Viewing the doctor-patient relationship through an educational lens: a reflection on running a diabetes clinic

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Abstract

Diabetes as a disease is characterised by a significant focus on patient training. This article explores the relationship between the diabetologist and the patient as a teacher-student relationship, and how the consultation setting can be modified to facilitate patient learning based on individual need.

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Key words: diabetes, education, educational theory

Choice of topic

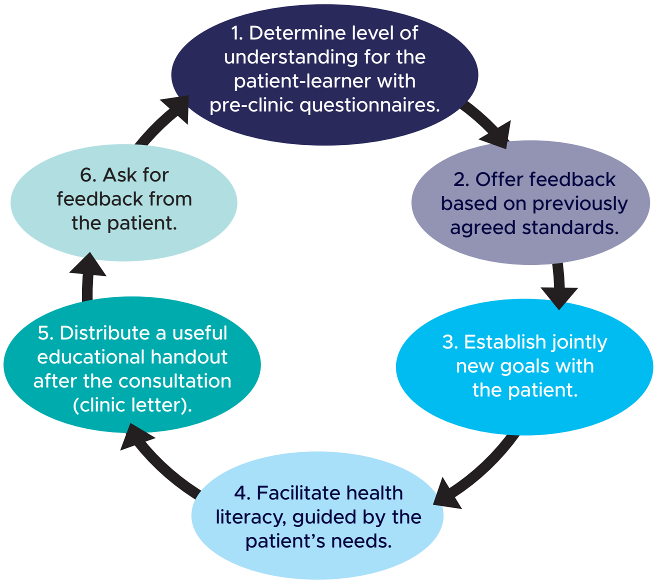
Diabetes as a disease is characterised by a significant focus on patient training. Diabetes education, usually offered in structured multi-participant courses, can improve HbA_{1c} and have a positive effect on the quality of life of people with diabetes.[1] Here I reflect on how I contribute to their education through my clinical practice.

Setting of the consultation

As a junior registrar, I tended to navigate most diabetes-related issues according to my own medical agenda. This kind of paternalistic/didactic consultation was more doctor-focused than patient-centred, with the physician leading the discussion instead of addressing the patient's own agenda and concerns.[2] This method had the potential to cause significant information overload for patients, reducing their receptive capacity due to emotional stress.[3] Additionally, this approach derived from the implicit premise that healthcare professionals (HCPs) are the main bearers of responsibility for clinical outcomes; in reality, the patient is primarily the active agent of daily decision-making about their diabetes, with HCPs having little influence on this outside the clinic setting.[4]

On reflection, I realised there was a reduction in power between me, as a doctor, and the patient, in my favour: I was better informed about diabetes and, thus, in a better position to make decisions for them. This was not necessarily in agreement with the patient's priorities. I noticed that, during follow-up appointments, many of the points discussed had not been implemented. In hindsight, this could have been the result of me communicating poorly what I thought to have been an agreed course of action or not having aligned my suggestions with the patients' concerns, which had not been adequately investigated beforehand.[5] Drawing from constructivism, according to which new knowledge can be obtained "through active integration of old and new information",[6] I decided to adjust the format of the consultation to support growth in the patient's knowledge based on what mattered to them instead (Figure 1).

Figure 1. Proposed consultation format



Restructuring the consultation setting – effective use of time

The first step was the use of the type 1 diabetes (T1DM) consultation tool as a pre-consultation questionnaire;[7] this was given to the patients while they were sitting in the waiting room before the clinic appointment.

Guided by these questionnaires, I changed how I initiated my consultations by directly asking patients whether they wanted to discuss a particular topic regarding their diabetes

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care. I then applied a modified version of the one-minute clinical preceptor model.[8]

1. **Reinforce what was done right**. The use of a strengths-based language can reduce patient stress and increase engagement during the consultation.[9] I was orientated to providing positive feedback at the start in order to make patients feel empowered and in control of their own diabetes.
2. **Get a commitment - probe for supporting evidence**. The learner-patient expanded on their own diabetes management following my reflective question; this process usually identified gaps in knowledge.
3. **Teach general rules - correct mistakes**. I then addressed the knowledge/skill gaps and provided relevant medical information.
4. **Identify next learning steps**. Finally, I summarised the main points, confirming the commonly agreed goals for the future.

The main benefit is that the patient becomes empowered to implement changes which they have jointly agreed with their doctor. A potential drawback is that this model requires the full cooperation of the patient before, during and after the consultation. This may be challenging for people with diabetes distress, who represent 40% of the total number of people with diabetes.[10]

It should be emphasised that the above suggestion has not been tested and represents a personal adaptation for the clinical needs of my own practice at a registrar level; it does highlight, though, the potential for educational theories to reshape diabetes delivery care in an outpatient clinic setting.

Communication: the clinic letter as an educational tool

Traditionally, the outcome of a consultation has been communicated to primary care via clinic letters, addressed to the patients' general practitioners rather than the patients themselves. This can be a barrier to communication between the speciality doctors and the patients, with the latter potentially perceiving letters written in such form as condescending.[11] Consequently, it can further worsen clinical outcomes by discouraging patients from taking more control of their own care due to the doctor-focused structure of the letter, the use of medical jargon and the inappropriate use of language.[11]

The clinic letter is part of what contributes to health literacy, which is about training patients on how to manage their own disease based on medical information.[12] Letters can serve as short summaries of important pieces of information, facilitating the patient's reflective process on what has already been discussed. Additionally, the digitalisation of record keeping in hospitals offers more tools when writing a letter, such as the inclusion of images, charts or web links for faster and more effective communication between the physician and the patient.

