Created by South African experts this unique, interactive learning programme will help you to successfully initiate insulin therapy in your patients with diabetes and to confidently manage their continuing care.

What you will gain…

Participation in this fully accredited CPD programme gives you the opportunity to learn how:

- Appropriate selection of patients for insulin therapy can significantly improve prognosis;
- Insulin can be easily and safely initiated by understanding and applying some simple steps; and
- To select the right insulin for the right patient at the right time

How you will learn…

START offers you the opportunity to freely obtain CPD points

- **e-based learning** in five modules – each module earns 3 CPD points
- **Watch** accompanying advice and tips from South African experts
- **Download** practical materials supporting you and your patients when you initiate insulin

Expert panel

Dr Adri Kok
Physician
Johannesburg

President of the International Society of Internal Medicine

Dr Bukiwe Peya
Specialist Physician & Endocrinologist
Alberton

Dr Sundeep Ruder
Endocrinologist
Life Fourways Hospital
Johannesburg

Prof David Segal
Endocrinologist
Wits Donald Gordon Medical Centre
Johannesburg

Dr Zane Stevens
Endocrinologist
Christiaan Barnard Hospital
Cape Town

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Module editor

Dr Sundeep Ruder
Endocrinologist
Life Fourways Hospital

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Module 5: Making patients partners in their care

Objectives of this module

- To provide key clinical messages and tips from expert clinicians that are practical and easy to introduce in daily practice

Patient doctor partnerships are not new

Around 400BC in Cos, Hippocrates opened a medical school addressing not only the empirical treatment of patients, but also a code of practice that puts the patient's needs first.[1] His school identified a moral and personal code of conduct required of the clinician to act in a patient's best interest first.

Centuries later, Galen blended empiricism with a philosophy which distinguished *this patient* from the disease as exhibited in the individual. While much of his writing is lost, what has been widely retained is the concept of the Art of Medicine which consists of three things: *The disease, the patient and the physician*. The physician is the servant of the art and the patient must combat the disease along with the physician.

The obligation of the physician is to use evidence-based medicine (EBM) and apply this practice ethically in terms of the four principles of beneficence, non-maleficence, justice and autonomy (Table 1).

Table 1. Foundation principles of ethical clinical practice

Autonomy	Respect patient's choices → consent
Beneficence	Act in patient's best interest → duty of care
Non-maleficence	Do no harm → duty of care Interventions should have more benefit than risk
Justice	Treat patients similarly Distribute care evenly/fairly

What is the role of EBM in patient-centred care?

Science is of absolute importance in medicine, and its practice and EBM are essential to clinical decision-making and promoting high-value individualised patient care. In the words of a founding father of EBM, the late David Sackett, EBM is the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Figure 1).[2,3]

The autonomy of the patient, as an ethical principle, defines the patient's freedom to choose. This depends on the individual's ability to self-reflect, deliberate on the issue with the attending clinician, and understand the risks and benefits in developing their individual preference.

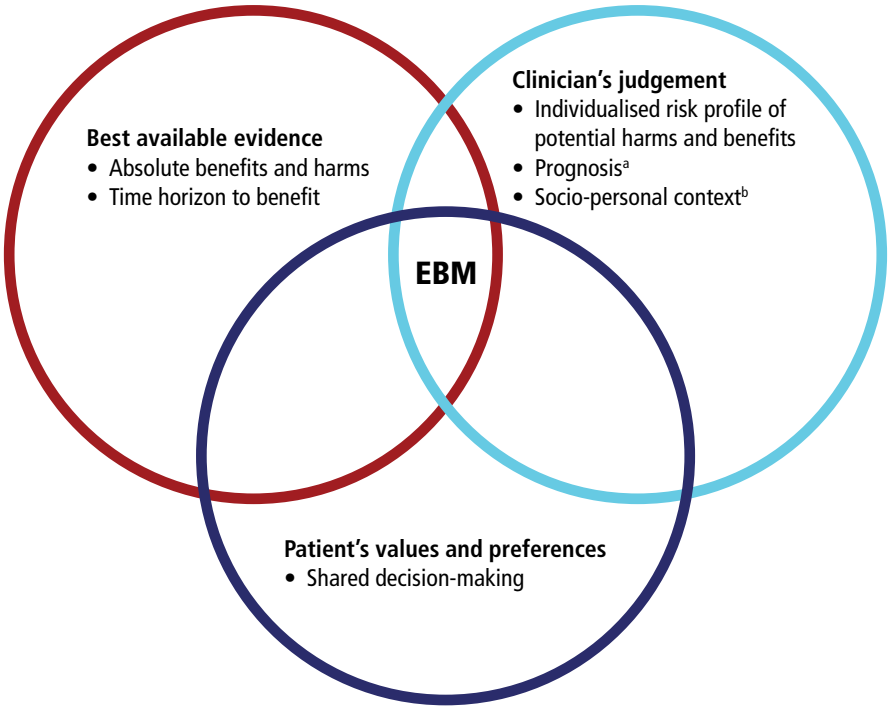
Other modules

Module 1
To explain when insulin use is appropriate and essential

Module 2
To provide clinical guidance on insulin choice in South Africa

Module 3
To support clinicians and build confidence in initiating insulin and intensifying therapy

