CHAPTER 59

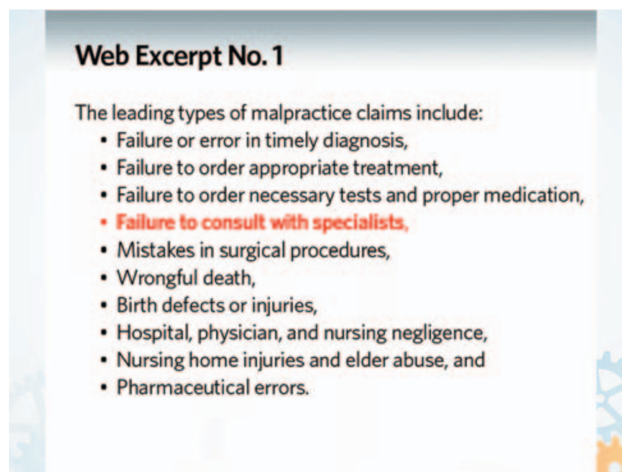
# COLLABORATIVE CARE: THE USE OF CONSULTANTS

*A. Louis Jimenez, DPM*

Figure 1.

Figure 2.

Figure 3.

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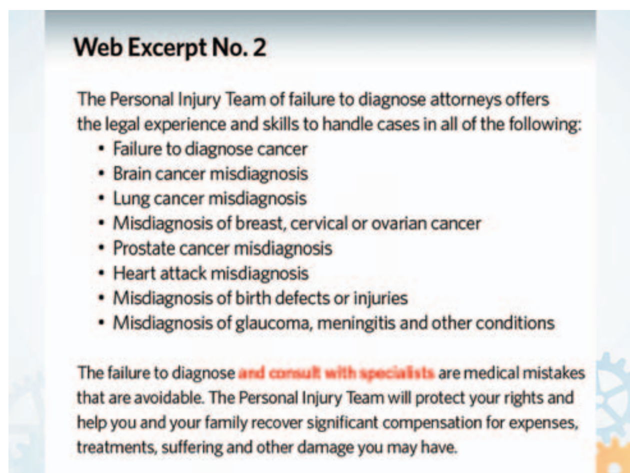


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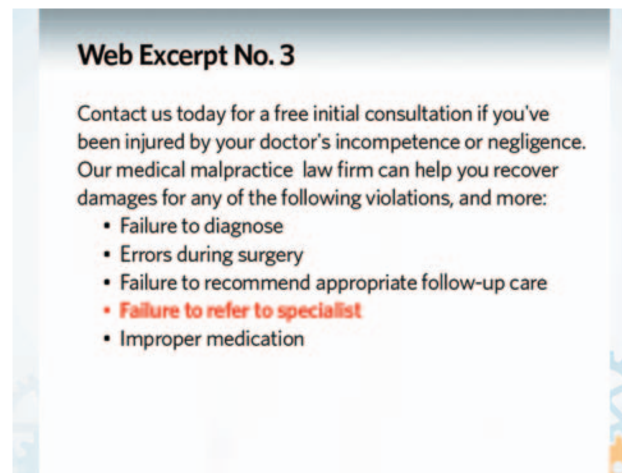



Figure 6.

## Web Excerpt No. 4

**What is Medical Malpractice?** There are hundreds if not thousands of scenarios in which medical malpractice can occur, including:

- Failure to disclose important medical information
- Delayed treatment, diagnosis, or testing
- Injuries during childbirth
- Prescription drug injury
- Injuries from medical equipment
- Failure to refer to a specialist
- Failure to follow-up on abnormal tests
- Premature discharge from the hospital

Our law firm can help identify if any misconduct has occurred and help you seek legal recourse and compensation if it has. Don't hesitate to get the help you need—call the medical malpractice attorneys now.

Figure 7.

## Web Excerpt No. 5

Medical Malpractice Attorney - Lawyer
A medical malpractice lawyer is a specialist in the area of law that assists people who have been injured by the mistakes of health care providers, or the survivors of those who may have died as a result of the mistakes of health care providers.

