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What employees with diabetes mellitus need to cope at work: Views of employees and health professionals

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Abstract

Objective: To identify and compare patient and professional perspectives on what enables employees with diabetes mellitus (DM) to maintain their position in the workplace. To provide information on how professionals can help DM patients cope at work.

Methods: Qualitative study using concept-mapping sessions involving 23 employees with DM and 22 health professionals (GP's, occupational physicians and specialists). All of the health professionals were experts in the field of diabetes care.

Results: Patients and professionals identified five common clusters of statements on what diabetics need to enable them to cope at work: the ability to accept and cope with DM, supportive health professionals, a supportive work environment, work adaptations and good information. Patients emphasized the importance of emotional acceptance of DM and communication with colleagues, while the professionals emphasized the patient's capacity for self-care.

Conclusion: The content of patient and professional perspectives on what is needed to prevent work-related problems for DM patients differed slightly. Patients rely on direct experiences in their own environment, professionals on medical knowledge accumulated in groups of patients.

Practice implications: Both perspectives were used to suggest a topic list for health professionals, which may help identify and address the occupational problems experienced by DM patients.

Keywords: Diabetes mellitus; Concept mapping; Continuing to work; Employment; Health professional's perspective; Patient's perspective; Work disability; Occupational health; Support at work

1. Introduction

Diabetes mellitus (DM) is a serious and increasing global health problem [1]. Despite improvements in diabetes care, the labor participation of people with diabetes is still lower than that of people without diabetes. The estimated work participation rate for individuals with diabetes is 62% between the ages 16 and 44 and 29% between the ages 45 and 64, in contrast to 77% and 50% for the general population in those age groups [2]. The increasing prevalence and chronic nature of diabetes implies that continuity of care and self-management should be an important factor in the management of this disease.

Many of the activities that are needed to achieve glycemic control can be carried out by diabetics themselves, such as monitoring of blood glucose levels, medicating, dieting and exercise. For that reason, enhancing patients' capacities for the self-management of diabetes has become an important focus in current diabetes care [3]. Patient–professional communication is a crucial element of effective chronic illness care. However, effective communication is complex because professional and patient perspectives may differ [4].

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Current research has found that physicians and patients sometimes have different perspectives regarding the experience of having diabetes. For example, one study has found that continuity of care was perceived by patients to include a wider range of components than what is traditionally associated with continuity of care [5]. Another study found that patients experienced the effect of diabetes in a more psychosocial than physiological manner than clinicians perceived [6]. Two other studies confirmed that patients and professionals had differences in what they considered to be quality of care for patients with diabetes [7,8]. Recent studies have found that diabetes patients were not content with the education they received in support of social, experiential, ethical and financial aspects and about managing the illness at the time of diagnosis [9,10].

Current health policies in Europe promote the prevention of sickness absence and job loss among employees with chronic health conditions such as DM. Health care providers are in a good position to provide such support, because of their central role in diabetes care: they have the possibility to identify patients' work-related problems at an early stage and to offer appropriate information and support if needed. However, current clinical guidelines and treatment protocols for diabetes care and occupational health care provide little information on how health professionals may support patients in managing diabetes effectively at work. There are some generic instruments that may be useful in identifying work-related problems experienced by patients with chronic health conditions [11–13] but these instruments do not focus specifically on patients with diabetes. Furthermore, there is hardly any research on the effectiveness of interventions in this area [14].

Disability researchers have noted that the development of any intervention to improve the work situation of ill workers requires information about the direct experiences of the immediate stakeholders themselves, and especially the patients [15]. Previous studies on patient and professional perspectives on living with diabetes have not focused specifically on the patient's work situation. For that reason, the aim of this study was to explore and compare the ideas of employees with diabetes and health professionals with experience in diabetes or occupational health care as regards the kind of support diabetic patients may need in their work situation. The results were used as the basis for developing a topic list that may help professionals to identify the work-related problems experienced by diabetics and to support them in their work situation.

2. Methods

We used a qualitative research method, 'concept mapping', to collect information on the perspectives of employees with DM and health professionals on factors that may enable job retention. This method can be used in groups of between 20 and 25 individuals to elicit ideas from individual members about complex issues and to map those ideas in a structured way at group level [16].

2.1. Participants

Purposeful sampling was used to select a group of up to 25 currently employed patients with diabetes mellitus and a group of up to 25 health professionals.

The inclusion criteria for employees were having been diagnosed by a doctor with diabetes mellitus type 1 or 2, being insulin dependent, having no other chronic illness which may affect work ability, having a paid job and being between 21 and 60 years old. Ninety-three patients who met the inclusion criteria for illness and age were selected at random by a diabetes consultant from the records of the diabetes outpatient clinic at the Academic Medical Center in Amsterdam (AMC). An invitation letter was sent to all the patients. Two weeks later, a researcher phoned 70 patients who had not responded to the invitation and checked if patients met the inclusion criteria for work. From the 70 patients, 50 patients could be contacted by phone. Finally, 25 patients who met the criteria for work and who were willing to participate in the study were accepted. All the participants signed an informed consent form before participating in the study. The non-response was mostly due to the fact that the concept-mapping session was held during the weekend and vacation time. The inclusion criterion for health care professionals was their experience in diabetes care. Participants were recruited through referrals from experts at the departments of internal medicine, general practice and occupational medicine of three university hospitals and the Dutch College of General Practitioners (NHG). Twenty-five professionals were invited to participate in the study. Twenty-two accepted the invitation. Three professionals did not complete a part of the assignment due to lack of time.

2.2. Data collection

Separate concept-mapping sessions took place for employees and professionals. A 4-h collective group session for the employees was held in September 2001 at AMC. The employees were first asked to generate statements completing the following sentence: "*What a person with diabetes mellitus needs to be able to keep on working is ...*". The concept-mapping method requires that statements do not contain multiple messages or are bonden to time and place. Therefore, a facilitator encouraged the participants to clarify unfamiliar terms or jargon, and helped to edit the statements if needed. Each statement was typed into a computer by an assistant and printed on a card. Subsequently, each participant received a stack of cards with all statements. They were asked to rate the statements according to priority on a Likert scale (1 = lowest priority and 5 = highest priority). The participants then sorted the statements in a logical manner according to themes by forming clusters.