

Rethinking Diabetes Care: From Glycemic Control to Holistic Metabolic Health

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ABSTRACT

Diabetes mellitus, particularly type 2 diabetes mellitus (T2DM), has traditionally been approached primarily through the control of blood glucose and glycated hemoglobin (HbA1c). The current understanding of diabetes acknowledges it as a complex metabolic disorder involving insulin resistance, obesity, hypertension, dyslipidemia, chronic inflammation, vascular dysfunction, and progressive injury to multiple organs, even though glycemic control is still a crucial part of managing the condition. Consequently, the overall burden of disease may not be sufficiently addressed by concentrating only on glucose reduction. By lowering cardiovascular, renal, hepatic, neurological, and metabolic risks while enhancing functional health and quality of life, the idea of holistic metabolic health broadens the therapeutic goal beyond reaching numerical glycemic targets. Current diabetes care emphasizes individualized glycemic targets together with weight management, nutritional quality, physical activity, blood-pressure control, lipid management, kidney and cardiovascular risk reduction, screening for complications, psychosocial well-being, and shared decision-making. The American Diabetes Association (ADA) Standards of Care 2026 explicitly describes glycemic management as only one component of the clinical encounter and recommends assessment and management of cardiovascular, kidney, liver, metabolic and psychosocial health alongside glucose control. Changing one's lifestyle is still essential for both prevention and therapy. Structured lifestyle intervention can significantly slow the transition from high-risk states to type 2 diabetes, according to landmark preventative trials. Additionally, pharmacological therapy has changed from glucose-centric treatment to medicines chosen based on their benefits for the heart, kidneys, and weight. Significant weight loss may enhance metabolic health and result in diabetes remission in the right people, but remission does not indicate that ongoing monitoring is no longer necessary. This article discusses the transition from conventional glycemic-centered diabetes care toward a comprehensive metabolic-health model, emphasizing prevention, nutrition, physical activity, weight management, cardio metabolic risk reduction, organ protection, personalized pharmacotherapy, behavioural health and patient-centred care.

Keywords: Diabetes Mellitus, Type 2 Diabetes Mellitus, glycemic control, metabolic health, insulin resistance, diabetes prevention, holistic management.

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1. INTRODUCTION

Diabetes mellitus is one of the major chronic metabolic disorders worldwide. Significant clinical, societal, and financial difficulties have been brought about by its rising incidence. The World Health Organization estimates that the number of individuals with diabetes rose from about 200 million in 1990 to 830 million in 2022. Diabetes is

linked to lower limb amputation, neuropathy, cardiovascular illness, stroke, blindness, and kidney failure¹.

The International Diabetes Federation's 11th edition of the Diabetes Atlas provides updated global, regional and national estimates for 2024 and projections to 2050, highlighting the continuing expansion of the diabetes

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burden and the need for effective preventive and therapeutic strategies².

In the past, managing diabetes has mostly focused on the straightforward question of how well blood glucose can be regulated. As a result, one of the most crucial indicators for evaluating diabetes control is HbA1c. Unquestionably, long-term hyperglycemia causes both micro vascular and macro vascular problems, which makes glucose control crucial. But diabetes is more than just a condition caused by high blood sugar.

Obesity, hypertension, dyslipidemia, chronic renal disease, fatty liver disease, sleep disturbance, cardiovascular risk, neuropathy, or psychological discomfort can all exist in a person with an apparently good HbA1c. On the other hand, overly aggressive glucose reduction can occasionally put susceptible people at risk for hypoglycemia and treatment burden.

This has led to a broader concept of diabetes care in which glucose is one therapeutic target among several rather than the sole definition of successful treatment.

The 2026 ADA Standards of Care specifically emphasizes that glycemic management is "a part, not the sole goal" of the clinical encounter and recommends comprehensive assessment of cardiovascular, kidney, liver, metabolic and other comorbidities³.

Thus, the modern question should not merely be:

"Is the patient's blood glucose controlled?"

but rather:

"Is the patient's overall metabolic and cardiometabolic health improving?"

This shift represents an important rethinking of diabetes care.

2. FROM GLYCEMIC CONTROL TO METABOLIC HEALTH

2.1 Glycemic control remains important

HbA1c remains an important indicator of average glycemic exposure. For many nonpregnant adults, the ADA 2026 Standards identify an HbA1c target of <7%, although targets should be individualized according to health status, hypoglycemia risk, comorbidities, functional status, treatment burden and patient preferences⁴.

Therefore, moving beyond glycemic control does not mean abandoning glucose targets.

