AOA Health Watch interviewed endocrinologist and diabetes expert Cheryl R. Rosenfeld, DO, about the obstacles physicians face to successful diabetes management. She also describes and dispels some common diabetes myths. Dr Rosenfeld is currently in private practice at North Jersey Endocrine Consultants in Denville, NJ, and is affiliated with Newark Beth Israel Medical Center and Saint Clare’s Hospital in Denville, NJ, and the New York College of Osteopathic Medicine of the New York Institute of Technology in Old Westbury, NY. She is widely published in both professional and lay publications.
HW: What is the greatest obstacle to successful diabetes management?

Dr Rosenfeld: Misinformation. Many patients accept some popular myths, as do some referring physicians. Patients may talk to friends or visit Web sites or patient blogs that dispense misinformation. Some commercial Web sites also tout products (particularly natural therapies) that are untested and could turn out to be harmful. I tell my patients with diabetes who have access to the Internet to visit the Web site of the American Diabetes Association at www.diabetes.org.

One of my patients recently voiced a common myth, saying “I don’t want to be on this much insulin.” I asked her why, and she responded, “It will hurt my kidneys.” The notion that insulin causes end organ damage is a myth. I usually tell patients that there are many published studies showing that patients with diabetes who are uncontrolled may develop end organ damage. This is not usually true, though, of patients who are well-controlled and on insulin. It is not the insulin that causes the kidney damage, but the lack of control. Often it takes many years for patients with uncontrolled diabetes to accept insulin and by then the damage is already done.

HW: What is a key to success in diabetes management?

Dr Rosenfeld: Generally time is the biggest help I can give my diabetes patients. I spend at least 40 minutes talking to new patients, questioning them on what they already know about their diabetes, how they have been treated, and if there are any social barriers to treatment. I want to know who lives at home, are they caring for someone else, and if they require special care.

For my elderly patients in particular, I want to know if they live alone or with family members. Next, I ask about their eating habits. Do they skip meals? Do they eat their meals? I also check on their medications. Do they admit to forgetting their medication? When? How often?

HW: Do you see health illiteracy as an important barrier to effective physician-patient communication?

Dr Rosenfeld: No longer. Patients today are savvy. Between the Internet and TV, patients generally have a lot of information. There is a TV program focusing on diabetes called dLifeTV, for example, airing Sunday evenings on CNBC. In fact, with people being more knowledgeable, they sometimes are in danger of extrapolating this information incorrectly when it applies to their own situation.

A case in point is a type 2 diabetes patient who visited my office asking for a pancreas transplant because he had heard that pancreas transplants are helpful in diabetes. Pancreas transplants are not for type 2 diabetes, and they don’t always work well for type 1 patients.

One of the greatest sources of consumer misinformation is from direct-to-consumer advertising on television. Sometimes patients get so much information that they become overwhelmed and find it difficult making good choices. That’s another reason why it is so important for patients to talk to their doctors, and for doctors to give adequate time to their patients.

HW: Many newly diagnosed patients with type 2 diabetes are fearful of being put on insulin. Is it better to tell them not to worry, that insulin therapy will only be needed when oral medications fail, or to tell them up front that insulin will be needed and that its use does not constitute a failure of oral therapy?
I spend time with many people who help I might have answered this question differently 10 years ago. Then I would have told patients that “Inevitably within 15 years of diagnosis of type 2 diabetes, most patients wind up on insulin because of progressive pancreatic failure.” I would explain that it is a natural occurrence in the disease and it doesn’t mean that they did anything wrong.

Today, I most likely would explain that newer medications that have been out for the past 10 years make beta cell failure, a little less likely, or less likely to occur within 15 years.

I also assure patients that insulin is not a punishment. For years physicians have held insulin over patients’ heads as a kind of warning. “I will give you insulin if you don’t start paying attention to your diet,” was the implication.

It is important to have a circle of people whom you know and trust. When you tell patients they should no longer cut their own toenails, you need trusted podiatrists to refer them to, for example.

A recent article in the Feb 8, 2008, New England Journal of Medicine showed that by taking a complete approach to patient’s diet, cholesterol, high blood pressure, kidney function, blood sugars, and so on, patients have positive outcomes. We have to do everything, not just one thing.

Another possible help to maintaining a medical home has been described in the lay press recently. New software allows patients to monitor their health progress using PHRs or personal health records. This may be useful for patients with access to a computer, but not everyone has access. I live in an area and the physician doesn’t look at it or acknowledge it. Because of this, many patients quit doing it.

**One of my pet peeves is when a patient monitors blood sugars and the physician doesn’t look at it or acknowledge it. —Dr Rosenfeld**

Instead I tell patients, “If your pancreas is not making an adequate amount of insulin to keep your blood sugars under control, I can give you all the pills in the world and you will still have high sugar.” Insulin is a kind of hormone replacement, I explain. “I am replacing a hormone your body is not making adequately.” I’ve never had anyone object after that.

