The Tongue is Mightier than the Sword

A large proportion of people living with diabetes are not able to meet their glycemic targets. Consequently, it is not uncommon for a physician to come across such a person in their practice. Often a few queries about their lifestyle reveal that they have not been able to do what they were advised to. One wonders why this person did not do what was obviously the best for him and his health. But in reality, our decisions and actions depend on a lot more than what rationality dictates.[1] Psychology, emotions, fears, biases, and priorities in each person's life determines their actions. Their behavior is the outcome of an interplay of complex factors, many of which may be beyond the realm of the physician.

So, what can you do as a physician? To begin with, understanding the difference between acute and chronic conditions is helpful. The traditional understanding of compliance is suitable for acute conditions where the treatment lasts for a short duration. Here, the responsibility of care can be borne by the treating doctor. In chronic conditions like diabetes, the responsibility of care rests in the hands of the person with diabetes. The treating doctor has limited control over the various lifestyle choices the person with diabetes will have in between the few clinic visits. Expecting the person with diabetes to follow instructions throughout the vagaries of life is, more often than not, too much to ask. While these concepts have been well known since decades, physicians continue their futile struggle with their patient with diabetes on the fundamentally flawed definitions of compliance.[2]

In this issue, Selvan *et al.* showcase how the physicians display their frustrations with seemingly "non-compliant" person with diabetes.[3] A majority of the physicians in this study communicated their displeasure as well as used scare tactics with people with diabetes who did not seem to take the necessary actions to control their blood glucose. A paternalistic and sometimes authoritarian approach towards a person with diabetes care was reported by a large number of physicians studied. While the actions of the physicians seem well intended, it is obvious that they are counter-intuitive. A person with diabetes who has not been able to follow the advised lifestyle modifications does not expect to meet a physician who is pleased with him. Similarly, most people with diabetes are already worried about the complications of diabetes from the very day of their diagnosis. A grim reminder of the same in the form of scare tactics, merely adds fuel to the fire. Literature indicates that the use of negative terms by the treating physician can lead to a disconnect between the doctor and the person with diabetes.[4,5] A healthy communication between the person with diabetes and healthcare provider improves diabetes self-management while scare tactics may be harmful.[6] A large percentage of people living with diabetes in India experience depression and poor quality of life.[7] Harsh words from their doctor may further negatively affect their mental health.

Selvan *et al.* also found that some physicians were practicing patient-centered approach---a finding which is encouraging. A person-centric approach has been advocated to improve patient outcomes.[8,9] Such approaches provide greater autonomy in the patient, thereby improving long-term adherence to treatments. For example, a major factor for medication adherence perceived by the patients is the ability to integrate the medications with their daily routine.[8] Such factors can be addressed by improving communication between the provider and the patients. Diabetes distress may reduce if reassurance and a well-articulated plan to control blood glucose is communicated to the patient.[10] Similarly, Selvan *et al.* noted that family centric approach was also being employed by some physicians.[3] A systematic review suggests that family interventions can improve diabetes outcomes.[11]

By keeping an open attitude, refraining from accusatory comments, and displaying empathy, the physician can improve patient reported outcomes. These factors may later on lead to improvement in hard outcomes such as glycemic control and lipid control.[12,13] In fact, physician empathy has shown to be associated with superior patient outcomes including HbA1c and LDL cholesterol values. Hojat *et al.*[14] have shown that patients being treated by physicians with greater empathy as measured by Jefferson Empathy Score, were likely to achieve HbA1c less than 7% as compared to those with lower empathy scores. In a prospective cohort study, risk of CVD events and all-cause mortality was lower in patients with diabetes who were treated by primary care practitioners with higher empathy scores.[15] Acute metabolic complications of diabetes also were found to occur less frequently in patients being treated by more empathetic physicians.[16]

Considering the benefits of empathy and good patient--physician communications, the integration of specific training in this regard at various levels in medical education is necessary. While some doctors may naturally be more empathetic and understanding of the patient's difficulties, other doctors can be taught that such a behaviour is beneficial not just in psychological respect but also in improving hard clinical endpoints. The National Medical Council (erstwhile Medical Council of India) has taken a step in this direction by including AETCOM (Attitude, Ethics, and Communications) modules to teach these soft skills to undergraduate medical students.[17] However, more work in this regard is required. Such modules should be incorporated not only into specialty and superspecialty courses but also in continuing medical education of the practicing doctors throughout the country.

In conclusion, life of a person living with diabetes is fraught with challenges. What such a person needs is a friend and a guide; not a judge or a critic. As a 15th century folk saying aptly puts:

'To cure sometimes, to relieve often, and to comfort always.' [18]

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