Instead, it means placing glucose control within a broader therapeutic framework.

2.2 The limitations of a glucose-only approach

Diabetes develops within a complex network of metabolic abnormalities. In T2DM, insulin resistance, impaired pancreatic β -cell function, adipose-tissue dysfunction, altered hepatic glucose metabolism and abnormal lipid metabolism interact with genetic and environmental factors.

A patient may therefore have several clinically important abnormalities simultaneously:

- Hyperglycemia
- Abdominal or generalized obesity
- Hypertension
- Atherogenic dyslipidemia
- Insulin resistance
- Metabolic dysfunction-associated steatotic liver disease
- Chronic kidney disease
- Cardiovascular disease
- Sleep disorders
- Physical inactivity
- Psychological stress
- Poor health-related quality of life

Treating only hyperglycemia leaves several of these pathways insufficiently addressed.

3. UNDERSTANDING DIABETES AS A MULTIDIMENSIONAL METABOLIC DISORDER

T2DM should increasingly be understood as a systemic metabolic disorder rather than an isolated abnormality of blood glucose.

3.1 Insulin resistance

Insulin resistance is a central feature of T2DM. Skeletal muscle, liver and adipose tissue progressively become less responsive to insulin. The pancreas initially compensates through increased insulin secretion, but progressive β -cell dysfunction eventually contributes to persistent hyperglycemia.

Insulin resistance is strongly influenced by excess adiposity, physical inactivity, dietary patterns, sleep disturbances and genetic susceptibility.

3.2 Adipose tissue dysfunction

Excess visceral adiposity is metabolically active. Dysfunctional adipose tissue can contribute to altered fatty-acid metabolism, inflammatory signaling and insulin resistance.

Consequently, management of excess weight is not merely cosmetic. It can be an important component of metabolic treatment.

3.3 Cardiovascular risk

Cardiovascular disease is one of the most important causes of morbidity and mortality in people with diabetes. Therefore, diabetes management should incorporate blood-pressure control, lipid management, smoking cessation, physical activity, weight management and

appropriate use of cardiovascular-protective pharmacotherapy.

The ADA 2026 recommendations emphasize individualized blood-pressure management and cardiovascular risk reduction as integral components of diabetes care⁵.

3.4 Kidney health

Diabetes is a major contributor to chronic kidney disease. Kidney assessment should therefore be incorporated into routine diabetes care, including appropriate evaluation of estimated glomerular filtration rate and urinary albumin excretion.

Current treatment strategies may include glucose-lowering agents with demonstrated kidney and cardiovascular benefits when clinically appropriate⁶.

3.5 Liver and metabolic health

Metabolic dysfunction-associated steatotic liver disease is increasingly recognized in people with T2DM and obesity. Assessment of liver health is therefore becoming an important part of comprehensive diabetes care. The ADA 2026 Standards specifically includes assessment for MASLD and MASH within comprehensive diabetes evaluation⁷.

4. PREVENTION: THE FIRST OPPORTUNITY TO CHANGE THE DISEASE TRAJECTORY

A major advantage of the metabolic-health approach is that it emphasizes intervention before complications become established.

Prediabetes represents an important opportunity for prevention. Individuals with prediabetes have increased cardiometabolic risk and may progress to T2DM, although progression is not inevitable. The ADA recommends addressing modifiable cardiovascular and metabolic risk factors in people with prediabetes and considering more intensive interventions in individuals at particularly high risk⁸.

4.1 Evidence from lifestyle intervention

The Diabetes Prevention Program demonstrated the power of structured lifestyle intervention. Participants assigned to intensive lifestyle intervention were given goals including approximately 7% weight loss and at least 150 minutes of physical activity per week. Over an average follow-up of 2.8 years, lifestyle intervention reduced diabetes incidence by 58% compared with placebo⁹.

Similarly, the Finnish Diabetes Prevention Study reported a 58% reduction in diabetes risk among high-risk individuals receiving lifestyle intervention¹⁰.

These findings establish an important principle:

Lifestyle intervention is not merely supportive therapy; it can modify the natural history of T2DM.

5. NUTRITION: FROM CALORIE RESTRICTION TO DIETARY QUALITY

Nutrition is one of the most powerful modifiable determinants of metabolic health.

Rather than prescribing a single universal "diabetic diet," contemporary management should consider:

- Total energy intake
- Dietary quality
- Carbohydrate quantity and quality
- Fiber intake
- Protein quality
- Fat quality
- Degree of food processing
- Portion size
- Meal patterns
- Cultural preferences
- Socioeconomic circumstances
- Individual metabolic response

The ADA 2026 Standards encourage dietary patterns that incorporate vegetables, legumes, plant-based protein sources, nuts and seeds and recognize Mediterranean-style dietary patterns as an option for improving glucose metabolism and reducing cardiovascular risk. Saturated-fat intake should be limited as part of cardiovascular risk reduction¹¹.

