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Ideal versus Real Conditions for Type 2 Diabetes Care: Diabetes Specialty Nurses' Perspectives

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Abstract

Background: Since diabetes specialty nurses are the professionals who spend the most time with patients living with diabetes, they probably have the greatest influence on the quality of diabetes care. Therefore, their personal perceptions about what constitutes "good care" in type 2 diabetes care are important to explore. **Aim:** The aim of this study was to describe conditions for "good care" in type 2-diabetes as perceived by diabetes specialty nurses. **Method:** Twenty-one experienced diabetes specialty nurses participated in three focus group interviews. Data were analyzed using qualitative content analysis. **Findings:** The findings are presented in four themes describing diabetes specialty nurses' perspectives on ideal versus real conditions for type 2 diabetes care: 1) Diabetes counseling built on empowerment versus governance; 2) Diabetes management built on comprehensive versus biomedical views; 3) Diabetes organization built on nurse-led versus physician-led care; and 4) Diabetes policies built on quality versus equality. **Conclusion:** The ideal diabetes care is perceived as complex to achieve. Conflicting paradigms, power relations, and departmentalization of work are influencing the potential to deliver ideal diabetes care and to increase satisfaction among diabetes specialty nurses and patients. The diabetes specialty nurses described themselves as the "hub" of diabetes care, and they perceived conflicts between ideal versus real conditions in type 2 diabetes care. Patient centredness is not a real condition in diabetes care.

Background

Diabetes specialty nurses' support of patients' self-management in order to prevent or alleviate diabetes complications and maintain wellbeing is one assumption for quality care.^{1, 2} In this study, "good care" is defined referring to the Swedish National Guidelines, declaring the quality indicators for diabetes care as updated knowledge and evidence, security, efficiency, equality, accessibility in reasonable time and patient centeredness. These guidelines preferably should direct diabetes health care managers and specialty nurses in their care planning.³ From a patient perspective, relational aspects of care commonly are emphasized as indicators of "good" care. Examples of such relational aspects in diabetes counseling are agreement about treatment goals, equality in counseling situations, and being met as a person with dignity and respect of autonomy.⁴

Diabetes specialty nurses' support of patients self-management focuses on encouraging dietary modification, increased physical activities, attainment of normal body weight, and smoking cessation.^{1, 5} Self-management support includes patient education, which traditionally has been a common way of conveying health messages to improve metabolic control in patients.^{6, 7} However, counseling about medical facts and treatment, and sufficient self-management has limited effect on metabolic control, particularly in the longer term, and does not result in lifestyle changes if not repeated over time with follow-ups.^{6, 7, 8, 9} Furthermore, such counseling does not seem to promote empowerment.^{10, 11} Recommended models for counseling in diabetes care are built on empowerment and patient centeredness, and are based on an equal relationship where patients are autonomous, well informed, and respected for their well-informed choices.^{12, 13} These models may also increase patients' satisfaction with care, which is highly dependent on the quality of care, the caring situation, and diabetes specialty

nurses' attitudes towards patients, as mirrored by communication in care situations.^{4, 14} However, some studies highlight that a patient empowerment approach is not commonly applied and has not been agreed upon by health care professionals. Furthermore, patient empowerment as a counseling approach has been expressed as something professionals have to 'grow into'.^{15, 16} Studies of various professionals' views on the essence of diabetes care reveal that professionals focus primarily on treating and informing patients.^{10, 11, 17}

Diabetes care in Sweden adheres to standards outlined in several quality-of-care documents, including national and international guidelines and regulations. Such documents focus mainly on reducing risks of complications and mortality and on the evaluation of metabolic measurements.^{1, 2, 3, 18} In diabetes nursing, counseling supporting patient empowerment including listening to patients' own goals and motives to reach personal and medical goals is important. A complex task for the diabetes specialty nurse is to try to unify goals deriving from the different paradigms of life world knowledge versus science.¹⁹ Diabetes specialty nurses are the professionals who spend the most time with patients in Sweden and therefore probably have the greatest influence on and knowledge about the quality of diabetes care.^{20, 21} Concluded, the quality indicators for good diabetes care are expressed in national guidelines from a societal perspective, and patients' perceptions of good care in several scientific reports, but the diabetes specialty nurses' perspectives of good care are not sufficiently highlighted. In order to highlight ideal diabetes care, not only from patients' biomedical or health economic perspectives, these investigators requested diabetes specialty nurses' views of good diabetes care, which may imply also their personal perceptions of challenges for diabetes care in future. The aim of this study was to describe conditions for "good care" in type 2 diabetes as perceived by diabetes specialty nurses.

