Letters to the Editor

The Future of Insulin Therapy Belongs in Primary Care

Published online November 25, 2026.

To the Editor: I am writing to express concern regarding clinical recommendations in the article by Marrison and colleagues on outpatient insulin management for type 2 diabetes.[1] Although providing clear guidance on traditional insulin titration is valuable, the overarching framework presented is fundamentally out of step with modern evidence and current standards of diabetes technology.

The authors recommend initiating basal insulin, followed by stepwise intensification to manual prandial or premixed injections.[1] This regressive framework disregards the massive clinical and cognitive burdens a multiple daily-injection regimen places on the patient and primary care physician. Recommending a complex manual injection regimen that requires strict calculations and heightens the risk of hypoglycemia while disregarding existing simplified, automated technology is a disservice to our patients.[1]

The 2026 American Diabetes Association Standards of Care in Diabetes explicitly supports the early integration of automated insulin delivery systems as the preferred method for adults with type 2 diabetes requiring intensive or multidose insulin.[2] Furthermore, multicenter safety data debunk the outdated assumption that pump technology is too complicated to manage in the primary care setting, demonstrating significantly more time spent in range and no increased risk of severe hypoglycemia or diabetic ketoacidosis compared with standard injection therapy.[3]

Framing automated insulin delivery systems as a specialist-only referral hurdle or last resort after injection failure reinforces institutional inertia and creates an artificial barrier to care.[1] Primary care physicians are capable of initiating and managing automated systems that can drastically simplify the patient experience.

It is time for family physicians to stop managing insulin with a pen and start leveraging the power of the algorithm. Our patients deserve the improved clinical outcomes and quality of life that modern diabetes technology provides.

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Author Disclosure: Dr. Huber disclosed relationships with Insulet Corporation (speaker; advisor) and Sanofi (speaker).

In Reply: We thank the author of this letter to the editor for the commentary and share their commitment to expanding automated insulin delivery in patients with type 2 diabetes. However, this critique relies on short-term, disease-oriented evidence and underestimates the barriers of clinician readiness, patient access, and equity that shape implementation in primary care.

The 2026 American Diabetes Association Standards of Care in Diabetes broadly supports automated insulin delivery, recommending it as the preferred delivery method over multiple daily injections, continuous subcutaneous insulin infusion, and sensor-augmented pumps in adults with type 2 diabetes. The guidance also encourages early initiation of automated insulin delivery in select individuals with type 2 diabetes who have not achieved individualized glycemic goals with basal insulin.[2] We acknowledge the guideline but remain concerned about the gap between recommendation and implementation in primary care.

The industry-funded 2IQP trial followed patients for only 13 weeks; this demonstrates disease-oriented glycemic surrogate improvements without meaningful differences in quality of life or assessments of morbidity or mortality.[3] At baseline, 71% of enrollees were already using continuous glucose monitoring devices, a technology-experienced cohort likely unrepresentative of the general population with insulin-treated type 2 diabetes. A 2025 meta-analysis of 20 studies of automated insulin delivery in people with type 2 diabetes found high heterogeneity (I^2 = 92%), with real-world studies showing smaller time-in-range improvements (9.72%) than randomized trials (20.30%) and larger effect sizes in shorter studies.[4] Short-term trial efficacy does not establish durable or generalizable automated insulin-delivery benefits across the socioeconomically diverse populations that family physicians serve.

Family physicians can develop the skills to initiate and manage automated insulin delivery systems; however, without training, infrastructure, and support, the capability alone does not ensure equitable implementation. In a national survey, primary care clinicians self-reported low confidence in insulin pump management (rating it 4 on a 10-point scale vs a rating of 10 among endocrinologists), with the greatest deficits in insurance navigation and device training.[5] Continuous glucose monitoring initiation is less than 10% among older adults with insulin-treated type 2 diabetes; Black and Hispanic patients and those in lower socioeconomic areas are significantly less likely to receive continuous glucose monitoring devices.[6] These are not arguments against automated insulin delivery but for the systems needed for equitable delivery.[7]

Outpatient insulin management and automated insulin delivery are distinct, complementary topics. The stepwise framework presented in our article reflects where patients begin. Increasing adoption of automated insulin delivery requires additional training and support for both patients and family physicians.

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Author Disclosure: No relevant financial relationships.

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