Care of persistent leg condition in insulin-dependent diabetic (03HDC02828, 9 November 2004)

General practitioner ~ Standard of care ~ Ulcerative condition ~ Unstable diabetic ~ Right 4(1)

A man's right leg was amputated below the knee as a result of a persistent leg condition, which had worsened over an eight-month period. The man's son complained that his father's GP should have treated his father with more care, given that he was a 76-year-old with poorly controlled diabetes. The son also felt that concerns raised by the district nurses caring for his father did not appear to have been followed up by the GP.

In April 2002, the patient consulted his GP about an inflamed and painful right ankle, and at the next consultation in July, the patient complained of rest pain. The rest pain continued and subsequently an ulcer developed on his right ankle, and oedema, erythema, crusting and blistering lesions appeared on both legs. The patient's blood sugar levels over this period also indicated that his diabetes was difficult to control.

At various times, the patient was seen by district nurses, a diabetic nurse, a wound care specialist nurse, and a dermatologist. He was not seen by a vascular surgeon (as he had been in July 2000) or a diabetes specialist, even though on several occasions such referrals were suggested to the GP by the attending nurses.

On 9 December, the patient was admitted to hospital with erythema, tissue ooze, and bullae. When his condition deteriorated he was transferred to another hospital, and on 31 December his lower right leg was amputated.

The GP stated: "At all times I was duly cognizant of the fact that diabetes increased the risk of progression of the condition of his legs and would reduce the rate of healing. It is for this reason that we kept [the patient] under close scrutiny during this time. When it was apparent that vascularity was compromised, the appropriate referral was made."

The Commissioner's general practice advisor considered that, as early as July, there were enough important indicators to suggest that the patient had a serious condition that warranted referral to a specialist or hospital.

A GP who made submissions on behalf of the patient's GP criticised the expert opinion, saying that it reflected the advisor's specialist background and set an unrealistically high standard that is not reflective of general practice. The vascular surgeon advising ACC on the medical misadventure charge also said that, while referral to a vascular specialist would have been appropriate in August, there was no evidence that the patient's GP had failed to observe a standard of care and skill in the circumstances.

In the face of this conflicting advice, the Commissioner felt it unreasonable to find the GP in breach of his duty of reasonable care and skill under the Code. However, if the expert's advice is currently regarded as "too gold standard" and exceeds accepted practice standards for GPs in New Zealand, further education is needed.