Can a Medical Malpractice Lawyer help?
Medical malpractice can occur in many different ways. Major categories include, but are not limited to: birth injuries, misdiagnosis or delayed diagnosis, improper or inappropriate treatment, botched surgeries, prescription errors, failure to refer, anesthesia complications, emergency room mistakes and nursing home abuse.

Figure 8.

## Web Excerpt No. 6

Common Areas of Medical Malpractice

- Failure to diagnose or treat a condition;
- Failure to timely diagnose or treat a condition;
- Failure to inform a patient of the risks of a condition or treatment, such as surgery;
- Injuring a patient during a procedure or treatment such as your baby during childbirth or cutting a nerve, blood vessel or other organ during surgery;
- Failure to refer the patient to a specialist (orthopedic, vascular, neurologist, cardiologist, etc.);
- Failure of the doctor to follow up on an abnormal test; and
- Discharge from a hospital or emergency room before the patient should have been, and as a result, the patient's condition or injury worsened.

Figure 9.

## Web Excerpt No. 7

Some medical errors constitute "medical malpractice," defined as health care that falls below accepted medical standards, causing a patient's injury or death. Examples of medical malpractice claims that we have handled involve:

- Failure to prescribe a necessary test or evaluation;
- Misdiagnosis of cancer and other medical conditions;
- Performing unnecessary surgery;
- Surgical errors such as operating in the wrong area of the body;
- Leaving surgical instruments such as sponges in the body;
- Failure to explain surgical risks to the patient;
- Post surgical infections;
- Nursing negligence;
- Improper drug prescriptions;
- Failure to refer a patient to a specialist; and
- Nursing home negligence

Figure 10.

Industry News

Soldier wins $2M medical malpractice case

Illinois man wins $2.1M medical malpractice case

A New York City jury awards $60M to woman deformed by a botched thigh lift

Clark County, Nevada District Court jury returns a verdict of $2.5M in a medical malpractice lawsuit involving cancer misdiagnosis

Figure 11.

Industry News

Jury award Indiana couple $8.1M in a medical malpractice lawsuit

Lawsuit filed for failure to diagnose cancer

NJ lawyers obtain $1.35M settlement in medical error court case

Widower wins $7.5M for failure to diagnose

Virginia jury awards $7.5M in failure to diagnose breast cancer case

Figure 12.

Industry News

Lackawanna County jury awards the family $20.5M for obstetrics malpractice case seven years

Family wins $11M in dental malpractice lawsuit

$2.3M settlement awarded in case that doctors failed to timely diagnose breast cancer

Woman wins $1.5M for doctors' failure to timely diagnosis breast cancer

Figure 13.

Figure 14.

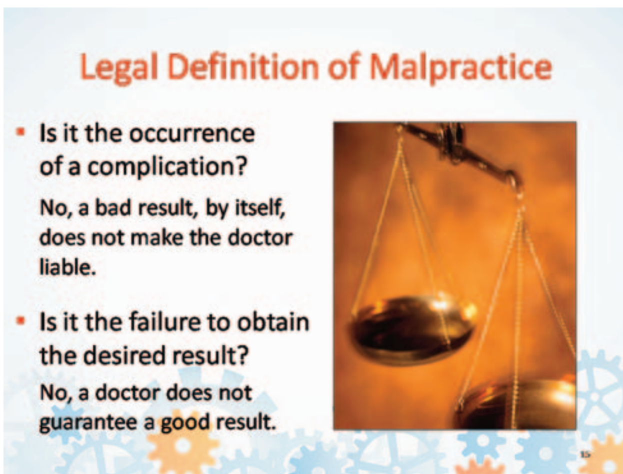



Figure 15.

Legal Definition of Malpractice

CONTINUED

- Is it an error in judgment?

No, doctors must employ their best judgment in exercising skill and applying their knowledge. The rule requiring a doctor to use his or her best judgment does not give rise to liability for mere errors in judgment.

