

Comprehensive Education Oriented to Patients with Diabetes Mellitus to Optimize Quality of Life

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The global perspective shows that, in recent years, there has been a considerable increase in the incidence of DM, acquiring a global epidemic dimension. Around four hundred sixty three (463) million people in the world suffer from diabetes according to the International Diabetes Federation [1]; 3 out of 4 people living with diabetes (352 million) are in an active age range; there are 111 million persons over 65 years with DM, representing that in elderly 1 in 5 people have diabetes. There is evidence that type 2 diabetes (T2D) among children and adolescents is on the rise in some countries. Additionally, 1.1 million children under 20 have type 1 diabetes (T1DM).

On the other hand, people at risk to sustain DM are in a frank increase, that may worsen because knowledge about the condition, its complications, pharmacological treatment, nutritional approach, exercise, metabolic control goals and lifestyle changes that are part of the bulk of comprehensive management are unknown by a very large number of patients and their relatives. In this scenario, education plays a leading role when it is assumed as a strategy in the construction, growth and development of the individual and society in order to optimize harmonious styles and conditions that allow achieving quality of life Contreras, etc [2]. Therefore, education as a therapeutic strategy is not an easy task, especially considering that it is exercised in different ways and acquires different meanings depending on the cultural, economic, social and political context in which the patients interact with their environment and their health professionals. Furthermore, the current dynamics streams of human development focus on people and their ability to guide their lives, to develop and achieve personal fulfillment, that is, to transform.

Diabetes therapeutic education (DTE), according to the World Health Organization [3], is an educational process integrated into treatment, by means of which, it is attempted to provide people with DM and their families the capability (knowledge, skills and attitudes) and the necessary support to be able to take responsibility for self-management. It is imperative that patients understand their clinical condition and the bases of treatment, so they can integrate it into their daily lives, be able to prevent, recognize and act in acute risk situations and prevent vascular risk factors [4]. In this sense, imparting diabetes education requires a series of knowledge, abilities, aptitudes and attitudes determined by health professionals who are dedicated to DTE.

Current trends advocate for the patient to learn how to self-manage their clinical condition. For this, the health professional must provide treatment by working on "empowerment", promoting their autonomy, so that the patient himself manages his entity in the different situations of his daily life and making his own decisions.

Good control of diabetes passes through a patient trained in knowledge related to the condition he suffers from. In this sense, the Diabetes Attitudes, Wishes and Needs second study (DAWN 2TM) [5] showed that only 48.8% of the participating subjects had engaged in any diabetes education program. Other data shows that people who receive some form of self-management education perform an annual eye

exam, a foot exam, and vaccinate more frequently than those who did not received it Clement., *et al.* [6,7] conversely, patients who have never gotten education about the disease are four times more at risk of complications attributable to the entity.

For the purposes of disseminating education, and in accordance with what was stated by the United Nations in the final document of the 1993 World Conference on Human Rights, integral or comprehensive education is defined as the formation oriented “towards the full flourishing of the person and towards strengthening human rights and fundamental freedoms. It is a comprehensive education capable of preparing autonomous subjects who are respectful of the liberties of others” [8]. In other words, it must be included in the cognitive, emotional and social sphere.

At present, having a comprehensive and thorough diabetes mellitus education has become a necessary task for the health sector. Adequate knowledge of the disease, adequate compliance with treatment, as well as family and social support, will be essential elements to achieve a better quality of life and constitute elements that make an integral diabetes education the prototype for patient training, family and diabetes educator.

In a structured comprehensive education program, the patient attends 2-hour medical care sessions (consultations) and is attended by a multidisciplinary team of professionals from Medicine, Nursing, Psychology, Nutrition, Social Work, Physical Training, Ophthalmologists (retina specialists), Podiatrists and Diabetes Educators. The axes that are interrelated for comprehensive diabetes education are: 1) Prevention; 2) Detection; 3) Treatment; 4) Self-control; 5) Rehabilitation and monitoring through a continuous remote support system. The program promotes empowerment and self-care in patients with diabetes through outpatient consultations complemented by ongoing training workshops.

In the authors' opinion, comprehensive diabetes education should be aimed at improving the quality of life of the patient through two main dimensions: 1) family micro environment tending to guarantee reduction of body overweight, optimizing metabolic control goals, systematic practice of physical activity, decrease in acute and chronic complications and decrease in feelings of disability, reducing hospital admissions and the daily dose of medications and 2) adequacy of the public health system and public health policies and health professionals and patients grouped into associations or foundations that guarantee individual and collective health through guidelines/protocols/national standards, based on evidence against diabetes; standardized criteria for the referral of patients from primary care to a higher level; national survey on risk factors and diabetes; diagnostic procedures blood glucose measurement (also strips to measure glucose and ketones in urine) oral glucose tolerance test, A1c test, ophthalmoscopy with dilatation, perception of foot vibration with diapason, Doppler test to determine the foot vascular state and retinal photocoagulation; availability of medicines in primary care centers.

There is no doubt that the expressions of Joslin [9-11] are still more valid than ever, “education is not a part of the treatment of diabetes, it is the treatment” and “The diabetic who knows the most, is the one who lives the most” and given that Diabetes Education is one of the fundamental pillars to achieve the short and medium term objectives and because any member of the health team can fulfill this role, it is necessary to give relevance of connoted value to education in DM as a therapeutic strategy.

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