

## The Return to Practice Programme: Portfolio Route

### Reflective case study

#### Introduction

This case study concerns a 68 year old lady with type 2 diabetes. Her diabetes had been diagnosed approximately 8 years ago at routine screening. I had seen her several times in the past and she had achieved good control of her diabetes, as judged by her glycosylated haemoglobin. She had no complications detected so far. Control of her diabetes had been achieved initially by dietary manipulation and then, more recently, with the addition of medication. She had started with Metformin and subsequently added in a sulphonylurea in the form of Gliclazide.

Given that her control was good her management had been handed over to the Practice Nurse and I hadn't seen her for over a year. The Practice Nurse then drew my attention to the fact that her control had worsened markedly in recent months. The nurse had seen her for a routine review 6 months previously and suggested an increase in her medication and also discussed the benefits of weight loss given that her weight had increased. The nurse commented that she had appeared reluctant to make any changes but hadn't been able to ascertain any particular reason for this. On follow up recently the diabetic control had further deteriorated. We therefore agreed that it might help for her to attend an appointment with me.

#### What happened next?

When she attended the appointment, we discussed her diabetes and the implications of poor control in terms of complications etc. After a while she looked upset and when I asked her if there was anything else troubling her, she became tearful. In response to some further gentle questioning it transpired that her husband, who, for historical reasons had been cared for by a different GP practice, had died of lung cancer about 9 months ago. She was understandably still grieving and finding it hard to take any interest in her own health.

Following this the consultation took a different turn and centred more on how she was coping and what support she had. Her family were not geographically close and so she was finding it difficult to overcome her sense of loss and her loneliness. She admitted that she simply did not have any motivation to look after herself. Her diet had slipped towards convenience rather than healthy eating. There were no features to suggest primary depression but more that the grieving process was still working through the normal stages.

With regard to her diabetes we agreed that her poor control, although not ideal was not of any immediate risk. Six months later, after more supportive consultations, and the fact that one of her daughters with grandchildren had moved closer, she was more inclined to think about her diabetes again.

## Reflections

This case and others like it are common in family medicine. For me it highlighted the need to look beyond the obvious when considering why patients' health behaviours may seem odd to us and we need to have the curiosity to ask why and delve a little deeper before coming to any conclusions. My reflections covered a number of different areas:

1. The case also reminded me of the inextricable link between a patient's psychological well-being and their physical well-being. In addition to this it was the change in her social situation that made more difference than anything else in terms of her desire to apply herself to her physical health again. It was her daughter moving to live closer (and probably more especially the opportunity to take on more responsibility for her grandchildren) that helped to renew her sense of self-worth.
2. In terms of communication skills, it was probably the reflection of a non-verbal cue that was the key to unlocking the mystery as to why this patient had allowed her diabetic control to slip. Simply noting the patient's mood and reflecting it back to them can help to bring to light new perspectives on what they are thinking, and why.
3. Another reflection was that of the need to have good communication between members of the health care team. In this case there was a disadvantage in that the husband was not cared for in the same practice and so it was not known that he had become terminally ill. The practice nurse was aware that there was something "not quite right" and did well to ask for a further review.
4. Finally, there was the need to allow the patient space and accept that for a time at least her diabetic control was simply not going to be ideal. This can be difficult, especially if there are targets to meet in terms of the diabetic register as a whole. Good medicine is much more complex than simply meeting all the targets all of the time.