Areas for future improvement

Over time, I unconsciously developed the expectation that the structured training that people with diabetes had already received when firstly diagnosed was adequate and that my role was there to support them beyond that. This was a reactive approach: managing the complications rather than proactively trying to expand their understanding of the disease, which could lead to better health outcomes in the long run. In hindsight, this way of thinking also underestimated the amount of information people with diabetes must absorb before implementing it; it additionally implied that learning is a static process, with knowledge already gained requiring no further practice or reinforcement.

Key messages

- ▲ Use the clinic letter as an educational handout.
- ▲ Follow an educational method during the clinic consultation.
- ▲ Ask patient to summarise 3 take-home clinic messages (teach-back technique).

Another area for me to explore is teaching patients how to learn during the clinic appointment. One such technique is the teach-back method: the patient is asked to summarise in their own words their understanding of the clinical information offered by the healthcare professional. This technique appears to be effective in confirming patient education.[13] In my own practice, I usually ask patients to summarise the three most important take-home messages instead of the whole session: this allows them to put emphasis on what they consider important and, perhaps, give me an insight into how they perceive what has been discussed.

A limitation for this model is that it focuses solely on patient education, when this process may in fact be inhibited by the psychological impact of diabetes.[14] One important requirement for sustainable learning outcomes is that both the teacher and the learner are positively motivated to work towards a common goal.[15] In people with diabetes, lack of motivation is not uncommon, as diabetes is often seen as a negative life-changing event to work against. Any such model should, then, incorporate the psychological intricacies of living with diabetes; further research is needed to elucidate this.

Conclusion

Although most points presented in this reflection are not novel,[16] the need for personalised care is further emphasised. Clinic appointments should be seen as a learning opportunity rather than a tick-box task. Clinic letters should be utilised as a handout of education reinforcement, not merely as a means of communication among healthcare professionals; patient-centred language can have a positive impact in this direction.

In diabetes medicine, our role as doctors is becoming multi-faceted: to empower our patients we need to bring together their established beliefs with a continuously evolving landscape of medical information. Understanding their world is the stepping stone towards change.

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References

1. Hopkins D, Lawrence I, Mansell P, *et al.* Improved biomedical and psychological outcomes 1 year after structured education in flexible insulin therapy for people with type 1 diabetes: the U.K. DAFNE experience. *Diabetes Care* 2012;**35**(8):1638-42. https://doi.org/10.2337/dc11-1579.
2. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA* 1992;**267**(16):2221-6.
3. Wang T, Voss JG. Information overload in patient education: a Wilsonian concept analysis. *Nurs Sci Q* 2022;**35**(3):341-9. https:// doi.org/ 10.1177/08943184221092451.
4. Mann KV. Theoretical perspectives in medical education: past experience and future possibilities. *Med Educ* 2011;**45**(1):60-8. https://doi.org/10.1111/j.1365-2923.2010.03757.x.
5. Skinner TC, Barnard K, Cradock S, *et al.* Patient and professional accuracy of recalled treatment decisions in out-patient consultations. *Diabet Med* 2007;**24**(5):557-60. https://doi.org/10.1111/j.1464-5491.2007.02129.x.
6. Reekie M, De Bosch Kemper N, Epp S, *et al.* Learning pathways: levelling, scaffolding & mapping curriculum. *J Prof Nurs* 2023; **46**:163-4. https://doi.org/10.1016/j.profnurs.2023.03.006
7. Health Innovation Network South London (HINSL) (2017). Type 1 Consultation (T1C) Tool User Guide [online]. Available at: chrome-extension://gphandlahdpffmccakmbngmbjnjiiahp/https://healthinnovationnetwork.com/wp-content/uploads/2017/01/Type-1-Consultation-Tool-User-Guide.pdf [Accessed 27.11.2022].
8. Chinai SA, Guth T, Lovell E, *et al.* Taking advantage of the teachable moment: a review of learner-centered clinical teaching models. *West J Emerg Med* 2018;**19**(1):30. https://doi.org/10.5811/westjem.2017.8.35277.
9. Dickinson JK, Guzman SJ, Maryniuk MD, *et al.* The use of language in diabetes care and education. *Diab Care* 2017;**40**(12):1791. https://doi.org/ 10.2337/dci17-0041.
10. Berry E, Lockhart S, Davies M, *et al.* Diabetes distress: understanding the hidden struggles of living with diabetes and exploring intervention strategies. *BMJ* 2015;**91**:279-80. https://doi.org/10.1136/postgradmedj-2014-133017
11. Rayner H, Hickey M, Logan I, *et al.* Writing outpatient letters to patients. *BMJ* 2020;**368**:1-2. https://doi.org/10.1136/bmj.m24
12. Paterick TE, Patel N, Tajik AJ, *et al.* Improving health outcomes through patient education and partnerships with patients. *Proc (Bayl Univ Med Cent)* 2017;**30**(1):112. https://doi.org/10.1080/08998280.2017.11929552
13. Yen PH, Leisure AR. Use and effectiveness of the teach-back method in patient education and health outcomes. *Fed Pract* 2019; **36**(6):284-9. PMID: 31258322
14. Rodin GM. Psychosocial aspects of diabetes mellitus. *Canadian J Psychiatry* 1983;**28**(3):219-23. https://doi.org/10.1177/070674378302800313
15. Anderson RM, Funnell MM. Compliance and adherence are dysfunctional concepts in diabetes care. *Diabetes Educ* 2000; **26**(4):597-604. https://doi.org/10.1177/014572170002600405.
16. Year of Care (YOC) (2011). Report of findings from the pilot programme [online]. Available at: https://www.yearofcare.co.uk/sites/default/files/images/YOC_Report%20-%20correct.pdf [Accessed 21.3.2024].