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Communicating in Diabetes:

How to Make People with Diabetes Understand Us in Consultation

The approach to chronic conditions, which includes diabetes, involves the integration of aspects related to prevention, comprehensive care, continuity of care, and, above all, the patient's protagonism (where social and psychological aspects of the patient must be taken into consideration). This is a person-centered approach, not disease-centered, emphasizing accompaniment of the patient. In this approach, communication is a fundamental tool, on which will largely depend what the patient assimilates, their involvement, the responsibility for their care, and the management of the disease. However, the communication process in chronicity is not simple: firstly, the language used must be selected appropriately, since thanks to it, the patient's quality of life and well-being can be enhanced; secondly, communication skills can (and should) be acquired, enhanced, and improved with practice.

"One word can lose everything,
one word can save everything."
— André Breton (1896–1966), French poet and critic

We generally learn in school that language is the human ability to express oneself and communicate—whether orally, in writing, or through gestures. However, the responsibility that comes with language is rarely addressed: being responsible means taking care with our words, both in form and content. In medical schools, postgraduate studies, and hospital training programs, we often encounter a type of language that has been passed down and is resistant to change. For example, terms that reduce people to their condition—such as "diabetic" or "obese"—are still common. Yet we have the power to choose language that puts the person first, such as "person with diabetes" or "person with obesity."

J. Dickinson, in one of his articles on diabetes education, writes: "Language is powerful and can have a strong impact on perceptions and behavior." This insight has led organizations such as Diabetes Australia, the International Diabetes Federation, and the National Health Service England to publish position statements on appropriate language use when speaking to patients, giving presentations, or writing research articles about people living with diabetes. Recently, similar movements have emerged in the care of individuals living with obesity. The American Diabetes Association (ADA), in its latest Standards of Care in Diabetes, emphasizes the importance of language and how healthcare professionals can use it in a more informative and educational way—whether with patients, colleagues, or broader audiences. The report includes five key consensus recommendations for language use:

- Use neutral, nonjudgmental language based on facts, actions, physiology, or biology.
- Use language that is free from stigma.
- Use language that is respectful, inclusive, and conveys hope.
- Use language that encourages collaboration between people with diabetes and health care professionals.
- Use person-centered language (e.g., "person with diabetes" instead of "diabetic").

Other important initiatives are also emerging—especially given the vast number of communication channels available today: social media, television, newspapers, the internet, etc. Various organizations offer guidelines for responsible language use, such as: using truthful and authentic information; avoiding misleading or confusing messages or images; promoting objective and neutral knowledge; fostering messages that encourage positive change (both individual and social); encouraging active participation; incorporating a gender perspective; and always showing respect and dignity toward people. »

https://concepto.de/redes-sociales/

"Words are half of whoever speaks them, and half of whoever hears them". ***Michel de Montaigne, French philosopher***

GOOD USE OF LANGUAGE CAN REDUCE ANXIETY, BUILD TRUST, EDUCATE, AND HELP IMPROVE SELF-CARE

» **The language used by health care professionals has a significant impact on how people living with diabetes and those who care for them experience their illness and live with it day by day**. Good use of language can reduce anxiety, build trust, educate, and help improve self-care (for example, by abandoning the use of terms like adherence and compliance, replacing them with diabetes education and commitment). Poor communication can be stigmatizing, harmful, and detrimental to self-care and clinical outcomes (negative language induces guilt, fear, anguish, due to the perception of condemning judgments by the person with diabetes).

Communication skills are clinical competencies that favor an effective consultation and can be taught and learned (until recently, they were considered innate qualities of the professional that could not be modified). **A paternalistic relationship should be avoided, and a patient-centered relationship should be built, where psychological and socio-family factors are included for a better approach to the person with diabetes:** exploring the illness and the experiences it causes, understanding the person completely, seeking agreements, including and promoting prevention and health promotion, nurturing the professional-patient relationship in each encounter, being realistic (available resources and time).