**HW: What is team-based care for diabetes and how does it relate to the emerging concept of a medical home?**

**Dr Rosenfeld:** Many people help with my diabetes patients’ care. I couldn’t do it all myself. In essence, effective diabetes care is team-based. In my practice, we maintain contact with primary care physicians and have certified diabetes educators and registered dieticians—and for patients with complications, a nephrologist and cardiologist. We also work with ophthalmologists and podiatrists.

where many people can’t afford computers.

Physicians’ offices are also becoming electronic. In certain areas patients do not have easy access to an endocrinologist but they can get around it to some extent by monitoring, and inputting the data.

I have been looking into an electronic health Web site for my office where patients can download their glucose monitoring. Monitoring helps patients pay attention to triggers that cause high blood sugar. Web sites can also force patients to review their overall medication list, triggering the question, “Do I need to be on all of these?” This is a reasonable question to ask their physicians. For patients without computers, particularly elderly people, we give glucose monitors and have them monitor their levels at least a couple of times a day even if they are well controlled.

One of my pet peeves is when a patient monitors blood sugars

and the physician doesn’t look at it or acknowledge it. Because of this, many patients quit doing it.

**HW: Is tight control of blood sugar only necessary in hospitalized patients who are being treated for diabetes?**

**Dr Rosenfeld:** Most definitely, no. Tight control is important for inpatients and outpatients in appropriate situations.

There is recent data related to patients with surgical critical care issues indicating that keeping blood sugar normal resulted in a 30% to 40% decreased mortality, improved outcomes and decreased length of hospital stay. The extent of benefit does vary from study to study.

We try to maintain blood sugars as close to normal as possible in hospitalized patients, which means blood sugars less than 180, and particularly in critically ill patients, most of the time as close as possible to 110. On the other hand, for patients whose life expectancy is low, say terminally ill cancer patients, there is probably no benefit from tight control. Tight control does come with a risk of hypoglycemia. For patients hospitalized for cardiac arrhythmias, which are exacerbated by the elevations in catecholamines that accompany a hypoglycemic episode, a low glucose could be a very dangerous situation.

**HW: What “tricks of the trade” do you employ to communicate effectively with those patient you are treating for diabetes?**

**Dr Rosenfeld:** I spend time with them—lots of time. I also listen carefully. Open communication is crucial. I ask patients if they are having difficulties and am quick to refer them for psychological care if I feel the demands of their illness and their life are too much for them. I tell my patients that emotional
issues affect blood sugars, as does stress. If they are depressed it will interfere with their ability to take good care of themselves.

HW: How do you explain “metabolic syndrome” to your patients and what it means to them?

Dr Rosenfeld: I call metabolic syndrome a warning signal for cardiovascular disease. I describe its components and tell them what components they have. Many people are worried about getting diabetes because of their high blood sugar, which we call “prediabetes” at this point. But I am more worried they are going to have a heart attack or stroke. I tell them that blood sugars aside, metabolic syndrome is a warning signal for cardiovascular disease, and the reason we treat every aspect of it, including the obesity that accompanies it, is to decrease cardiovascular risk.

HW: As an osteopathic endocrinologist, is your management of patients with diabetes any different from that of an allopathic endocrinologist?

Dr Rosenfeld: I am not certain, but I would like to think that I am more complete in making sure that diet, exercise and emotional well-being are part of my care. I never simply throw a prescription at a patient and say “Here, take this.” I strongly believe in the osteopathic ideal of treating the whole patient, which isn’t just a blood sugar.

I have been told that I am different, but I know of many MDs who contribute to the complete care of the patients with diabetes in their practices by taking care of their patients’ emotional well-being and diet, and sending them to dieticians and exercise programs.

Perhaps other osteopathic physicians and I differ from allopathic physicians by recommending osteopathic manipulation. For example, adhesive capsulitis, or frozen shoulder syndrome, is frequently seen in patients with type 1 diabetes and is usually treated by most allopathic physicians with cortisone injections or surgery. In fact, the disorder is best attended to by manipulation and physical therapy, which is the treatment that I would consider before anything else.

HW: What is one thing every primary care physician can do to address the obesity epidemic?

Dr Rosenfeld: First, they should be healthy themselves so they can be good role models. I keep in reasonably good shape by exercising. Second, instead of telling patients to go on a diet without giving instructions, I refer patients to a good dietician.

HW: What have you found most satisfying about managing patients with diabetes?

Dr Rosenfeld: I am most satisfied to see patients with good control who feel well—especially when I see them years later and they still have good control and are without complications.\textsuperscript{nw}