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Editor

The boy done well

“The single biggest problem in communication is the illusion that it has taken place.”

George Bernard Shaw

Football (aka soccer) reaches more people than any other sport – billions during the recent World Cup – and with that level of global interest comes a widely understood game vocabulary. From simple words that replace the names of equipment to coloured cards, football is effective at getting its message across. Although the chattering classes are invariably sniffy about football parlance, it is a truism that this form of communication is readily understood by a huge tranche of the population.

For those of us who deliver routine clinical diabetes care, getting the message across is a regular feature of our jobs, and may form both the most interesting and the most frustrating part of the role. Frustration, clinicians often report, arises from the perceived failure of patients and their families to take the advice that we believe will benefit them. Yet, with 5.2 million people in the UK lacking functional literacy skills, and 6.8 million lacking functional numeracy skills (House of Commons Public Accounts Committee, 2009), it is worth considering that perhaps the clinician is speaking a language the person with diabetes does not understand – and that good diabetes care is being lost in translation.

Population literacy and numeracy are deeply relevant to the clinician working with people to manage their diabetes. It has long been known that diabetes, deprivation and illiteracy go hand in hand (Meadows, 1995). It has recently been reconfirmed that increased risk of premature death among people with diabetes correlates with decreasing level of educational achievement (Dray-Spira et al, 2010).

I have previously shown that some of the materials on diabetes care produced for people with diabetes and their families have low “readability” scores (Kerr, 2007). In addition, patient manuals provided by the manufacturers of insulin pumps contain calculations that will be unintelligible to a significant minority of adults due to poor numeracy (Kerr and Marden, 2010). While quality-assured, structured diabetes education programmes are relatively successful under trial conditions (Loveman et al, 2008), the real-world uptake of these programmes continues to disappoint. The reasons for this are multifactorial, but literacy and numeracy deficiencies are likely deterrents to entering, or completing, diabetes education programmes.

Given the above, it is clear that a revolution in the provision of information and diabetes education is needed so that the name of the game is inclusion. We need to provide support and guidance, in a range of mediums, that is understood by all. This should perhaps also apply to instructions for medical devices (e.g. blood glucose monitors), and pharmaceutical package inserts. We clinicians need to swallow our intellectual pride and embrace the popular parlance; football (minus the swear words, of course) could teach us a few things about clear, simple communication. Unfortunately, diabetes is not a game of two halves and we must all start talking the same talk.

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