

Patient–practitioner communication in diabetes and diabetes-related foot complications

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Article points

- 1 The roles of ‘patient’ and ‘healthcare professional’ are changing as decisions on care become more shared and less practitioner-instructed.
- 2 Self-care behaviours remain a cornerstone of successful management of diabetes and the foot in diabetes — especially during COVID-19.
- 3 Effective communication between patients and healthcare professionals is at the heart of effectively motivating patients to undertake good self-care behaviours.

Key words

- Diabetes-related foot problems
- Patient-practitioner communication
- Self-care behaviour

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Successful diabetes care requires teamwork between practitioners and patients which is predicated upon trust. The cornerstones of this teamwork are effective communication between both parties and shared decision-making. This suggests two premises upon which healthcare provision then exists — firstly, the patient must assume some control and accountability for their own health and health outcomes; and secondly, effective communication between the healthcare professional and the patient is of crucial importance. The focus on effective communication is likely to be ever-greater in the world post-COVID-19. This article explores the role and influence of patient and healthcare professional communication in the context of diabetes and diabetes-related foot problems.

With a changing landscape of public health comes a change in the way that healthcare is delivered and received. Never has this been more apparent than the changes that will be needed in a post-COVID-19 world. In more recent years, healthcare professionals across a wide number of disciplines have been moving away from a more traditional, didactic view of the patient-practitioner relationship towards notions of concordance and equity of decision making between both parties (Neuner-Jehle et al, 2017).

This change of direction, while far from complete, has redefined the way in which healthcare professionals might best deliver their care as clinicians as they become encouraged to view their service users as ‘health partners’, rather than as a passive recipient of health care. The subtlety of this change takes healthcare decisions and practices out of the sole power of the clinician and more equally shares them with the patient. This initiates two

premises upon which healthcare provision then exists — firstly, the patient must assume some control and accountability for their own health and health outcomes; and, secondly, effective communication between the healthcare professional and the patient is of crucial importance (Vranceanu et al, 2012; Beverley et al, 2016; Neuner-Jehle et al, 2017). This is particularly relevant when it comes to the management of chronic, non-communicable diseases like diabetes where effective self-care is a crucial aspect of optimal disease management and outcome (Shrivastava et al, 2013). It becomes an important consideration, now more than ever, to examine the role and value of effective patient-practitioner communication during this COVID-19 pandemic where many routine healthcare appointments are being postponed and replaced by virtual consultations. This means that good self-care becomes an ever-more essential tool in the management of the foot in diabetes, like in so many

other aspects of chronic disease, where contact with the physician will be much more limited (Rogers et al, 2020).

Role of communication

Words can shape or reinforce a patient's coping strategies (Vranceanu et al, 2012) and ineffective health communication between patients and healthcare practitioners has long been argued as a contributory factor towards suboptimal care and, consequently, sub-optimal outcomes (White et al, 2015). Despite fairly wide-held beliefs to this effect, evidential proof of the direct effect of patient-practitioner communication on clinical outcomes has been hard to demonstrate. However, Riedl and Schüler (2017) conducted a systematic review specifically looking at the influence of doctor-patient communication on health outcomes and concluded that "different domains of the doctor-patient relationship and communication had convincing effects regarding different subjective and objective outcomes". Their systematic review found that when information was shared effectively between doctors and patients, the patient's therapeutic compliance and quality of life were improved alongside their health status.

This has been a phenomenon long recognised in clinical care across a wide array of chronic health and social care contexts and has been the foundation upon which strategies like motivational interviewing have been developed (Frost et al, 2018). Riedl and Schüler (2017) identified from this systematic review that when asked about their preferences, patients rated open communication as the most important aspect of their patient-physician relationship which, itself, is based upon trust.

Indeed, Moffat (2006) highlighted that patient-practitioner communication that was not open and built on trust lead to an underestimation of disease severity and, therefore, maltreatment as a result of patients not feeling secure enough to report important lifestyle changes. Thus, it would appear that developing good and effective communication with patients is a crucial and potentially undervalued mechanism to help improve clinical outcomes within chronic health issues – not least by promoting adherence to therapeutic interventions and improved self-care behaviour.

Notions of self-care

Self-care in diabetes is a well-established facet of achieving optimal disease management and clinical outcomes because the vast majority of day-to-day care and management of the disease is handled by patients and/or their families (Shrivastava et al, 2013). The American Association of Diabetes Educators (2008) identified seven essential self-care behaviours in diabetes that predict good outcomes. These are: healthy eating; being physically active; monitoring of blood sugar; compliance with medications; good problem-solving skills; healthy coping skills and risk-reduction behaviours (which includes reducing risk of foot ulceration via good foot care). All of these behaviours have been seen to positively correlate with good glycaemic control, reduction of complications and improvement in quality of life (Odegard and Capoccia, 2007; Povey and Clark-Carter, 2007; American Diabetes Association; 2009; Shrivastava et al, 2013).