Method

Design

This qualitative, descriptive study was based on focus group interviews using qualitative content analysis to derive how diabetes specialty nurses describe conditions for "good care" in type 2 diabetes. The focus group interviews took place between January and May 2009.

Participants

A convenient sample of experienced diabetes specialty nurses from 17 health care centers in mid-sized cities in northern Sweden was invited to participate in the study. The nurses were contacted either by their executive managers or through a coordinating diabetes specialty nurse. The nurses were informed about the study by telephone or in person before the focus group interviews, and all of those requested accepted participation. Nineteen women and two men were included. All were registered nurses, specialty nurses in primary health care, and had specialized education in diabetes care. The participants had been nurses from 15 to 41 years and had been working in diabetes care between 2 and 19 years.

Data Collection

Participants were interviewed in three focus groups of six to eight people since this group size was estimated to be small enough to maximize discussion yet still maintain order.²² The interviews were introduced with an open question about the participants' perceptions of conditions for good care in type 2 diabetes from the diabetes specialty nurses' perspectives. The participants were also asked to give examples of occasions when they felt that they succeeded, as well as when they felt they failed in offering quality care and reasons for that.

The role of the interviewer was to moderate the interviewees to maintain focus, to inspire broader or deeper answers by probing, and to support all interviewees in co-operating and reflecting upon the questions. When divergent opinions were obvious, the participants were asked to clarify their thoughts for further discussion and reflection. An observer participated and kept memorandum notes of the content of the interview, which was reviewed within the group before finishing the interview.²³ Interviews were performed either at a health care centre or at another public area connected with the nurses' work and lasted between 50 to 90 minutes. All interviews were recorded and transcribed verbatim.

Ethical Consideration

The study was approved by the Regional Ethical Review Board. Participants were informed about the study and about the fact that participation was voluntary; they could choose to leave the interview at any point without giving any reason. Participants were guaranteed confidentiality. All participants were de-identified during the analysis and in the presentation of quotations. Findings are presented at group level only, and

some quotations have been modified to decrease the participants' risks of identification.²⁴

Analysis

Data were analyzed using qualitative content analysis according to Graneheim and Lundman.²⁵ Content analysis systematically analyzes written or verbal communication,²⁶ focusing on differences and similarities in the text. The interpretation process results in themes. A theme is a thread of meaning running through categories on an interpretative level.²⁵

The analysis was performed in several steps. First, the text was transcribed and thoroughly read times by all authors in order to gain a basic understanding of the content. An initial understanding was discussed in the research group. Then, the text was read again by the first author and meaning units corresponding to the aim were identified and condensed. The condensed meaning units were labeled with codes and sorted into subcategories and tentative categories based upon similarities and dissimilarities. Finally, to arrive at an agreeable interpretation, each category was critically read and analyzed by all authors, and themes were formulated. Throughout the analysis process codes, categories and themes were discussed and reflected upon in the research team, resulting in consolidation of the findings.

Findings

The findings demonstrate a contradiction between ideal versus real conditions for "good" type 2 diabetes care. Four themes illustrate the findings: 1) Diabetes counseling built on empowerment versus governance, 2) Diabetes management built on comprehensive versus biomedical views, 3) Diabetes organization built on nurse-led versus physician-led care, and 4) Diabetes policies built on quality versus equality. The themes are illuminated by quotations from the original text. Table 1 demonstrates the findings about ideal versus real conditions of diabetes care as described by diabetes specialty nurses.

	Approach for Diabetes Counseling	View on Diabetes Management	Organization of Diabetes Care	Foundation for Diabetes Policies
Ideal Conditions	Empowerment	Comprehensive	Nurse-led	Quality
Real Conditions	Governance	Biomedical	Physician-led	Equality

Table 1. Ideal versus Real Conditions for Type 2 Diabetes Care

Diabetes counseling built on empowerment versus governing

Participants described that ideal diabetes care requires effective counseling to get empowered patients. Empowered patients were described as those who are active in self-management, adherent and aware of their responsibility for taking action. They were also described as willing to confide their problems in order to gain the nurses' support in solving those problems. Meeting such patients who take initiatives and are actively involved in their own self-management, maintaining contact with the diabetes specialty nurses and asking for help when needed were described as consistent with ideal diabetes care. The nurse participants also expressed that active patients demonstrate their efforts to manage the disease, which they viewed as a confirmation that the diabetes care was working.

