VIEW POINT

Perspectives on patient-centered care in diabetology

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ABSTRACT

Much has been written about patient-centered care (PCC) in medical literature. PCC has been praised as the ultimate objective of medicine by some. However, critics have pointed out the obvious: The antonym of PCC is doctor-centered medical care. Is doctor-centered care wrong? And what do we practice if we do not follow PCC? Can physicians transfer all responsibility for decision making to patients, in the name of PCC? Do patients have a right to choose outcomes, and make clinical decisions to achieve those outcomes? Most of the work on PCC has been done in the fields of family medicine and primary care. Minimal publications are available to highlight the role of PCC in endocrinology and diabetology. This brief communication discusses some concepts of PCC, and expands upon this term, to assess its relevance to diabetology.

Key Words: Diabetes, family-oriented care, patient-centered care, person-focused care, relationship-centered care, shared decision making

INTRODUCTION

Although the term patient-centered care (PCC) is of modern origin, the concept has been well known for centuries. The famous Ayurvedic physician, Atreya, describes his Quadruple, which postulates that the patient is an integral part of the four equally important "angles" required to achieve effective treatment.[1] The other three angles (which we prefer to term as "angels") mentioned by him are the physician, the drug, and the attendant (family member taking care of the patient).

The term client-centered therapy was introduced to psychology by Rogers, in 1946,[2] many centuries after Atreya expounded his Quadruple. In modern medicine, Balint was the first to use the term patient-centered medicine, in 1969. He suggested that each patient had to be understood as a unique human being.[3] Stewart *et al.*, working on the same concept, popularized a patient-centered interviewing method for history taking.[4]

In 1988, the term PCC was coined to encourage doctors and other healthcare professionals to shift focus from disease to patient. Eight characteristics of care were identified by the Picker Institute to indicate quality and safety of medical care, from a patient's point of view.[5] These include respect for the patient, coordinated and integrated care, information/education for patient/family, physical comfort, emotional support, involvement of family and friends, continuity, and access to care.

In USA, the Institute of Medicine 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."[6]

Many authors describe PCC based on the assumption that it is a valid framework for primary care or family medicine alone. The necessity of PCC in specialty practice, especially those concerned with chronic disease, is not highlighted adequately.

PCC AND DIABETES CARE: NATURAL HARMONY

Diabetes care seems to be a natural ally for PCC, tailor made for PCC to flourish in Diabetes is a lifestyle disorder, caused or exacerbated in part by patient-centered factors

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such as dietary indiscretion, lack of physical activity, and mental stress. No amount of drug therapy will be effective if the patient does not make a self-motivated, concerted effort to change his or her lifestyle.

Even for pharmacotherapy, it is the patient who finally decides whether to consult a particular healthcare provider, whether to adhere to the prescribed treatment, and to persist with therapy or not. This is especially true in pay-from-pocket markets, where the patient has the right to choose his or her physician.

In such a scenario, a patient-centered approach is absolutely necessary for diabetes management.

IS PCC ALWAYS CORRECT?

Is PCC a panacea for all clinical conditions and complications in diabetology? Is PCC essential in every aspect of diabetes care? Does the physician abrogate all rights and responsibilities to the patient in the name of PCC? And, does PCC give the patient a right to make unhealthy choices and decisions, and defend them as part of PCC?

At times, this dilemma appears minor. If a patient with secondary failure of dual combination oral hypoglycemia chooses triple oral therapy over insulin, this is "acceptable" use of PCC. At other times, there is no confusion regarding right or wrong, but as the physician's perception of immediate adverse effects is low, no fuss is created. A patient choosing to indulge in dietary indiscretion on a regular basis, for example, may hide behind the veneer of PCC. The doctor may choose not to create a major issue of this indiscretion, if he feels it does not constitute an immediate threat to health. There is a group of clinical situations, however, which may be organ-, limb-, sight-, or life-threatening, if appropriate therapeutic choices are not made, and not implemented, immediately. Laser therapy, insulin therapy, and surgery for foot ulcers are examples of these.

DRAWING THE LINE

Where do we draw the line? A physician usually suggests decisions based upon his/her estimate of severity of disease, while a patient chooses from these decisions based upon his idea of perceived severity of disease. A diabetologist, for example, may recommend amputation of a gangrenous toe, as it has a high index of severity. The patient, on the other hand, may think of it as "just a small painless black spot," expressing a low perceived index of severity.

The way to ensure optimal therapeutic outcome is by ensuring concordance between physician and patient. This can be done if similarity is achieved between the physician's index of severity and the patient's index of perceived severity. This, in turn, is possible only if patient and physician communicate well with each other, and patients are not only empowered,[7] but educated as well. The concepts of diabetes literacy and diabetes numeracy come into play here.