5.1 Practical nutritional principles

A sustainable metabolic-health dietary strategy may emphasize:

1. Adequate intake of non-starchy vegetables.
2. Whole grains and minimally processed carbohydrate sources where appropriate.
3. Legumes and pulses.
4. Nuts and seeds in appropriate portions.
5. Adequate protein individualized to the person's needs and kidney status.
6. Reduction of refined carbohydrates and sugar-sweetened beverages.
7. Limitation of highly processed foods.
8. Reduction of excessive saturated fat.
9. Appropriate portion control.
10. Dietary patterns that can realistically be maintained over the long term.

The objective should not simply be a temporary reduction in blood glucose but the development of a sustainable eating pattern that improves overall metabolic health.

6. PHYSICAL ACTIVITY: A THERAPEUTIC INTERVENTION

Physical activity improves insulin sensitivity, cardiovascular fitness, muscular function and overall metabolic health.

Regular exercise can be divided broadly into:

- Aerobic activity
- Resistance training
- Flexibility and mobility exercises
- Reduction of prolonged sedentary behavior
- Functional physical activity

The WHO recommends at least 150 minutes of moderate-intensity physical activity per week for prevention of T2DM.

For people with diabetes, physical activity should be individualized according to age, fitness level, comorbidities, medication use, cardiovascular status and risk of hypoglycemia.

Importantly, the objective should not be restricted to "exercise for weight loss." Exercise has benefits that extend beyond body weight, including improved insulin sensitivity, muscle function, cardiovascular fitness and psychological well-being.

7. WEIGHT MANAGEMENT AS A CORE COMPONENT OF DIABETES CARE

The relationship between obesity and T2DM has fundamentally changed the therapeutic landscape.

For people with T2DM and overweight or obesity, weight management can improve glycemic control and several cardiometabolic risk factors. The ADA 2026 Standards recognize structured lifestyle intervention, weight-management pharmacotherapy and metabolic surgery as potential components of individualized treatment when appropriate¹².

The clinical objective should therefore be reframed from:

"Control the glucose despite obesity"

to:

"Address the metabolic drivers contributing to diabetes."

Meaningful weight reduction can improve insulin sensitivity and glycemic control. In selected individuals, substantial and sustained weight loss may even result in remission of T2DM.

However, remission should not be interpreted as permanent cure. The international consensus definition emphasizes sustained improvement in glycemic status without glucose-lowering medication and recognizes the possibility of recurrence¹³.

8. PHARMACOLOGICAL THERAPY: CHOOSING TREATMENT BEYOND HBA1C

Modern pharmacotherapy provides an important opportunity to move beyond glucose-centered prescribing.

Drug selection should consider:

- Glycemic efficacy
- Hypoglycemia risk
- Body-weight effects
- Cardiovascular disease
- Heart failure
- Chronic kidney disease
- Liver disease
- Cost and accessibility
- Patient preference
- Treatment burden

The ADA 2026 Standards specifically recommend considering individualized glycemic and weight goals, cardiovascular, kidney and liver comorbidities, and hypoglycemia risk when selecting glucose-lowering treatment¹⁴.

In selected people with T2DM and established cardiovascular disease or chronic kidney disease, glucose-lowering agents with demonstrated cardiovascular and/or renal benefits may be prioritized as part of comprehensive risk reduction.

This represents an important paradigm shift:

The best diabetes medicine is not necessarily the drug that lowers HbA1c the most; it may be the therapy that provides the greatest overall benefit for the individual's metabolic and organ health.

9. CARDIOVASCULAR RISK REDUCTION

A holistic approach requires systematic assessment of cardiovascular risk.

Important components include:

- Blood-pressure measurement and treatment
- Lipid assessment and management
- Smoking cessation
- Weight management
- Physical activity
- Dietary improvement
- Assessment of established cardiovascular disease
- Appropriate cardioprotective pharmacotherapy

For people with diabetes and hypertension, ADA 2026 recommends individualized blood-pressure targets; a target below 130/80 mmHg may be appropriate when it can be safely achieved, with consideration of lower systolic

targets in selected individuals at high cardiovascular or kidney risk¹⁵.

The key principle is that cardiovascular prevention should occur simultaneously with glycemic management rather than after glucose targets have been achieved.

