Medicolegal case of a person with type 2 diabetes: Medical history

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Article points

1. The duty of care of the GP to their patients with diabetes is to ensure that the appropriate interventions are put in place and that the potential ramifications and complications associated with the condition are explained to the patient.
2. It is incumbent on the GP to explain the diabetes-related complications to the patient, to ensure compliance is maintained and individualised targets met.
3. These discussions need to be documented in the medical notes to ensure that if any micro- or macrovascular complications develop, there is proof that the GP has taken the appropriate steps to inform their patient.

Key words

- Duty of care
- Medicolegal
- Negligence
- Non-compliance

Author

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The incidence of type 2 diabetes is increasing worldwide and Australia is no exception to this increase. According to the Australian Institute of Health and Welfare, the prevalence of diabetes doubled between 1989–1990 and 2011–2012 (from 1.5% to 4.2% of Australians). And year on year, the total number of people with diabetes continues to increase, from around 898 800 in 2007–2008 to around 999 000 in 2011–2012. The care of people with diabetes is mainly organised by GPs and primary care, and the role of the GP is to manage a complex, multi-system condition with significant and far-reaching micro- and macrovascular complications. The author presents a medicolegal case that they were a medicolegal expert to. The particular case demonstrates the importance of note-taking, especially when managing a person with type 2 diabetes on insulin who is non-compliant to treatment.

The inexorable rise in medicolegal claims is evident. In 2009–2010, 2990 claims were made against Australian medical practitioners (Australian Institute of Health and Welfare [AIHW], 2012), increasing to 4225 claims in 2012–2013 (AIHW, 2014). Obstetrics and gynaecology (9%) and general practice (18%) are the two most commonly ligitated against clinical specialities (AIHW, 2012), and general practice continues to be the speciality most litigated against over recent years.

Within the spectrum of disorders managed in general practice, none is more challenging than type 2 diabetes. The current treatment paradigm recommends an individualised approach to the management of glycaemic control, as well as the implementation of appropriate cardiovascular risk factor reduction strategies. The duty of care of the GP to their patients with diabetes is to ensure that the appropriate interventions are put in place and that the potential ramifications and complications associated with the condition are explained to the patient. It is incumbent on the GP to explain these complications to the patient to ensure compliance is maintained and individualised targets met. These conversations with the patient need to be documented in the notes to ensure that if any micro- or macrovascular complications develop, there is proof that the GP has taken the appropriate steps to explain this to their patient.

I present a case where legal proceedings were brought against a GP by a patient for negligence. Note-taking by the GP was sparse, and as a result there was no proof that the GP had fully explained the consequences of poor compliance to treatment. This case demonstrates the potential pitfalls for the GP in not maintaining good clinical notes.

Definition of negligence

It is important for the GP to understand the legal definition of negligence. For a claim to succeed, the patient (plaintiff) must prove, on

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the balance of probabilities, a series of steps (Kroesche and Jammal, 2015):

- Duty of care – a relationship needs to be established where the duty of care of the patient by the medical practitioner was in existence.
- Standard of care – that there was a breach in the standard of care, usually judged against an accepted standard for a GP practising in Australia.
- Causation – that as a result of the breach of duty of care, a harm occurred to the patient and that this harm would not have occurred but for that breach of duty of care.

Case report

MV is a woman who began attending a medical centre in 2004 when aged 44 years. MV visited her GP once or twice a year, and at appointments, an HbA_{1c} test would be ordered along with a biochemical screen and a urinary albumin:creatinine ratio (ACR). The only comment made in the notes at this time was "*poor compliance*". Between 2006 to 2013, MV was not near to achieving the HbA_{1c} target of 53 mmol/mol (7%; the current target cited by Australian guidelines [Gunton et al, 2014]). The lowest HbA_{1c} recorded was 79 mmol/mol (9.4%) in 2006 and the highest was 136 mmol/mol (14.6%) in 2013. The average HbA_{1c} was 12.8% (116 mmol/mol) over this period of time.

Despite multiple entries in the medical notes as to the elevations of blood glucose, there was no written confirmation that MV was informed of the potential consequences of not adhering to the medications she was prescribed, or the consequences of the macro- and microvascular complications that MV was at risk of developing by sustaining such high HbA_{1c} levels. Neither were there any notes recording attempts to ascertain the reason behind the high HbA_{1c} results. Pre-mixed insulin continued to be prescribed by the GP at identical doses, despite no records of self-blood glucose monitoring measurements or notes from the GP prescribing self-monitoring.