Where alternative procedures are available to a patient, any one of which is medically acceptable and proper under the circumstances, there is no negligence in using one rather than another.

Figure 16.

Malpractice

The required elements of proof in a medical malpractice case are:

1. A deviation or departure from accepted practice, and
2. Evidence that such departure was a proximate cause of injury or damage.

Figure 17.

Malpractice

CONTINUED

- By undertaking to perform a medical service, a doctor does not guarantee a good result. The fact that there was a bad result to the patient, by itself, does not make the doctor liable. The doctor is liable only if (he, she) was negligent. Whether the doctor was negligent is to be decided on the basis of the facts and conditions existing at the time of the claimed negligence.

Figure 18.

## Malpractice

CONTINUED

- A doctor's responsibility is the same regardless of whether (he, she) was paid.
- If the doctor has reason to doubt that he or she has sufficient competence to handle the case, the doctor may be liable for failure to advise the patient to a consult a more skillful doctor.

Figure 19.

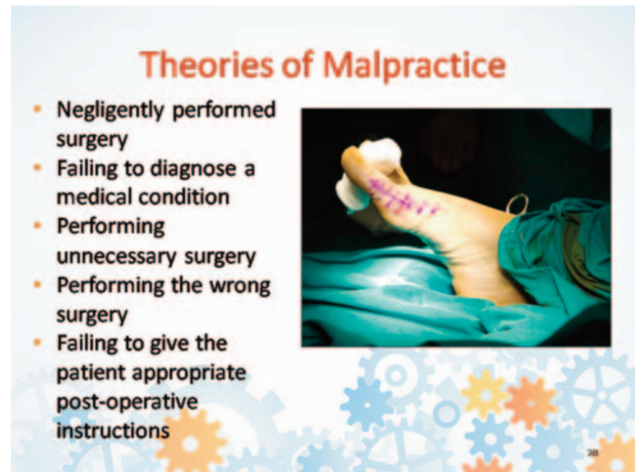



Figure 20.

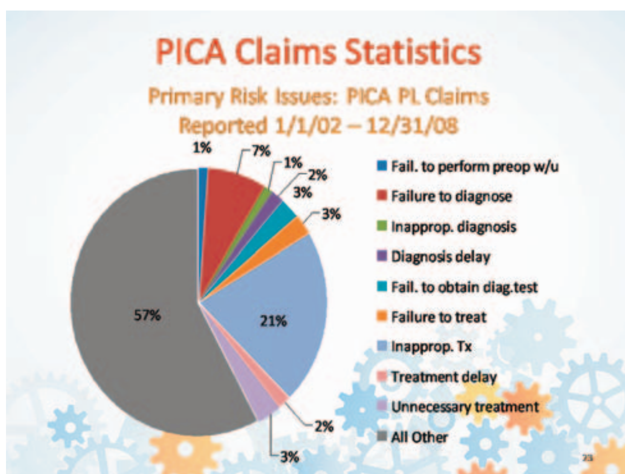
## Theories of Malpractice

CONTINUED

- Failing to properly monitor and treat a diabetic ulcer
- Failing to attempt conservative therapy prior to surgery
- Negligently prescribing or administering medications
- Failing to follow up on a test ordered by the podiatrist
- **Failing to refer a patient to a medical specialist**

Figure 21.

Figure 22.

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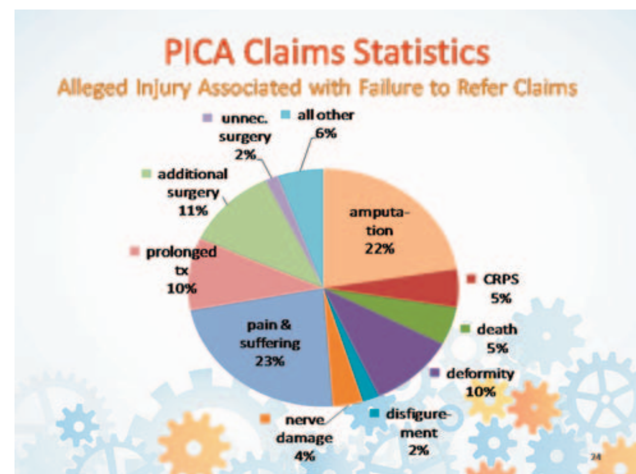


Figure 24.

