CASE **CLOSED**

SUMMARY: The insured performed a surgical repair of Charcot foot that resulted in a below-the-knee amputation. The patient later passed away and a wrongful death lawsuit was brought against the insured.

The Patient and Condition

The patient was a male in his late 40s. He had a past medical history of type 2 diabetes, obesity, and diabetic neuropathy. The patient was also a smoker. He had been treated for several years at a wound care center by another podiatrist and was eventually referred to our insured for evaluation. The patient was diagnosed with DM 2 Charcot joint and non-healing wound.

The Treatment

The insured performed a surgical repair of the Charcot deformity. The surgery was performed without incident.

The Injury

The surgery resulted in multiple recurrent wounds. Nearly four months post-op, a Syme amputation had to be performed, followed a week later by a below-the-knee amputation. Two months after that, the patient was admitted to the ER with tachycardia and treatment for massive pulmonary embolism. The patient passed away nine days later from cerebral edema.

The Allegations

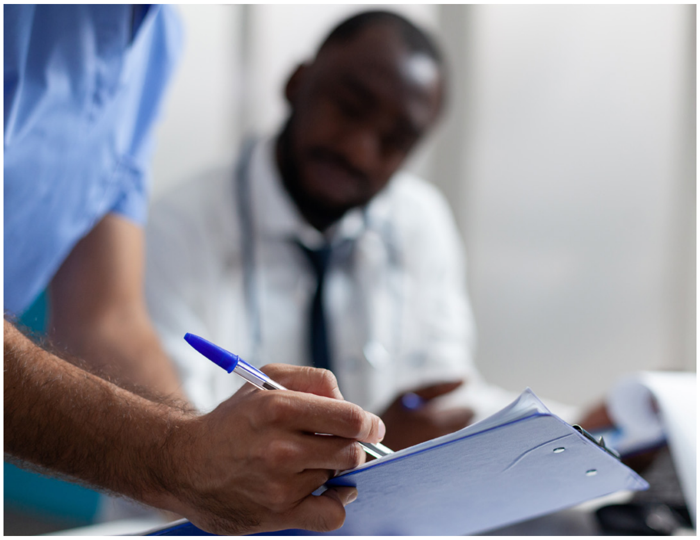
A wrongful death lawsuit was brought against the insured. The insured was also accused of negligence.

The Defense

The expert witness for the defense testified that the patient's death was not a result of negligence by the insured, using the patient's medical and hospital records as the basis of why the cause of death was unrelated to any aspect of the care rendered by the insured. Experts in podiatric surgery, with specific expertise in Charcot and infectious disease, also provided strong reports. Additionally, the defense was able to use the deposition of the deceased patient's wife which confirmed noncompliance, as well as a subsequent trauma which occurred after the last visit with the insured.

The Outcome

This case resulted in a unanimous verdict on behalf of the insured.



Risk Management Tips

- **Informed consent documentation is critical for surgical procedures.** The fact that a surgery is a salvage procedure – which carries a significant risk for subsequent amputation – should be clearly stated in a surgical consent form signed by the patient. It's critical that the patient understands the risk of any procedure and consents to the treatment.

- **Involve family members and other medical providers in the informed consent process, as well as the treatment plan, if possible.** In a situation where there is a choice between not performing or performing a time-sensitive, limb-saving procedure on a patient who has been noncompliant, there is an increased chance of a medical malpractice action. Therefore, it is helpful to discuss the decision-making process and treatment plan with the patient's family physician, as well as ancillary treating specialists, and the patient's spouse or family. Luckily, in this case, the insured did this and documented accordingly.

- **Be diligent with your documentation and be specific when documenting progress notes.** For example, in this case, the progress notes made consistent mention of a complaint of pain; however, it also would have been beneficial for the doctor to note that this was neuropathic pain which was present prior to surgery.

- **Use caution when using the term "dehiscence" in your documentation.** When using the term "dehiscence" in your documentation, it is important to note that there are no signs of infection – or alternatively, if there is infection, document the recommended treatment. Indicate the size and whether this is a superficial opening or full thickness. If known, indicate the reason such as irritation/trauma of incision, removal of fibrinous debris upon suture removal, allergic reaction, etc. Be sure to note the recommended care of the dehiscence.