

## Brief Communication

# The ADA-EASD patient-centered guidelines for management of hyperglycemia: Are they patient-centered enough?

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### A B S T R A C T

**Background:** The American diabetes association (ADA) and European association for the study of diabetes (EASD) recently issued an updated position statement on the management of hyperglycemia in type 2 diabetes. The choice of nomenclature of these guidelines is refreshing as it highlights a patient-centered approach to managing diabetes.

**Discussion:** This debate looks at these guidelines through the prism of patient-centeredness, it tries to assess if the authors of the ADA-EASD position statement have been able to “walk the talk” with respect to the patient-centered approach that they advocate.

**Conclusion:** We conclude that the guidelines can be made more patient-centered, by emphasizing psychosocial and psychiatric comorbidity of diabetes, ethno pharmacy, and patient-friendly insulin regimes and oral fixed dose combinations, in a culturally competent, globally acceptable manner.

**Key words:** Basal insulin, cultural competence, diabetes, patient-centered care, premixed insulin, shared decision making

## INTRODUCTION

The American diabetes association and European association for the study of diabetes (ADA-EASD) position statement<sup>[1]</sup> chooses the definition of the Institute of Medicine, which describes patient-centered care (PCC) as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”<sup>[2]</sup>

The following words should be noted: Respect, responsive (ness), preferences, needs, values, guide (ance). These characteristics can be used to determine the “patient-centeredness” of the guidelines.

This debate discusses whether the ADA-EASD position statement lives up to its claim of being a patient centered guideline.

## DISCUSSION

### Initial sections

The guidelines begin with a definition of PCC, and the rationale for applying PCC to type 2 diabetes cares. They touch the concepts of patient involvement, decision aids, shared decision making, and adherence. In this section, the authors seem to follow PCC in letter and spirit.

The guidelines then discuss epidemiology and impact of type 2 diabetes the relationship of glycemic control to outcomes, and the pathogenesis of diabetes.

While the medical impact is mentioned, including “serious psychiatric illness,” no effort is made to describe the psychological and psychosocial effects of diabetes. No mention is made of the potential impact of on psychiatric conditions such as depression.<sup>[3]</sup>

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The guidelines present an exhaustive “biomedical” view of the pathogenesis of diabetes, but omit the autonomic nervous system and “stress” from discussion.<sup>[4]</sup> The background also neglects patient-centric factors which contribute to the diabetes pandemic, viz, diet, physical inactivity and life-style.

The section does, however, end by stating “type 2 diabetes – is heterogeneous – a point to be considered when determining the optimal therapeutic strategy for individual patients.”

The guidelines use ADA’s recommendations of HbA1c as a benchmark.<sup>[5]</sup> Patient desires and values, and availability of resources and support systems are highlighted as factors to help in deciding individual targets. The scale proposed by Ismail-Beigi<sup>[6]</sup> is utilized to facilitate PCC.

### Therapeutic options

Life-style is unique for each patient. While guidelines recommend “standardized general diabetes education,” they promote “personalized” diet, and highlight encouraging consumption of foods consistent with an individual’s preference and culture. They emphasize: “Health-care team should remain non-judgmental.” They give a choice to start lifestyle change alone, or life-style modification along with metformin, and practice PCC by suggesting physical activity based on mobility and age.

The guidelines strongly suggest that “agent- and patient-specific properties, such as dosing frequency, side-effect profiles, cost and other benefits” be used to guide selection.

The guidelines write that “an insulin treatment program should be designed specifically for an individual patient,” and ask for a “balance with the convenience of the regime.” Thus far, the guidelines remain patient-centered.

While discussing the choice of anti-diabetic drugs, they mention “specific patient preferences should play a major role in drug selection.” However, it appears to be a strong bias which makes them conclude that alpha-glucosidase inhibitors are “less attractive candidates?” In Asia, these drugs are commonly used as well as “attractive.” The efficacy and good side effect of both acarbose and voglibose is well documented in diverse ethnic populations.<sup>[7]</sup>

While discussing intensification to dual combination therapy, the guidelines reiterate “advantages and disadvantages of specific drugs for each patient should be considered.” However, there is no mention of fixed dose combinations (FDCs). At this stage, the guidelines

begin to display a concern for resource-limited settings, encouraging less expensive agents, while cautioning about cost implications of mandatory monitoring and side effects.

While intensifying to triple combination, physicians are reminded that “rationale, benefits, and side-effects of each new medication should be discussed with the patient.”

It is while discussing transition to, and titration of insulin, however, that a major deviation from the principles of PCC is made. The guidelines describe pre-mixed insulin as being “perhaps more convenient but less adaptable,” while in practice, its titration is more patient-friendly than that of basal insulin. Titrating the dose of basal insulin to achieve normal HbA1c is difficult, as it is difficult to manage prandial glycemia with this insulin.<sup>[8]</sup>

The guidelines mention a twice daily regime for premixed insulin, while it can actually be given once or thrice daily as well.<sup>[9,10]</sup> The authors feel that premixed insulin is “somewhat inflexible,” while in reality it is a flexible method of managing basal and postprandial glycemia with minimal injections.

They also go on to say that premixed insulin is “appropriate for certain patients who eat regularly.” A majority of diabetic patients do eat regularly.

In a back handed compliment of sorts for Asia – perhaps Asians eat regularly, hence the most commonly prescribed insulin is premixed insulin in Asia!

In this section, the authors seem to lose respect for, and responsiveness to, patients.

They also fail to convey a globally acceptable or culturally competent attitude toward diabetes therapy.

The guidelines mention impact of age, life expectancy, weight and comorbid conditions on drug choice. The use of racial, ethnic and genetic features in deciding optimal therapy is described as “being in its infancy.” While this may partly be true, the authors have chosen not to look at data which suggest greater postprandial hyperglycemia, and better outcomes with premixed insulin<sup>[9,11]</sup> in Asian subjects. Such ethnopharmaceutic research must be encouraged as part of patient- or community-oriented care.

The guidelines encourage research related to costs, patient related outcomes, pharmacogenetics, and patient-based drug choice. They conclude with a comforting remark “Informed judgment and the expertise of experienced clinicians will therefore, always be necessary.”

## CONCLUSION

The current guidelines for management of type 2 diabetes are a strong statement in favor of patient-centered approach. The guidelines remind us of our enhanced responsibility in choosing the “right” therapy for each patient, in a patient-centered manner, without relying on “dictatorial” algorithms.

At the same time, this approach increases the burden on authors to think, write, and act in a patient-friendly manner, while framing guidelines. A revised version should have more emphasis on psychosocial and psychiatric comorbidity of diabetes, on emerging data related to ethnopharmacy, and on patient-friendly insulin regimes and oral FDCs. A more culturally competent guideline, framed in a globally acceptable manner, will live up to the objectives of PCC.

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