Some people say exactly what they need, for example, "I am too fat and I want to lose weight and I want to meet you every month until my vacation in July." Then I feel happy and relaxed. They have "drive" themselves and that is what we wish all patients would have. (FG2)

Participants stated that in ideal care it was important that diabetes specialty nurses made clear to patients what they expected from them and what the patients are responsible for. The nurses also said that their responsibility was to inform and support patients in improving their lifestyle and to help them manage self-tests and medication. The patients' responsibility was to follow the advice given.

You have to make clear whose responsibility the disease management is. My responsibility is to inform them about how to manage it. (FG3)

However, in contrast to these ideal conditions, the nurses talked about patients who did not take enough responsibility. These patients were perceived as hard to manage and needed governing to handle self-care, which represented the real condition. The nurses viewed tangible proposals for self-care actions as important for patients and as necessary for the self-care to be effective. Participants stated that some patients in particular need governance since they reject self-care and do not understand that good self-care is in their own best interests.

Many patients need knowledge and learning about disease management. They need to know what they should do and how they should think. (FG1)

The majority of the nurses said that they lacked tools and knowledge to effectively counsel non-compliant patients, and therefore the diabetes care lacked quality. The nurses perceived that they continued to perform annual diabetes check-ups in these patients, but often considered such a waste of time since the information they gave at the check-up often did not have the desired effect. These patients "did not know what's good for them".

The question is how much time you should spend on a patient such as this one. I asked him what we should do since I couldn't reach him. I said that I would call him annually but nothing more. He had previously sometimes asked us to pep him up, but sometimes you have to end it. (FG1)

Diabetes management built on comprehensive versus biomedical views

The nurses described that ideal diabetes care requires effective management of the disease. A comprehensive view on patients was desirable, and they described that diabetes specialty nurses were able to provide comprehensive care. The nurses expressed themselves as engaged with their patients and kept on developing their skills. They described diabetes specialty nurses in general as having an unflagging interest in their work with patients, which they said was invaluable. This engagement, they stated, 'rubbed off' on their patients, who then prioritized and took more responsibility for their diabetes self-care.

For me, diabetes management is much more than managing blood sugar. I am interested in why people perform self-care. It is fascinating to consider how you can influence a brain to start to think in another way. Why is it like that? I can influence one person with one word a lot while many words for another person mean nothing. (FG2)

The nurses described patient centeredness as being an ideal comprehensive approach, acknowledging the patient's experience of living with diabetes, which required that the diabetes specialty nurse was sensitive and asked questions about the patient's preferences, and tried to understand how the patient experienced and understood the illness. With an emphasis on relational aspects, the nurses related how they focused on building trust and on viewing the patient as a whole. Participants felt that this approach increased their patients' confidence in them, allowing the patients to open up to the nurses and be honest, daring to ask questions, and admitting their problems. This trustful relationship was perceived by the nurses as supporting the patients' capacity for self-care.

Patient-centered support is when the patient drives the car and I am the co-driver. Many times, they have the best solutions themselves, but I may rouse this self-care capacity, which is important. This is one reason why they prefer to visit us instead of seeing a doctor. (FG2)

Participants described the real condition of mainly focusing on biomedical measurements, metabolic balance, and targets for metabolic measurements and that these measures were seen as most essential in diabetes care. The diabetes specialty nurses considered themselves as highly competent in diabetes care and expressed themselves willing to develop in that role through attending meetings with experts, and participating in conferences and educational sessions on new diabetes treatments. They stated that this development distinguished them from many General Practitioners (GPs) who – they experienced – were not up-to-date with the latest developments in diabetes treatment and generally seemed less engaged while the diabetes nurse specialists performed follow-ups with patients according to recommendations in guidelines and had more stringent limits regarding blood glucose than do the GPs.

