

# Patient-centered care in diabetology: sub-Saharan African perspectives

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## Introduction

Patient-centred healthcare, while a common terminology, is a concept that is rarely understood by many care providers. It is **not** technology-centred, doctor-centred, hospital-centred, or disease-centred. Patient-centred care is part of a shift in healthcare focus that has been occurring over time. As the number of patients with chronic conditions, e.g. diabetes, continues to increase, health systems cannot cope if they remain focused on a disease rather than the person. They require the involvement of the patient to adhere to treatment, make behavioural changes, and to self-manage. There is a group realisation that patient-centred care (PCC) which addresses the needs and preferences of patients, may also be the most cost-effective way to improve health outcomes for the growing number of patients with diabetes.<sup>1</sup>

## Historical background

The term 'patient-centred care' (PCC) was introduced by Michael Balint in 1970, in order to give a name to a particular way of thinking.<sup>2</sup> PCC referred to a concept attempting to understand the complaints offered by the patient, and the symptoms and signs found by the healthcare professional, not only in terms of illness, but also as expressions of the patient's unique individuality, tensions, conflicts, values, and problems.<sup>2</sup>

This was in contrast to the illness-centred way of thinking which considered the human being as a complex bio-medical machine and thus attempted to understand the patient's complaints in terms of illness, that is, in terms of a pathologically changed part of the body or of a part-function of the body.

These two ways of thinking led to different understandings of the patient and his problems. The understanding based on illness-centred thinking, Balint called traditional diagnosis; the understanding based on PCC, he called the overall diagnosis.<sup>2</sup>

Capra<sup>3</sup> gave an account of the holistic medical tradi-

tions namely:

- the phenomenon of shamanism which is so prevalent in non-literate cultures of Asia and Africa, even till date;
- the system of classical Chinese medicine that forms the basis of most Eastern medical traditions;
- the tradition of Hippocratic medicine that lies at the roots of Western medical science.

The Hippocratic tradition, in contrast to shamanism and classical Chinese medicine, holds firmly the conviction that illnesses are not caused by supernatural forces, but are natural phenomena that can be studied scientifically. However, an emphasis on the fundamental interrelations of body, mind, and environment is shared by all three traditions.

## Aims and methods

The aims of this review areas follows:

- To underscore the rationale of PCC which should be entrenched in the minds of those working in the field of diabetology and accepted in the same way as evidence-based care.
- To identify, highlight, and promote the principles of PCC from the African perspective.

Data were collected by consultation of information on the internet (using search engines and online databases) and in libraries. Sources used included: international, regional, national, and local healthcare policies and regulations; and peer-reviewed academic and research papers (including theses); as well as printed books and reports. Review papers were particularly vital to ensure we did not 'reinvent the wheel' and this review acknowledges and cites such works.

## Evolution of patient-centred care

The central hypothesis of the client-centred approach is that the patient has within himself or herself vast resources for self-understanding and for constructive changes in ways of being and behaving and that these resources can best be released and realised in a relationship with certain definable qualities. It is the quality of the relationship between the health professional and the patient that is central to the therapeutic process. The three key attitudinal elements or characteristics of the health professional that are vitally important in providing PCC are: genuineness, unconditional positive regard and empathy.<sup>4,5</sup> Empathy is one of the most powerful ways

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we have to impact on the PCC because almost always, when a person realises he has been deeply heard, his eyes moisten and in some real sense 'he weeps for joy'.<sup>6</sup>

This focussing on the person rather than the disease became one of the key principles of family medicine<sup>4</sup> and is central to the concept of PCC. The family physician is committed to the person rather than to a particular body of knowledge, group of diseases, or special technique.<sup>7</sup> The re-discovery of the concept of PCC during this century has been a most exciting process. It actually began with the recognition by general practitioners (family physicians) of a lack or deficiency in their medical training.<sup>2</sup>

The theme of PCC represents the application of holistic thinking to patient care and recognising the person as an integrated biopsychosocial whole at a given stage of his or her life-cycle.<sup>8</sup> Healthcare professionals must realise that before explanation and advice can be given to a patient, they must make three diagnosis: the diagnosis of the disease, the diagnosis of the concept or fears of the disease in the minds of the patients or parents, and thirdly the diagnosis of the patient's capacity to understand the explanation and follow the advice.<sup>9</sup> The patient's reasons for coming to the doctor have been found to include ideas, attitudes, feelings, and expectations. The ascertainment of these reasons for coming is in addition to the doctor's task of making a diagnosis.<sup>10</sup>

Essentially the health professional's role is that of a catalyst, facilitating the inherent potentials exist within each patient and family, and helping them to find healthy solutions to their problems instead of disease.<sup>11</sup>

## Dimensions of PCC

PCC is a collaborative effort patients, patients' families, friends, and healthcare professionals aimed at achieving the common goal of the patients' recovery. This is placing the patient at the centre of the healthcare system and developing good services that revolve around them and are responsive to their needs and preferences. This is depicted graphically in Figure 1 in which the attributes of PCC, as discussed above, are represented and reorganised in a system theory format. A system theory approach basically involves a system of input, process, and output situated within an environment.<sup>12</sup> The environment in which the proposed system is situated is the field of healthcare (be it medical, nursing, or pharmacy practice).

