# Managing multiple long-term conditions in 2026: The power of integrated healthcare

RCGP, London | 1 July 2026

31RD London Conference | PCDO Society



See the person – the initial consultation and screening in primary care

Helping people come to terms with the diagnosis of Type 2 diabetes

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Ensuring the correct diagnosis

What and when to test



## Disclaimer/Disclosures

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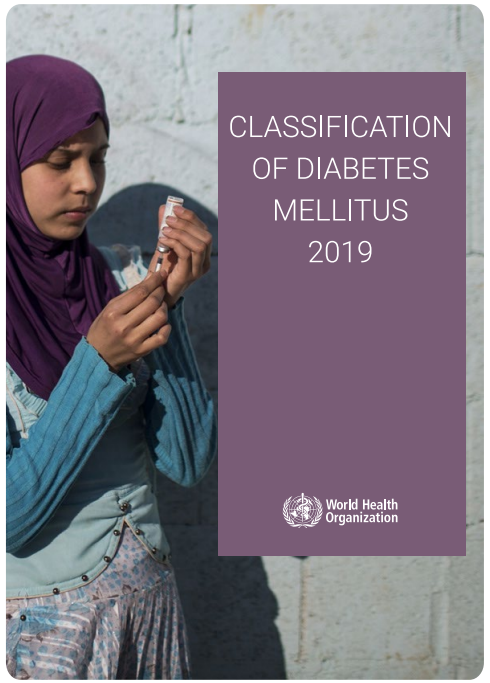
Received funding from the following companies for providing educational sessions and documents, and for attending advisory boards:
Abbott, Bayer, Boehringer Ingelheim, AstraZeneca, Daiichi Sankyo, Dexcom, Eli Lilly, Menarini, Novo Nordisk, Roche and Sanofi.

# How many type of diabetes can you name?

| | | | | |
|---|---|---|---|---|
| Type 1 diabetes | Type 2 diabetes | Mature-onset diabetes of the young (MODY) | Slowly evolving immune-mediated diabetes of adults | Gestational |
| Type 3c diabetes | Ketosis-prone type 2 diabetes | Steroid-induced | Post-transplant | Cystic fibrosis-related |
| Diseases of endocrine system | Infection-related | Immune checkpoint inhibitor-related | ?Non-diabetic hyperglycaemia (NDH) | Related to genetic syndromes |

# Why classify diabetes?




- To clarify risk (for example, DKA)
- To guide lifestyle advice
- To guide therapy choices
- To ensure early, optimal outcomes
- To prevent/delay complications
- To identify co-pathologies
- To develop new preventative and management strategies
- To guide research



World Health Organization. Classification of Diabetes Mellitus. 2019. Available at: https://www.who.int/publications/i/item/classification-of-diabetes-mellitus (Accessed March 2026).

# Important considerations

| | |
|---|---|
| It may not be possible to ‘classify’ diabetes at onset | |
| Misdiagnosis is common and can occur in ~40% of adults with new T1D[1] | • Adults with T1D misdiagnosed as having T2D<br>• Individuals with MODY misdiagnosed as having T1D |
| ~38% of children with T1D will present with ‘classical’ DKA[2] | • In adults the presentation of T1D can be more variable, including periods of temporary remission from the need for full-dose insulin replacement |
| Occasionally T2D presents with DKA (ketosis-prone T2D) – more so in some ethnic populations than others | |
| Antibody testing e.g., islet cell or C-peptide may be required to clarify diabetes type | • 5–10% of people with T1D **do not** display autoantibodies[3]<br>• A few people with T2D **DO** display autoantibodies |



DKA: diabetic ketoacidosis; GAD: glutamic acid decarboxylase.

1. Lancet Reg Health Eur 2023;29:100661; 2. Bessant E. J Diabet Nurs 2025;29:JDN373; 3. Simmons K, Michela AW. Rheum Dis Clin North Am 2014;40:797–811.