Figure 25.

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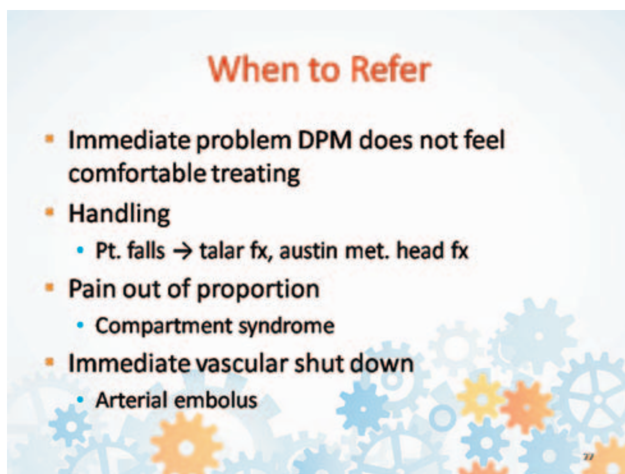



Figure 27.

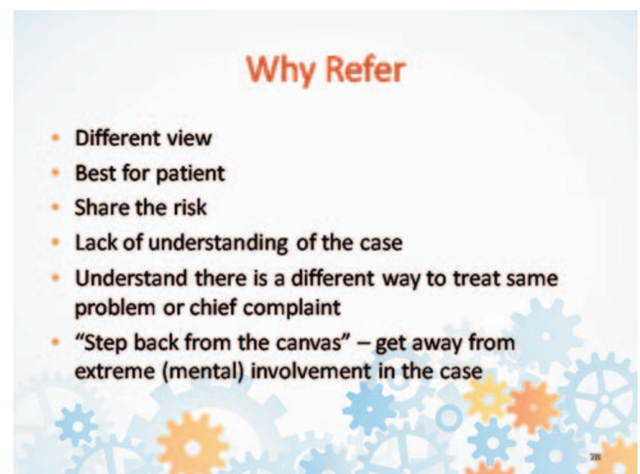



Figure 28.

Figure 29.

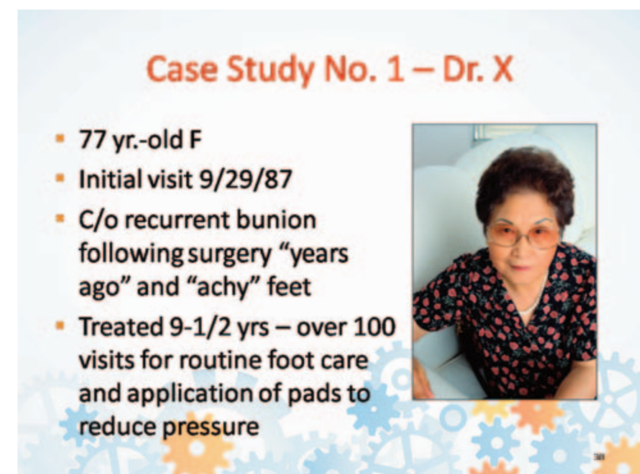



Figure 30.

## Case Study No. 1 – Dr. X
CONTINUED

- Throughout 2003 pt. c/o feet hurting more frequently and intensely than usual
  - No signs of vascular problems
  - DP/PT 2/4 bilat
- August 2005, initial note that DP & PT pulses weak (1/4)
  - C/o burning sensation in feet
  - Ingrown necrotic L great toenail (excised 9/8/05)

Figure 31.

