In this series a number of case histories in (imaginary) diabetic patients are presented. Many of the problems thrown up by the cases are common; some arise in hospital practice, others in the community. Each case history has been sent to colleagues who work in UK Diabetes Care Teams, who have written down their opinion as to what advice might be given or what action could be taken.

Dr John Wales, Honorary Consultant Physician to the Diabetes Centre in the General Infirmary at Leeds, provides a short summarising commentary on the clinical problem and suggests advice and/or solutions. His opinions will hopefully balance the ideal world of diabetic patient care in the UK with the real world.

You are invited to read the case history, establish your own opinion on how you would handle the case, discuss the case with your team colleagues, then read pages 297 and 298 to see whether you agree with the Experts’ opinions wholly, in part, or not at all.

If you wish to let us know your views on the advice given, write to the journal; readers’ comments may be published in a later issue.

Now, please meet the diabetic patient Harold . . .

Harold is an 85 year old retired civil servant who has had diabetes for two years. He has lived in a retirement home since his wife died 8 years ago. His son insisted on the move as he did not think his father could cope living alone. Harold is quite active, going out alone particularly to a British Legion Club of which he was once Entertainment Secretary. His diabetic control is not good (HbA1c 9.5%; NR 4.0–6.5%) and both he and his carers confess that he does not keep to his diet unless he knows the Diabetes Nurse Specialist or GP is coming to visit him. He is prescribed tolbutamide 500 mg three times/day, which he appears to take regularly, although the care assistants have found some of the tolbutamide tablets discarded in his room. His eldest son feels that his father’s diabetic control would be improved if he were not allowed outside the room on his own. What is your advice to the home, his son and the patient?

On pages 297 and 298 you can read our Experts’ opinions on the questions raised by Harold.
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Harold: too old for treatment?
Here are the Experts’ opinions on Harold’s care, which is given on page 287. See if you agree with them.

Expert 1
A General Practitioner
Harold’s diabetes was diagnosed two years ago. At that time he had lived in a retirement home for six years. Staff, as well as his family, have to take some responsibility for his care yet allow him the freedom to remain active.

Around the time of diagnosis all his carers and himself should have received dietetic guidance with a diabetic eating plan. The home should be able to supply a high fibre low fat diet.

One of Harold’s main problems is compliance, with both diet and drugs. I would advise that the residential home supervise the regular administration of Harold’s medication. Once compliance is improved there is the possible danger of hypoglycaemia and thus careful medical supervision, either by the GP or DSN, should take place during this period. Quality of life is very important and thus Harold should continue pursuits such as meeting old cronies and eating at the British Legion club. Any exercise that Harold is able to take part in should be encouraged.

As long as his diabetic control is stabilised he should continue to eat at his club and, if necessary, his diabetic control could be tailored to meet this need. Obviously alcohol intake should be monitored and advice given accordingly.

One of the most important issues with the care of elderly diabetic patients is to make sure that crippling hypoglycaemia and hyperglycaemia symptoms do not affect every day life – thus it is important that Harold does not experience polyuria or polydipsia, incontinence or mental confusion. However, I would be very happy to allow his control to be not as tight as one would wish to achieve in his ‘grandchildren’. One of the most important issues is to ensure that he receives regular chiropody and that his retinae are screened annually.

There is good evidence that in some parts of the United Kingdom diabetic patients in institutional care do not obtain adequate diabetes management. This is a multifactorial problem often related to the presence of confusion, recurrent infections, difficulty in swallowing associated with stroke or other neurological disorders, immobility due to leg ulcers and pressure sores or other problems such as aphasia, deafness or blindness.

Clinical experience shows that patients in institutional care have special needs and this can be provided by increased community support from experienced health professionals such as DSNs with ready access to patients and educational advice given to care staff.

Expert 2
A Diabetes Nurse Specialist
Harold is an 85 year old man, presumable previously fit and well, who has had type 2 diabetes for two years.

To provide specific advice to the home, the son and Harold himself, I would first have to be clear about what we are trying to achieve for Harold as regards his diabetes control!

Initially I would establish from Harold whether he is ‘suffering’ in any way from hyperosmolar symptoms of poor glycaemic control. If he is, then it may be possible to improve Harold’s quality of life by improving his HbA1c.

I would then ask Harold what would be the most acceptable way of doing this for him: either by taking his tablets on a regular basis (he may not realise the effect of the tablets on his well-being) and/or by reducing some of the sugar content of his diet (which of course may be one of the few pleasures in his life). I would also consider swapping his tolbutamide to a twice daily sulphonylurea to aid his adherence.

Whilst his HbA1c is somewhat raised at 9.5%, it may be considered reasonable for a man of his age if he has no evidence of microvascular or macrovascular complications in the absence of hyperosmolar symptoms.

My advice to the son would be to explain the above to him and hopefully reassure him that restricting his father’s life in order to achieve improved glycaemic control will have little benefit to his father’s quality of life.

Finally, my advice to Harold, after assisting Harold to make the right decision for himself (as discussed above) is to enjoy his life!

Expert 3
A Consultant Physician in Medicine for the Elderly
There are two main questions here. Harold’s glycaemic control and his lifestyle, but they are linked by his competency to make decisions for himself.