## PCC versus African health systems

The concept of PCC has attained centre stage in diabetology. Current guidelines, released by the American Diabetes Association and the European Association for the Study of Diabetes (ADA/EASD) use the term 'patient centred approach' while defining strategies for management of hyperglycaemia.<sup>13</sup> This has led many students of diabetes to feel that PCC is a modern concept. Yet others assume that PCC is a Western idea, whose utility is limited only to advanced, educated-nation societies. Many

African healthcare professionals doubt the relevance of PCC, and its sister concepts of shared decision making (SDM) and patient empowerment (PEM), in their setting.

The definition chosen by the authors of the ADA/EASD guidelines', and crafted by the Institute of Medicine, USA, encapsulates the essence of PCC. PCC is defined as 'care that is respectful of and responsive to individual patient preferences, needs, and values' and that ensures 'that patient values guide all clinical decisions.'<sup>14</sup> Does African medicine embody PCC? Is PCC relevant for

Africa? What can be done to strengthen PCC in the context of African diabetology? While these questions have been addressed earlier, in the context of the holistic approach of Afro-Asian cultures, the concept of PCC has not been discussed from a sub-Saharan viewpoint.<sup>15</sup>

## Traditional African medicine

Traditional medicine has existed in various parts of the African continent for centuries. Modern medicine, including diabetology, is judged by the yardsticks of traditional beliefs. The fact that a significant proportion of educated Africans still turn to traditional medicine for diabetes care, should cause one to wonder why? Is it perhaps that traditional African medicine is more patient-centred than modern diabetology? Do people with diabetes expect PCC, and turn to traditional healers for this care?

## Aetiology of diabetes

The traditional medical systems of Africa do not conceptualise chronic disease, and do not follow a biomedical model of disease. Rather, acute illness are explained by a psychological model which utilises supernatural happenings as aetiological factors. The patient's existing belief systems and knowledge level is taken into consideration while making a diagnosis. A chronic disease such as diabetes is broken down into a series of acute episodes, and explained accordingly. The aetiology of illness, including diabetic complications, may be explained by the supernatural. The IKung tribe of the Kalahari desert, for example, believe that all disease is caused by the God 'Hishe', who also sends down cures through medicine men. The Ibos of Nigeria attribute disease to multiple causes, including enemies who practice 'igba ogwu' (igba ntutu, nshi) or implantation of harmful objects into a person's body. Ifa medicine, practiced by Yorubas of Nigeria, ascribes disease to a disturbance of the internal or external milieu of the individual. In this context, Ifa medicine predates modern medicine by many centuries, by propounding and utilising the biopsychosocial model of illness. All African-belief medical systems keep the patient at centre stage while explaining the aetio pathogenesis of disease, and do so in comprehensible culture-specific terminology. This basic rule should be followed by modern health providers too, if optimal adherence to prescribed therapy is expected.

