Salma is an approximately 60 year old lady of Indian extraction who came to the UK from Kenya with her husband and young family 32 years ago. She is now obese (BMI 34 kg/m²) and diabetic with ischaemic heart disease, for which she takes diltiazem, enalapril and isosorbide mononitrate, ibuprofen and coproxamol for polyarthropathy and temazepam to help her sleep. She also takes metformin 850 mg tds with meals but her control is poor (HbA₁c 9.4% (NR 4.0–6.5%)). She eats a mixture of Eastern and Western diets and has seen the community dietitian every year since diagnosis. Salma does not speak much English although she can understand more. She usually attends clinic with her youngest daughter. Salma looks after the house, does the cooking and looks after three grandchildren while their parents work. Salma rarely goes out of the home except to see her Indian neighbours. Her main complaints are headaches, neck pains, tingling in the feet and hands, cramps at night, shortness of breath, polyarthritis, and, occasionally, ‘pain all over’. She seems depressed but does not have a disturbed sleep pattern. At her last visit, her daughter asked whether her mother’s symptoms could be improved as the daughter is about to be married and will leave the parental home. She doubts whether her father will cope. What is your advice?

On pages 109–110 you can read our Expert opinions on the problems posed by Salma. What would you do?

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8. Salma: The problems of a poor understanding of diabetes

Here are the Experts’ opinions on Salma’s case, which is given on page 102. See if you agree with them.

**Expert 1**  
**A Diabetes Nurse Specialist**

Salma’s story is sadly not uncommon. Most professionals working in diabetes will have similar patients in their clinics. Salma’s problems are highlighted as poor control of diabetes, obesity, generalised pain, ischaemic heart disease, depression, language difficulties and being about to lose her daughter from home due to her impending marriage. Some of her problems could therefore be described as social in nature, requiring appropriate intervention from both community and secondary care.

Some health authorities now employ health development workers who practice in the community, with the ethnic minorities, to help improve communication and promote health initiatives. These development workers are of similar ethnic origin, able to speak the various languages and are trained in aspects of diabetes. The aim of involving such workers is to help direct patients to appropriate services for Asian patients.

Salma’s literacy level needs to be assessed. Oral medication such as metformin has side effects and is not always tolerated by patients, but, equally, not always highlighted as a problem without careful questioning. Dietary information given may be inappropriate to Salma’s cultural and religious beliefs. There may be lack of understanding of the connection between control of diabetes and feeling generally unwell. Lack of understanding of diabetes by other family members could also be contributing to Salma’s feeling of isolation and depression.

I am sure with improved communication and understanding between Salma, her family and health professionals an improvement in diabetes control, with subsequent general feeling of well being, could be achieved.

**Expert 2**  
**A Consultant Physician**

Salma’s history prompts me to ask some supplementary questions. What is her waist measurement and total serum cholesterol level? What is the result of her last exercise stress test and when is her bypass graft likely to take place? Is it appropriate for Salma to be taking such a large dose of metformin when suffering from ischaemic heart disease? Why has she neck pains with tingling in her hands and is there any evidence of cervical facet joint or radicular disease? Has she objective evidence of dyasesthesiae in her feet and/or loss of nerve sensation?

Having given these various caveats, my advice would be for her to change to insulin therapy, which would at least improve some of her problems, very likely shortness of breath and cramps, and if her tingling in her feet was neuropathic, all related to her metformin treatment, would also improve that. It would do nothing of course for her weight but, by the looks of it, that is not an easily surmountable problem anyway. I would give sufficient insulin to actually achieve a reasonable control, i.e. HbA1c of less than 7.5%, which may well be 200 units or so a day. Assuming that her ischaemic heart disease had been managed I think she then would be able to cope physically and only after a time on insulin therapy would it be possible to work out whether she would need to see a psychologist as well.

**Expert 3**  
**A Diabetes Dietitian**

Many aspects of the diabetes service to Asian patients need careful planning, better communication and more consideration. It has been suggested that difference in disease symptomatology, language barriers, poor knowledge of services, difficulties with transport and differences in willingness to seek medical help may all influence the apparent accessibility of diabetes services for Asian patients.

It is also argued that perceived lack of social support and socio-economic deprivation are also associated with stress, and a major risk factor in this ethnic group. Many individuals are unaware of the diabetes-specific benefits such as free prescriptions if on medication, free annual eye tests if over 40 etc. The involvement of a social worker with an up-to-date knowledge of the benefits system may be of considerable practical help. Consideration needs to be given to which foods are available, affordable and acceptable within the family.

