it is important to activate patients and engage them in setting their own goals.

These drivers are particularly important in the context of vulnerability. We have seen that it was the most vulnerable patients, the older frail patients and those with multiple comorbidities that were most affected by the universal pursuit of aggressive treatment targets. It is the vulnerable that require much more sensitive management with the need to balance different needs and risks. And we often find vulnerability in the patients who struggle to adapt to life with diabetes – those that may not engage well with diabetes care. In this edition of the journal we have some exemplar innovations that address many of these issues.

In the report from Shepherd, we hear about the important issue of patients with maturity onset diabetes of the young (MODY) and the role diabetes nurses can play in identifying these patients and ensuring appropriate care. These patients are vulnerable as they can receive inappropriate treatment that can be detrimental to their well-being. The report contains methods for identifying these patients and individually tailored treatments that will help ensure better care outcomes.

Another important vulnerable group of patients with diabetes are patients at the end of life. James's report highlights the need for a sensitive and, again, individualised approach to care management for these patients. At the end of life the challenge is to promote comfort and quality of life. The report gives diabetes nurses a framework to help them consider the needs of patients, relatives and carers through this difficult and vulnerable period during the different stages in end of life care. Again, we see that individualisation is important and that diabetes nurses should be taking a lead in maximising the quality of life in these patients and in symptom alleviation.

Young infants are by definition vulnerable. Having to manage a complex health problem like diabetes with a demanding technology such as an insulin pump can be very difficult for families. These families can feel vulnerable; this vulnerability is captured in the report from Forsner *et al.*, which highlights the needs of parents and infants with diabetes in relation to pump therapy.

We also have a report from Halkoaho *et al.* identifying the difficulties patients face in living with type 2 diabetes. The report illustrates that patients value a supportive approach with strong relational care and that, when health professionals promote their own agenda focusing on medications and lifestyle change, this can be alienating. This is, again, vulnerability: it is the vulnerability of the patient's interest in their diabetes and the belief that they can do things that will make a difference to their own health.

Vulnerability is also an important global issue. We include in this edition a report from the recent World Diabetes Congress in Melbourne at the end of last year. As you will read from Gill Hood's account, there are many significant international issues and developments in diabetes. At the global level, vulnerability is expressed in the disproportionate impact of diabetes on some populations. These populations are often in some of the poorest countries and communities, with limited resources to respond to effects of diabetes on the health of their citizens and on their economy.

Therefore, it is incumbent on us all to identify patients and carers who may have different levels of vulnerability in the context of a life with diabetes. It is equally important that we act to develop systems and strategies to ensure good care for all vulnerable patients. So, as we move toward individualised models of care, diabetes nurses need to develop sensitive and intelligent approaches to care. We hope the examples contained in this issue of the journal will provide you with some useful points of reference and that all-important inspiration.

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Reference

1. American Diabetes Association. Standards of Medical Care in Diabetes – 2014. *Diabetes Care* 2014;37(Suppl 1):S14–S80.