I will assume that his is not confused (normal Abbreviated Mental Test), has no obvious psychiatric illness, and is not doing anything obviously directly risky to his health (e.g. sprinting across busy dual carriageways). If there were any doubts, a psychogeriatrician should be consulted as an independent expert regarding mental competency.

His is cheating with his diet, and probably poorly compliant with medication. I would try to optimise these by involving the dietician, changing to a sulphonylurea that is easier to swallow, e.g. gliclazide, enlisting the help of the care staff to supervise treatment and spending some time with Harold explaining why one wishes for good control in him, e.g. UKPDS results, better cognitive function with better glycaemic control etc. After this, it is the patient’s decision whether he wishes to comply or not.

Regarding his lifestyle, we have already decided that it is his choice; incarcerating him in this home in which he is probably the fittest subject (excluding the staff), and denying him his socialisation at the British Legion, will make his life miserable, and can
worsen self-neglect. An 85 year old male with diabetes may not have long to live anyway.

The son and the home might well be correct that locking him in a room, with close control of diet, medication, exercise and alcohol, would probably improve his diabetic control. However, the overall effect on the quality of life would be detrimental, and with Harold being mentally competent it is illegal. Furthermore, in light of the patient confidentiality clause within the Patient’s Charter, one would need Harold’s permission to talk to his son and carers (who are not medical staff in any sense of the word, and do no need to know Harold’s personal details).

The son is an overbearing character, having already forced his father into a home, when perhaps extra services would have enabled Harold to stay in his own home; there would nowadays be questions asked about this placement, or more particularly the funding of it. The son may well be overweight, and taking little exercise; he needs to be told that he is at very high risk of type 2 diabetes, needs to lose weight, climb 14 flights of stairs per day (or similar exercise), and have a fasting plasma glucose measured every 3–5 years.

At the end of the day, this is a case of service user self-determinism, and if the relatives and home staff do not like this that is their problem, not ours or Harold’s; I would tell these folk that Harold is capable of making his own decisions and that is final.

**Summary of the Experts’ opinions**

( **Dr Wales writes**)

Elderly patients like Harold often pose a real dilemma for their carers. We are clear about what should happen to improve the outcome of diabetic care but individual patients sometimes are unable or unwilling to change. How far can we ethically proceed to impose good practice ‘for the patient’s own good’?

All our Experts agree that, after clearly explaining to Harold, his son and to the residential home what the aims of his antidiabetic therapy are, it is up to him to decide what he wishes to do; and that these wishes should be respected. It is interesting to see that our physician with an interest in the elderly is more forceful in this regard and would invoke legalities to make his point. Some geriatricians suggest that leaving the decision about the degree of antidiabetic therapy to the patient is tantamount to accepting poor treatment or control merely because of the patient’s age.

Also, as our Experts explain, there is a good deal of work (and common sense) to show that compliance with therapy falls as the number of occasions the medication needs to be given increases. A once daily antidiabetic drug would be preferred for Harold. I doubt whether a discussion of the UKPDS with Harold would help greatly: much more likely to confuse. In my experience clear and simple advice, particularly with regard to diet, works best.

Our general practitioner makes an excellent point on the need for regular and repeated advice about diabetes care to be given to staff in residential and nursing homes because more elderly people are living in such homes and the staff change constantly. Again, such advice needs to be simple and practical.

There is also another, rather theoretical concern about Harold’s care. In the flurry of guidelines, ministerial edicts and Audit Commission reports, Harold, even with all the expert advice offered, is unlikely to be counted as a success for his diabetes carers in the ‘box-ticking’ game. If his ‘carers’ do become more prescriptive in his movements, restrict his diet, and make moves to improve his compliance, Harold might well be deemed to be a successful clinical audit undertaking – yet he will die an unhappy man. What is the success in that?

Do you agree with our Experts opinions? If you do not, or wish to make a comment, please write to the Editor and if possible we will try to publish them in a later edition of Practical Diabetes International.

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**CONSULT THE EXPERTS**

**Clinical problems in diabetes care**

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Diabetes One Stop

We’re in the midst of a technology slump with an allegedly saturated personal computer market, and yet proper leverage of computing power still appears to be the exception rather than the rule. This is a low-tech picture which is doubtless all too familiar to many working in UK diabetes care. Sometimes, the means available to manage this complex, multi-system, chronic disorder must seem primitive, but the benefits from a more technically sophisticated approach are not always obvious, nor universally appreciated.

Well-designed and well-implemented decision support systems are improving professional care and patient self-care where they are used, and, in the future, may be as important as pharmaceutical interventions in improving outcomes. Indeed, some believe that the goals of St. Vincent will only be delivered through this sort of technology.

As a resource, diabetesonestop is part of this technological armoury, providing a constantly updated information resource to the diabetes community as well as a centre around which it can coalesce. The recently launched Best Practice Roundtable is a forum hosted within the ‘Causes & Complications—Diabetic Foot’ section that is particularly exciting. It is designed as a catalyst to discussion, where challenging perspectives on improving care can be proposed, debated and turned into meaningful ways forward. Why not join the discussion at www.diabetesonestop.com?

Mike Edmonds’, Consultant Physician, Diabetic Foot Clinic, Kings College Hospital, London has written a deliberately provocative discussion document on reducing amputations. Comments posted to the site to expand the discussion will provide the substance for a conference on the subject later in the year. Exploiting technology to synthesise ideas like this is crucial if we are to seize the initiative on the growing worldwide epidemic.