## Case Study No. 1 – Dr. X
CONTINUED

- 3/7/06 – last visit
  - C/o painful feet & sore toes
  - DP & PT pulses 1/4
  - No edema, but very red 2$^{nd}$ toe
  - Dense hyperkeratoses, bursitis of the 5$^{th}$ toes, hammertoes 3-4, interdigital keratoses between R 4$^{th}$ & 5$^{th}$ toes and L 1st & 2$^{nd}$ toes
  - Debrided hyperkeratoses /fungal nails, applied interdigital foam & protective padding with foam rubber & moleskin

Figure 32.

## Case Study No. 1 – Dr. X
CONTINUED

- 3/23/06 – pt. to another podiatrist
  - "Injury on medial side of 2$^{nd}$ toe"
- 3/28/06 – "ulcer deepening to the capsule"
  - 2$^{nd}$ pod suspected diminished vascularity/PVD
  - Prescribed antibiotics, home health, vascular consult, & bone scan to r/o osteo
- 3/29/06 – angiography of LLE
  - All 3 tibial arteries severely diseased & occluded at upper calf level
- 4/8/06 – Amputation of L 2$^{nd}$ toe by vascular surgeon

Figure 33.

## Case Study No. 1 – Dr. X
CONTINUED

- Lawsuit filed
- Allegations –
  - Negligence in failing to diagnose & treat vascular problem
  - Failure to refer patient to vascular specialist in 2005 when pulses were noted to be weak
- Plaintiff's expert –
  - Dr. X should have arranged for vascular consult as soon as pulses were noted to be weak
  - At that time, bypass surgery was an option which would have precluded need for amputation

Figure 34.

## Complications Happen – Lessons Learned

- May reduce risk of a complication by judicious consultation
- Patient disclosure and communication
  - Will make decisions together
  - Will not abandon – will be with pt. all the way

Figure 35.

## Signs that May Indicate Referral

- Non-responding temperature elevation
  - May not be local infection
  - Medication affect?
- Regular treatment plan not working
- Pt. hesitant to move part – stimulates CRPS
- Subjective complaints inconsistent with objective findings

Figure 36.

## Signs That May Indicate Referral
CONTINUED

- Patient interruptions (children, family) during discussion concern
- Language barrier
- Patient non-compliance
- Patient not listening – "talker"
- Family member problem
  - Spouse very upset, not logical, accusatory

Figure 37.

## Case Study No. 2 – Dr. Y

- 41yr.-old F
- 1st visit 12/11/06
- C/o painful bone spur on R
- Hx. of similar problem – successfully repaired by another podiatrist
- Dr. Y diagnosed insertional Achilles tendonitis & Haglund's deformity
- Treated conservatively: injection, heel lift & splint

Figure 38.

## Case Study No. 2 – Dr. Y
CONTINUED

- 12/28/06 –
  - Conservative tx. did not relieve pain
  - Unable to wear shoes/walk in comfort
- 4/3/07 –
  - C/o heel is "killing her"/getting worse
  - Wanted surgery
- 5/2/07 – Surgical excision of Haglund's deformity
- 5/3/08 – Emergency office visit
  - C/o cast tight
  - Foot cold/capillary return delayed
  - Dr. Y removed cast & applied posterior splint

Figure 39.

## Case Study No. 2 – Dr. Y
CONTINUED

- 5/10/07 –
  - C/o numbness/pain forefoot medially
  - Forefoot had cold, vibratory & soft touch sense
  - Hallux, 2nd, & 3rd digits lacked pin prick sense dorsally and laterally
  - Pain meds "not working"
  - Unable to wear shoes/walk in comfort
- 5/17/07 –
  - Forefoot still numb/painful
  - Dr. Y performed nerve block
  - Unna boot/CAM walker dispensed w/instructions

Figure 40.