Foot self-care practices are not uniquely or precisely defined but appear within the literature to consistently comprise of: daily washing and drying of the feet; daily visual foot examinations; application of skin moisturiser; avoiding walking bare-footed (even within the home); ensuring that bathing water is not too hot; attending regular professional footcare and following professional advice in relation to foot care practices (McInnes et al, 2011; Fan et al, 2014; Bonner et al, 2016; Bus et al, 2016). In addition to these physical practices, within their systematic review, Bonner et al (2016) pointed out that these could also be extended to include understanding risk factors associated with diabetic foot ulcer (DFU) development and managing complications outside of clinical encounters. It is evident that diabetes self-care requires people with diabetes to make many dietary and lifestyle modifications supported by healthcare professionals to help them maintain a higher level of self-confidence which, in turn, leads towards a successful behaviour change (Dogru et al, 2019).

Self-care is widely considered to be the most cost-effective way of managing diabetes and delaying or preventing of the development of associated complications yet self-care also appears to be under-utilised by patients (Shrivastava et al, 2013) and sometimes under-appreciated by healthcare professionals (Hunter et al, 2014). More specifically,

the literature indicates that foot self-care behaviours remain a significantly under-utilised exercise in the prevention of DFUs (Perrin et al, 2009; McInnes et al, 2011; Freitas, 2014; Neta et al, 2015).

A systematic review of the literature in this area by Matricciani and Jones (2015) supported this conclusion and further iterated that foot self-care practices should be a specific consideration for patients currently at low-risk of developing foot complications. One possible reason for why there appears to be such under-utilisation of self-care practices in diabetes – particularly in relation to foot health – is that the complex interplay outlined above may often not come together effectively if healthcare professionals are unable to sufficiently help motivate patients towards the requisite behaviour change (Dibbelt et al, 2009). This focuses the question of how to bring qualities of empathy and subject-knowledge – with which healthcare professionals are typically well-equipped – to supply appropriate support and motivation to patients to enact the necessary behaviour change(s) and/or sustain behaviours considered to be crucial to self-care practices.

Using effective communication to promote self-care behaviours

Successful diabetes care requires teamwork between practitioners and patients, which is predicated upon trust. The cornerstones of this teamwork are effective communication between both parties and shared decision-making (Beverley et al, 2015). This shared decision-making in practice resembles the patient sharing their medical, personal and lifestyle history with their physician who, in turn, processes that information into a series of therapeutic options for the patient with clear benefits and risks of each presented clearly and unbiasedly. This allows the patient to indicate their preference of option for discussion without concern or fear that their choice may be disagreeable for the practitioner (Beverley et al, 2014). Patient autonomy is key here and the ability of the practitioner to promote an environment of genuine patient autonomy is vital to the quick and robust development of trust in the relationship (Von Korff et al, 1997; Nimmon and Stenfors-Hayes, 2016). Other factors that influence this trust are how the patient is treated during the consultation and

how much time they perceive that they have been afforded in the consultation (Beverley et al, 2015).

A first element to further expand upon here is how the patient is treated. Verbal communication is central to how a patient feels they have been treated (Dickinson et al, 2017). This ranges from friendly greetings and a genuine interest in them as individuals through to the specific language used to describe the patient, their behaviour and/or their condition (Dunning et al, 2017). Indeed, language is powerful and can have a strong impact on perceptions, behaviour and experiences. It is the principle vehicle for the sharing of knowledge and understanding. Words are immediately shaped into meanings when people hear or read them and those meanings can affect how a person views him- or herself (Fleischman, 1999; Benedetti, 2008).

The way a person views themselves and the beliefs they carry about their abilities and disease-state has been suggested to be a predictor for how they engage with their condition (Vedhara et al, 2014). This phenomenon is referred to as self-efficacy. While this is an important concept within the broader consideration of self-care behaviours, studies looking to investigate self-efficacy as a specific variable in foot self-care and foot health outcomes in diabetes have found no strong evidence that it is a significant variable in isolation. Perrin et al (2009) investigated the relationships between foot-care self-efficacy beliefs, self-reported foot-care behaviour and history of diabetes-related foot pathology in a regional city of Australia. The conclusion of this study was that there was little association or correlation between self-efficacy beliefs and actual foot care behaviour.

Wendling and Beadle (2015) drew very similar conclusions within their US-based study, while in-depth literature reviews by Chew et al (2014) and Matricciani and Jones (2015) identify that key future research is needed to carefully consider what factors contribute to individual diabetes self-care behaviours within specific contexts if there is to be an interventional approach to improve this as a significant advancement in preventative diabetes care. This, however, serves as a reminder that behavioural science is a complex interplay and indicates why considering multiple variables in the practitioner-patient encounter is important.