# LYLA'S LAW



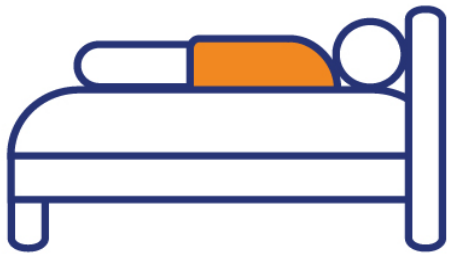
Do you know the symptoms of

# Type 1 diabetes?

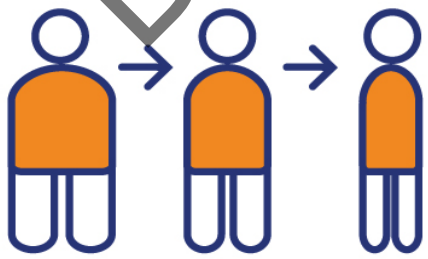
**Toilet**

**Thirsty**

**Tired**

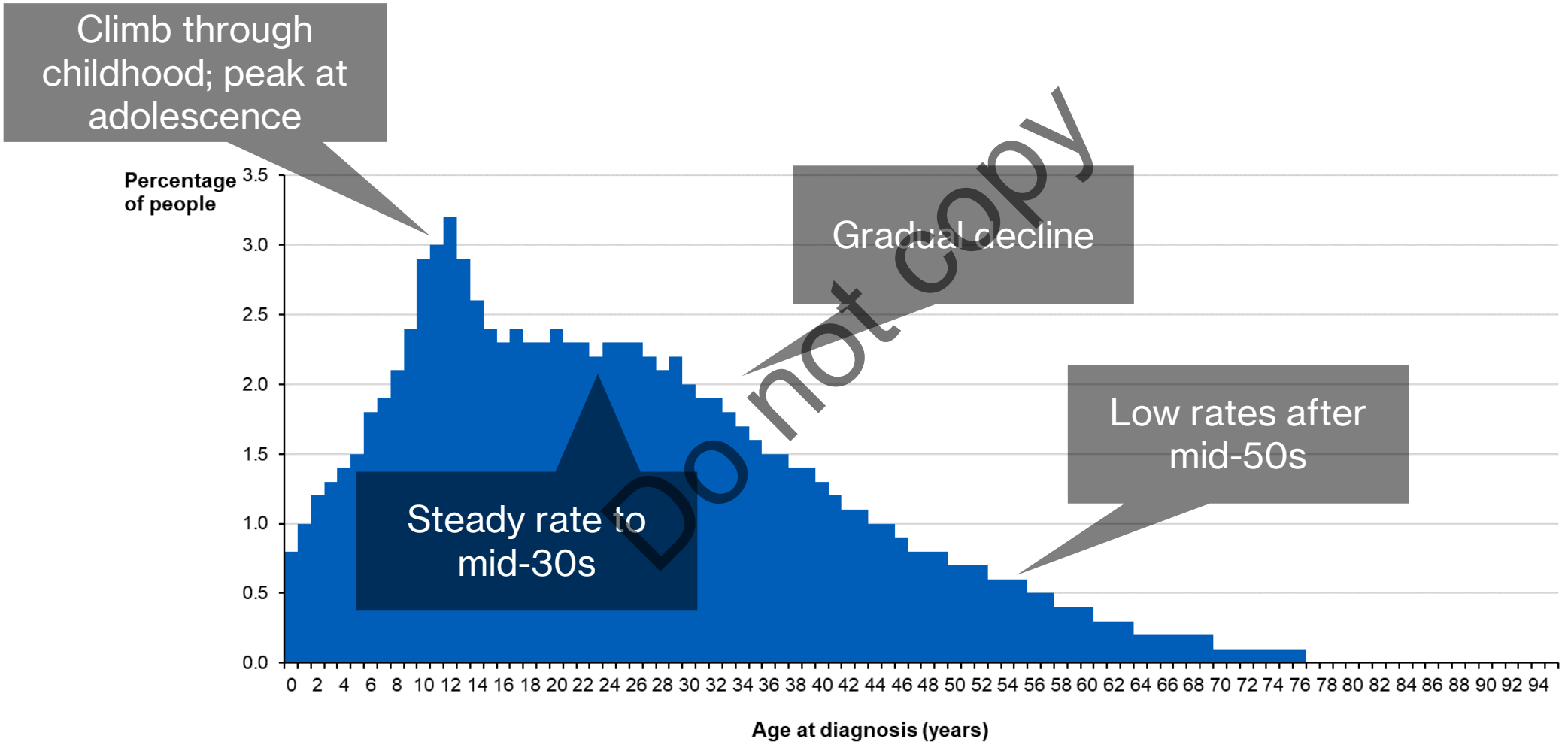


**Thinner**



- ✓ Capillary blood glucose stat
- ✓ Ketone check
- ✓ If in doubt > A+E

# People with type 1 diabetes, by age of diagnosis
## (England and Wales, 2019-20)

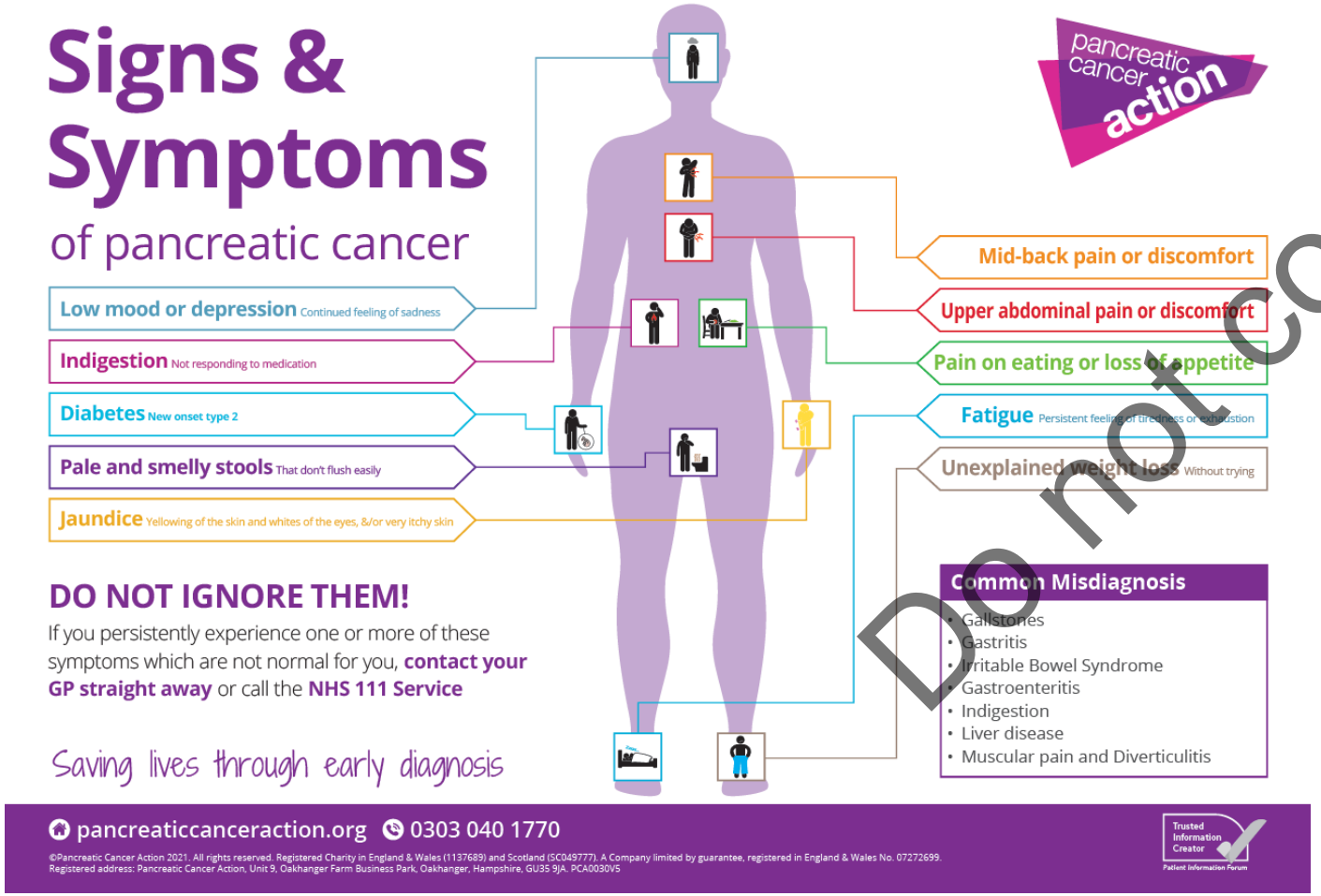





NHS Digital. National Diabetes Audit, 2019-20 , Type 1 Diabetes. 2021. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit/national-diabetes-audit-2019-20-type-1-diabetes (Accessed March 2026)

# Pancreatic Cancer

NICE National Institute for Health and Care Excellence




**Suspected cancer: recognition and referral**

NICE guideline
NG12
Published: 23 June 2015
Last updated: 15 April 2026



Consider an urgent, direct access CT scan, or an urgent, direct access ultrasound scan if CT is not available, to assess for **pancreatic cancer in people aged 60** and over with weight loss and any of the following:

- diarrhoea
- back pain
- abdominal pain
- nausea
- vomiting
- constipation
- **new-onset diabetes**

# Diagnosis of type 1 diabetes

Typically **(but not always)** 1 or more of:

- Ketosis
- Rapid weight loss
- Age of onset <50 years
- BMI <25 kg/m$^2$
- Personal and/or family history of autoimmune disease

- **Do not: use age or BMI alone to exclude or diagnose T1D in adults**
- **Do: measure diabetes-specific autoantibodies in adults with an initial diagnosis of T1D**
  - False negative rate is lowest at the time of diagnosis
  - False negatives can be reduced through quantitative tests for 2 different diabetes-specific autoantibodies
- **Do not: routinely measure serum C-peptide to confirm T1D in adults**
  - Consider non-fasting serum C-peptide (with a paired blood glucose) if diabetes-specific autoantibodies are negative and diabetes classification remains uncertain



BMI, body mass index; T1D, type 1 diabetes.

NICE. Type 1 diabetes in adults: diagnosis and management. 2022. Available at: https://www.nice.org.uk/guidance/ng17 (Accessed March 2026)

# Circulating pancreatic islet autoimmune antibodies

- Suggest a person at risk of or having already developed T1D
- Antibodies associated with T1D:

| Islet cell cytoplasmic antibodies (ICA) | Antibodies to insulin (IAA) | Insulinoma antigen 2 (IA-2) | Glutamic acid decarboxylase isoform (GAD) | Zinc transporter isoform 8 (ZnT8) |
|---|---|---|---|---|
| | **most commonly found in children** | | **most common antibody found in adults** | |



- Can be detected prior to diagnosis; frequently decline from the time of diagnosis
- Can be absent in longstanding disease
- Autoimmune T1D is also associated with other autoimmune conditions:
  - Thyroid disease
  - Coeliac disease
  - Addison's disease
  - Pernicious anaemia
  - Vitiligo

T1D, type 1 diabetes.

Milne N & Thomas T (eds.). Oxford Handbook of Diabetes Nursing. 2nd edn. Oxford: Oxford University Press; 2025.

# C-peptide levels

- Marker of endogenous insulin
- Measure with a paired glucose
- Levels may vary depending on insulin sensitivity



| C-peptide | <200 pmol/L | 200–600 pmol/L | >600 pmol/L |
|---|---|---|---|
| | Severe insulin deficiency | | Substantial endogenous insulin secretion |
| **T1D** | Confirmed | Likely | Unlikely |
| **T2D** | Unlikely | Seen in longstanding T2D | Likely (if duration >3 years) |
| **MODY** | Unlikely | Potentially (if longstanding T1D and antibodies negative) | Likely (if duration >3 years) |

MODY, mature-onset diabetes of the young; T1/2D, type 1/2 diabetes.

ABCD. Standards of Care for Management of Adults with Type 1 diabetes. 2020. Available at: https://abcd.care/resource/standards-care-management-adults-type-1-diabetes-2020 (Accessed March 2026)