The learning of skills, attitudes, and knowledge to optimally conduct the clinical interview must be recognized and worked on (therapeutic failures may be due to factors such as the absence of structured learning in a clinical interview). The essential elements of the »

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ESSENTIAL ELEMENT	TASKS
ESTABLISH RELATIONSHIP	Promote collaboration between doctor and patient. Respect the patient's active participation in decision-making.
OPEN THE DISCUSSION	Allow the patient to complete their opening statement. Encourage the patient to express their concerns. Establish and maintain a personal connection.
GATHER INFORMATION	Use open and closed questions appropriately. Structure, clarify, and summarize the information. Listen actively using verbal and non-verbal techniques.
UNDERSTAND THE PATIENT'S PERSPECTIVE ON ILLNESS	Explore contextual factors (family, culture, gender, age, socioeconomic and spiritual status). Explore beliefs, concerns, and expectations about health and illness. Recognize and respond to the patient's ideas, feelings, and values.
SHARE INFORMATION	Use language the patient can understand. Check for understanding. Encourage questions.
REACH AGREEMENTS ON PROBLEMS AND PLAN	Encourage participation in decisions to the extent the patient desires. Check the patient's willingness and ability to follow the plan. Identify and list support and resources.
CLOSE THE CONSULTATION	Ask if the patient has any other pending issues. Summarize and confirm the agreed-upon action plan. Discuss follow-up (e.g., next visit, plan, possible unexpected events).

"The people will forget what you said, they will forget what you did, but they will never forget how you made them feel." ***Maya Angelou***

THE LEARNING OF SKILLS, ATTITUDES, AND KNOWLEDGE TO OPTIMALLY CONDUCT THE CLINICAL INTERVIEW MUST BE RECOGNIZED AND WORKED ON

» Clinical Interview (as a doctor-patient communication process) according to the Kalamazoo Consensus 2001 are:

The Clinical Interview with chronic patients can present a series of challenges, which, by establishing basic rules and identifying frequent errors to avoid, can be addressed to improve the communicative process (Borrel, F):

1. A diagnosis of chronic illness often changes the lives of people with diabetes. At this time, resistance, emotional blocks, and other adaptive reactions may be perceived. Improvement proposals: try to find out what the patient knows about the disease, clearly name the type of disease they have, but respect the initial phase of resistance (if necessary, address it in another interview), pay attention to aspects of their lives to create alliances.

2. Reactions of denial or avoidance (identified by lack of compliance or adherence). Empathy should be shown, flexibility should be established in therapeutic plans, teamwork should be implemented (important role of nursing), close monitoring should be conducted, and even contact with the pharmacy or inclusion in community activities.

3. Addressing discrepancies optimally strengthens the therapeutic relationship: the ultimate responsibility for the patient's behavior lies with the patient themselves, which does not imply not showing flexibility (for example, if they want another opinion, or consider other therapies); do not show anger if they have followed other professional recommendations, but respecting does not mean ceasing to influence decisions, as the maximum benefit for patients should be sought. In the failure of a relationship, the professional should not always be blamed; the person with diabetes, the media, opinions of other patients, etc., can also influence it.

4. Establish the foundations of the relationship on the patient's trust and realistic expectations: see people with diabetes beyond their role as patients (they have hobbies, worries, illusions) and know their family life cycle.

Patients value a series of characteristics in their doctors, which are necessary to improve clinical interviews:

- **Cordiality:** respect, kindness, consideration, and attention in the established relationship, shown mainly through non-verbal communication (looking at the patient, tone of voice used, calling them by their name, shaking their hand, etc.).