First noted in 2009, an annual deterioration in ACR was observed. The gradual but significant deterioration in ACR levels indicates the advent of microvascular disease affecting the kidneys. No comments were made in the notes as to the potential nephropathy developing, nor were there any notes indicating that MV had been made aware of the abnormality and its significance.

During 2006 and 2013, MV was referred to two endocrinologists, of which she attended one of the consultations. The correspondence from the endocrinologist confirmed poor glycaemic control and the almost non-existent adherence to insulin. Despite this, there was no evidence in the medical notes referring to the correspondence, nor any advice to return to the endocrinologist for ongoing management.

Apart from elevated blood pressure readings (average 142/94 mmHg), no other examinations were recorded. No comment was made about peripheral pulses or sensation, and no referral was made to check for the presence of diabetic retinopathy.

In 2014, MV presented to her GP complaining of a swollen right leg. She had recently been issued with standard shoes that were required for her job in a nursing home. She had been wearing these shoes for a week.

The history recorded in the notes were: "*swollen leg for 2 dys* [sic], *no CP no SOB*"*. The GP prescribed Lasix® (furosemide), a diuretic to remove fluid build-up by increasing the amount of urine produced. No history of recent events was taken, and no physical examination was recorded – the GP did not remove the footwear MV was wearing.

Three days later, MV presented to hospital with a high fever and a gangrenous right foot that eventually required an amputation below the knee. MV subsequently commenced legal proceedings against the GP. This case was subsequently settled out of court for an undisclosed sum.

Discussion

The lack of compliance and the apparent refusal to follow-up with the relevant endocrinologists will have contributed to the ultimate

* CP=chest pains; SOB=shortness of breath.

Page points

1. It is important for GPs to understand the legal definition of negligence.
2. There can be numerous reasons why someone is not compliant with treatment, such as caring for dependent family members or having no transport to get to appointments.

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Page points

1. It is within the competence of all GPs practising in Australia to identify those individuals with diabetes who are poorly controlled and who are at significant risk of developing the complications of the condition.
2. Understanding the reasons why someone is non-compliant or not reaching their glycaemic target requires thorough investigation and attempts to remedy the situation.

complications that MV developed, which was accepted by their legal representatives. It is not known why MV was non-compliant; there are multiple causes of non-compliance, such as caring for dependent family members or having no transport to get to appointments. That being said, while it is an issue for the treating GP, it should not effect how an individual's care is managed to ensure duty of care is maintained. The onus was on the GP to ensure an appropriate HbA_{1c} target was set and to record discussions of the consequences of poor glycaemic control in the medical notes. Had this been done, there would have been no case for the GP to answer.

Conclusion

It is within the competence of all GPs practising in Australia to identify those individuals with poorly controlled diabetes who are at significant risk of developing the complications of the condition. HbA_{1c} has been the benchmark for assessing glycaemic control since the landmark UKPDS (UK Prospective Diabetes Study, 1998). The UKPDS established that retinopathy, nephropathy and possibly neuropathy are benefited by lowering blood glucose in type 2 diabetes with intensive therapy compared to conventional therapy. The intensive treatment arm achieved a median HbA_{1c} of 53 mmol/mol (7%) while the conventional therapy arm achieved a median HbA_{1c} of 63 mmol/mol (7.9%). The overall microvascular complication rate was decreased by 25% when following the intensive treatment (Genuth et al, 2002). It is critical that GPs practising in Australia should assess the HbA_{1c} level and know that 53 mmol/mol (7%) should be the goal for treatment as per current individualised targets for HbA_{1c} (Australian Diabetes Society, 2009). That said, understanding the reasons why someone is non-compliant or not reaching their glycaemic target requires thorough investigation and attempts to remedy the situation.

The only way to mitigate the risk of legal proceedings is to demonstrate clear and effective documentation as to the goals of treatment for diabetes. The Chronic Disease Management Plan (Medicare item No. 721) is a useful tool to use to set goals in a clear and evidence-based manner.

This instructive case serves as a reminder to all GPs, regardless of their competence in treating type 2 diabetes, of the need to communicate the risks of not complying with appropriate lifestyle modification and anti-diabetes medicines, and having very high HbA_{1c} levels for a prolonged period of time. The dictum of "no notes, no defence" still holds true and reminds all GPs to maintain clearly structured, detailed, contemporaneous notes and to detail issues such as poor compliance and its consequences, thereby ensuring the risk of litigation is mitigated. ■

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