10. KIDNEY PROTECTION

Diabetes care should routinely consider renal health.

Important measures include:

- Monitoring kidney function
- Assessing urinary albumin excretion
- Controlling blood pressure
- Optimizing glycemic management
- Avoiding unnecessary nephrotoxic exposure
- Promoting healthy weight and physical activity
- Using kidney-protective therapies when indicated

The ADA 2026 Standards identify lifestyle measures and selected pharmacological therapies as components of comprehensive kidney-risk management in diabetes.

This illustrates why metabolic health cannot be represented by HbA1c alone.

11. PREVENTION AND EARLY DETECTION OF COMPLICATIONS

A patient-centred diabetes program should include systematic screening and early intervention for:

Microvascular complications

- Diabetic retinopathy
- Diabetic kidney disease
- Peripheral neuropathy

Macrovascular complications

- Coronary artery disease
- Cerebrovascular disease
- Peripheral arterial disease

Other metabolic complications

- MASLD/MASH
- Obesity
- Hypertension
- Dyslipidemia

Early detection provides an opportunity to prevent progression and preserve function.

The ADA 2026 comprehensive evaluation framework explicitly includes assessment for ASCVD, heart failure, chronic kidney disease, retinopathy, neuropathy and metabolic liver disease¹⁶.

12. SLEEP, STRESS AND MENTAL WELL-BEING

Metabolic health is closely connected with behavioural and psychological health.

Chronic stress can adversely affect eating behaviour, physical activity, sleep and self-management. Similarly, poor sleep may interfere with appetite regulation, daytime activity and metabolic health.

Therefore, diabetes care should include attention to:

- Sleep duration and quality
- Psychological stress
- Depression and anxiety when clinically indicated
- Diabetes distress
- Social support
- Treatment fatigue
- Work and family circumstances
- Financial barriers to treatment

The objective is to develop a treatment plan that patients can realistically follow rather than a theoretically ideal plan that cannot be sustained.

13. PATIENT-CENTERED AND SHARED DECISION-MAKING

A holistic approach recognizes that there is no single diabetes treatment plan suitable for everyone.

Treatment decisions should account for:

- Age
- Duration of diabetes
- Life expectancy
- Comorbidities
- Functional status
- Hypoglycemia risk
- Weight
- Financial resources
- Health literacy
- Cultural dietary practices
- Family support
- Personal priorities

The ADA 2026 Standards emphasize shared decision-making and treatment plans based on individual values, preferences, prognosis, comorbidities and practical considerations.

A patient's own goals should therefore be considered clinical outcomes.

For one person, the priority may be weight reduction; for another, prevention of kidney disease; for another,

avoiding hypoglycemia or maintaining the ability to work and remain physically active.

14. MONITORING BEYOND HBA1C

HbA1c remains important, but metabolic health requires a broader dashboard.

Glycemic parameters

- HbA1c
- Fasting plasma glucose
- Postprandial glucose where appropriate
- Continuous glucose monitoring metrics in selected patients

The ADA recognizes time-in-range and other continuous glucose monitoring metrics as useful measures in appropriate individuals.

Anthropometric parameters

- Body weight
- BMI
- Waist circumference
- Changes in body composition where appropriate

Cardiovascular parameters

- Blood pressure
- Lipid profile
- Cardiovascular risk assessment

Renal parameters

- eGFR
- Urinary albumin-to-creatinine ratio

Lifestyle parameters

- Physical activity
- Dietary adherence
- Sleep
- Smoking status

Patient-centered outcomes

- Quality of life
- Diabetes distress
- Treatment burden
- Functional capacity

This broader monitoring strategy provides a more meaningful picture of whether a person is becoming metabolically healthier.

15. ROLE OF TECHNOLOGY IN MODERN DIABETES CARE

Digital health technologies are increasingly relevant to diabetes management.

Depending on the individual, these may include:

- Continuous glucose monitoring
- Smartphone-based glucose tracking
- Digital lifestyle programs
- Teleconsultation
- Remote monitoring
- Electronic reminders
- Digital nutrition and activity tracking

Technology should not replace clinical judgment. Instead, it should facilitate better communication, self-management and timely intervention.

The most useful technology is the one that produces meaningful information and can be incorporated into a sustainable care pathway.

16. INTEGRATIVE AND HOLISTIC PERSPECTIVES

A holistic approach does not mean replacing evidence-based medical treatment with unproven therapies. Rather, it means integrating appropriate medical, nutritional, behavioral, physical and psychosocial interventions around the individual patient.