Module 4
To provide tools and guidance in the effective use of patient-centred insulin regimens



[a]Prognosis e.g. age, comorbidities and functional status
[b]Socio-personal context should include lifestyle, social support and workload capacity, purpose and goals in life

Figure 1. EBM is a composite of evidence, judgement and values[2]

What is patient-centred care?

Patient-centred care has a wide, intuitive appeal and is perhaps a reaction to a perceived or real overemphasis on data and technology in modern medicine.

Harvey Picker, in the early 2000s, was instrumental in developing a patient-centred approach to healthcare in the United States. The dimensions have been defined as follows (Figure 2):[4]

1. Respect for patient's preferences, values and expressed needs
2. Co-ordination and integration of care and services
3. Information, education and communication
4. Physical comfort
5. Emotional support
6. Involvement of family and close others
7. Continuity and transition from hospital to home
8. Access to care and services

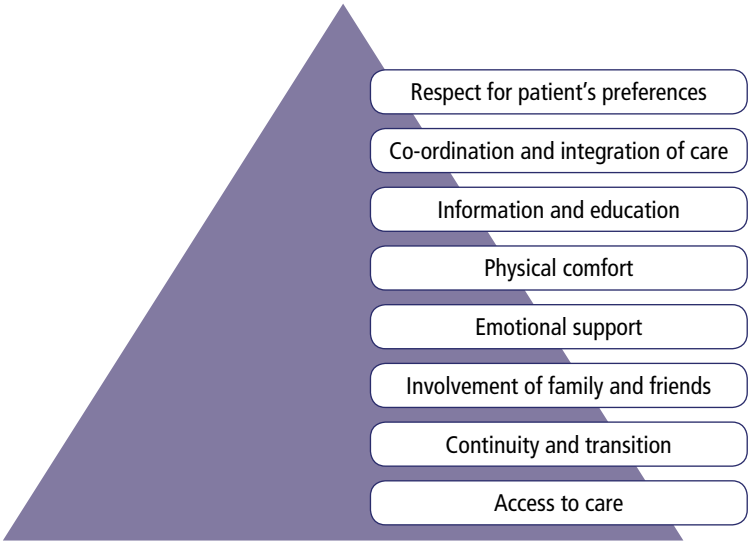


Figure 2. Picker's eight principles of patient-centred care[4]

How to develop shared decision-making in daily practice?

Shared decision-making need not result in a lengthy consultation, but it does require the clinician to develop the art of communicating through proper questioning and listening to the patient's views. It is a balancing act where the roles of physician and patient meet to develop a strategy (Figure 3).

What are the stages of the shared decision-making process?

It is useful to keep the four stages of the shared decision-making process in mind when consulting:[5]

1. A two-way exchange between clinician and patient
   The physician communicates the suitable treatment options, detailing potential risks and benefits of each, in a simple manner. The patient communicates their values and preferences.
2. Deliberation on this information
   The physician and patient discuss the possible outcomes, their values and preferences.
3. Selection of an option that is consistent with the values and preferences of the patient
4. Time taken to review this decision
   This occurs both immediately after the initial decision is made and at future points and times of consultation.

