

Impact of Family Medicine Education on the Standard of Care for Diabetes Patients

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Introduction

A crucial part of diabetes care aimed at preventing complications is diabetes self-management education (DSME). DSME is a more structured instructional method than standard treatment, delivered by certified, trained diabetes educators (CDE). Many diabetes patients in Kenya have not yet received this crucial aspect of therapy. The situation is similar at the family medicine clinic of the Aga Khan University Hospital (AKUH), Nairobi; the majority of patients are not CDE-educated. Non-blinded randomised clinical trial with individuals with type 2 diabetes who have sub-optimal management (HbA1c 8%). DSME via CDE along with standard treatment was the intervention, as opposed to standard care from family physicians. HbA1c mean difference after six months of follow-up was the primary outcome. Body mass index and blood pressure were secondary outcomes [1].

Diabetes mellitus (DM) is a chronic condition with crippling side effects. It is advised that diabetic patients make a variety of self-management choices and perform intricate care tasks. People with diabetes are assisted in making these choices and engaging in these activities to enhance their health outcomes via diabetes self-management education (DSME) and support. DSME may be the foundation for reducing and avoiding severe consequences from diabetes, as well as the accompanying monetary and personal expenditures. Our goal was to evaluate how a diabetic self-management education programme affected the glycaemic control of diabetes patients. In Ismailia, Egypt, in the family medicine clinic of the Suez Canal University hospital, a quasi-experimental pre-post study was carried out. After applying the inclusion criteria, 116 participants with uncontrolled DM were enlisted using a straightforward randomization procedure [2].

Description

Family medicine education

Health education is crucial in resource-limited settings like ours, where DM poses a significant financial burden and necessitates the immediate involvement of clinicians at all levels, especially primary care doctors as they are frequently the first to provide care and come into contact with both known and recently detected diabetics. Primary care physicians can provide these patients with health education to encourage them to adopt healthy lifestyle practises, stay motivated for routine glucose status testing, and be aware of diabetic complications. To achieve glycaemic control and stop the emergence of diabetes complications, diabetic people must make the ensuing changes in their knowledge, attitude, and practises [3].

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Date of Submission: 04 August, 2022; Manuscript No. JGPR-22-79409; Editor Assigned: 05 August, 2022, PreQC No. P-79409, Reviewed: 16 August, 2022; QC No. Q-79409, Revised: 21 August, 2022, Manuscript No. R-79409; Published: 28 August, 2022, DOI: 10.37421/2329-9126.2022.10.466

The study complied with the Helsinki Declaration with regard to data gathering. It was requested that the institutional ethics committee approve. The study's objective was stated to each participant, and they were all given the assurance that their information would be kept strictly confidential and utilised solely for academic purposes. Before the entire surgery, every one of them gave their free and informed consent. If they choose not to take part in the study, the participants had that option. The baseline levels of understanding, attitude, and practises about DM were evaluated. Each participant got a thorough history review, clinical examination, and any necessary laboratory investigations. In addition to verbal counselling at baseline, the case group participants got health information about their disease, medications, dietary changes, and lifestyle modifications in the form of a "patient education leaflet." [4].

Data analysis: The findings were statistically evaluated to see how health education has affected diabetic patients' knowledge, attitudes, practises, and glycaemic control. The Armonk, New York-based IBM SPSS Statistics for Windows, Version 11.0 SPSS software was used for the analysis after the data were imported into Excel spread sheets. The effectiveness of the health education intervention was evaluated using a pre-tested closed-ended questionnaire, where each response received a score of 1 or 0 (Yes, No). Information on the knowledge, attitude, and practise aspects of diabetic patients was derived using means. To evaluate the efficacy of the health education intervention, a paired t test was used on the pre-test and post-test outcomes of knowledge, attitude, and practise regarding diabetes. A P value of 0.05 was considered statistically significant [5].

Environmental, physical, social, emotional, intellectual, and spiritual health is all included in health education. Sincere health education can improve people's knowledge, attitudes, and behaviours and help them better manage their diabetes. It is widely recognised as a crucial component of comprehensive diabetes care, particularly in places with limited resources where diabetes is a significant financial burden. The complications of DM negatively affect patients' and their families' quality of life and have a severe long-term impact on their financial and social well-being. Numerous studies conducted thus far point to the benefits of health education in terms of halting illness development and avoiding consequences.

The average knowledge, attitude, practise, and KAP SUM scores of the patients in this study, tested at the conclusion of the study compared to the controls, significantly increased from the baseline. Thus, educating people about their health significantly improved knowledge, attitude, and practise in all three areas of managing diabetes. The intervention group had significantly more general diabetes knowledge than the controls, increasing from 18.05% to 25.43%. After receiving health education, the intervention group's patients exhibited a significant improvement in their mean scores for knowledge about diabetes, self-care habits, and consequences of diabetes. At the last follow-up from, a considerable drop in the fasting and postprandial blood glucose levels was also noticed.

Conclusion

The Suez Canal University hospital in Ismailia, Egypt, hosted the family medicine clinic where 12 weekly sessions of the DSME intervention programme were held. The first session covered programme introduction, different forms of diabetes, and discussion of the symptoms, signs, and treatments of hyper- and hypoglycaemia. At the start of the first diabetes self-management session, the

participants were asked to express how they felt about the diabetes diagnosis. The other eleven sessions covered topics including managing symptoms, taking medications, staying active, checking your blood sugar, and managing problems. Each participant brought home tasks at the conclusion of each session with the intention of consolidating the lessons learned and sharing their experiences, successes, and challenges the following week.

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How to cite this article: Emara, Reham Abo. "Impact of Family Medicine Education on the Standard of Care for Diabetes Patients." *J Gen Pract* 10 (2022): 466.