Common, but not easy

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Everything without tells the individual that he is nothing; everything within persuades him that he is everything.

X. Duodan

Type 2 diabetes mellitus (T2DM) has been on the rise globally in the past 30 years as a result of several drivers—aging, urbanization, and lifestyle changes including considerable dietary shifts and an increasingly sedentary way of life. By 2030 almost 450 million people—about 8% of the world's adults between age 20 and 79—will have the condition, and most of them will live in low- and middle-income countries.[1] Sadly, T2DM is being diagnosed at younger ages, potentially leading to a greater burden of complications later in life.[1]

We see the same trends in Canada, and the cost of managing diabetes is expected to rise substantially in the next decade.[2] In April 2018, Diabetes Canada published updated clinical practice guidelines (CPGs) aimed at helping physicians better care for their patients with T2DM.[3]

Like most family doctors, when I think of T2DM, I tend not to think of a unifying and wholly predictable disease. Instead, I think about the many people in my practice with the condition and the individual challenges and burdens that living with T2DM presents for them and for me as their family physician.

I think of Steven, for example, in his late 40s, who developed T2DM more than a decade ago. He was at high risk because of his genetics, obesity, and sedentary life. Chained to a desk 10 or more hours a day, Steven has been either unable or unwilling to change his way of life. Although treated appropriately with medication for his diabetes, blood pressure, and cholesterol, he continues to smoke, in spite of offers to help him quit. He was diagnosed around the time he and his wife separated. What effect did his diagnosis[4] and the burden of medications I prescribed[5] have on his mental health and his relationship?

I also think of Krishna, now in her 80s, who has lived with T2DM since she retired at 65. I especially think of the effect of the diagnosis at that critical milestone in her life and its effect on the quality of her retirement years.[4] Her hemoglobin A_{1c} levels have steadily risen in the past few years as she has aged and become less active, and she has stubbornly resisted my attempts to add more medication. Happily, she has not suffered any serious medical complications so far and generally feels well "… for my age, Dr Pimlott," I can hear her say.

The 2018 Diabetes Canada CPGs are thorough and comprehensive but also, as a result, complicated. Integrating the most helpful and effective recommendations into a busy and increasingly complex family practice setting is challenging. In the past, passive dissemination has led to predictably limited effects on practice. A recent study of the 2013 guidelines using data from patients older than 40 from the Canadian Primary Care Sentinel Surveillance Network revealed no improvement in prescribing of appropriate vascular protective medications following publication of the guideline.[6]

Complicating matters is that individuals respond differently and in complex ways to being diagnosed with diabetes and to their ongoing responsibility for self-care, with implications for long-term health.[7] Poverty, which afflicts a substantial proportion of Canadians with diabetes, complicates care further.[8] Indigenous patients are also disproportionately affected.[9]

In this issue of *Canadian Family Physician,* we publish a concise summary of key recommendations from the 2018 Diabetes Canada CPGs aimed at helping family physicians more readily integrate them into their practices (**page 14**).[10] Also included are practical tips to integrate some of these approaches into the electronic medical record (**page 43**),[11] as well as an equity care framework to help address social barriers faced by Indigenous patients with T2DM (**page 25**).[9]

In another recent study of the effects of previous diabetes CPGs on practice, the authors concluded:

> The complexity of diabetes care requires systemic adoption of organization of care interventions, including interprofessional collaboration and consensus. Augmenting our strategy to include scalable models for professional development, integration of guidelines into electronic medical records, and expansion of our target audience to include health care teams and patients, may optimize guideline uptake.[12]

It also requires personalization of care and clearly understanding each patient's experience living with this condition.

Cet article se trouve aussi en français à la **page 7.**

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