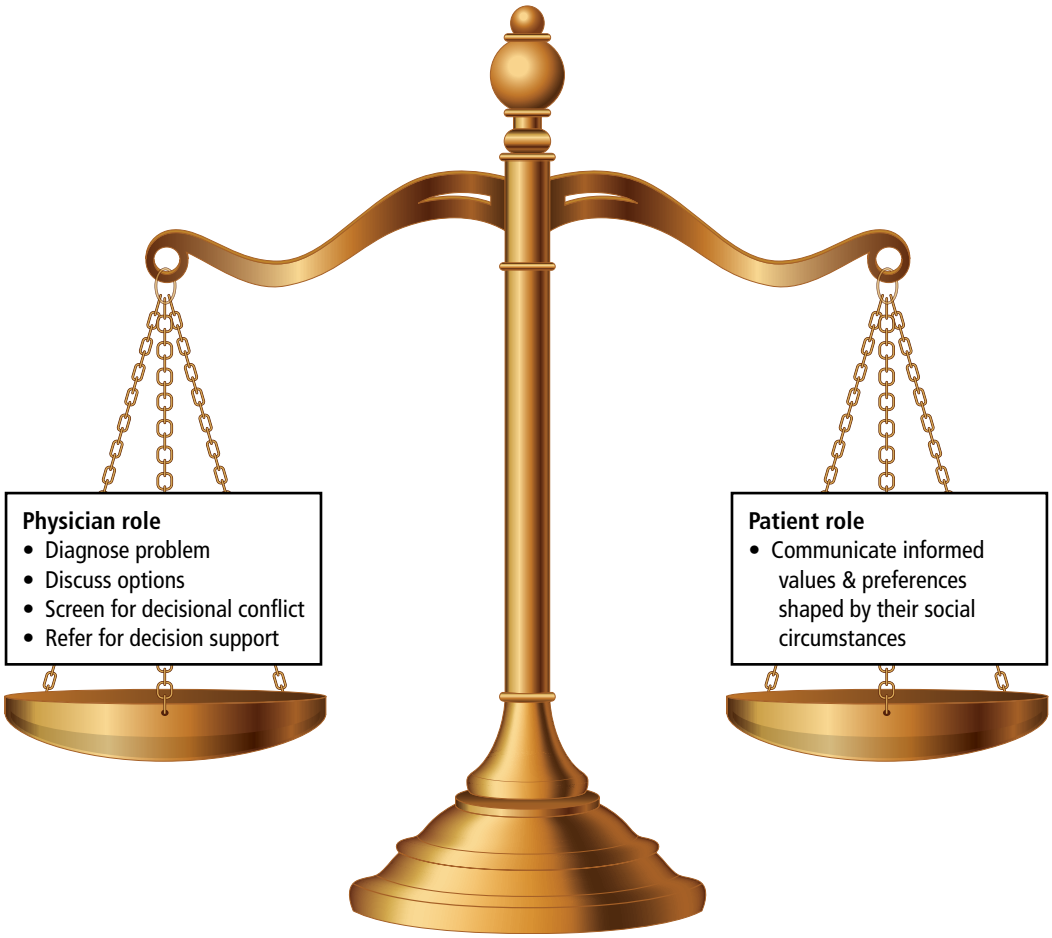


Figure 3. Shared decision-making process

Patient-centred care and insulin treatment – three scenarios

Dealing with fear and anxiety at initiation

To assist patients in alleviating fear and anxiety around taking or administering insulin, the first step is to help them understand the necessity of insulin to maintaining life. If an ultimate benefit and minimal risk are apparent to the patient, this logic already reduces, to some extent, fear and anxiety. In this context, other fears and anxieties about injecting and adverse events can be addressed, reassuring the patient that technologies exist that minimise or subvert these concerns.

It is useful to relate the experiences of other patients who had similar perceptions but are now managing their insulin very well; that many of them report that administering insulin is less painful than pricking yourself deeply on the finger. This encourages the patient to try, and their confidence increases as they gain experience.

Some fears and anxieties may not be centred on the direct administration of insulin. 'Herd fear', another barrier that needs to be addressed, is where a diabetic family member may have experienced complications when initiating insulin that has been perceived to have been caused by the insulin – "When he started insulin, he had a heart attack". It is necessary to educate the patient on the long-term complications of diabetes, which is high-risk condition for a cardiovascular event in patients with poor glycaemic control. In the example of the family member, insulin was probably prescribed to minimise this cardiovascular risk.

To help the patient understand and allay their particular fear, we have to ask patients about why it is that they have this specific fear, as it may be underpinned by nonsensical or illogical thought processes and misinformation.

Avoiding hypoglycaemia

It is very important to coach patients on the range of mild, moderate and severe symptoms of hypoglycaemia. Ask patients 'Have you understood what I've said?', and sometimes it's also okay to ask them to explain it back to you; this is a good technique for keeping their attention and focus during the conversation, and to recognise gaps in their understanding. Remember, education and awareness is fundamental to shared decision-making about treatment of choice.

Other important factors for consideration are the type of device being used, and funding issues and cost benefits. Educate the patient on each of your proposed options and the very minimal risk of hypoglycaemia at initiation and intensification of insulin therapy, if the circumstances are ideal. In the absence of this education and without preparing the patient for what to expect, that risk of hypoglycaemia goes up. The outcome will be determined by this individualised approach.

At intensification of insulin therapy

Intensification of insulin treatment, be it an increase in dose or number of injections or the addition of a prandial, can instil fear in the patient that perhaps their disease is worsening; 'Am I in a bad state? How am I going to cope with this injection burden? How many times am I going to have to monitor? Are we not winning?'.

This is an opportunity to, once again, coach patients on the lifestyle aspects of diabetes and its management. The need for insulin intensification can be minimised by maintaining positive lifestyle choices in diet, exercise, sleep and stress management, among others.

This is also an opportunity to explain that intensification is necessary when a certain target has not been met and this may be due to disease progression, which often happens in type 2 diabetes. Explain that the β-cells may no longer have the capacity or reserve to continue producing insulin at the level that is needed.