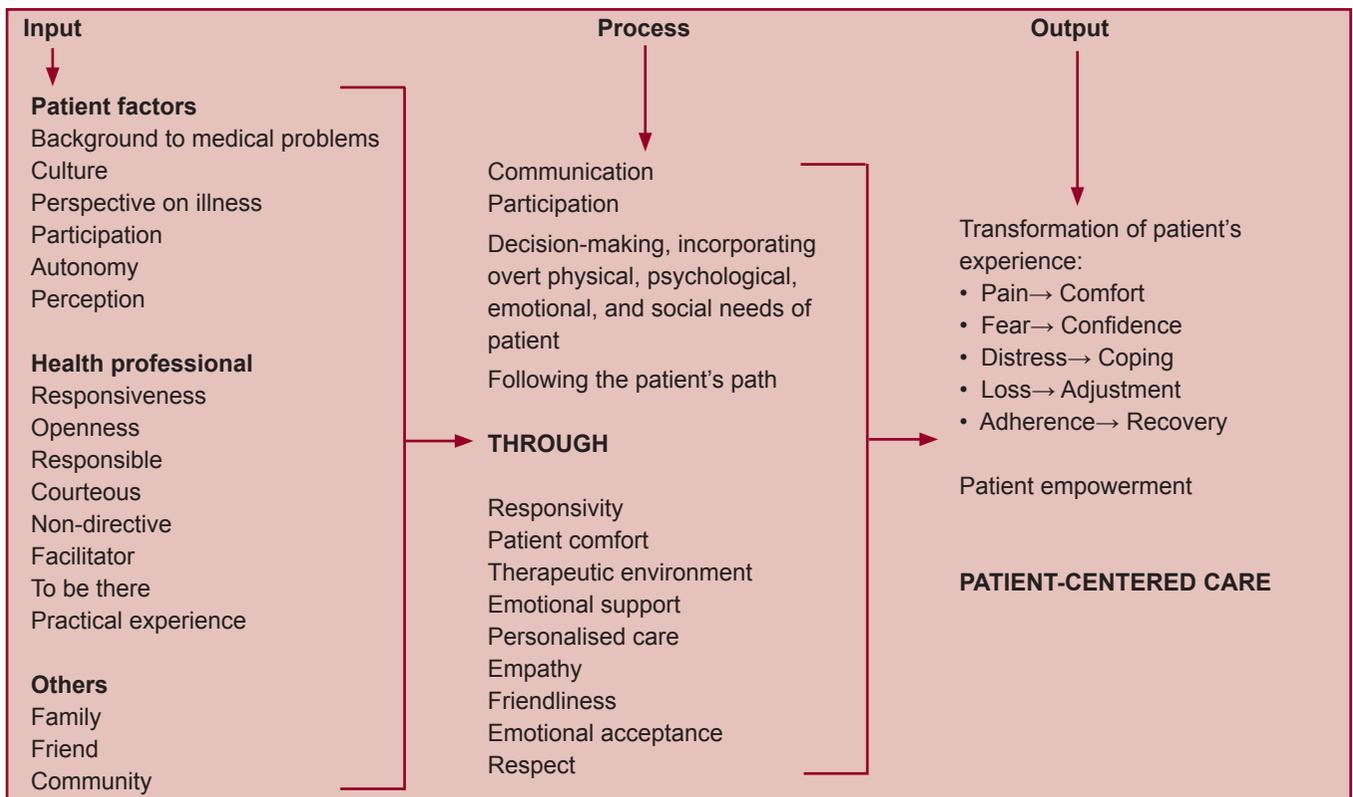


Figure 1 A system perspective on patient-centred care (modified from reference 12)

## Diagnosis of diabetes

African medicine, in general, follows a patient-centred trajectory. Diagnosis of disease is done by history taking, observation, and touching, which again make the individual feel at the centre of the therapeutic process. Other methods such as divination and dream interpretation are used by the sangomas of South Africa and Ifa priests of Nigeria. These methods of diagnosis require active involvement of the patient, which is a feature of PCC. While laboratory investigations are essential, asking people with diabetes to keep food diaries, self-monitoring logs, or record their insulin doses regularly, are means of strengthening patient involvement in the process of diagnosis.

## Traditional management

Traditional healers or medicine men have used available herbs, animal products, and non-pharmacological ways of treatment to help patients fight acute illnesses such as fever and pain. Management of disease is effected in an individualised, multitherapeutic manner. Dietary restrictions are an important aspect of all African medical systems. Herbs are used by many traditional medical practitioners including the Inyanga of Swaziland. Yet others use charms, incantations and dances to cure disease. These are the fore runners of placebos, psychotherapy, and physical therapy used in modern medicine. In all these aspects traditional African medicine displays char-

acteristics of lifestyle modification and PCC, which are embedded in traditional practice.

## The African community and diabetes

African society lays a strong emphasis on the family, community, tribe, and religion. This implies that a person with diabetes cannot be treated in isolation. Appropriate modulation of the family and village is an integral part of traditional medical care. As such, this mirrors (or rather, predates) the family therapy and community involvement strategies of modern diabetology. Traditional African medicine has a strong religious and cultural dimension, and is integrated in the social fabric of society or community. Treatment is prescribed not only to an individual, but often to the family or community as well.

In the rapidly changing social scenario that we live in, the importance of family in diabetes care cannot be underestimated.<sup>16</sup> Domestic causes of stress, such as marital discord and financial challenges, are common precipitating factors for uncontrolled hyperglycaemia. Correcting these, and involving the family in providing a positive nutritional, physical and emotional environment, certainly helps in achieving good glycemic control. At the same time, the role of the community cannot be overlooked.<sup>17</sup> An extension of PCC is requesting community leaders to encourage healthy habits, infrastructure such as playgrounds, and allow diabetes education at social platforms such as weekly markets. Community elders can function as 'diabetes evangelists', spreading

the word about diabetes care, and promoting healthy diabetes care-seeking behaviour in the population. Religious leaders and traditional chiefs have an important role to play in this regard. One should utilize the services of traditional medicine practitioners to improve diabetes awareness as well.

## Modern African environment

The modern Africa is changing rapidly. In the current socioeconomic environment, the average African enjoys better literacy, education, communication, and awareness than before. This holds true for the average African person with diabetes as well. Given a choice, he or she would expect to have a say in his or her medical management; he or she would certainly make appropriate choices, provided they are made diabetes literate and numerate, through a process of patient education.<sup>18</sup> The concept of PCC should also incorporate the financial aspect of therapy, especially in countries where people pay from their pocket for medical expenses. It should understand geographical realities as many patients have to travel long distances to seek medical advice or obtain drug supplies. The existence of social support, cold chain facilities, and laboratories for the monitoring of glycaemia are other issues which need to be addressed while formulating a PCC programme.

## Conclusion

PCC as a concept is perfectly suited to the current African health environment. In fact, this approach needs to be expanded and developed to fit the African context. Family-centred and community-oriented therapy must be practised, keeping the family and community as interventional units. Elements of traditional medicine must be incorporated into counselling strategies to make them more effective. PCC should be considered an integral, centuries-old part of African diabetes care, rather than

being thought of as a Western concept which has to be forcibly transplanted on to African soil.

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