## Case Study No. 2 – Dr. Y
CONTINUED

- 5/23/07 –
  - Less pain/numbness
  - Impression – resolving cast tightness neuropathy
- 6/1/07 – symptoms continued to resolve
- 6/7/09 –
  - New c/o numbness/tingling/pain dorsum R foot
  - Foot still cold, hypersensitive – guarding extremity
  - Residual bump at surgical site
  - Impression – Compression type neuropathy
  - Ordered PT, Percocet
  - Created window in Unna Boot

Figure 41.

## Case Study No. 2 – Dr. Y
CONTINUED

- 7/2/07 –
  - C/o 2 areas of burning/severe, sharp pain – requested additional pain meds
  - Bump in area of original Haglund's
  - Dr. Y suggested 2nd opinion for nerve injury & bump
- Late July 07 –
  - Diagnosed with CRPS
  - Treated with pain management specialist

Figure 42.

## Case Study No. 2 – Dr. Y

CONTINUED

- Lawsuit filed
- Allegations –
  - Negligence in performing surgery
  - Negligence in application of cast
  - Failure to timely diagnose CRPS
  - Failure to refer to specialist for treatment of CRPS
- Plaintiff's expert –
  - Surgery negligently performed – Haglund's not removed
  - Cast placed too tight
  - Dr. Y failed to timely diagnose & refer the pt.

Figure 43.

## Why Don't Podiatrists Refer?

Figure 44.

Figure 45.

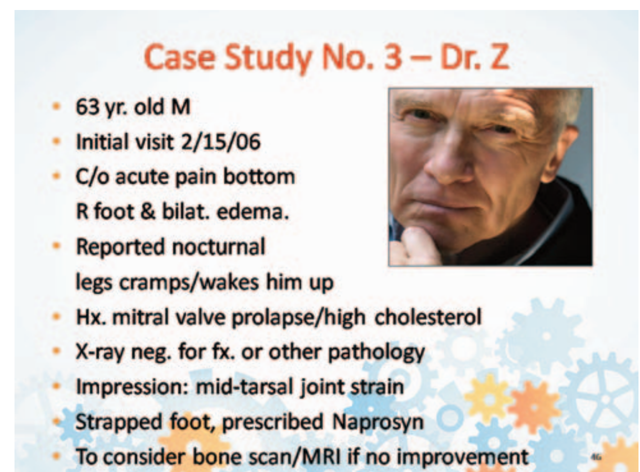



Figure 46.

## Case Study No. 3 – Dr. Z

CONTINUED

- 2/22/06 –
  - 75% relief of pain w/tape, but pain returned after removal of tape
  - Pt. reported 3-day hx. of fever and vomiting
  - MRI showed inflammation w/marrow edema plantar lateral cuboid, non-specific soft tissue swelling dorso-lateral aspect, but no stress fx.

Figure 47.

## Case Study No. 3 – Dr. Z

CONTINUED

- 3/1/06 –
  - Pitting edema bilat.
  - Pt. reported fever broke w/Tylenol, but had wt. loss & night sweats
  - Dr. Z applied removable Coban cuff
- 3/18/06 –
  - Bilat. pitting edema still present – pt. reported diet high in sodium
  - Continued night sweats/fever
  - Dx = bursitis plantar aspect L
  - Applied u-pad, advised pt. to reduce sodium intake

Figure 48.

## Case Study No. 3 – Dr. Z
CONTINUED

- 3/26/06 –
  - No documentation re: edema, night sweats, wt. loss, fever or nocturnal leg cramps
  - Dx = plantarflexed L 3rd metatarsal
  - Casted for orthotics bilaterally
- Early April 2006 –
  - Pt. diagnosed with endocarditis & CHF
  - Underwent aortic valve replacement, mitral valve repair & cardiopulmonary bypass procedure

Figure 49.

## Case Study No. 3 – Dr. Z
CONTINUED

- Lawsuit filed
- Allegations –
  - Failure to diagnose endocarditis & CHF
  - Failure to refer for timely treatment of endocarditis & CHF which caused the pt. to require surgery
- Plaintiff's expert –
  - Pt.'s signs/symptoms (fever, night sweats, lower extremity pitting edema w/ hx. of MVP) were consistent w/endocarditis & CHF
  - Dr. Z failed to properly work up the pt. and refer to a cardiologist or to hospital.