# Monogenic diabetes

Rare form resulting from mutations in a single gene

Caused by a specific gene mutation

Separated into neonatal diabetes and MODY

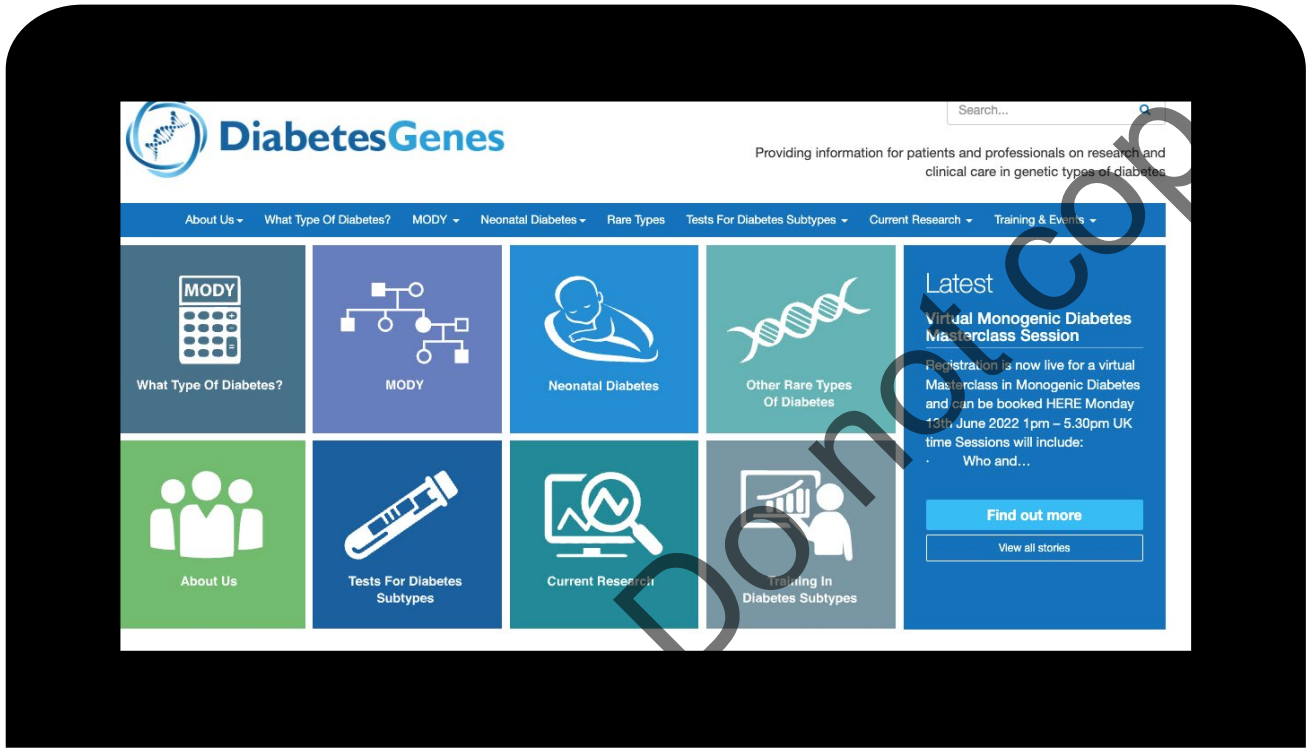
## MODY – key facts

- Affects 3.6% of diagnoses <25 years of age
- Initially misdiagnosed around 77% of cases
- Often develops before the age of 25 years
- Present in families from one generation to the next
- May be treated by diet or tablets (typically sulfonylureas); does not always need insulin treatment



MODY, mature-onset diabetes on the young..

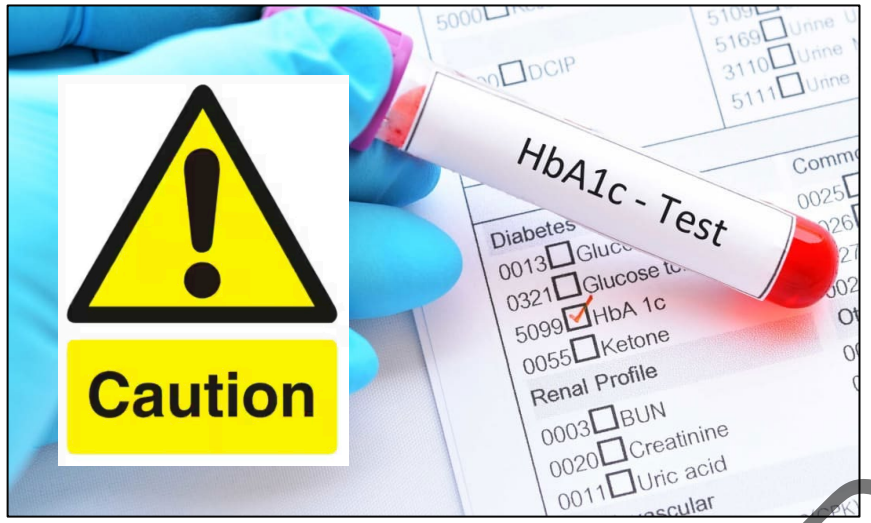
# MODY calculator




**diabetesgenes.org/**

MODY, mature-onset diabetes on the young..

# Situations where HbA1c may be an unreliable measure






| Increases $HbA_{1c}$ ▲ | Decreases $HbA_{1c}$ ▼ |
|---|---|
| **Erythropoiesis** | |
| ▲ Iron deficiency<br>▲ Vitamin B12 deficiency<br>▲ Decreased RBC production<br>▲▼ Pregnancy (increased in third trimester) | ▼ Administration of erythropoietin, iron or vitamin B12<br>▼ Reticulocytosis<br>▼ Chronic liver disease<br>▲▼ Pregnancy (reduced in first trimester) |
| **Glycation** | |
| ▲ Alcoholism/chronic alcohol ingestion<br>▲ Chronic renal failure<br>▲ Decreased RBC pH<br>▲▼ RBC transfusion (variable effects)<br>▲▼ Genetic determinants (variable effects) | ▼ Chronic ingestion of aspirin, vitamin C or vitamin E<br>▼ Certain haemoglobinopathies<br>▼ Increased RBC pH |
| **RBC destruction (increased or decreased RBC lifespan)** | |
| ▲ Asplenia | ▼ Haemoglobinopathies<br>▼ Splenomegaly<br>▼ Rheumatoid arthritis<br>▼ Drugs such as antiretrovirals, ribavirin, interferon-alpha, dapsone |
| **Interference with $HbA_{1c}$ assays** | |
| ▲ Severe hyperbilirubinaemia<br>▲ Uraemia/carbamylated haemoglobin<br>▲ Alcoholism/chronic alcohol ingestion<br>▲ Large doses of aspirin<br>▲ Chronic opioid use | ▼ Hypertriglyceridaemia<br>▲▼ Haemoglobinopathies (variable effects) |
| **Altered haemoglobin** | |
| ▲▼ Fetal haemoglobin (variable effects)<br>▲▼ Haemoglobinopathies (variable effects)<br>▲▼ Methaemoglobin (variable effects) | |

Diggle J (2025) HbA1c: Practicalities and pitfalls. *Diabetes & Primary Care* **27**: 81–6

# What does this all mean?

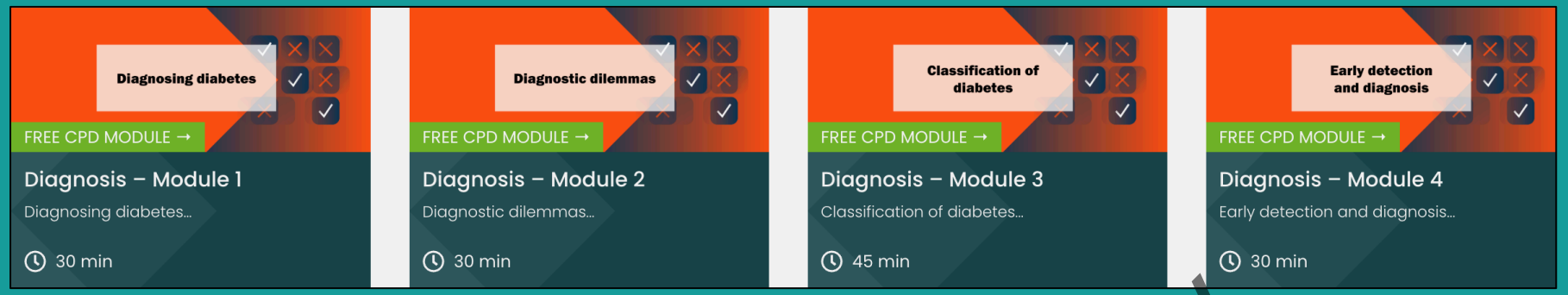
Our priority is to keep those in our care safe

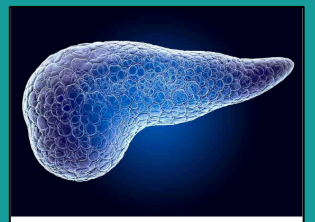
The most dangerous error is to miss DKA and the essential need for insulin

Weight loss is a reason to suspect insulin deficiency

If you are not confident, refer to your specialist team

If you have access to ‘specialist’ tests, know when to use them and what they are telling you



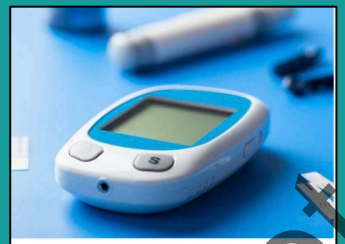



**At a glance factsheet: Recognition and management of pancreatogenic (type 3c) diabetes**

Essential information on recognising this often misdiagnosed type of diabete... and its management in primary

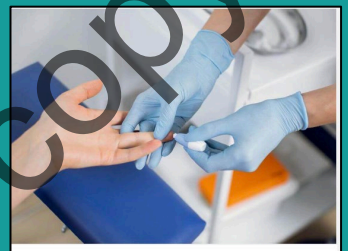
**At a glance factsheet: Diabetes and cancer**

The potential links between diabetes and cancer, plus practical recommendations o... management of



**At a glance factsheet: Ketones and diabetes**

Key information, advice and resources on reducing the risk of elevated ketone levels in... people with diabetes.



**How to correctly diagnose and classify diabetes**

Guidance on making the correct diabetes diagnosis in primary care.



