The clarity, timing, and authority of the delivery of a diagnosis of type 2 diabetes had important meaning for patients


How do patients with newly diagnosed type 2 diabetes perceive their diagnosis?

**DESIGN**

Constant comparative method with direction from a grounded theory approach.

**SETTING**

16 general practices and 3 hospital clinics in the Lothian region of Scotland, UK.

**PATIENTS**

40 patients diagnosed with type 2 diabetes in the previous 6 months. Almost all patients were white and treated by diet alone or diet plus metformin and/or gliclazide.

**METHODS**

Patients participated in semistructured interviews of about 1 hour, which included questions on how they came to be diagnosed with diabetes, how they felt when they found out they had diabetes, and their experiences with diabetes services. Interviews were tape recorded and transcribed verbatim. Data collection and analysis occurred concurrently. Regular team meetings were held to identify recurrent themes, explore patients’ underlying reasoning, discuss deviant cases, and identify new research questions.

**MAIN FINDINGS**

*First contact.* Before diagnosis, more than half of patients presented to their general practitioners (GPs) with symptoms, which expedited the diagnostic process. Receiving the results of urine tests was often a telling experience, and patients came away with the impression that diabetes was the cause of their abnormal results. For the remaining patients, diagnosis was initiated by medical procedures such as routine blood tests.

*The hospital appointment.* After receiving the results of blood glucose tests, most patients were referred to a hospital clinic. 5 patients were not referred because their general practice had its own diabetes clinic or specialist. However, these patients assumed that they were not sent to hospital because, for example, the hospital clinic was oversubscribed or their disease was not as serious as that of other patients. Patients referred to hospital were positive about their experiences. They felt that they were the focus of attention and appreciated hospital education sessions, which covered aspects of diabetes management that they had not thought about. Most, however, believed that they were referred to hospital for confirmation of their diagnosis by a diabetes consultant. Some patients believed that their GPs were unwilling to deliver a definitive diagnosis. Others perceived hospital consultants as having more expertise and specialist knowledge than GPs and, therefore, having the competence to make a “proper” diagnosis. Even when GPs were thought to have been clear about the diagnosis, some patients were unwilling to accept the diagnosis until it had been confirmed by a consultant.

Many patients believed that hospital consultations were important for obtaining an accurate diagnosis and determining a management regimen.

*The waiting.* Patients felt that delays were inevitable in getting hospital clinic appointments. However, some experienced waits of any duration as problematic, especially if they perceived diabetes to be a potentially serious condition requiring immediate medical attention. Many believed that clinic staff would “help to clear up a lot of anything that’s unknown.” Most patients waited several months for a hospital appointment and, in the interim, saw a dietician or nurse in a primary care setting. Sometimes, lengthy waits for hospital clinic appointments were perceived by patients as an indication that their condition was not serious, or even that they might not have diabetes.

**CONCLUSION**

The perceptions of patients with newly diagnosed type 2 diabetes about their diagnosis focused not just on identifying and naming the disease, but also on the meaning related to the clarity, timing, and authority of the delivery of the diagnosis.

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**Commentary**

The study by Parry et al raises several interesting points for practising nurses to consider. In this study, clients attributed specific meanings to individual stages of the diagnostic process based on individual assumptions. These meanings were often based on a lack of information and on personal beliefs about the roles and authority of the professionals involved. In considering our own practice, it would be worthwhile exploring clients’ understanding of the process of referral for diagnostic procedures or expert opinion. Examining how procedural and organisational information is presented to clients and identifying existing beliefs or misconceptions may prove illuminating. Nurses should also consider whether organisational procedures inform the client or introduce opportunities for misconceptions to proliferate. Consideration of client perceptions of authority in the healthcare system in specific cultural settings may also provide insight and improve understanding of behavioural patterns. The establishment of a medical diagnosis and naming of a condition in concrete terms was also important to the clients in this study. In an observational study on the information and decision making preferences of adult cancer patients in hospital, Blanchard et al also found that assigning a definitive medical name or label to an affliction helped patients to begin to consider the impact of the disease on their lives. Open disclosure of early diagnostic information is an area of controversy and raises issues of accountability for practitioners and advocacy for clients. Lastly, the findings of Parry et al acknowledge the vulnerability of clients during the diagnostic phase of disease management. Nurses should consider the implications of any uncertainty introduced into the process (whether real or perceived) for their clients.

Bernard Mark Garrett, RN, PhD
School of Nursing, University of British Columbia
Vancouver, British Columbia, Canada
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