PCC is of no value unless patients are actually empowered to take "correct" or responsible decisions. PCC and patient empowerment[7] assume a basic level of diabetes literacy and numeracy, which is distinct from educational level and general literacy. Health literacy is the ability to understand health information and to use that information to make good decisions about one's health and medical care.[8] Extending this concept to diabetes, one may define diabetes literacy as—The ability to understand and utilize information related to diabetes, so as to achieve optimal health. Similarly, health numeracy is defined as the individual-level skills needed to understand and use quantitative health information, including basic computation skills, ability to use information in documents and non-text formats such as graphs, and ability to communicate orally.[9] Diabetes numeracy, in practical terms, will mean the ability of a patient to understand his objective reports (including self monitoring of glucose, HbAIc, and other laboratory results), and seek/accept/initiate appropriate action in order to optimize them.

RESOLUTION OF CONFLICT

PCC is a basis upon which one can make the right decisions in diabetes care. As diabetes is a chronic disease, patients often tend to develop close relationships with their service providers. This emotional bonding is quite common in eastern cultures, and contributes to the success of the patient-physician pair in achieving pre-set therapeutic goals.

A concept which has been highlighted in earlier medical literature,[10] but not adequately in endocrine journals,[11] is that of shared decision making (SDM). SDM is accepted in the majority of medical situations where different "reasonable" paths of action are available. It is the clinician's duty to offer various available options, along with their advantages and disadvantages. At the same time, the empowered patient shoulder responsibility for choosing the therapeutic option about which suits him best.

In situations in diabetology, which are potentially limb-, sight-, or organ-threatening, or life-threatening, the physician should assert charge and ensure that appropriate medical decisions are made. However, this should not be done in an autocratic manner. An accelerated process of negotiation and motivation should be started, support

enlisted from family, friends, and paramedical staff, and a "finite" trial of appropriate therapy begun. In clinical scenarios where there is no immediate, major threat to life, one can proceed in a slower manner. The patient should be encouraged to participate actively in decision making, no matter what the scenario is. If the patient is cognitively challenged, his or her family should be involved in SDM.

EXPANSION OF PCC

Other aspects of medical care, such relationship-centered approach, and person-specific care, also deserve mention in this context. These frameworks do not seek to replace, but rather to strengthen and complement PCC. In doing so, these concepts hold out the real possibility of improving the quality of diabetes care that we practice.

RCC is a framework which recognizes that the nature and quality of relationship between patient and provider needs to be given due importance.[12] The best of treatment will not work, at least in diabetes care, if the patient does not trust the prescriber. Conversely, the physician will not be able to deliver his or her best if he or she is uncomfortable with the patient, or develops antipathy or apathy toward him.

Focusing upon relationship building and strengthening is equally important in diabetology as is PCC.

Person-focused care is another concept particularly suited to chronic diseases such as diabetes. PFC views the patient not in terms of single OPD visits, but as a person who needs long-term care.[13] PFC is a concept which challenges diabetologists to recognize, document, and try to improve patient's problems, rather than diagnoses. Just as biomedical science recognizes the natural history of diabetes, and we appreciate the dynamic nature of the disorder, PFC underscores the variability that can occur across time. It makes the physician view chronic disease management as a chronic or long-term process; with its own dynamism, PFC will vary both from patient to patient (inter-patient variation) as well as within the same individual, from time to time (intra-patient variation).

A natural extension of PFC, at least in eastern cultures, will be what we term family-oriented care. The family has been recognized as a major influence on childhood diabetes.[14] However, this is true for adult diabetes as well. Supportive stimuli from the family to maintain a healthy lifestyle and healthcare-related behavior go a long way in achieving good glycemic control. Resistances to insulin or unwillingness to cooperate in ensuring a healthy diet are some examples of a potentially disruptive influence of family on diabetes care.

Another framework that we propose is community-oriented approach. The patient of diabetes lives not as an isolated entity, but as part of his or her community. The community can have an important impact on diabetes care. The responsiveness of an individual to the environment surrounding him (both physical and human) is termed as eco-sensitivity. As the person with diabetes spends just a miniscule part of his life with the healthcare provider, our suggestions and advice may not hold water in face of resistance from the community. Encouragement by the community members and opinion made by religious leaders is necessary to maintain any change in behavior. This is equally true for behavior related to lifestyle (diet, physical activity, stress) and to healthcare (acceptance of glucose monitoring, acceptance of injectable therapy).

CONCLUSION

PCC is certainly an essential part of diabetes care, and is mandatory if we are to achieve optimal results. However, there may be certain clinical situations where PCC has certain limitations. There include case scenarios which are potentially limb-, sight-, organ-, or life-threatening. However, the concept of PCC has evolved to address these and other issues as well. The impact of PCC can be strengthened if we work toward patient empowerment by improving individual, and community, diabetes literacy and diabetes numeracy. Steps to enhance patient communication skills also contribute to improving the quality of SDM. In cases of diabetes which are "severe," an accelerated SDM model is suggested, which is more appropriate. Emphasis on RCC and PFC, as well as family and community-oriented care, is necessary if diabetology is to fully harness the advantages of PCC.

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