Good care requires a competent and skilled diabetes nurse. It's very important that the diabetes nurse is updated on the latest guidelines ... Patients have said that they got more out of the meeting with me than they did out of the visit to their GP, which may refer to the fact that GPs have broader areas of interest

than just diabetes. (FG3)

The nurse participants described situations where GPs did not have enough time to motivate the patients to intensify their self-care and just left this care aspect to the nurses or prescribed medication instead. The principal task for GPs in diabetes care was, by the nurses, described as prescribing medication.

Diabetes organization built on nurse-led versus physician-led care

The nurses described that ideal diabetes care requires an effective organization to reach the goals for diabetes care. Nurse-led care was by these participants seen as ideal, since this care could improve continuity and evaluations of treatment recommendations. Continuity and regularity among personnel, and particularly continuity in diabetes specialty nurse contacts, was desirable. The nurses stated that as the patients got to know their nurse, they felt safe and secure. This fact, the nurses perceived, became even more important when a shortage of physicians existed, which, according to them, was common. They also expressed that they were the ones who represented continuity in diabetes care. Meeting the patient more often, so they expressed, gave the nurse a unique position based on personal awareness of the patient as a whole, something described as being of particular interest in nursing. Regularity in appointments and follow-ups to the diabetes specialty nurse were described as important for providing quality care. The responsibility for registry in the National Diabetes Register (NDR) was also described as very important and related to regularity in appointments, and increasing their chances to remind patients of the importance of self-management to reach treatment goals.

I have thought about the annual national diabetes register control [that we are responsible for]. They summon your car for an annual vehicle test, and [it's] the same – if you have a chronic illness, you have a lot to win by preventing. (FG2)

The nurses stated that ideally prescriptions by the GPs should take into account recommendations made by the nurses, who – as they told – managed everything else in diabetes care. Furthermore, the nurses said that GPs' support of the nurses' suggestions for intensified or changed treatment would be one way of showing respect for the diabetes nurses' specialized up-to-date knowledge, skills, and patient-centered attitude. The nurses expressed that commonly GPs had "old-fashioned" ideas about the severity of type 2 diabetes, as well as about targets for HbA1c, blood pressure, and serum lipids.

The problem is that most of them haven't had the opportunity to update their knowledge, through participation in diabetes courses for example. At one occasion, our GPs participated in a 3-day education session with us and afterwards it was much better. (FG1)

Participants described the real conditions as diabetes care that is physician-led since the GPs were the ones who finally decided about the treatment. The nurses said they would like improved collaboration with the GPs, including respect for the nurses' unique competence and their updated standpoints regarding treatment goals and treatment options. They expressed that GPs needed to update their own diabetes knowledge in order to support the nurses. The nurses described GPs as 'lone wolves' who usually did not collaborate on or discuss treatment options and prescriptions with the nurses. They stated that many GPs used outdated targets and therefore their recommendations were not in sync with the nurses, who often requested intensified treatment (e.g., insulin therapy, while the GPs were more willing to wait before prescribing). The nurses expressed a problem with this attitude since they perceived that it made them lose their authority among patients.

I have discussed insulin with the patient and he meets the doctor who is doubtful. It most often ends in a wait-and-see situation, which is devastating to me ... It is about respect for my position. I mean, if I identify a need for intensified treatment and talk to the doctor who is the prescriber, then it's important that I get a positive response. (FG1)

Diabetes policies built on quality versus equality

Participants also described that the policies for diabetes care ideally should be build on quality and equality. However, current diabetes care was described being organized more towards equality. Offering annual and semi-annual appointments irrespective of the actual needs by the patients were one example of striving for equality. Ideally, the nurses perceived that offered diabetes care should be based on quality evaluations, and accessibility should be adapted after patients needs. They also expressed that enough resources must be available and health care managers must support quality diabetes care.

The nurses described strong support from managers higher up in the health care organization as ideal. The managing executives' support of diabetes care was seen as particularly important with regard to

being given enough time and other resources for diabetes care.

An understanding from primarily the leaders but also the co-workers is important. To understand the work we do and the demands to reach these treatment goals [for quality]. They must work for it actively, not only by telling us that they understand; they must work for it. You should feel that the whole organization is involved first, and then it can work. I mean, the bosses should state that diabetes is important and that they support the guidelines that are to be followed. (FG2)

The diabetes nurses expressed that, in reality, diabetes care was both unequal and lacking quality. People living far from a health care centre were described as disadvantaged, with less access to optimal care. Long distances were obstacles that nurses suggested could be solved by the health care organization (e.g., by relocating diabetes nurses to sparsely populated areas). The nurses described inequality in health care availability as depending on the number of nurses and GPs in the catchment area. The nurses said that – ideally – all patients should have the opportunity to get their questions answered the same day as they contacted the nurses. However, in reality, the nurses could not live up to this ideal, but patients mostly found it acceptable to wait for a physician considerably longer.

