



## BRIEF REPORT

# Barriers to Self-Care among Diabetic Patients and Ways to Recognize and Address

Faris Matloub, MD\*

Consultant Family Physician, Department of Primary Health Care, Dubai Health Authority, United Arab Emirates

\*Corresponding author: Faris Matloub, M.D, Consultant Family Physician, Department of Primary Health Care, Dubai Health Authority, United Arab Emirates



## Introduction

Diabetes is an irreversible syndrome that has many complications. Although patients can lead a reasonably normal lifestyle, its late complications can reduce life expectancy and cause major financial burden. These include macrovascular conditions, leading to an increased prevalence of coronary artery disease, peripheral vascular disease, and stroke, in addition to microvascular damage which negatively affect the quality of life causing retinopathy, nephropathy and neuropathy.

Newly diagnosed diabetics are advised to quickly adopt healthier lifestyle changes in their diet and daily exercise routines to optimize their blood glucose readings, however, in daily practice physicians encounter plenty of barriers to care which exert real challenges can hinder compliance with the medical and nutritional advices given which in the healthcare provider as well as the patient role are paramount. Identifying these barriers is essential to empower patient and improve commitment to the management plans.

## Diet

One of the biggest troubles encountered in daily practice is lack of knowledge and understanding of the meal plan. It is interesting to know that these barriers are common in most parts of the world [1]. Most of the food ingested by local people in the Arab Gulf, where I practiced for 20 years is carbohydrate-rich diet where rice, bread and sweetly food are the standard.

We address this point by booking all diabetics to sit for 30 minutes with a “nutritionist/dietician” at time of

diagnosis, and annually afterward. Glycemic index of commonly consumed food items is discussed along with example of healthy choices for the 3 daily meals/snacks using visual aids, written material and demonstrations. Since the physician words have a considerable impact, we take few minutes each consultation thereafter to emphasize some healthy nutritional tips. The clinic conducts several diabetes-related activities during the year where food and nutrition are discussed and some “myths” get rectified.

## Lack of Information

Lack of understanding of information and a plan of care is an important barrier faced in facilitating self-care behaviors among diabetics. Many patients we attend thinking that having their medicine regularly is all what they need to do and ignore the necessity for other duties as routine aerobic exercise program and maintaining weight within desirable limits.

Others, they do not know the importance of HbA1C, LDL, micro-albuminuria and why we, physicians are chasing these parameters to their corresponding target levels. They often got frustrated from inability to achieve glycemic, blood pressure or lipid control.

Few others do not understand importance of insulin, body fat and, triglycerides and so on.

Our main helper in this respect comes from our colleagues, “Certified diabetes/health educators”. We book the patient to sit with them at least once a year; plus other information we – as clinicians- provide during visits. We are assisted by diabetes case managers, who

provide verbal and written information in the form of simplified colored pamphlets and educational handouts that remind patients while at home. We also support participating in group education that encourages questions and discussion of feelings and fears.

### Continuity of Care

In the Arab Gulf region, most of the diabetic services are provided at the primary care. There is an important task to build a trusting doctor-patient relationship whereby patients come not only in cases of sickness and emergency situations but on regular health promoting visits, to do blood work regularly, renew and review medications, get flu vaccines and referrals to hospital when needed. This is in consistence with many other areas of the world where the most common deciding factor that made patients visit their doctor for follow-up care was for an emergency followed by an appointment scheduled by the primary care physician [2].

There is another barrier represented by the uncoordinated care between primary care provider and the hospital. Lack of information, feedback and duplication of lab, medications and procedure were noticed which could be annoying and bothersome for the patient.

We overcome that with the e-Referral between primary care and hospital doctors. This was enhanced by providing complete data and proper documentation of the interaction, which preserve advantages such as rapid response, case-based education, building of relationships between PCPs and specialists, identification of cases that require formal consultation, and the patient convenience and cost savings associated with avoiding a visit.

### Self Monitoring of Blood Glucose

Self Monitoring of Blood Glucose "SMBG" is considered one of the cornerstones of diabetes care and is widely recommended to achieve optimal results [3]. However, there might be some disagreement from some practitioners because of the lack of strong evidence about the effectiveness of SMBG in improving glycaemic control [4].

In my practice we has many patients with limited financial resources, who do not entertain insurance plans where regular SMBG is not practiced due to costly glucometers and test strips.

However, we keep educating the patient to regularly check blood glucose is an imperative step in successful diabetes management especially for those with Type 1. It can show an insight about the positive effect of exercise and the negative effect of food items on the blood glucose [3]. Since 3 years we are providing free metes and strips during follow up visits. We are working with pharmaceutical companies to provide them with cost price for those do not entertain insurance plan.

### Physical Inactivity & Disabilities

Among the difficulties we encounter in initiating active lifestyle as well as continuity. The hot, humid weather throughout most of the year plays a dominant role. Physical inactivity is observed also among diabetics who supposed to be educated to stay active as concluded a study that showed the physical activity practice of type 2 diabetic patients in the UAE is largely inadequate to meet the recommended level necessary to prevent or ameliorate diabetic complications and that interventions aiming at overcoming the barriers to physical activity are urgently needed [5].

On the other hand, physical disabilities have been reported to be more prevalent among individuals with diabetes. This is not surprising, given the co-morbidities often seen with diabetes like osteoarthritis and IHD. However, it was found that not all physical disabilities encountered in this population are directly caused by diabetes [6].

In the primary care setting, we address these problems through proper evaluation, investigations advice given by health educators. Consultation with hospital doctors is frequently needed to assist in fixing problems like knee osteoarthritis, IHD, peripheral neuropathy to let patients feel energetic to be active.

### Adherence to the Medication

Many diabetics could only reach their targets through long list of medications regimen which is a real challenge to remember to take medication, difficulty in keeping track of medication, not having medication, prohibitive cost of medication and not understanding the rationale for change.

A lot could be achieved through collaborative relationships with practitioners who encouraged patient education about the medicine use, maintaining routine medication administration times allowing self-management and provided positive attitude. Booking an appointment with clinical pharmacist is now possible in the local hospitals to discuss more about drugs.

### Depression

Depression is one of the obstacles that impede collaborative relation between diabetics and their healthcare provider. Recent research has found that the incidence of depression is twice as high in people with diabetes (Anderson, et al. 2001, Rubin, et al. 2004).

In our practice, it became mandatory to screen for depression and start antidepressant therapy at the primary care level and referring difficult patients to the hospital.

### Family Support

We are faced with diabetics who are living alone, most of them are of the geriatric populations and some

has physical disability that represents a major barrier to self-care, compliance, and adherence to change of behavior. Physical barriers can pose a challenge in helping individuals achieve self-care goals [7]. We work in cooperation with “home-care” teams composed of nurses, social workers, health educators and occasionally a physician to ensure delivery of best achievable level of care that could be offered.

## References

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