Editorial

Patient-centered care in diabetology: From eminence-based, to evidence-based, to end user-based medicine

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"Thus I have explained to you knowledge still more confidential. Deliberate on this fully, and then do what you wish to do."

Lord Krishna, speaking to Arjuna.
Bhagavad Gita 18.63

The term patient centered care (PCC) was used over two decades ago, by the Picker Institute to encourage health care professionals to shift focus from disease to patient.[1] The Institute of Medicine, taking this concept further, defined PCC as "care that is respectful of and responsive to individual patient preferences, needs, and values" and that ensures" that patient values guide all clinical decisions".[2] This definition has been quoted by the recently released diabetes management guidelines as well.[3]

While there has been broad acceptance of PCC in diabetes care earlier as well,[4] credit goes to the Diabetes Attitudes, Wishes and Needs (DAWN) movement,[5] and to the nomenclature of the current patient-centered diabetes guidelines[3] for generating global interest in diabetes-related PCC.

Many doubts arise regarding the versal applicability of PCC, however. Can physicians transfer all decision making to patients in the name of PCC? Do we abdicate all responsibility, when we move from evidence-based medicine to end user-based management? Do patients have a right to choose outcomes, and make clinical decisions to achieve those outcomes? Is PCC essential in every aspect of diabetes care? Is PCC appropriate for the Asian or African patient, who lives in a society with low literacy levels and suboptimal attitudes towards modern medical care? This editorial explores these grey areas.

Many of us initially learnt eminence-based medicine, which gradually gave way to evidence-based medicine (EBM). Did physicians, who shouldered all responsibility for patient wellbeing during the earlier era, then abdicate their duties to clinical trialists and statisticians? Or did their work increase, as they now had to ensure that eminence was concordant with evidence? Similarly, as we move from EBM to end-user based medicine or PCC, will our responsibility decline? Or will we have to meet enhanced expectations, as we work to augment diabetes literacy and numeracy in our patients, improve their communication skills, and ensure that they participate with equipoise in shared decision making (SDM)? Will we have to work harder, or work hardly, if we deal with patients empowered in the real sense of the word?

Do patients have a right to choose targets and outcomes, and make clinical decisions? Almost always, the patient does make the final decision. The doctor, at best, can suggest the best possible course of action, during a few-minute long consultation, but it is the patient who walks the talk. In situations in diabetology, which are potentially limb-, sight-, or organ-threatening, or life-threatening, however, the physician should assert charge, and ensure that appropriate medical decisions are made. Though this should not be done in an autocratic manner. An accelerated process of negotiation and motivation should be initiated, support enlisted from family, friends and paramedical staff, and a "finite" trial of appropriate therapy begun.[6]

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It would do no harm to remember that there are few medical conditions where we are actually sure there is only one correct method of treatment. It is safer, then, to practice SDM, a concept which has been highlighted earlier.[7] SDM is accepted in situations where different "reasonable" paths of action are available. It is the clinician's duty to offer all available options, along with their advantages and disadvantages. At the same time, the empowered patient shoulders responsibility for choosing the most suitable option. And here comes the catch: It is our responsibility to ensure that the patient is empowered and able to choose correctly.

Is PCC essential in every aspect of diabetes related decision making? PCC is certainly an essential part of diabetes care, and is mandatory if we are to achieve optimal results. However, in potentially limb-, sight-, organ-, or life-threatening situations, PCC may have limited applicability. Even then, respect for the patient's values must be maintained. The concept of PCC will continuously evolve to address these, and other, issues.

Is PCC appropriate for Asia and Africa? AfroAsian cultures tend to have a more holistic view of health and disease, and conflicting views about the etiology of diabetes. Hence, PCC assumes greater importance for us. The low level of literacy in some developing countries, however, is a serious challenge for PCC. PCC and patient empowerment[8] assume a basic level of diabetes literacy, and these should be strengthened by continuous efforts. A recent Australian example of collaboration between health educators and adult literacy teachers can show us the way.[9]

Is PCC the end of an evolutionary process in medical care, or a means to an end, viz., good diabetes care? PCC is an evolving concept, whose full prowess is yet to be harnessed. Other, expanded, concepts of PCC, are equally important from an AfroAsian perspective, considering the strong influence of family, community, and culture. Relationship centered care (RCC) is a framework which recognizes that the nature and quality of relationship between patient and provider needs to be given due importance.[10] The best insulin will not work if the patient does not trust the doctor. It becomes the physician's duty, therefore, to ensure a feeling of mutual trust, or reciprocal respect.[11]

Another relevant expansion of PCC is family-oriented care (FOC).[12] One should treat the family as a unit, rather than considering the individual patient: This helps ensure optimal lifestyle modification, provides an environment which accepts modern diabetes care, and most importantly, stresses upon diabetes prevention in unaffected family members. The community-oriented approach to diabetes is yet another useful concept for AfroAsian diabetology. The patient of diabetes lives not as an isolated entity, but as part of his or her community.[12] The responsiveness of an individual to the environment surrounding him (both physical and human), is termed as ecosensitivity.[6] Encouragement by the community members and opinion-makers like religious leaders is required to maintain any change in behavior.

Emphasis on family and community-oriented care is necessary if diabetology is to fully harness the advantages of PCC in AfroAsia. The impact of PCC can be strengthened if we work towards patient empowerment by improving individual, and community, diabetes literacy and diabetes numeracy. Enhancing patient communication skills also contributes to improving the quality of SDM.

At the same time, one should not forget the merits of EBM. It is EBM which has helped diabetology grow over the past few decades into a robust scientific discipline. Much more research, and debate, is required to ensure that EBM and end-user based medicine are able to work together, in a complementary, and effective, manner.

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