The most important thing is that we are accessible to patients – that we are there when they have questions and calls, and that we can answer them. (FG2)

The nurses described diabetes care quality as insufficient, with much potential for development. They also considered the use of models for quality registration and evaluation as an important step towards improved quality of care. In particular, the nurses expected the NDR to influence care quality by allowing comparison between various units and various treatment options. However, except for the NDR, the nurses described the tools for quality evaluation as insufficient, and a lack of resources and knowledge about using such tools. Evaluations of patient satisfaction with care were described as lacking in general.

I lack instruments for evaluation. I would like to know what the patients appreciate – does it work, and does it work with the doctors? Do they appreciate the visits with me or not? What would they like? – Something for general use to get some comparison or evaluation ... (FG1)

The nurses described ideal care as relying upon enough resources to deliver such care. The nurses mainly defined resources as time devoted to the delivery of diabetes care. Increased resources meant increased opportunities for preventive actions and consequently fewer people falling ill, earlier detection, and reduced complications among those diagnosed. With lacking resources, they preferred to focus on newly diagnosed patients and those with insulin treatment while the needs of other patient groups were minimized. The nurses described retrenchment programs as a threat that had led to a lower priority for patients with diabetes.

You have to drop those who have satisfactory blood glucose control and concentrate on those newly diagnosed or patients with insulin that are in need of more efforts. You differentiate your work tasks somewhat. (FG1)

Discussion

The aim of this study was to describe ideal versus real conditions for type 2 diabetes care from a diabetes specialty nurse perspective. The theme “Diabetes counseling built on empowerment versus governing” deals with **attitudes to patients (i.e., their freedom, will, and autonomy)**. **Ideally, patients should** take initiatives and be active and adherent (i.e., make the lifestyle changes recommended by the diabetes specialty nurses). Another ideal condition is that diabetes counseling is empowering and at the same time provides governing guidance; something that might be seen as a contradiction. According to the empowerment philosophy,¹² patients prefer to identify and use their inherent abilities to control the illness. Within this approach, patients take responsibility for their own self-care and take necessary action in order to counteract complications, with the diabetes specialty nurse acting as support. A patient's success in achieving such empowerment is related to a caring relationship with the nurse, which should be based on equality and respect.^{4, 11} Modern counseling built on patient centeredness and empowerment instead of adherence/compliance requires an adjustment of the traditional controlling role based upon authority. Communication from top to bottom (i.e., informing and telling people how to perform self-care and expecting them to follow such) apparently does not work.¹⁰

The participants told that a patient centred approach was important and that they were patient centred in their work. However, it seemed that person centered care was subordinated and something professionals find interesting but time was lacking for its impact on daily work. Ekman et al.²⁷ declared that person

centred care should not be anything professionals practice just when time allows. Instead, this care should be systematically and consistently practiced. Patient centred care, which these investigators interpret as equivalent with person centred care, is emphasized in curricula for quality diabetes care.³ Patient centred care, from these investigators' perspective, has been defined as including a partnership between patients and professionals, where the patient is seen as a person not merely a disease or a state. The patient is viewed as competent and autonomous and should therefore be respected as a person. Patient centred care is planned and performed in collaboration and in accordance with the patients' preferences and needs.^{27, 28, 29} A majority of the participants in this study had been educated in motivational interviewing (MI),³⁰ which is a patient centred and empowering, guiding style to elicit and strengthen motivation for change.³¹ However, the Swedish Board of Health and Welfare³ currently has stated that MI is not a recommended method in diabetes care. A systematic literature review on various approaches used in patient education in diabetes care³² has reported that MI does not affect hemoglobin A1c levels in evaluations up to 12 months. This new recommendation might influence the nurses causing confusion in their counseling approach.