# Primary Care Diabetes and Obesity Society Resources for HCPs

https://diabetesonthenet.com/journals/diabetes-primary-care/

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3rd London Conference | PCDO Society

See the person – the initial consultation and screening in primary care

Helping people come to terms with the diagnosis of Type 2 diabetes

Nicola Milne and Jane Diggle

Addressing the emotional impact of the diagnosis at the initial consultation

Consultation tips to reduce blame, shame and bias

## Disclaimer/Disclosures

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Editor-in-Chief of *Diabetes and Primary Care Journal*
Tutor for iHEED Post-graduate Diploma in Diabetes (University of Warwick)

Received funding from the following companies for providing educational sessions and documents, and for attending advisory boards:
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# The emotional and psychological side of diabetes

- Mental health conditions (e.g. depression, anxiety)
- Diabetes-related distress
- Family and social relationships
- Technology and treatment-related burnout
- Financial strain

Difficult to quantify but often the primary determinants of quality of life for people with diabetes

The mental toll of constant vigilance, frustration over lifestyle limitations and the anxiety of disappointing results, acute and potential long-term complications can be overwhelming.



- **Feelings of guilt (linked to stigma and discrimination)**
- **Type 2 Diabetes often framed as being the consequence of lifestyle choices**

https://www.psychologytoday.com/us/blog/ask-an-epidemiologist/202407/the-emotional-side-of-diabetes

# What do we mean by diabetes stigma?

**‘…….the adverse social judgement, stereotypes, and discriminatory attitudes directed toward people living with diabetes because of having the condition’**

- 80 % of people with diabetes have faced negative attitudes
- 1 in 5  people has experienced discrimination
- Moderate to strong association between diabetes stigma and weight stigma (‘double stigma’).
- Prevalence varies by country and culture, but diabetes stigma is present everywhere that it has been investigated.



Review

Bringing an end to diabetes stigma and discrimination: an international consensus statement on evidence and recommendations

Jane Speight*, Elizabeth Holmes-Truscott*, Matthew Garza, Renza Scibilia, Sabina Wagner, Asuka Kato, Victor Pedrera, Sonya Deschênes, Susan J Guzman, Kevin L Joiner, Shengxin Liu, Ingrid Willaing, Katie M Babbott, Bryan Cleal, Jane K Dickinson, Jennifer A Halliday, Eimear C Morrissey, Giesje Nefs, Shane O'Donnell, Anna Serlachius, Per Winterdijk, Hamzah Alzubaidi, Bustanul Arifin, Liz Cambron-Kopca, Corinna Santa Ana, Emma Davidsen, Mary de Groot, Maartje de Wit, Phyllisa Deroze, Stephanie Haack, Richard I G Holt, Walther Jensen, Kamlesh Khunti, Karoline Kragelund Nielsen, Tejal Lathia, Christopher J Lee, Bridget McNulty, Diana Naranjo, Rebecca L Pearl, Suman Prinjha, Rebecca M Puhl, Anita Sabidi, Chitra Selvan, Jazz Sethi, Mohammed Seyam, Jackie Sturt, Mythily Subramaniam, Helle Terkildsen Maindal, Virginia Valentine, Michael Vallis, Timothy C Skinner

**People with diabetes often encounter stigma (ie, negative social judgments, stereotypes, prejudice), which can adversely affect emotional, mental, and physical health; self-care, access to optimal health care; and social and professional opportunities. To accelerate an end to diabetes stigma and discrimination, an international multidisciplinary expert panel (n=51 members, from 18 countries) conducted rapid reviews and participated in a three-round Delphi survey process. We achieved consensus on 25 statements of evidence and 24 statements of recommendations. The consensus is that diabetes stigma is driven primarily by blame, perceptions of burden or sickness, invisibility, and fear or disgust. On average, four in five adults with diabetes experience diabetes stigma and one in five experience discrimination (ie, unfair and prejudicial treatment) due to diabetes, such as in health care, education, and employment. Diabetes stigma and discrimination are harmful, unacceptable, unethical, and counterproductive. Collective leadership is needed to proactively challenge, and bring an end to, diabetes stigma and discrimination. Consequently, we achieved unanimous consensus on a pledge to end diabetes stigma and discrimination.**

Lancet Diabetes Endocrinol 2024; 12: 61–82

*Joint first authors

School of Psychology and Institute for Health Transformation, Deakin University, Geelong, VIC, Australia (Prof J Speight PhD, E Holmes-Truscott PhD, J A Halliday BHealthSci); The Australian Centre for Behavioural Research in Diabetes, Diabetes Victoria, Melbourne, VIC, Australia (Prof J Speight, E Holmes-Truscott, J A Halliday, Prof T C Skinner PhD); The diaTribe Foundation, San Francisco, CA, USA (M Garza BS); Diabetogenic, Melbourne, VIC, Australia (R Scibilia); JDRF International, New York, NY, USA (R Scibilia); Department of Prevention, Health Promotions & Community Care, Copenhagen University Hospital—Steno Diabetes Center Copenhagen, Copenhagen, Denmark (S Wagner MSc, Prof I Willaing MPH, B Cleal PhD, E Davidsen MSc, K Kragelund Nielsen PhD, Prof H T Maindal PhD); Department of Health and Social Behavior, School of Public Health, The University of Tokyo, Tokyo, Japan (A Kato PhD); Faculty of Nursing, Universidad Andrés

## Introduction

People with diabetes require daily self-care to stay healthy and avoid, delay, or manage short-term and long-term complications. This burden can be exacerbated by stigma (ie, negative social judgments, stereotypes, and prejudices),[1] which takes many forms (panel 1). This burden can also be exacerbated by discrimination (ie, unfair or prejudicial treatment),[2] which has been described as the endpoint of the stigmatisation process.[3] Furthermore, evidence indicates that diabetes stigma has multifaceted effects on the dignity, health, self-care, and wellbeing of people with diabetes.[4–5] There is also growing evidence that diabetes stigma can affect public and government support and funding for diabetes research, prevention, care, and treatments.

In 2010, the International Diabetes Federation put out a call to action to “stop discrimination against people with diabetes”.[6] The International Diabetes Federation recommended enabling people with diabetes to claim their rights and responsibilities (as later detailed in their Charter[7]); increasing public awareness of diabetes and reducing diabetes stigma; and supporting people with diabetes to be at the centre of this response. This call to action was a novel, ambitious, and crucial step forward. In 2013, the first systematic review of diabetes stigma showed wide-ranging potential harms but a scarcity of research focused on this important issue.[1] Subsequently, both advocacy and research on diabetes stigma have increased substantially, including raising awareness, sharing experiences, and understanding the nature, extent, and repercussions of diabetes stigma. Arguably, there has been greater and earlier recognition in research of the stigma associated with other health conditions (eg, cancer and mental illness in the 1960s, epilepsy in the 1970s, HIV in the 1980s–1990s, and obesity in the 2000s) than with diabetes.[2–9] Insights from these areas suggest that research and advocacy are both crucial but each is likely to be insufficient in isolation.[10–11]

The pivotal change required to bring an end to diabetes stigma starts with consolidation of, and international consensus on, the evidence and recommendations. Such consensus can have the power to galvanise collective leadership, commitment, and actions to challenge the status quo (ie, the embedded negative judgements, stereotypes, and prejudice present in discourse and decision making about diabetes).[1] To challenge the status quo, all sectors of the community—including, but not limited to, people with and affected by diabetes and those working in advocacy, research, health care, industry, policy, and media—need to state unequivocally that diabetes st… and unacce… ing better o… Our aims… stigma and… on brief s… recommen… an evidenc… and comm… end to diab…




Speight J, Holmes-Truscott E, Garza M, et al. Bringing an end to diabetes stigma and discrimination: an international consensus statement on evidence and recommendations. Lancet Diabetes Endocrinol. 2024;12:61-82. doi:10.1016/S2213-8587(23)00347-9

# Where and how does stigma manifest (and are HCPs immune)?

## People with diabetes may experience diabetes stigma from numerous sources[1]:

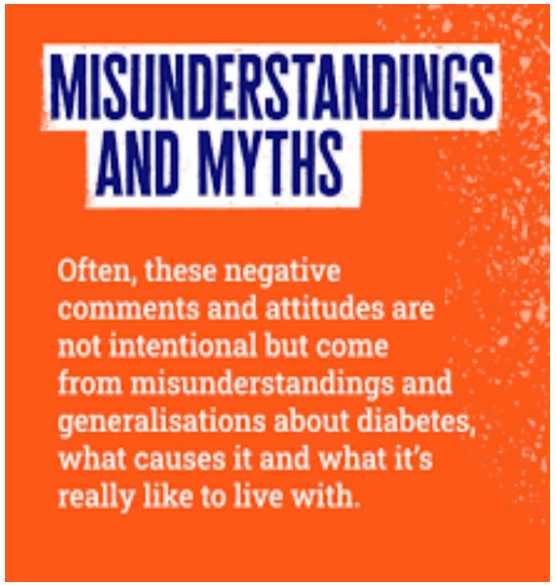
- General Public
- Family and friends
- Colleagues
- By other people with, or affected by diabetes
- Healthcare professionals