The second element that surrounds the

development of trust between patient and practitioner is that of the perception of time that a patient feels that they are afforded in the consultation. While a lack of perceived consultation time is a frequent frustration of patients, it is also a frequent frustration voiced by clinicians too (Stuckey et al, 2015). Interestingly, however, the systematic review by Riedl and Schüler (2017) indicated that skilfully trained clinicians in consultative techniques, such as motivational interviewing, did not need more time in their consultations to develop trust, rapport, meaningful conversation and, indeed, effective information exchange. This provided both clinicians and patients with the perception of more consultation time and improved satisfaction levels for both parties. The development of effective communication in this way feeds into trust and can facilitate the occurrence of information exchange in a way that is more likely to yield better outcomes in terms of therapeutic adherence and improved/sustained self-care behaviours (Song et al, 2014; Beverley et al, 2015).

The unintended power of words

While effective communication has been argued here as a means to help facilitate good self-care practice and effective disease management it would be remiss not to consider the pitfalls that can emerge as a consequence of poor communication. Riedl and Schüler (2017) outline the deteriorating effect that insufficient relationship building may have on health outcomes when they report that poor communication can directly lead to patients not furnishing their clinicians with the necessary details upon which to consider and propose therapeutic options. Moreover, Snow et al (2013) insightfully highlighted an issue presenting itself more commonly in the era of the ‘information superhighway’ that is the internet — namely practitioners becoming frustrated and concerned by ‘well-informed’ and ‘mis-informed’ patients. While the latter is an understandable frustration and can add difficulty to the consultation for the clinician who has to ‘undo’ misinformation prior to offering relevant information, the former is a more puzzling phenomenon to fully understand but Snow et al (2013) offer at least one insight into this — that the well-informed patients are perceived as being ‘less-

compliant’ than the ‘less well-informed’ patients as the former group tended to challenge the clinicians points and suggestions more often. An example if ever it were needed that the role of the clinician in the 21st century will be less frictional and more conducive to effect patient-practitioner outcomes if it was seen as a ‘therapeutic alliance’ between both parties, rather than the traditional ‘expert’ and ‘passive recipient’ roles, respectively.

A final point to consider in this context is best encapsulated by Barsky (2017) who wrote an article entitled ‘The iatrogenic potential of the physician’s words’. This article has had an impact at helping to understand the concept of nocebo and nocebic language and is extremely useful at shining a light on how communication with patients can affect the outcome (and expected outcome) of medical treatment. Dickinson et al (2017) produced a comprehensive overview of how the use of language in diabetes care and education can have profoundly significant effects in individuals with diabetes. So much so, that a task force of representatives from the American Association of Diabetes Educators and the American Diabetes Association convened to discuss the issue of language in diabetes care and education and, consequently, publish ‘guiding principles for communication with and about persons living with diabetes’. The premise upon which this publication was predicated was that “language lies at the core of attitude change, social perception, personal identity, intergroup bias and stereotyping” (Dickinson et al, 2017). Ill-use of language about persons with diabetes can result in negative and disparaging attitudes and, thus, contribute to an already stressful experience of living with the disease.

By contrast, encouraging and collaborative messages can enhance health-outcomes in diabetes (Polonsky et al, 2017). Dunning et al (2017) point out that how health professionals (and the wider public) talk about people with diabetes plays an important role in engagement, conceptualisation of diabetes and its management, treatment outcomes and the psychological wellbeing of the individual. For people with diabetes, language has an important impact on motivation, behaviours and outcomes. The main focus of the guiding principles for communication with and about persons living with diabetes publication was that at the most

fundamental level, collectively we all need to steer away from nocebic, ‘handicapping’ language; this undermines the integrity of individuals as whole human beings distinct from their diagnosed condition and propagates the myth that diabetes ‘happens to them’ and is something they, therefore, cannot live free from. The language in particular focus is:

- ‘Diabetic’ (which implies that a person is disabled as a whole and/or equates the person with their medical condition)

- ‘Suffering with diabetes’ (which has negative overtones)

- ‘Unmotivated’; non-compliant’; ‘resistant’ (which is directly judgemental)

As a result, the following recommendations came from Dickinson et al (2017):

- Use language that is neutral, non-judgemental and based on facts, actions or physiology/biology

- Use language that is free from stigma

- Use language that is strengths based, respectful and inclusive and imparts hope

- Use language that fosters collaboration between patients and providers

- Use language that is person-centred.

This example illustrates within a defined context how language can be a very powerful tool within the armoury of a clinician. The principles can be applied across the disciplines into different facets of health, but the psychological impact of the language practitioner’s use is consistent across all examples. Nocebo is definitely a factor to be aware of in this context. Only by being acutely aware of it may practitioners modify their words and behaviours and seek to use the power of words in a way that is of significant benefit to patients.

Conclusion

The impact of the effect of communication between practitioner’s and patients is not conclusively demonstrable but there are many aspects to it which, individually, are shown to have consequences. The science of human behaviour and that of behaviour change is nothing if not complex and developing more understanding of the nuances of human behaviour, the nuances of a chronic disease like diabetes and the nexus between the two is required. There is a gap in the knowledge base here – particularly within the precise focus of the

foot in diabetes. This should be an area for further research focus. ■

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