

From Blame to Understanding: Moving Diabetes Care Forward

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Frequently, I am asked to speak to groups of primary care physicians about diabetes care. I often start by asking physicians what the biggest obstacle to better diabetes care is. For the last two decades, the invariable consensus has been: "My patients won't do what I tell them to do."

I have to admit that there are times when I feel this way myself. We all have patients with diabetes whose daily routines feature long periods of physical inactivity broken only by frequent binges of extreme dietary indiscretion. It is very easy to take on a parental role with such patients, blaming them in subtle or not-so-subtle ways for their poorly controlled diabetes.

However, when we select a parental role, assigning blame and judging behavior, we often do a disservice to the patient. We may become overinvolved, and the patient's problems of diabetes care may become our problems. As one patient told me in a moment of unusual candor, "I've been coming to you for 4 years now, and you still don't have my diabetes under good control." As often as we blame the patient, the patient may blame us. This same patient, after professing for years that she was strictly adherent to a diet recommended for diabetes care, confessed that she ate nearly an entire pumpkin pie every Sunday. "I didn't have the courage to tell you. I thought you would yell at me." I felt vindicated—the poor control *was* her fault, not mine. Nevertheless, the lack of open communication had been a significant obstacle to good diabetes care for many years, an outcome clearly detrimental to the patient.

In this issue of the *Journal*, Hunt and colleagues¹ provide a fascinating picture of how adults with diabetes cope with their disease and its treatment. The picture that emerges is one that has intuitive credibility to most primary care physicians: Patients with diabetes want nothing more, nor less, than the ability to lead normal lives. A great deal of "nonadherent" patient behavior is actually a creative, highly personalized attempt to limit the ways in which this bother-

some disease affects "normal" social, family, and work roles. How many of us without diabetes eat meals at the same time each day, are conscious of the caloric content and nutritional properties of nearly everything we consume, and consistently make healthy food choices? How many of us get 30 minutes a day of physical activity, regularly monitor and aggressively control all major cardiovascular risk factors, and rub lotion on our feet to reduce callus formation each night before we go to bed? How many of us, if asked, would cheerfully stick our fingers for blood 3 or 4 times a day, and inject medications subcutaneously multiple times a day in varying doses to respond to anticipated variation in food intake or physical activity?

When we see a patient with diabetes, we often reduce this saga of human experience, this cauldron of emotion and adventure, into a couple of yes or no questions. Have you been following your diet? Have you been checking your glucose and taking your shots? These questions effectively block an open and honest dialogue about diabetes and its care in a person's life.

A more effective use of visits with a diabetic patient may be to incrementally construct a picture of that particular patient's life.^{2,3} We can understand small successes and celebrate them with the patient. We can learn how the patient views diabetes, what is important in his or her life, how these areas intersect. What happened with your diabetes yesterday, or last Sunday, or the night when you got this particularly high or low glucose test at home? What are the most frustrating times for you with regard to your diabetes? What do you do when you go out to a restaurant? Have you told people at work that you have diabetes? What do your spouse or children think about your diabetes? Have any of your recent glucose readings surprised you? What did you suppose was going on?

Factors that are closely related to a patient's diabetes related behaviors include (1) whether the patient really believes that diabetes is a serious condition, (2) how positively (or negatively) the particular patient views his diabetes medications, and (3) the patient's fear of hypoglycemia.^{1,4} Engaging a

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patient in open and nonjudgmental dialogue that is directed toward these and other important concerns can help us understand patient behavior more completely, and guide our efforts to provide practical, behaviorally oriented information that patients can use.⁵

It is time to break the widespread but self-defeating clinical tradition of blaming patients for poor diabetes care. Instead, we should focus on our own behavior and the ways in which we can improve the diabetes care we deliver in the office and community. Recent reports indicate that improvements in the organization and treatment of diabetes in the last several years have steadily reduced the number of patients with Hb A_{1c} >10% and increased the proportion of patients with Hb A_{1c} <8% in some primary care settings. Part of the improvement is related to the more widespread use of registries and patient recall systems to monitor diabetes care,^{6,7} and part is because of more shared decision-making and dialogue with "activated" patients.⁸ Newer diabetes drugs, such as metformin, are less likely than sulfonylureas or insulin to cause hypoglycemia or weight gain, and are well suited for use with patients who are struggling to establish healthy exercise or eating habits (only use metformin if the serum creatinine level is <1.5 mg/dL).

There are other interventions that can help forestall the devastating macrovascular complications of diabetes. The blood pressure goal for patients with diabetes is <130/85 mm Hg, and ACE inhibitors are the preferred drug for initial treatment of hypertension in many adults with diabetes. The use of enteric-coated aspirin 325 mg once a day can substantially reduce the risk of cardiac events in adults with diabetes, and can be recommended in those without proliferative retinopathy or other contraindications to the use of aspirin. Use of statins to control elevated LDL cholesterol levels in diabetes patients with known coronary artery disease reduced cardiac events 57% and mortality about 25% in a recent randomized trial.⁹

Hunt et al¹ remind us that, in this era of rapid advances in the technology of diabetes care, our ultimate effectiveness as healers is as dependent on our ability to establish an effective emotional bond with our patients as it is related to our knowledge of physiology and pharmacokinetics. After a diagnosis of

diabetes, most patients progress through many degrees of denial before they ultimately come to grips with the seriousness of their diabetes. After this realization occurs, many patients are able to let go of their old normal life and develop a new normal life; one that accommodates the daily routines of diabetes care. During their long struggle with diabetes, patients need to know that we are familiar with the particulars of their lives, that we understand their problems, and that we will recognize and celebrate their successes, however small or transient they sometimes may seem.

The time has come to stop blaming patients for poor diabetes care. Instead, we can develop a shared problem-solving model of diabetes care that facilitates open and honest communication, increases our awareness of patients' struggles and strategies, and supports patients through the dark times of denial. For many of our patients, a new day will dawn. Many will successfully develop a new normal life that meets their personal needs for control—in all aspects of their lives. As we care for patients and help them through this difficult process, we are in a truly privileged position. We are given the opportunity to be both healer and comforter. May we have the wisdom to be both.

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