Evidence is lacking regarding the optimum strategies for reducing modifiable cardiovascular risk factors, such as obesity among Asian diabetic people. In my opinion it would be important to direct any education to follow Salma’s knowledge, attitudes and beliefs.

Salma’s literacy level needs to be established. The use of relatives as interpreters has been shown to lead to significant mis-translations, and professional interpreters are known to perform better. In my opinion, it is impossible to adopt a counselling style to clarify attitudes and beliefs, without a skilled interpreter. The loan of appropriate diabetes education video material can raise discussion points prior to an interview and help to
consult diabetes knowledge afterwards.

In my experience arranging a joint one hour interview with a diabetes nurse specialist, dietitian and interpreter has led to increased identification and clarification of knowledge deficits and misunderstandings. Accurate, appropriate written information is a high priority, and the additional use of colour photographs, and available plate-models of Asian foods, can greatly enhance the interview discussion, and negotiation and identification of effective goals for dietary change.

If Salma has not considered changing her food behaviours to help her weight and cardiovascular risk, it is important to discuss her feelings about this and help her to begin to take a ‘health focus’ to think about changing. Good communication between the diabetes centre and her community dietitian would allow her to choose when, and how, to receive help in the future, and may encourage her to do so.

If she has begun to think about food changes, it is important to help her with clarification of the benefits of 10% weight loss, or of weight maintenance if this is her preferred option. In my experience, identification of high fat foods, and helping her to choose realistic food changes, are a priority to increase her self-confidence. Her decision may be helped by description of the portions of foods that are appropriate for her to achieve a 300–500 kcal deficit to her requirements, and the long term weight loss this can achieve.

**Summary of the Experts’ Opinions (Dr. Wales writes)**

All our experts agree that Salma would be symptomatically improved provided her diabetic control can be improved. Whereas the consultant physician views this as a medical problem and recommends a change from metformin to insulin therapy, the other two experts see the main problem as Salma’s inability to communicate and her consequent lack of understanding of diabetes and its treatment. This is probably shared by her family. They suggest that more time and effort should be expended in trying to improve her understanding by using interpreters and giving advice, particularly dietary advice bearing in mind Salma’s cultural and religious background. This can be expensive in time and money but there are areas in the UK such as Leicester and Bradford where teaching aids are more advanced. Both these experts suggest that if better communication can be established and treatment improved then Salma’s control will be better, her symptoms will improve and it will be easier for her husband to cope on his own.

You should resist any suggestion that the daughter should not get married in order to remain to look after her mother. I have rarely known such a sacrifice to be successful. The carer resents the loss of their freedom and the patient feels beholden. Many years ago, families in the Middle East and the Indian sub-continent had an extended role with three or four generations of one family living under one roof. The question posed by Salma’s daughter would then not apply.

Patients like Salma pose a problem for most clinics. I would endorse much of our Experts’ advice in improving medical treatment as well as improving Salma’s understanding of her diabetes and its treatment. If you can achieve this, then you can reassure Salma’s daughter and wish her well in her new life.

What do you think of the advice given by our Experts about Salma? Write to the Editor of *Practical Diabetes International* with your views and we will try to publish them.

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**Diabetes UK**

To enable an even greater number of those whose first language is not English to receive important information and support about diabetes over the phone, Diabetes UK has introduced an interpreting service to its Careline. The service will connect professional interpreters with non-English speaking callers and Careline counsellors.

The prevalence of diabetes in communities of Asian and African-Caribbean origin is sometimes as much as four times higher than those of European origin, reflecting the great need for an interpreting service.

An extensive range of languages is offered for non-English speaking callers, ranging from Punjabi to Cantonese, and will greatly benefit many of the 1.4 million people with diabetes in the UK and the estimated further million yet to be diagnosed.

**Political Parties must back action to tackle diabetes says Diabetes UK**

Diabetes UK called upon MPs of all political parties to back its Diabetes Pledge to improve NHS diabetes care.

Diabetes UK’s Diabetes Pledge launched in the House of Commons on 6th March 2001, pinpoints problems of late diagnosis and people not getting the appropriate levels of diabetes care that they need. MPs from across the political divide were urged to pledge their support for improved standards ahead of the launch of the Diabetes National Service Framework later this year.

The Diabetes Pledge sets out that people with diabetes deserve to receive the best standards of care irrespective of who they are, where they live or their complications.

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**From Arabic to Yiddish—Language is no barrier to care at Diabetes UK**

[Further details and contact information provided for Diabetes UK services.]

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