Figure 50.

Figure 51.

## Optimizing the Referral Process

Figure 52.

Figure 53.

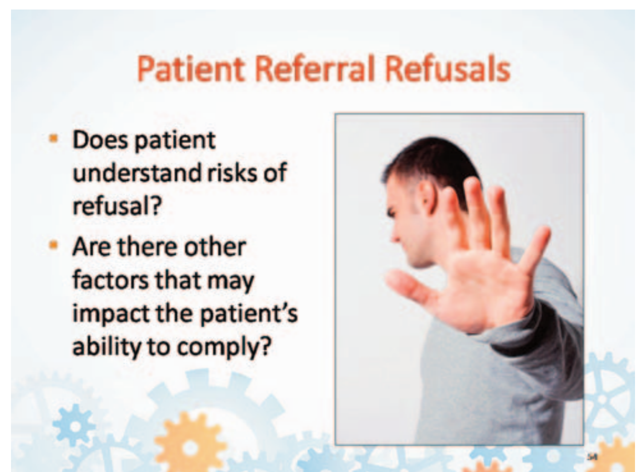



Figure 54.

## Patient Referral Refusals

CONTINUED

- Informed refusal discussion
  - Recommendation for referral
  - Benefits of referral
  - Risks of failure to comply
  - Alternatives and benefits/risks of each

Figure 55.

## Failure to Follow Up

- The most common reasons patients gave for failing to follow up:
  - The belief that the problem had resolved (47.5%)
  - Lack of time (37.3%)
  - Disagreement over the need for the referral (26.5%)
  - Insurance company's refusal to pay (2.3%)

*Forrest CB, Shadmi E, Nutting PA, et al.: Specialty referral completion among primary care patients: Results from the ASPN referral study. Ann Fam Med 5:361–367, 2007*

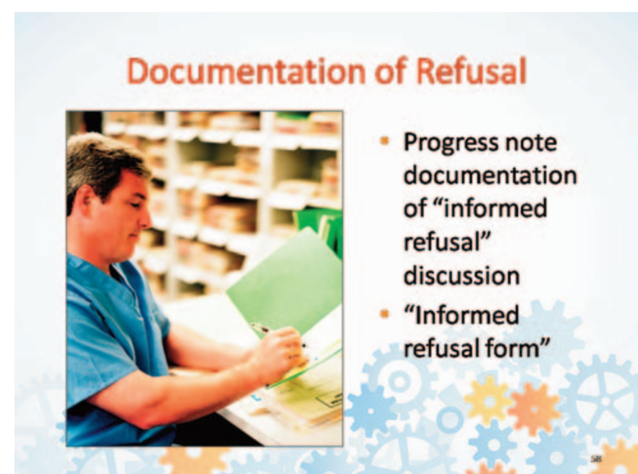
Figure 56.

## Influential Communication

- Eye contact
- Body language
- Avoid ambivalence: Perhaps, Maybe
- Use power words: Essential, Critical and Important

Figure 57.

## Documentation of Refusal



- Progress note documentation of "informed refusal" discussion
- "Informed refusal form"

Figure 58.

## Downside to Not Referring

- Complication
- Complicate the complication
- Questioning:
  - Patient
  - Family
  - Other doctor
  - Attorney

Figure 59.

## Key Systems to Ensure Consultation Compliance

- Communicate
- Schedule the appointment
- Confirmation - Track referrals electronically
- Follow-up with patient

Figure 60.

## Triaging the Consultations

- Level 1 Consults
- Level 2 Consults

Figure 61.

Figure 62.

## Level 2 Consultations

- Non-emergent
  - Examples: Chronic pain, non emergent post op complications
- Protocol
  - Write out consultation with contact information of specialist
  - Follow up with patient one week for confirmation

Figure 63.

