Implications of the patient with type 2 diabetes in self-management of the disease: a pendent challenge

Implicación del paciente con diabetes tipo 2 en el autocuidado de su enfermedad: un reto pendiente

D. Figuerola
Fundación Reserva Carrasco i Formiguera. Barcelona

We, the health professionals (HP) who see persons with diabetes know that, among the recommendations of the guidelines and the daily clinical practice, there is sometimes a great distance. Recent publications confirms what everybody knows but is not always recognized: the efficiency of the health system is very low in chronic diseases as the T2D, and the percentage of the patients who achieve all the foreseen objectives (weight, blood pressure, HbA\(_1c\), cholesterol, triglycerides, etc.) is almost anecdotal. Thus, in a relative biased sample (middle class, higher education, 45 minutes per visit, etc.) of patients with T2D seen at a specialized site as ours, one of each five smoke, the 55% show HbA\(_1c\) of more than 7%, half of the patients has a systolic blood pressure >135 mmHg, a third part shows LDL cholesterol values higher than 100 mg/dL, and a forth part does not take platelet anti-aggregants. The question is mandatory. If we count with the knowledge and resources to achieve the proposed clinical objectives, how can these results be explained? And especially, which are the steps we have to adopt to improve them?

The causes of the scarce compliance should be looked after in three aspects: the disease itself, the attitude of the patient and the attitude of the professional. The T2D is generally a silent disease and of long evolution, in which the patient rarely perceives an immediate benefit with the treatment. On many occasions, the “intensive” treatment gives place to discomforts that did not exist before, as for example the hypoglycemias. Moreover, the treatment is complex because it requires taking the medication scrupulously, to undergo a diet, perform self-analysis of the glucose, foresee and treat hypoglycemias, etc. Finally, and unlike the T1D, in which the sensitivity to the insulin is usually normal, in T2D there is an insulin resistance component whose pharmacology treatment has not been very effective. Though the recently incorporated drugs have improved the possibilities, the reality is that in cases of obese patients with long evolution T2D, to pretend an HbA\(_1c\) <7% is a very frustrating experience.

As regards to the patient, four factors determine preferably its adscription to the treatment, so for the patient to accept and persevere in the therapeutic the patient should: be persuaded that he suffers the disease; believe that the disease and its consequences might be serious for him, be convinced that the treatment might be beneficial and that the benefits compensate the possible side effects, as well as the social nuisances and the economic costs it entails. It is evident that the patients who believe that the treatment provides them many benefits, that the difficulties are not insurmountable and that they are aware of the seriousness of the disorder and of its vulnerability as regards it, would undergo the treatment better than the others. However, to know about the seriousness of the disease is not enough reason to change the attitudes, as fear might induce to negation (“It might happen, but not to me”) and the susceptibility to the treatment consequences might act negatively; for example, the probability of hypoglycemia due to insulin might induce some persons to keep insufficient doses. The knowledge and beliefs affect the treatment results and vice versa, so this dynamic interrelation indicates that the predictions of this model are changeable and dependent of particular circumstances, among which the education and the advices that the patient receives are included.

In view of the above, the follow-up of the therapeutic recommendations of any disease will improve if the HPs are able to:

- Transmit the conviction that the treatment reduces the complications.
- Help to get over the barriers that the patient perceives.
- Place themselves “by and in place of the patients” (empathy).
- Strengthen the belief that the consequences of the disease can be reduced.

The concept of locus of control is useful to explain a good part of the behavior mechanisms that generate the therapeutic compliance. Two polarities are considered: place of internal control and place of external control. The persons who have it external attribute the disease control to the chance and/or rely completely...
on the therapist or on the technology, and those who have it internal tend to be self-referential and believe that they are responsible. The persons with a place of internal control tend to achieve a better control of the disease. However, a place of fiercely internal control might entail an inadequate attitude, as in biology not all the results will depend on factors that might be controlled by the will. In any case, the control place is modifiable, and with cognitive-behavioral techniques we can achieve that the persons who believe that the destiny regulates their disease end up recognizing that they have a certain participation in the control process of their disorder. In any case, the lived experiences shall change the patient’s criterion, but never the speeches.

Most of the health professionals believe in the need of implementing educational therapy. However, in spite of the intellectual conviction and a relative favorable attitude, the reality is that we are far away from having a comprehensive medication assistance to treat biomedical and psychosocial aspects strictly. The behavior of the biomedical model is so deeply rooted in the society that sometimes the patients answer to the question “How is everything going? How are you?” putting the analysis on the table, without understanding that the question is an invitation to say how they feel and not a questioning about the HbA1c.

A biomedical formation addressed to the diagnosis and treatment of acute diseases as those the physicians keep on receiving basically is an inadequate background to approach the treatment of chronic diseases. Without a minimum training in psychology and pedagogy, the HPs will always feel fatigue, discouragement and frustration as regards to the diabetic patients, and the endocrinologists will divert their attention to the thyroids or hypophysis, while the internal physicians will focus on the collagen or the immunology. It is undoubtedly that either by genetic code or by personal training, some HPs have better skills as regards to communication with others and obtain better assistance results. The enthusiasm, the conviction about what they do, the use of humor and the imagination are, among others, some of the common characteristics among these persons. Moreover, it is proved that women are more efficient than men. However, medicine and education are not only art or charisma, but also science, so all the HPs might improve their skills in education of patients if they decide to.

In order to improve the efficiency of the health system through the involvement of the patient in his self-management, it is essential to re-formulate objectives and health strategies in depth, to form HPs in psychosocial disciplines and team work. Fortunately, individual barriers start breaking in many health sites, thanks to the incorporation of professionals in nursing, psychology, nutrition, podiatry, physical education, etc., which give a new dimension to the treatment of persons with diabetes, “diffusing” the professional profiles. It is a long way and it requires deep changes regarding to the training of health professionals and in the assistance structures. A real challenge that we expect to achieve in the future years. Undoubtedly, due to ethics reasons, but also to be more efficient.

Declaration of potential conflict of interest

D. Figuerola states that there are no conflicts of interest as regards to the content of this article.

References