- **39–44% of physicians view patients with type 2 diabetes as lazy or unmotivated[2]**
- **Many physicians witness colleagues making negative comments about patients with T2D[2]**

1.Speight J, Holmes-Truscott E, Garza M, et al. Bringing an end to diabetes stigma and discrimination: an international consensus statement on evidence and recommendations. Lancet Diabetes Endocrinol. 2024;12:61-82. doi:10.1016/S2213-8587(23)00347-9 2. Lee, K.M., Hunger, J.M. & Tomiyama, A.J. Weight stigma and health behaviors: evidence from the Eating in America Study. Int J Obes 45, 1499–1509 2021

# What causes diabetes stigma?




- **Blame narratives:** Society often blames individuals for diabetes and its complications.
- **Negative stereotypes:** Assumptions of laziness, weakness, or lack of willpower.
- **Knowledge gaps:** Stigma reinforced by misunderstanding, fear, or disgust.
- **Sensationalist messaging:** Media and campaigns use oversimplified or fear-based imagery.
- **Harmful language:** Judgmental terms like “non-compliant”, “uncontrolled”, “failing”.



Speight J, Holmes-Truscott E, Garza M, et al. Bringing an end to diabetes stigma and discrimination: an international consensus statement on evidence and recommendations. Lancet Diabetes Endocrinol. 2024;12:61-82. doi:10.1016/S2213-8587(23)00347-9

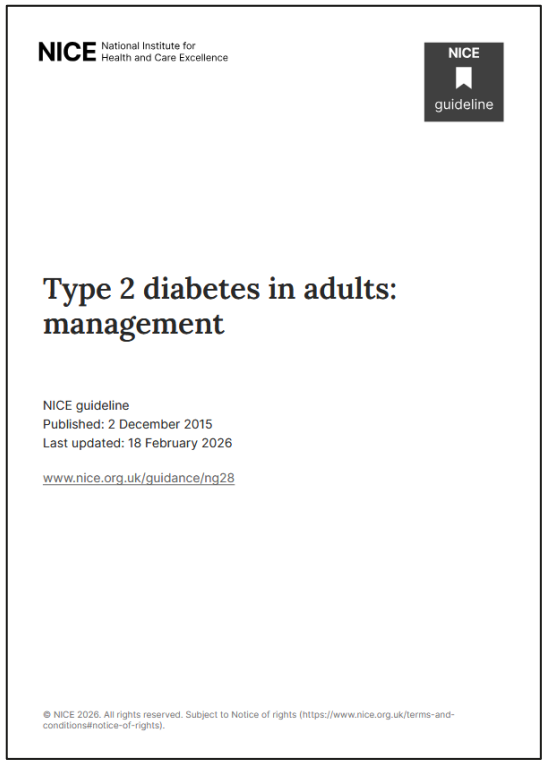
# What is the impact of diabetes stigma?

| Psychological Well-Being | Social Well-Being | Physical Well-Being |
|---|---|---|
| • Increased depressive and anxiety symptoms,[4]<br>• Increased diabetes distress,[4]<br>• Decreased quality of life,[5]<br>• Decreased self-esteem,[4] self-efficacy,[6] and resilience.[7] | • Social withdrawal or isolation,[8]<br>• Worse interpersonal relationships with family, friends, and healthcare professionals,[6,8,9]<br>• Concealing diabetes from others.[10] | • Higher HbA1c,[11]<br>• Higher BMI,[12]<br>• More frequent severe hypoglycemia,[11] diabetes-related ketoacidosis (DKA),[11] retinopathy,[11] hospitalizations,[13]<br>• Avoiding diabetes self-care behaviours including monitoring glucose levels, delivering insulin, and taking diabetes medications,[10]<br>• Avoiding healthcare appointments and screenings (for diabetes or diabetes-related complications).[14] |



Refer to source for full reference list : https://www.dstigmatize.org/resources/what-is-diabetes-stigma/

# The initial consultation – a pivotal moment that shapes how someone perceives their condition and how they manage it



NICE National Institute for Health and Care Excellence

NICE guideline

## Type 2 diabetes in adults: management

NICE guideline
Published: 2 December 2015
Last updated: 18 February 2026

www.nice.org.uk/guidance/ng28



| Nine Annual Care Processes for all people with diabetes age 12 and over | |
|---|---|
| **Responsibility of Diabetes Care Providers (included in the NDA 8 Care Processes)** | |
| **1 - HbA1c** | **5 - Urine Albumin/Creatinine Ratio** |
| **2 - Blood Pressure** | **6 - Foot Risk Surveillance** |
| **3 - Serum Cholesterol** | **7 - Body Mass Index** |
| **4 - Serum Creatinine** | **8 - Smoking History** |
| Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices) | |
| **9 - Digital Retinal Screening** | |

NICE recommended care processes http://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes


Recent data published by Diabetes UK showed that 75% of people living with Type 2 Diabetes experience societal, familial, or clinical judgement regarding their condition[1].

**If we do not actively validate these emotions during the initial diagnosis phase, we miss the window to build a secure therapeutic relationship**



1. https://www.diabetes.org.uk/about-us/news-and-views/86-people-type-1-and-75-people-type-2-experience-judgement-their-condition

# At diagnosis, the person may experience a sudden shift in how they see themselves, their health, and their future.

**Shock and disbelief** — “This can’t be happening to me.”

**Fear and uncertainty** — concerns about complications, medication, lifestyle changes. “What does this mean for my future?”

**Guilt and self-blame** — often fueled by societal narratives about weight and “personal responsibility”.

**Stigma and shame** — internalised and external stigma strongly influence engagement. “Will people judge me?”

**Loss of control** — feeling overwhelmed by new information and expectations.



1. https://www.diabetes.org.uk/about-us/news-and-views/86-people-type-1-and-75-people-type-2-experience-judgement-their-condition

# How we communicate in the first consultation shapes long-term engagement, trust, and outcomes.

**Use person-first language** — Prioritise “person living with diabetes” and avoid labels or moralising terms.

**Replace judgement with collaboration** — Focus on shared goals, problem-solving, and supportive phrasing rather than compliance language.

**Avoid fear-based messaging** — Use balanced, empowering education instead of sensationalist imagery or complication-focused warnings.

**Address knowledge gaps** — Provide clear, accessible explanations of causes, management, and variability in glucose patterns.

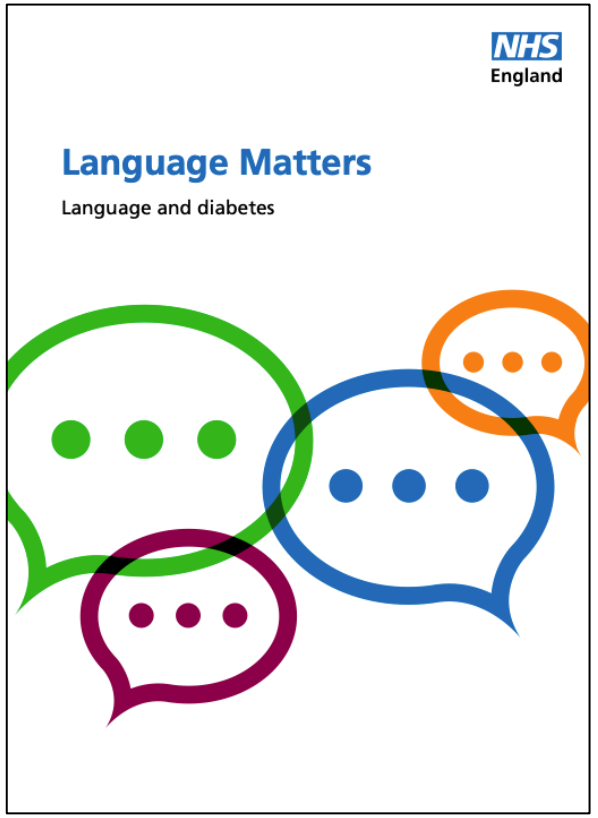
**Normalise treatment progression** — Frame medication changes as expected parts of a long-term condition, not personal failure.

