Joint decision making: What does this mean for the older person with diabetes?

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Although it is not quite winter yet, acute hospitals like my own are still experiencing regular admissions of older, frail people with diabetes. Sometimes other long-term conditions in older people are the reason behind the admission and these conditions will invariably compromise an older person's diabetes control.

Given the pressure on hospital beds, my team, like all specialist teams, regularly review why people are admitted to hospital, what we can do to help them and how we can help them to avoid admissions in the future. Sometimes, a person is admitted to hospital because something goes wrong with their support in the community; other times, the cause may be unavoidable but often the cause of admission to hospital can be attributed to the health decisions that people make about themselves. These decisions stem from their own health beliefs and vary hugely in different individuals based on whether they have an internal or external locus of control.

Risk perception

The research article presented in this month's section focuses on risk perception among older South Asian people. The paper outlines the health beliefs of older South Asian people and the impact of locus of control on risk perception and associated decision making. Whilst some issues identified will be culturally related, the notion of health beliefs influencing "whose diabetes is it anyway" is relevant to all. It raises the concept of concordance, which is associated with joint-decision making, with the person with diabetes adopting some level of self-management: Is this as relevant to older people, and if so, what could it mean to them?

Traditionally, the clinical consultation involved a health professional giving information and a plan of action; basically the "patient" was told what to do. More recently, it has been realised that this is not always a successful strategy, as the cost of non-adherence to medication, poor clinical outcomes and increase of long-term conditions threatening to bankrupt the NHS has meant other solutions have been sought. Self-empowerment, partnership working and an organised and proactive healthcare system are the tenets on which the initiative "Year of Care" is based (see www.yearofcare.co.uk).

This seems a logical approach, but is it evident throughout the UK? Clearly if it was working, for example, if people were engaged and if current systems and care were cost effective, there would be no requirement for Year of Care. We know that the Quality Outcomes Framework influences practice organisation, but like acute care, it is based on a reactive and illness model, not the proactive, health model that the Year of Care advocates.

Furthermore, for some of our older people, the notion of being in charge of their health decisions is alien. They expect the clinician to decide, and often lack confidence in making health changes, and would not go against what their doctor has told them. Instead, they may lie about whether they are taking their medication for fear of upsetting the healthcare professional and will not express how they are feeling about their illness.

Whilst this is not true of all older people, dementia, frailty and dependence on others can restrict the ability to self care and may prevent regular access to clinicians, and this may delay the review of agreed care plans. It is important, therefore, that we consider the individual, their capability and confidence when we engage in collaborative care planning. We should appreciate that this collaboration will vary from person to person and that necessary steps should be taken to support each individual and their health choices. ■