EDITORIAL

Type 2 diabetes mellitus in the age of COVID. Reflections on telemedicine and patient education

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ABSTRACT

The COVID-19 pandemic has abruptly changed the way primary care centres work. Our manner of addressing patients has changed from the classic in-person care model to telemedicine.

What has the COVID pandemic meant for practitioners, patients and diabetes? Has it changed how we address patients? What do the patients think of these changes?

It might seem easy at first to answer these questions. Perhaps all that is needed is to relate what we do every day in our consultations and ask our patients directly; however, they represent many faces and viewpoints, in some cases with very different perceptions.

The COVID-19 pandemic has abruptly changed the way primary care centres work. Our manner of addressing our patients with in-person care in almost its entirety, with a few experiences of healthcare by telephone or email and in telemedicine (TeleDerma, retinography, virtual consultations with certain specialties, etc.), has transitioned to healthcare by telephone to avoid the potential spread of the disease in healthcare centres. This abrupt change, in some cases without the appropriate technical means and with primary care centres lacking sufficient telephone lines and Internet connections, has resulted in an urgent need for patients and practitioners to adapt.

The incidence of COVID-19 has for months dominated the work of primary care practitioners, occupying a large portion of their activity and generating exclusive care circuits in health centres. We have therefore been forced to cease certain activities, which we understood could be delayed, especially in chronic diseases such as diabetes, hypertension and chronic obstructive pulmonary disease, both in preventive activities and in monitoring and education. For some authors, this situation in the medium term will mean the development of the so-called "third wave" as a result of the lack of care for these chronic diseases, which could affect the development of complications specific to each disease and, in the case of diabetes, complications from both the microvascular and macrovascular standpoints. This situation, coupled with the lack of literature that can help us perform proper telephone care, has led to initiatives, such as the one in question, to generate guidelines to help provide appropriate, comprehensive care with quality criteria.

On the other side of the problem, there are the individuals with diabetes, who have seen their health care (let us call it traditional) change considerably, along with all of the prevention and avoidance measures indicated by the health authorities, given that these patients are considered at risk. This significantly limited their presence in health centres and diverted their care to a telephone/telematic system for which many had neither the means nor the skills.

From that moment, there was a change in healthcare systems for patients with the addition of telemedicine calls, which include not only care over the phone but also the

use of other communication systems that should be incorporated into our daily work, such as video consultations, e-consultations, virtual consultations with specialists, healthcare centre websites, specific applications of pathology and social networks and all those that can facilitate the relationship, communication, education and training of our patients.

With this document, we aim to provide continuity to the "protocol of care through telemedicine to individuals with diabetes", which we recently included in our website and will only indicate a starting point for developing a new form of assessing, addressing and educating individuals with diabetes. To our understanding, this new approach is here to stay and will, of course, be developed.