# Language Matters

- Words have the power to harm as well as heal
- Language can either reinforce stigma or promote engagement.
- When our language is negative or stigmatising it:
  - Affects emotional well-being – leading to feelings of guilt, anxiety, frustration, and judgment[1]
  - Affects motivation for self-care behaviours
  - Alienates and isolates people with diabetes
  - Can have a lasting impact at diagnosis[1]



**But don't forget non-verbal communication too: tone of voice, facial expression, the environment**




https://www.languagemattersdiabetes.com

1. Jane K. Dickinson, Susan J. Guzman, Melinda D. Maryniuk, Catherine A. O'Brian, Jane K. Kadohiro, Richard A. Jackson, Nancy D'Hondt, Brenda Montgomery, Kelly L. Close, Martha M. Funnell; The Use of Language in Diabetes Care and Education. *Diabetes Care* 1 December 2017; 40 (12): 1790–1799. https://doi.org/10.2337/dci17-0041

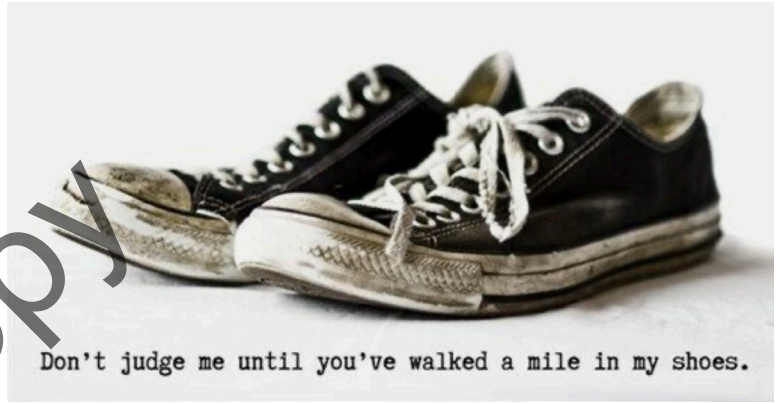
# Supportive, non-blaming phrases

| Less Helpful Phrase | Preferred Alternative | Why this works |
|---|---|---|
| “Your sugars are high — you’ve got diabetes.” | “Your results show your body is finding it harder to use insulin effectively.” | Physiology-focused; avoids blame and moral language. |
| “This is a lifelong problem” | “This diagnosis gives us a chance to protect your long-term health” | Reframes diagnosis as opportunity and hope. |
| “You need to sort your lifestyle out.” | We can look together at small, realistic changes that support your health. | Supports autonomy; avoids shame. |
| ““This is because of your weight.” | “Type 2 diabetes develops for many reasons — weight is just one factor.” | Reduces stigma; reflects multifactorial aetiology. |
| “There’s nothing you can do about it.” | “There are effective treatments and tools we can use to support you.” | Builds hope and self-efficacy. |
| “You’ll have to manage this alone” | “You’re not on your own — we’ll plan this together” | Builds partnership, collaboration and sense of support |
| “You need to try harder” | “Many people feel overwhelmed at first — that’s completely understandable” | Normalises emotional responses; reduces shame. |

# ‘See me not my diabetes’

“I would like to be asked “how are you”? Not how is your diabetes? How are your sugars? How’s your sight, feet, kidney function… I am not a computer screen of test results and even a nod to that would improve matters so much for me.”

www.diabetes.org.uk/futureofdiabetes



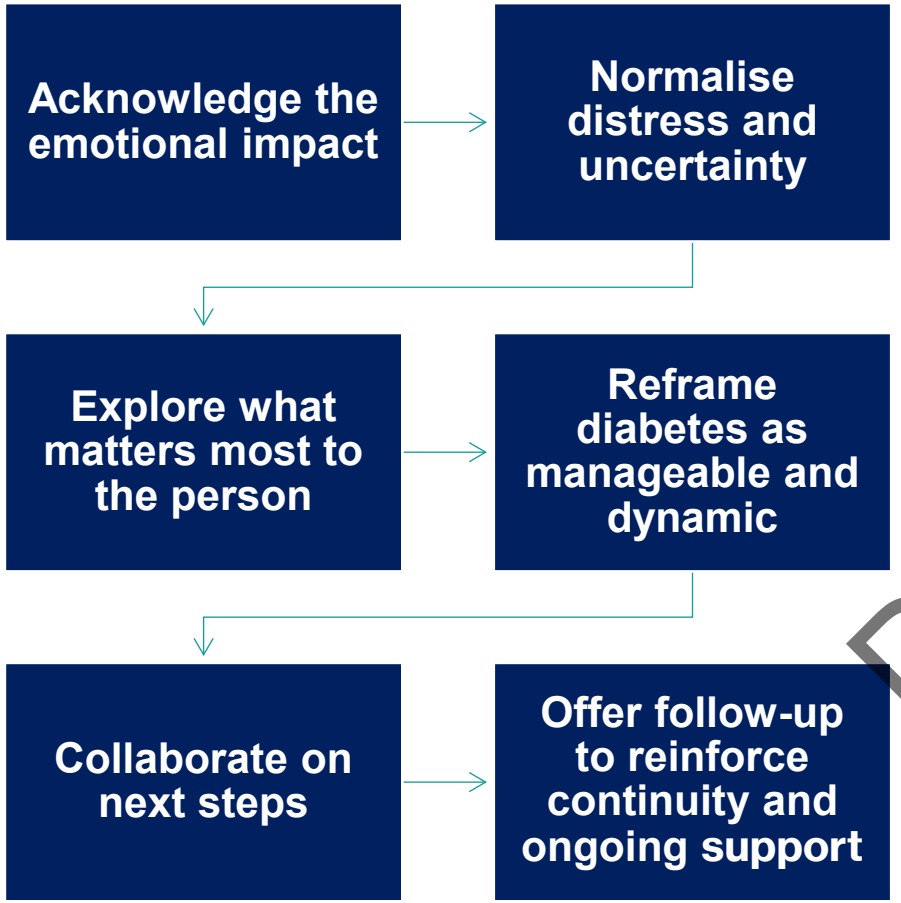

Understand another person’s experiences, challenges and perspectives before judging them



- **'What is the most difficult part of living with diabetes for you?’**
- **‘What are your greatest concerns about your diabetes?’**
- **‘How is your diabetes getting in the way of other things in your life right now?’**

Turner M, Barton AH (2026) “See me, not my diabetes”: a person-centred guide to better care. *Journal of Diabetes Nursing* **30**: JDN407

# Primary care clinicians can profoundly influence adjustment through language, empathy, and partnership.




**Validate emotions** — *"I know this is a lot to take in. It's completely normal to feel overwhelmed."*

**Collaborative goal-setting** — co-create, don't prescribe.

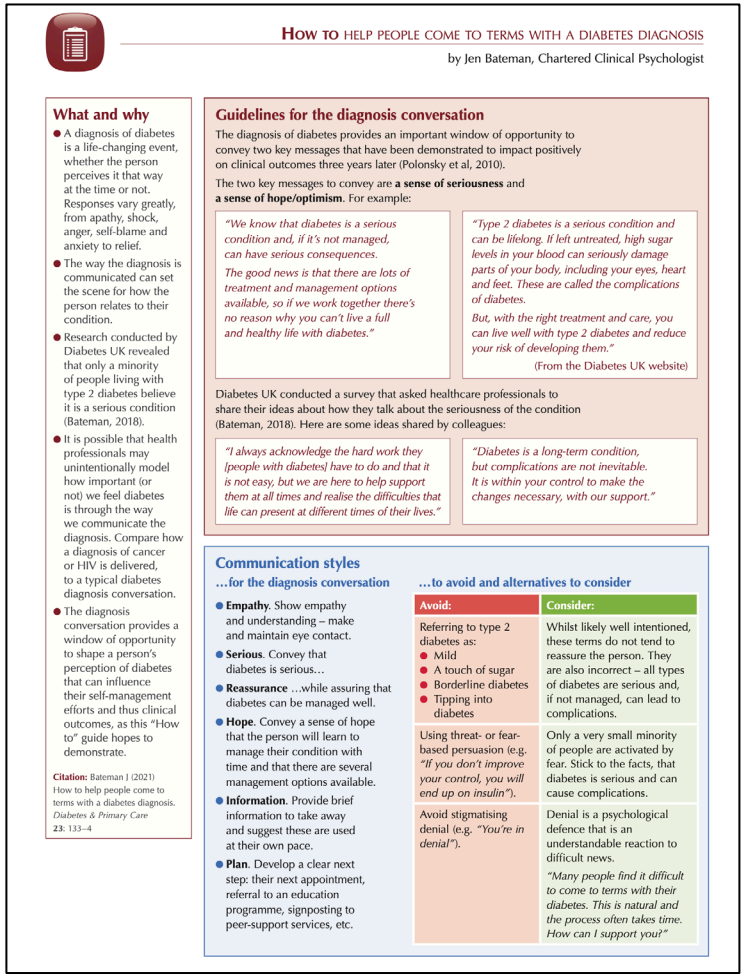
**Shift away from directives** (must, should, can't) to options (could try this, could consider that).