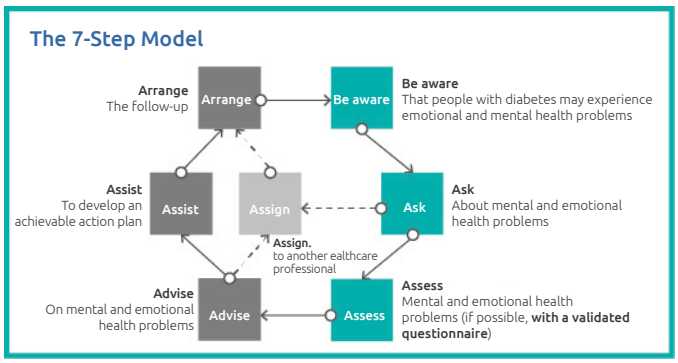
- **Reactivity:** the time that elapses from when the sender finishes speaking until the receiver begins, which reflects the professional's ability to listen in a bidirectional way (do not interrupt, use silences, avoid the continuous use of the computer inhibiting communication, facilitate free narration with verbal and non-verbal elements, etc.).

- **Assertiveness:** the professional's ability to transmit credibility and security to the patient, without hostility or aggressiveness (respond emotionally calmly to patient complaints and demands, do not be aggressive in responses if professional capacity is doubted, know how to ask for help if the professional's clinical capacity is exceeded, etc.).

- **Empathy:** the ability to identify with the person with diabetes and share their feelings. It does not mean agreeing with them and is therapeutic per se. It is important for professionals to strive to be more empathetic, understanding, and increase their communication skills.

Communication is a skill that can be learned with time and practice and can always be improved. **Motivational interviewing** is a style of professional-patient relationship centered on the person's experience, where the professional's attitude to achieve the appropriate bond is empathy, warmth, tolerance, mutual cooperation, authenticity, and respect for the patient's autonomy. It is the professional who stimulates, but tries to ensure that the decisions for change come from the patient. Motivating or helping to change means getting the patient to discover their motivating elements or reasons. »

https://www.sediabetes.org/wp-content/uploads/Manual_psicologia_diabetes_SED_Completo_V-Digital.pdf



"Watch your thoughts, for they become words. Watch your words, for they become actions. Watch your actions, for they become habits. Watch your habits, for they become your destiny." ***GANDHI***

» It is a dynamic model that describes a seven-step process that can be applied in clinical practice as part of a person-centered approach. It is an adaptation of the 5 As model, named after the initials of each of the steps: "Ask," "Assess," "Advise," "Assist," and "Arrange." The two new contributions to this model, "Be Aware" and "Assign," reflect the need to monitor emotional distress and the potential need to refer the person with diabetes to other reference professionals.

Some keys to effective communication:

- Active listening: listen to what and how they say it, show interest, avoid interruptions, etc.
- Body language: observe the person's non-verbal communication and take care of non-verbal language as professionals (barriers in the position of closed arms, etc.).
- Information clarifications and paraphrasing: repeat key information if important, encourage the person to ask questions and/or to say in their own words what we have explained, etc.
- Develop a good connection: through repeated consultations, establish a relationship far from criticism or lack of support, maintain a balanced conversation (do not be only or mostly the professional speaking).
- Explain things and give instructions clearly: use simple language (avoid technical terms), provide information in writing, establish expectations at the beginning of the consultation (for example, regarding the time available), communicate if we are going to refer to another professional, do not make them feel despised or irrelevant, etc.
- Feedback: give the opportunity to express their opinion.
- Listen in silence: allow silences and know when to ask if they last too long.
- In conclusion: summarize plans at the end of the consultation, propose a follow-up visit, thank them for sharing their experiences, etc. D

CONCLUSIONS:

- Language in diabetes makes an important and positive difference in the emotional well-being, self-care, and health outcomes of people affected by diabetes.

- The best clinical and functional outcomes in people with diabetes (chronic disease) are achieved when they are informed and activated by a team of health care professionals (teamwork, multidisciplinary, proactive).

- Communication skills are clinical competencies that favor an effective consultation and can be taught and learned.

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