The dangers of litigation in diabetic foot care

Jeremy J Bending

People with diabetes are at greatly increased risk of lower limb amputation. The denial and grief over the loss of both body image and function that can result may often be followed by anger at healthcare practitioners who are blamed for 'causing the amputation'. This grief reaction occurs in the context of the increasingly litigation-prone climate in which we live. Community podiatrists, who often work alone and in isolation, both personally and professionally, appear to be especially and increasingly at risk of being blamed for causing ulcers, infection and ischaemia leading to amputation. It is necessary to recognise this risk and to discuss the ways in which complaints can be avoided and patients supported.

Why are complaints made?

There are reasons that make podiatrists particularly vulnerable to complaints. Patients and other health professionals may not understand the need to remove callus (an important cause of ulceration) and the importance of sharp debridement in this process. When callus is removed to expose an underlying ulcer, patients and others may believe that the ulcer has been caused by the podiatrist cutting the foot. Diabetic feet can deteriorate rapidly – within a few hours of a break in the skin – often without the warning signs of pre-existing inflammation (redness, warmth, swelling, pain and loss of function) in patients who may also be immunocompromised. The lack of awareness of the potential for disaster may reflect poor footcare education, but also an unconscious guilt and a profound sense of denial about the responsibility for self-care. Lack of touch in peripheral sensory neuropathy produces a very abnormal view of the 'boundaries of self' and a loss of responsibility for feet that cannot be felt. In a symptom-led healthcare system this failure to report problems can lead to disaster.

Avoiding complaints

Clear explanation in simple language at every stage of diagnosis and treatment is central to avoiding dissatisfaction, complaint or litigation. Verbal communication should preferably be reinforced by simple written instruction. All podiatrists involved with the care of high-risk people with diabetes should be state registered and preferably have acquired additional training, such as the Postgraduate Diabetes Foot Module of the UK Society of Chiropodists and Podiatrists. Clear referral guidelines and patient pathways should exist and be followed, with open access available to hospital diabetes specialist foot care clinics. Contact with and, if possible, a period of observing and working in the local multidisciplinary diabetes foot care clinic is essential.

Patients with diabetes who develop foot problems should not be 'held on' to and such patients should be referred via rapid access to a specialist team within 24 h. Proper documentation is good professional practice and colour digital photographs can be very helpful both as a clinical record and, should the need arise, in providing medico-legal evidence.

In summary, therefore, podiatrists should be aware of the risks of dissatisfaction and complaint following diabetic foot problems. In order to minimise this risk, community podiatrists working with people with diabetes should:

(1) Establish close links with the local diabetes foot clinic and, if possible gain experience of observing or working in that clinic

(2) Conduct regular case conferences if high-risk patients fail to heal within a short period of time

(3) Audit practice outcomes

(4) Have clear written guidelines on management, follow-up and referral.

In these ways, problems can be avoided and a much improved service developed that is aimed at better patient understanding and the avoidance of the tragedy of loss of limb. ■

Dr Jeremy J Bending is Consultant Diabetologist, Eastbourne District Diabetes Centre