**Frame diabetes as a complex, polygenic condition** driven by genetics and environmental factors.

**Avoid moralising words** — "good/bad", "success/failure".

**Normalise treatment escalation** — progression is biological, not a personal failure.

**Pace information:** Don't overwhelm with too much on day one; arrange an early, dedicated follow-up.



## How to help people come to terms with a diabetes diagnosis

by Jen Bateman, Chartered Clinical Psychologist

### What and why

- A diagnosis of diabetes is a life-changing event, whether the person perceives it that way at the time or not. Responses vary greatly, from apathy, shock, anger, self-blame and anxiety to relief.
- The way the diagnosis is communicated can set the scene for how the person relates to their condition.
- Research conducted by Diabetes UK revealed that only a minority of people living with type 2 diabetes believe it is a serious condition (Bateman, 2018).
- It is possible that health professionals may unintentionally model how important (or not) we feel diabetes is through the way we communicate the diagnosis. Compare how a diagnosis of cancer or HIV is delivered, to a typical diabetes diagnosis conversation.
- The diagnosis conversation provides a window of opportunity to shape a person's perception of diabetes that can influence their self-management efforts and thus clinical outcomes, as this "How to" guide hopes to demonstrate.

**Citation:** Bateman J (2021) How to help people come to terms with a diabetes diagnosis. *Diabetes & Primary Care* **23**: 133–4

### Guidelines for the diagnosis conversation

The diagnosis of diabetes provides an important window of opportunity to convey two key messages that have been demonstrated to impact positively on clinical outcomes three years later (Polonsky et al, 2010).

The two key messages to convey are **a sense of seriousness** and **a sense of hope/optimism**. For example:

> *"We know that diabetes is a serious condition and, if it's not managed, can have serious consequences.*
>
> *The good news is that there are lots of treatment and management options available, so if we work together there's no reason why you can't live a full and healthy life with diabetes."*

> *"Type 2 diabetes is a serious condition and can be lifelong. If left untreated, high sugar levels in your blood can seriously damage parts of your body, including your eyes, heart and feet. These are called the complications of diabetes.*
>
> *But, with the right treatment and care, you can live well with type 2 diabetes and reduce your risk of developing them."*
>
> (From the Diabetes UK website)

Diabetes UK conducted a survey that asked healthcare professionals to share their ideas about how they talk about the seriousness of the condition (Bateman, 2018). Here are some ideas shared by colleagues:

> *"I always acknowledge the hard work they [people with diabetes] have to do and that it is not easy, but we are here to help support them at all times and realise the difficulties that life can present at different times of their lives."*

> *"Diabetes is a long-term condition, but complications are not inevitable. It is within your control to make the changes necessary, with our support."*

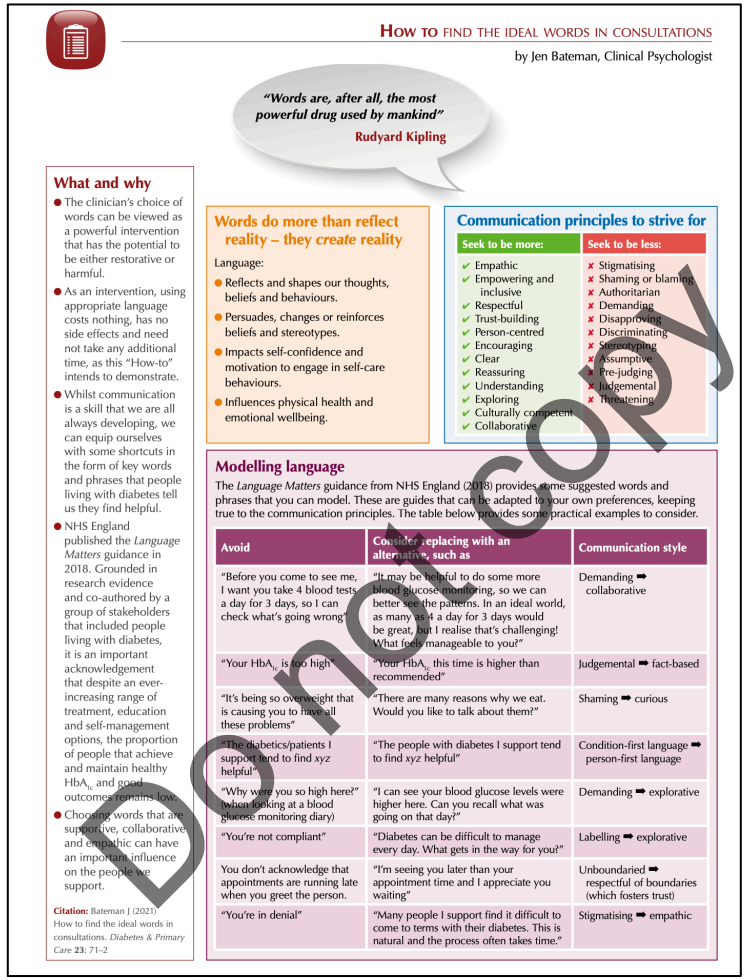
### Communication styles

#### …for the diagnosis conversation

- **Empathy**. Show empathy and understanding – make and maintain eye contact.
- **Serious**. Convey that diabetes is serious…
- **Reassurance** …while assuring that diabetes can be managed well.
- **Hope**. Convey a sense of hope that the person will learn to manage their condition with time and that there are several management options available.
- **Information**. Provide brief information to take away and suggest these are used at their own pace.
- **Plan**. Develop a clear next step: their next appointment, referral to an education programme, signposting to peer-support services, etc.

#### …to avoid and alternatives to consider

| Avoid: | Consider: |
|---|---|
| Referring to type 2 diabetes as:<br>• Mild<br>• A touch of sugar<br>• Borderline diabetes<br>• Tipping into diabetes | Whilst likely well intentioned, these terms do not tend to reassure the person. They are also incorrect – all types of diabetes are serious and, if not managed, can lead to complications. |
| Using threat- or fear-based persuasion (e.g. *"If you don't improve your control, you will end up on insulin"*). | Only a very small minority of people are activated by fear. Stick to the facts, that diabetes is serious and can cause complications. |
| Avoid stigmatising denial (e.g. *"You're in denial"*). | Denial is a psychological defence that is an understandable reaction to difficult news.<br>*"Many people find it difficult to come to terms with their diabetes. This is natural and the process often takes time. How can I support you?"* |



## How to find the ideal words in consultations

by Jen Bateman, Clinical Psychologist

> *"Words are, after all, the most powerful drug used by mankind"*
>
> Rudyard Kipling

### What and why

- The clinician's choice of words can be viewed as a powerful intervention that has the potential to be either restorative or harmful.
- As an intervention, using appropriate language costs nothing, has no side effects and need not take any additional time, as this "How-to" intends to demonstrate.
- Whilst communication is a skill that we are all always developing, we can equip ourselves with some shortcuts in the form of key words and phrases that people living with diabetes tell us they find helpful.
- NHS England published the *Language Matters* guidance in 2018. Grounded in research evidence and co-authored by a group of stakeholders that included people living with diabetes, it is an important acknowledgement that despite an ever-increasing range of treatment, education and self-management options, the proportion of people that achieve and maintain healthy $HbA_{1c}$ and good outcomes remains low.
- Choosing words that are supportive, collaborative and empathic can have an important influence on the people we support.

**Citation:** Bateman J (2021) How to find the ideal words in consultations. *Diabetes & Primary Care* **23**: 71–2

### Words do more than reflect reality – they *create* reality

Language:

- Reflects and shapes our thoughts, beliefs and behaviours.
- Persuades, changes or reinforces beliefs and stereotypes.
- Impacts self-confidence and motivation to engage in self-care behaviours.
- Influences physical health and emotional wellbeing.