When the patient has been educated on the various aspects of diabetic disease in the months or years before insulin intensification is necessary, they are pre-prepared for this scenario and this facilitates ease of discussion on the implications of failure to achieve target HbA_{1c} and addressing not just fasting plasma glucose, but prandial glucose as well. Intensification options and available pen and glucose monitoring technologies must be discussed. Generally, patients are quite receptive to this kind of approach.

Benefits of patient-centred care

Patient-centred care inspires active patients. When patients understand their disease, they start taking care of their health. These patients are also calmer and more confident, showing improved adherence and compliance with resultant improvement in the cardiometabolic parameters of blood pressure, weight, HbA_{1c} and lipograms, and thus outcomes.

Overall, the entire patient-centred experience leads to better outcomes from every avenue. It leads, in the long term, to less expenditure on unnecessary repeat investigations arising from individual needs that have not initially been addressed, reduces side effects and reduces the need for multiple referrals. Although a lot of discussion is required initially, "hard work now pays off later… It's a 'poison now, nectar later' approach, but if we go for the easy 'nectar now' instant gratification approach, it becomes 'poison' and more difficult later."

Conclusion and key learning points

The key learning points of this programme are that it's important, as clinicians, to:

1. Understand, in the context of diabetes beyond cardiometabolic parameters only, the patient's needs in terms of their value systems and goals
2. Learn the art of communicating, through proper questioning and the ability to listen to where those needs are
3. Incorporate diabetes care in an individualised way to meet specific needs, rather than in a linear algorithmic manner, so that the patient encounter becomes more organic
4. Communicate and educate in a manner that the patient is receptive to, in a language and a culture that they understand, and invite the patient to critically think around the subject
5. Ask questions rather than using prescriptive education. Encourage the patient to consider a subject, because when they think about it, it becomes their own lived experience. To give knowledge is one thing, but for it to metamorphose into wisdom requires questioning and reflection. This is a very important aspect the clinician can bring into the consult.

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Module 5

Making patients partners in their care

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1. The principle of acting in the patient's best interests first as a moral code of conduct required of a clinician was described by:

☐ **A** Hippocrates ☐ **B** Galen ☐ **C** Sackett

2. The philosophy of distinguishing 'this patient' from the disease as exhibited in the individual was described by:

☐ **A** Hippocrates ☐ **B** Galen ☐ **C** Sackett

3. Which of the listed ethical principles oblige the physician to practice EBM?

☐ **A** Beneficence ☐ **B** Non-maleficence ☐ **C** Justice
☐ **D** Autonomy ☐ **E** All the above ☐ **F** A and C

4. EBM is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

☐ **A** True ☐ **B** False

5. Which statement is false? EBM is:

☐ **A** Essential to clinical decision-making
☐ **B** Essential to promoting high-value individualised care
☐ **C** Necessary only to substantiate clinical judgement

6. Eight principles of patient-centred care have been designed by:

☐ **A** Sackett ☐ **B** Picker ☐ **C** Galen

7. Which statement regarding the principles of patient-centred care is true?

☐ **A** Respect for patients' preferences, values and expressed needs are more significant than access to care and services
☐ **B** Information, education and communication with the patient is more important than the involvement of family and friends

8. Shared decision-making for a suitable treatment option should focus on:

☐ **A** EBM for best outcomes ☐ **B** Patient values and preferences ☐ **C** A and B

9. The most important step to alleviating the patient's anxiety and fear of administering insulin is:

☐ **A** To reassure that pen technologies exist to minimise the pain
☐ **B** To ensure they understand the necessity of insulin to maintaining life
☐ **C** To explain that long-term complications of diabetes disease are not caused by insulin

10. Education about diabetes disease progression is sufficient to allay all fears patients may associate with insulin administration.

☐ **A** True ☐ **B** False

11. Strategies to avoid hypoglycaemia include:

☐ **A** Coaching patients on the range of mild, moderate and severe symptoms ☐ **B** The type of device being used
☐ **C** Cost benefits ☐ **D** All the above
☐ **E** A and B

12. The patient may be resistant to insulin intensification because of:

☐ **A** Fears that their disease is worsening ☐ **B** The cost of increasing the dose
☐ **C** Increasing the number of injections ☐ **D** All the above
☐ **E** A and C

13. The need for insulin intensification can be minimised by maintaining positive lifestyle choices in diet, exercise, sleep and stress management.

☐ **A** True ☐ **B** False

14. Which statement regarding patient-centred care is false?

☐ **A** Improved adherence and compliance, with improved cardiometabolic parameters
☐ **B** Increased expenditure is outweighed by improved outcomes

15. Central to patient-centred care, the clinician needs to learn the art of communicating through proper questioning and the ability to listen to where those needs are.

☐ **A** True ☐ **B** False