Despite the emphasis on empowerment in curricula and guidelines, diabetes nurses seem to have difficulty agreeing upon this advocated approach. Empowerment and compliance are poles apart in care philosophy, where compliance is given prominence. The care relationship is between the nurse, who is the expert and active in the effort to transfer a message, and the inexperienced patient, who is expected to passively comply with the message.^{10, 11, 16} One explanation for nurses' expectations regarding adherence is that professionals and patients represent different paradigms which is suggested as a plausible reason for the limited effects of traditional compliance-based patient education.^{6, 33} Zoffmann and Kirkevold³⁴ have expressed this paradigm clash as a conflict of "life versus disease". Henderson,³⁵ among others, accentuated the importance of a partnership between patients and professionals, and stressed that partnership demands an abandonment of exerting power from professionals to patients. Current empowering educational methods concentrate on adapting diabetes management to patients' lives in order to facilitate more independent lives.⁵ However, such an approach requires an interest in the patients' experiences and a more patient-centred approach in diabetes care.^{17, 36, 37}

The theme "Diabetes management built on comprehensive versus biomedical views" deals with the perspectives professionals hold in diabetes care. A particular paradigm forms a particular perspective on health and illness and will affect care. Furthermore, a comprehensive approach may influence patients' satisfaction with care and probably the work satisfaction among nurses.⁴ Patients' perspectives on illness and care derive from their own life world, which is subjective and filled with personal meanings of illness and pragmatic motives for illness management.¹⁴ Health professionals' perspectives on disease and care usually derive from a biomedical or epidemiological disease paradigm with foundations in the natural scientific world of conceptions.^{14, 38} The nurses in this study asserted that they, in contrast to the physicians, besides medical knowledge had a comprehensive understanding of their patients, including psychosocial aspects that influenced patients' opportunities to adhere to treatment recommendations. Despite this, these investigators have interpreted that their comprehensive view on patients with illness was subordinated by the biomedical view of the disease. The diverging perspectives deriving from views on illness and disease are previously reported as hardly working together.¹⁹ An ongoing "medicalization" of illness, health care and nursing, along with a focus on biomedical measurements rather than patient centredness and patient satisfaction, is possibly adding to these problems.

The theme "Diabetes organization built on nurse-led versus physician-led care" deals with the question about who most effectively are leaders of diabetes care organizations and of diabetes care teams. These nurses seemed to perceive themselves as qualified but quite powerless, and requested authorization from managers higher up in the health care organization to give them a mandate and time to prioritize diabetes care and lead the diabetes care team. Some studies hold up nurse-led care compared with traditional physician-led care roles as a model, while others assert that nurse-led care does not affect the quality of diabetes care.^{39, 40} International and national guidelines recommend multidisciplinary teams in order to support patients with diabetes.^{1, 3} The nurses' negative views of physicians is a shaky foundation for the organization of diabetes teams, an approach that is lately gaining prominence in Sweden. General practitioners in Sweden do not often participate in team-developing education or regular ongoing diabetes education, and therefore in some degree may have been allowed to fall behind in their knowledge of current treatment goals for diabetes. Nurses have been given increasing responsibility for work tasks that were previously performed by physicians, which means that they often find themselves more up-to-date than GPs even in medical questions. A traditionally subordinated group may experience difficulties to hold a position that is more prominent and become equal, even if the members progress and update their knowledge and working methods.⁴¹ The nurses furthermore perceived they were not

getting enough credit and respect from the physicians for this effort. The health care organization is still highly hierarchic and physicians have a key position in relation to patients as well as other professionals.

Most diabetes specialty nurses are female, and most GPs are male in Sweden. Even when these gender lines are crossed, the role of physician derives from a male tradition, and the role of nurse from a female tradition. Diabetes specialty nurses expect interest and support from GPs; however, the nurses are disappointed when they do not feel they are respected for their engagement. One interpretation is that the nurses expected physicians to follow masculine stereotypes by having more power when they are supporting the nurses, while the nurses themselves were fighting against a stereotypical feminine pattern in their struggle to take responsibility for new work tasks and become more medically oriented.⁴² Gender order may be explained as the construction and ranking of gender to the disadvantage of women. Gender order has been described as a self-perpetuating mechanism within work organizations.⁴³ In the interpretation of the data, these conditions are common in the health care organizations where the diabetes specialty nurses work.