### Communication principles to strive for

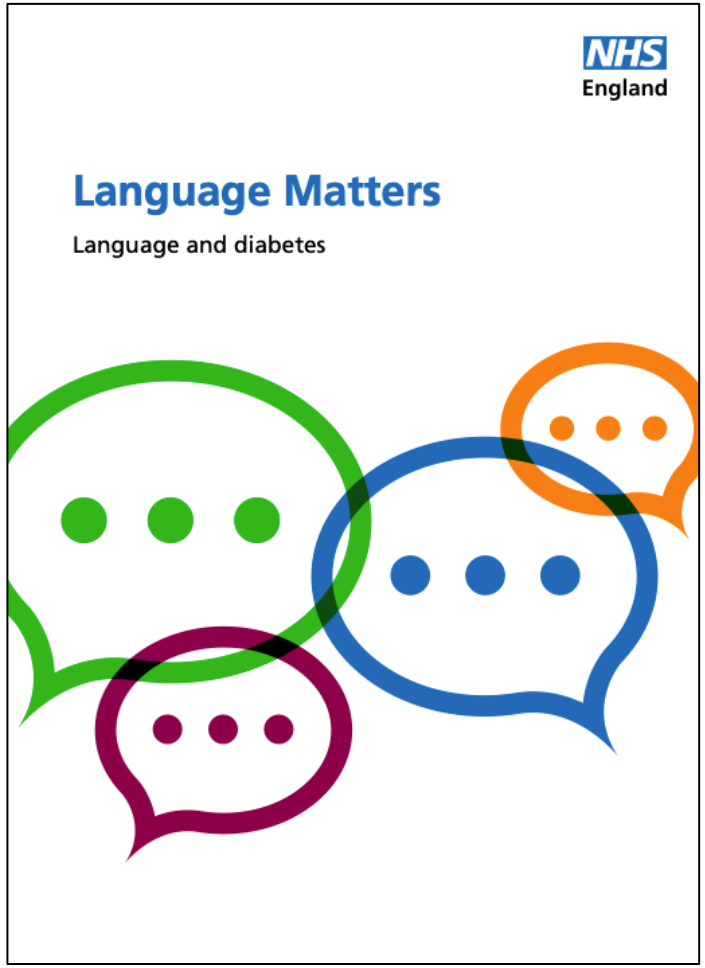
| Seek to be more: | Seek to be less: |
|---|---|
| ✔ Empathic | ✘ Stigmatising |
| ✔ Empowering and inclusive | ✘ Shaming or blaming |
| ✔ Respectful | ✘ Authoritarian |
| ✔ Trust-building | ✘ Demanding |
| ✔ Person-centred | ✘ Disapproving |
| ✔ Encouraging | ✘ Discriminating |
| ✔ Clear | ✘ Stereotyping |
| ✔ Reassuring | ✘ Assumptive |
| ✔ Understanding | ✘ Pre-judging |
| ✔ Exploring | ✘ Judgemental |
| ✔ Culturally competent | ✘ Threatening |
| ✔ Collaborative | |

### Modelling language

The *Language Matters* guidance from NHS England (2018) provides some suggested words and phrases that you can model. These are guides that can be adapted to your own preferences, keeping true to the communication principles. The table below provides some practical examples to consider.

| Avoid | Consider replacing with an alternative, such as | Communication style |
|---|---|---|
| "Before you come to see me, I want you take 4 blood tests a day for 3 days, so I can check what's going wrong" | "It may be helpful to do some more blood glucose monitoring, so we can better see the patterns. In an ideal world, as many as 4 a day for 3 days would be great, but I realise that's challenging! What feels manageable to you?" | Demanding ➡ collaborative |
| "Your $HbA_{1c}$ is too high" | "Your $HbA_{1c}$ this time is higher than recommended" | Judgemental ➡ fact-based |
| "It's being so overweight that is causing you to have all these problems" | "There are many reasons why we eat. Would you like to talk about them?" | Shaming ➡ curious |
| "The diabetics/patients I support tend to find *xyz* helpful" | "The people with diabetes I support tend to find *xyz* helpful" | Condition-first language ➡ person-first language |
| "Why were you so high here?" (when looking at a blood glucose monitoring diary) | "I can see your blood glucose levels were higher here. Can you recall what was going on that day?" | Demanding ➡ explorative |
| "You're not compliant" | "Diabetes can be difficult to manage every day. What gets in the way for you?" | Labelling ➡ explorative |
| You don't acknowledge that appointments are running late when you greet the person. | "I'm seeing you later than your appointment time and I appreciate you waiting" | Unboundaried ➡ respectful of boundaries (which fosters trust) |
| "You're in denial" | "Many people I support find it difficult to come to terms with their diabetes. This is natural and the process often takes time." | Stigmatising ➡ empathic |



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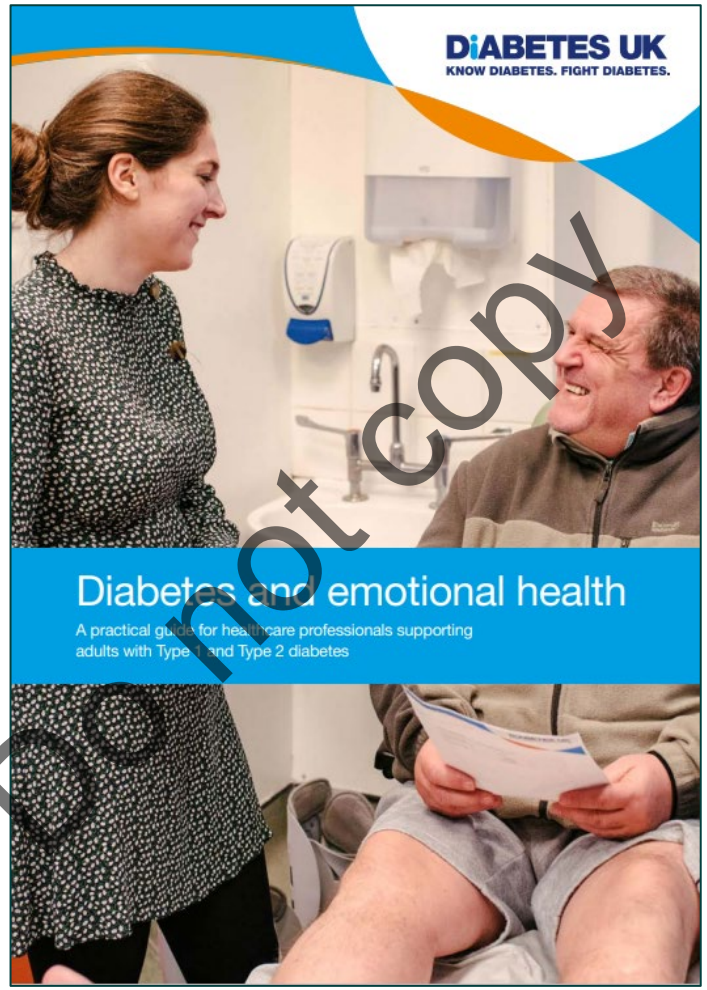
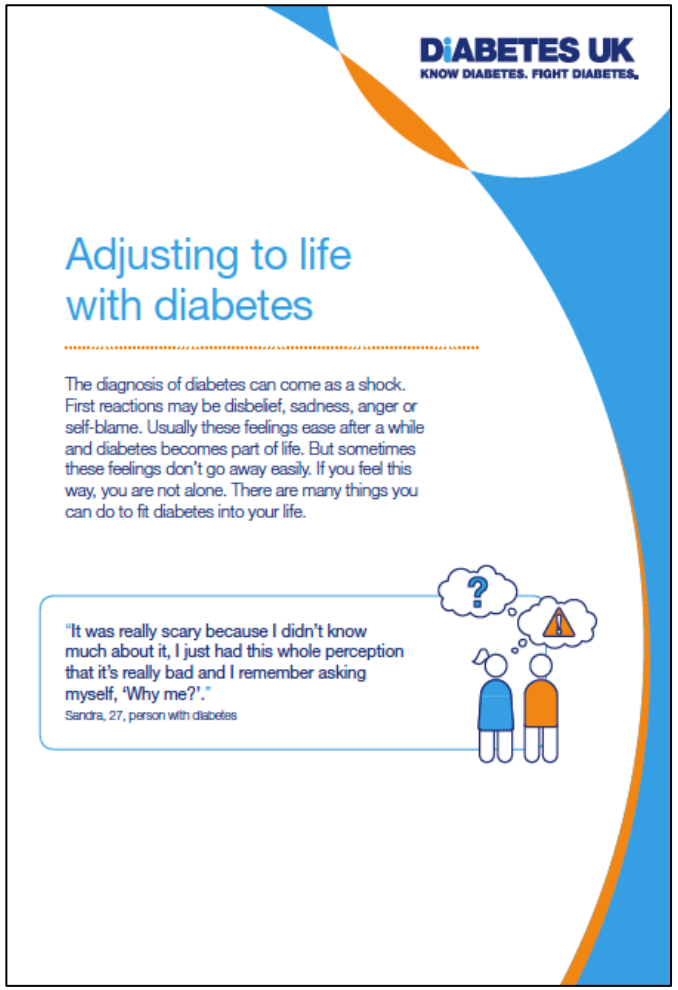
Bateman J (2021) How to find the ideal words in consultations. Diabetes & Primary Care 23: 71–2

https://www.languagemattersdiabetes.com


https://www.diabetes.org.uk/support-us/campaign/strike-out-stigma




Diabetes UK (2019) Diabetes and Emotional Health – a practical guide for healthcare professionals supporting adult with Type 1 and Type 2 diabetes – Chapter 2 Facing Life with Diabetes




https://www.diabetes.org.uk/living-with-diabetes/emotional-wellbeing/coping-diagnosis

“

- PEOPLE WILL FORGET WHAT YOU SAID, PEOPLE WILL FORGET WHAT YOU DID, BUT PEOPLE WILL NEVER FORGET HOW YOU MADE THEM FEEL

“

- MAYA ANGELOU

”

# Managing multiple long-term conditions in 2026: The power of integrated healthcare

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Thanks for your attention!