In settings where traditional medical systems such as Ayurveda are practiced, lifestyle concepts and selected traditional interventions may be studied as complementary components of diabetes care. However, claims regarding antidiabetic effects of individual herbs or traditional preparations should be supported by appropriate pharmacological, clinical and safety evidence.

Patients should not discontinue prescribed glucose-lowering, cardiovascular or kidney-protective medications in favor of unproven alternatives.

The central principle should remain:

Evidence-based care + individualized lifestyle intervention + appropriate pharmacotherapy + prevention of complications + continuous monitoring.

17. RETHINKING THE DEFINITION OF TREATMENT SUCCESS

Traditional treatment success has often been described primarily in terms of HbA1c.

A broader definition of success could include:

- Appropriate glycemic control
- Reduced hypoglycemia
- Healthy or improving body weight
- Improved blood pressure
- Improved lipid profile
- Cardiovascular risk reduction

- Preservation of kidney function
- Prevention or delay of complications
- Improved physical fitness
- Improved sleep and psychological well-being
- Reduced treatment burden
- Improved quality of life
- Patient satisfaction with care

Thus, successful diabetes management should be viewed as improvement in the total metabolic-health profile rather than normalization of a single laboratory parameter.

18. PROPOSED HOLISTIC METABOLIC HEALTH MODEL

A practical framework for contemporary diabetes care can be represented by eight interconnected domains:

1. Glycemic Health

Achieve individualized glucose targets while minimizing hypoglycemia.

2. Weight and Body Composition

Prevent excess weight gain and pursue clinically meaningful weight reduction when appropriate.

3. Cardiovascular Health

Control blood pressure and lipids and reduce cardiovascular risk.

4. Kidney Health

Detect and manage diabetic kidney disease early.

5. Liver and Metabolic Health

Recognize and address metabolic liver disease and related metabolic abnormalities.

6. Lifestyle Health

Optimize nutrition, physical activity, sleep and avoidance of tobacco.

7. Psychological Health

Address diabetes distress, stress, depression, anxiety and treatment burden when present.

8. Patient-Centered Care

Incorporate individual preferences, culture, resources and personal goals into treatment decisions.

This multidimensional framework allows diabetes care to move from a disease-centered approach toward a person-centered metabolic-health model.

19. CHALLENGES IN IMPLEMENTING HOLISTIC DIABETES CARE

Despite strong evidence supporting comprehensive diabetes management, implementation remains difficult.

Major barriers include:

- Limited access to multidisciplinary care
- High treatment costs

- Medication availability
- Low health literacy
- Sedentary lifestyles
- Urbanization
- Unhealthy food environments
- Limited time for clinical counseling
- Poor long-term adherence
- Psychological barriers
- Social and economic determinants of health

The solution therefore requires more than prescribing medications. It requires healthcare systems capable of supporting nutrition counselling, physical activity, diabetes education, behavioural support and long-term follow-up.

20. FUTURE DIRECTIONS

The future of diabetes management is likely to become increasingly personalized.

Emerging areas include:

- Precision medicine
- Continuous glucose monitoring
- Artificial intelligence-assisted risk prediction
- Digital therapeutics
- Personalized nutrition
- Metabolic phenotyping
- Novel weight-management therapies
- Earlier identification of high-risk individuals
- Cardiovascular and renal risk-based treatment selection
- Research into durable diabetes remission

The central challenge will be translating these developments into accessible and affordable care.

Future diabetes care should therefore not ask only whether a new intervention lowers glucose. It should also ask whether it improves meaningful clinical outcomes, protects organs, reduces treatment burden and enhances quality of life.

21. CONCLUSION

Diabetes care is undergoing an important conceptual transition. Glycemic control remains essential, but it should no longer be considered the sole measure of successful treatment. T2DM is a complex metabolic disorder involving glucose dysregulation, adiposity, insulin resistance, cardiovascular risk, kidney disease, liver disease, physical inactivity and psychosocial factors.

Evidence from major prevention trials demonstrates that lifestyle intervention can substantially reduce the risk of

developing T2DM. Contemporary guidelines further emphasize individualized glycemic goals, weight management, cardiovascular and renal risk reduction, nutrition, physical activity, complication screening and shared decision-making.

The future of diabetes management should therefore move **from glucose-centric treatment toward holistic metabolic health.**

The ultimate goal should not simply be:

"Lower the blood glucose."

It should be:

"Improve metabolic health, protect organs, prevent complications, preserve function and help the person live a healthier and better-quality life."

This represents not a rejection of conventional diabetes care, but its logical evolution toward a more comprehensive, individualized and patient-centered model.

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