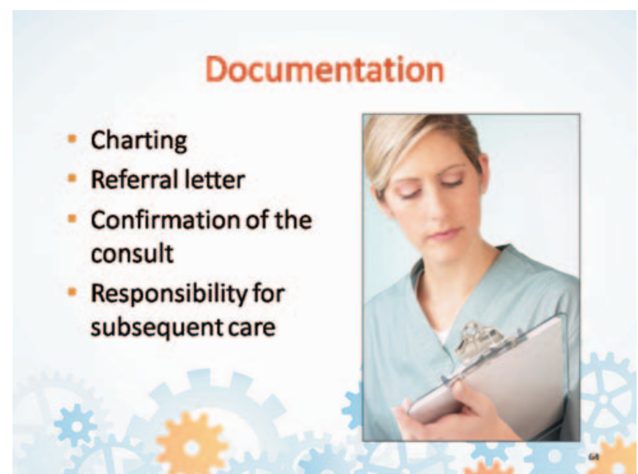



Figure 64.

## Documentation

Charting

- Initial referral
  - Reason for referral
  - Name of referral doctor
  - Phone call to referral doctor
  - Date of appointment with referral doctor
  - Patient instructions/education
- Date(s) of receipt and review of referral report OR follow-up actions taken if report not received timely

Figure 65.

## Documentation

Charting, CONTINUED

- Review of referral report with patient
  - Date report reviewed with the patient
  - Discussion with patient
  - Plan of future treatment
  - Provider responsible for future care
- Any follow-up actions taken

Figure 66.

## Documentation
Referral Letter

- Basic patient information
  - Name, DOB, address, phone number
- Reason for referral
  - Primary complaint
  - Other medical problems
- Your contact information

Figure 67.

## Documentation
Confirmation of the Consult

- Initial and date the consultation report upon review
- Document review of results with patient
- Document any necessary follow-up actions
- Training and delegating your staff to get the job done
- Ultimately the doctor's responsibility

Figure 68.

## Documentation
Responsibility of Subsequent Care

- Clearly document who is responsible for subsequent care
- If multiple providers, who is the "captain of the ship?"

Figure 69.

## Tracking Referrals

- EMR Systems
- Logs, tickler systems, etc.

Figure 70.

## Referral Log

Week of: ______________________

*Details recorded in patient's chart.

| PATIENT'S NAME/DOB | Referred To | Reason for Referral | Date Referred | Appt. Date | Date Report Received in Office | Date Report Reviewed by Doctor | Date Report Reviewed with Pt. | Follow-up Needed (YES/NO) | IF APPLICABLE, FOLLOWED UP BY* (NAME) |
|---|---|---|---|---|---|---|---|---|---|
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Figure 71.

## Responsibilities of the Podiatrist as a Consultant

- Evaluate the patient
- Communicate with the patient
- Communicate with the referring doctor
- Determine responsibility for future care

Figure 72.

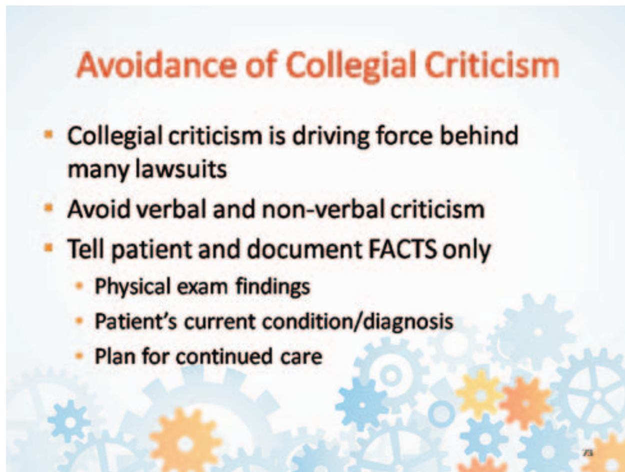


Figure 73.

Figure 74.