Communication in diabetes care

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Introduction

The psychosocial domain of diabetes is as important as the biomedical aspects of the syndrome. This perspective traces the evolution of diabetes care model, describes the psychological morbidity of diabetes, enumerates management strategies, and supports readers in improving their communication skills.

Concept of Diabetes Care

Once upon a time, perhaps, medical practice was physician centric and eminence based. The physician decided treatment based upon his education and experience, and could not be challenged. This unipolar construct of health care gradually gave way to a patient-centered model, in which the patient's attitudes, wishes and needs were taken as the guiding principle of management.[1]

This concept has been integrated into modern diabetes care, which now proposes the practice of "responsible patient centered care". This model, which enumerates ten R's (Table-1), balances the biomedical and psychosocial needs of the patient, and the rights and responsibilities of both patient and physician.[2]

The health care dyad has also undergone a transformation in diabetology-Instead of two individuals, diabetes care is considered an interaction between patient, family and community on one hand, and the health care team and health care system on the other.[3] This concept has been presented as the 3x3 P rubric (Box-1).[4] These aspects of diabetes care are important not only because they are linked with communication, but also as they all influence health-related attitudes and outcomes.[5]

While this discussion may seem 'before its time' to readers in many countries, the concepts that we describe are age old and timeless. Thousands of years ago, the Indian physician Atreya described his quadruple. Atreya's quadruple stated that four constituents needed to be empowered and strengthened, in order to ensure optimal management. These are the patient, physician, drug and attendant. Each of these is further described as having four ideal characteristics. These form the four quadruplets of Atreya.[6] Thus, patient-centered care, team work and community/family involvement in medicine is ancient wisdom and practice.

Box-1: The 3 X 3 P rubric.

People	Professionals	Parallel players
Persons with diabetes	Physician	Policy makers (government)
Partner (family)	Paramedical professionals	Pharmaceuticals (drugs)
Public (society)	"Process' (health care system)	Payers (insurance)

Table-1: The Ten R's.

- Respect
- Responsiveness
- Restrain from self-harm
- Realistic approach
- Resource husbandry
- Relevance
- Reaching out
- Revision, when needed/anticipated
- Reflection

Diabetes Distress

Diabetes is marked by various psychological and psychiatric responses, some of which may be dysfunctional. Such morbidity is acknowledged by the bio psychosocial model of health,[7] and covered in modern management guidelines.[8,9]

The most common emotional response to diabetes, perhaps, is diabetes distress. Diabetes distress is defined as "an emotional response characterized by extreme apprehension, discomfort, or dejection, due to perceived inability in coping with the challenges and demands of living with diabetes".[10] Diabetes distress symptomatology is similar to that of depression but lacks the severity to be classified as major depressive disorder (MDD) according to DSM-5 criteria.

The treatment of diabetes distress is based upon communication, and is purely non-pharmacological in nature. As it does not meet the criteria for depression,

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anti-depressants or anxiolytics should not be prescribed. The diabetes distress management strategy is highly individualized, and varies according to patient needs, health care provider ability, and health care system policy. If not addressed in a timely manner, diabetes distress may impact overall health, and prevent attainment of therapeutic goals.

Communication Concepts

We suggest a few treatment strategies which are helpful in managing diabetes distress. The cornerstone of managing diabetes distress is 'Diabetes therapy by the ear'.[11] This construct includes the triptych of active listening (diagnosis), empathic expression (treatment), and filtering of irrational or inaccurate facts and misinformation. A mnemonic which paraphrases this is the 5 I strategy, which enjoins us to discuss potential sources of diabetes distress and explain management skills to patients (Table-2).[10]

Table-2: The 5 I Approach.

◆ Initiate discussion
◆ Identify source and degree of diabetes distress
◆ Inform means of minimizing diabetes distress
◆ Incorporate healthy coping skills
◆ Improve quality of diabetes care & support

Table-3: Coping skills training: AEIOU approach.

To enhance the coping skills of an individual, so as to help her/him deals with the stress of living with diabetes
◆ Assess coping skills
◆ Eliminate negative skills
◆ Internalize positive skills
◆ Observe on ongoing basis
◆ Understand & upgrade

Coping skills training is an important part of preventing and managing diabetes distress. This intervention is important for both patient and physician. The AEIOU framework provides a construct which facilitates coping skills training in the diabetes clinic (Table-3).[12] This can be used in conjunction with the Gluco Coper tool, which assesses coping skills, to help the patient live a confident life with diabetes.[10]

Polishing Physician Skills

The astute diabetes care provider needs to achieve, and maintain, proficiency in both biomedical and psychosocial spheres of medicine. It is relatively more challenging to learn "psychosocial" or communication and motivation skills. This section presents a few pedagogic tools that we have found helpful in explaining this concept.

Table-4: Attributes of a good physician: We CARE.

Confident competence
Authentic accessibility
Reciprocal respect
Expressive empathy
Straightforward simplicity

Table-5: WATERing the relationship: Method of communication.

Every interaction should proceed as per the following style:
Welcome warmly
Ask & assess
Tell truthfully
Explain with empathy
Reassure & return

Table-6: The 3 I approach.

◆ Motivation for acceptance of therapy; adherence to therapy
◆ Useful for injectable drugs
◆ I= inform (explain the pros and cons of proposed intervention; achieve information equipoise)
◆ I= incubate (allow patient time to contemplate)
◆ I= initiate (initiate planned intervention after ensuring shared decision making)

Table-7: Minimizing the discomfort of change.

1. Achieve concordance between felt needs and actual needs
2. Abbreviate bad news, and prolong pleasant news
3. Praise, and create pride
4. Allow contemplation of change
5. Give choice in change
6. Make change subtle, in small bits
7. Do not enforce change
8. End on a pleasant note

The basic foundations of a physician patient relationship is communication. This can be strengthened by careful and diligent practice. Tables-4, 5 and 6 highlight three mnemonics which list the attributes a good diabetologist should manage a conversation, and how she/he should proceed whenever she/he wishes to facilitate a major behavioural change.[13-15] Behavioural change is best achieved if it is broken into smaller steps. This helps reduce the discomfort of change as well (Table-7).[16]

Summary

This perspective does not seek to provide an overview of nonpharmacological management of diabetes and its

psychological morbidity. Rather, it offers a framework which helps the diabetes care professional link all possible interventions under a single umbrella. This single, and seemingly simple, concept that we suggest, is Communication.

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