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Diabetes and guidelines in practice

LEDER

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Good patient information, including a diabetes education course, is a patient right.

Between 316 000 and 345 000 people in Norway are estimated to be living with diabetes. Of these, approximately 90 % have type 2 diabetes and roughly 60 000 have not been diagnosed (1). The purpose of diabetes treatment is to prevent complications and preserve a good quality of life. Treatment for hypertension, high cholesterol and hyperglycaemia, as well as guidance on quitting smoking, eating a healthy diet and getting regular physical exercise, reduce the risk of complications and excess mortality (2).

Hare et al. have conducted focus group interviews of 17 GPs, and the results are published in this issue of the journal (3). The study aimed to investigate GPs' experiences with and thoughts about diagnosing and following up people with type 2 diabetes. The doctors described how the diabetes care they provided was patient-centred and based on their clinical experience, indicating that guidelines were advisory rather than compulsory. This enables the provision of individualised and personalised care, but it can also result in inadequate follow-up pursuant to national guidelines.

Published in 2009, the national guidelines on the treatment of diabetes are intended to ensure good-quality treatment, prevent undesirable variation and establish appropriate priorities (2). In consultations with individual patients, however, doctors must weigh up the advantages and disadvantages of treatment. Many familiar dilemmas arise when doctors have to apply a large number of disease-specific guidelines for patients with comorbidities (4). This is often relevant in cases of diabetes. Patients with complications or comorbidities require several different medications, which can increase the risk of potentially dangerous adverse effects. However, a study from a Norwegian GP practice showed that overtreatment of elderly patients with diabetes, defined as at risk of hypoglycaemia, occurred much less frequently than in comparable studies from the United States (4).

Experienced GPs in the study by Hare et al. agreed that more patients than previously with no known diabetes want a health assessment that includes an HbA1c test (3). Current guidelines on diabetes recommend to first use a validated risk score form instead of an HbA1c test for people of ethnic European descent (2). An HbA1c test should be used primarily for patients of African and Asian descent, upon clinical suspicion of diabetes and

for conditions that entail a high risk of diabetes (2). The doctors who were interviewed knew about the recommended risk score, but chose instead to make a holistic evaluation of the risk of diabetes (3). As Hare et al. aptly point out, this can give rise to a social gradient, whereby people who do not request an exam can remain undiagnosed longer.

All doctors who treat patients with diabetes must be informed of the benefits of using the NOKLUS diabetes form and that patients have a right to receive information about the diabetes education course

The Specialist Health Service Act states that education for patients with chronic disease is one of four main tasks of Norwegian hospitals (2). The website of the Norwegian Diabetes Association informs those with recently diagnosed diabetes that they have a right to patient education – in practice, a diabetes education course. According to a survey from 2020 (5), however, two out of three doctors are not aware of this patient right, and data from the Norwegian Diabetes Register for Adults show that only one in four people with type 2 diabetes have attended such a course. The GPs in the study by Hare et al. also discussed referrals to a diabetes education course (3). Most of them preferred to assume responsibility for patient education themselves, even though motivating patients to adopt lifestyle changes can be challenging and time consuming.

Some GPs in the study criticised the use of the NOKLUS diabetes form (3). Those who used it claimed that the form provided more structured follow-up and that it simplified the work involved in annual check-ups. We have shown that the form promotes greater application of recommended procedures, but it varies widely as to whether or not GPs actually implement them (6). The most compliant one-fifth of doctors in the study implemented six recommended procedures for most of their patients, while the least compliant one-fifth rarely examined any type 2 diabetes patients for albuminuria or nephropathy. This is a problematic variation in treatment quality, especially because patients treated by doctors in the least compliant one-fifth had a higher risk of cardiovascular disease (own unpublished data). The financial incentives for first-time users of the form and for annual submission to the Norwegian Diabetes Register for Adults have recently increased slightly, but remain relatively modest. The consent requirement has been replaced with a patient's right to refuse, which will most likely increase the use of the form.

The study by Hare et al. is relevant for everyone who is interested in diabetes, and it provides useful input for the ongoing revision of the guidelines. All doctors who treat patients with diabetes must be informed of the benefits of using the NOKLUS diabetes form and that patients have a right to receive information about the diabetes education course.

REFERENCES:

1. Stene LC, Ruiz PL, Åsvold BO et al. How many people have diabetes in Norway in 2020? Tidsskr Nor Legeforen 2020; 140. doi: 10.4045/tidsskr.20.0849. [PubMed][CrossRef]

2. Helsedirektoratet. Nasjonal faglig retningslinje for diabetes. https://www.helsedirektoratet.no/retningslinjer/diabetes Accessed 16.3.2021.

3. Hare L, Hetlevik A, Yogaranjan R et al. Type 2-diabetes i fastlegepraksis – en fokusgruppestudie. Tidsskr Nor Legeforen 2021; 141. doi: 10.4045/tidsskr.20.0623. [CrossRef]

4. Tran AT, Berg TJ, Mdala I et al. Factors associated with potential over- and undertreatment of hyperglycaemia and annual measurement of HbA1c in type 2 diabetes in norwegian general practice. Diabet Med 2020; 37: e14500. [PubMed]

5. Kalveland J. Nesten to av tre svarte feil om legemiddel-bruk. Dagens Medisin 8.10.2020. https://www.dagensmedisin.no/artikler/2020/10/08/nesten-to-av-tre—svarte-feil-om—legemiddel-bruk/ Accessed 16.3.2021.

6. Nøkleby K, Berg TJ, Mdala I et al. Variation between general practitioners in type 2 diabetes processes of care. Prim Care Diabetes 2020; 14: S1751-9918(20)30334-X. [PubMed]

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