The theme concerning "Diabetes policies built on both quality and equality" deals with the striving for both quality and accessibility but also a compromising due to lacking resources to reach high quality care for all patients (i.e., a health economic and care philosophical problem hard to solve). The nurses described strong support from higher up in the health care organization as ideal. The managing executives' support of diabetes care was seen as particularly important with regard to being given enough time and other resources for diabetes care. Equal access to evidence-based diabetes care is not possible to reach due to large geographic catchment areas, shortage of GPs, lacking resources, and insufficient support from managers. However, the participants suggested a strengthened diabetes nurse organization where nurses are relocated to rural areas to perform and lead diabetes care. Lacking resources seem to polarize equality and quality. However, reports exist on effective health care led by nurses in rural areas.^{44, 45}

Methodological Discussion

The majority of the participants were female which may have influenced the findings. However, most diabetes specialty nurses are female and therefore, these investigators consider the findings transferable to other, similar contexts. Furthermore, this study describes perceptions of Swedish diabetes nurses. However, these investigators consider the findings as transferable to similar context since nurses in primary health working with patients with diabetes work in a similar way, with national and international policy documents as guidelines.

Focus group interviews are suitable for calling attention to various aspects of an area of research since many participants' experiences and reflections are raised in the discussions. The disadvantage is that "group thinking" can occur and may be exacerbated if participants who are not in agreement do not have an opportunity to state their views. When specialists who usually work in relative isolation come together, they possibly strive to make a good impression on others and may present themselves and their views in a somewhat idealized light.

According to Krippendorff,²⁶ a text never implies one meaning only; the interpretation merely implies the most probable meaning from a particular perspective. Thus, the interpretation of study findings should be seen as one possible understanding of diabetes nurses' perception of ideal versus real conditions for type 2 diabetes care. The trustworthiness of this interpretation is based on the fact that throughout the analysis, process codes and categories as well as themes were discussed both among the research group and in seminars with other researchers in order to validate the findings.

Implications for Practice

Routines for person centred care must be established to initiate, integrate, and safe guard partnership between professionals and patients in daily clinical practice. The study findings indicate that person centredness is not a real condition in diabetes care. Diabetes specialty nurses commonly describe their work as patient centred, but it seems difficult for them to provide patient centred care in practice. Therefore, diabetes specialty nurses and also physicians need training in providing patient-centred care and opportunities for reflection about their work demands in order to better support patients' self-management in type 2 diabetes. The roles of nurses and physicians must be clearer, and respect must be built between them based on an understanding of their unique competences. A desired outcome is enhanced collaboration between nurses and physicians to reach a common understanding about their different work tasks in diabetes care. Both nurses' and physician's competences are needed. Joint education, patient centred training and discussions about the performance of high quality diabetes care,

including relational aspects, are therefore important. A crucial element is that patients are present at meetings with the diabetes team to ensure that the patient perspective of care is represented. Ongoing "medicalization" of illness, health care and nursing, with quality registration that focuses primarily on biomedical measurement, may lead to a compromised comprehensive care model. A large problem is that nurses describe lack of time to care for people who really need time-consuming support. Furthermore, nurses may lack the tools to manage "difficult" patients. A vision for the future is that patient centred care is implemented more structured and that diabetes specialty nurses view non-adherent patients as a challenge and furthermore, that they reflect upon their own role and attitudes when communication with patients is insufficient.^{34, 36, 46} Suggested future research is for evaluations of patient-centred nursing interventions in diabetes care, where team-work in diabetes care is focused and where patient centredness and biomedical issues are integrated.

Conclusion

A main finding is that ideal conditions for "good" diabetes care are perceived as complex to achieve. Diabetes specialty nurses perceived ambivalences between ideal versus real conditions in type 2 diabetes care. Conflicting paradigms, power relations, and departmentalization of work influence the potential to deliver "good" diabetes care. Nurses described themselves as patient-centred but when they explained how they commonly worked in counseling with patients, these investigators interpreted them as less patient centered. In appointments, their focus was on biomedical issues and not on the patient's experiences of living with diabetes. Patient centred care is something professionals find interesting, but they express that time is lacking for implementing such care in daily work. The participants expressed that they were the "hub" of diabetes care, but they were subordinated by the physicians. In order to achieve "good" diabetes care, GPs and nurses should collaborate more to try to understand each other's areas of responsibility in order to improve the diabetes care. This collaboration should be built on respect for nurses' and physicians' professional competences and is a prerequisite to support patients' self-management and treatment as well as to reach effective team work based upon quality and patient centredness.

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