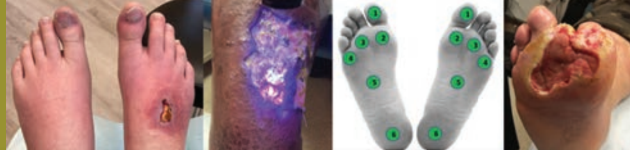

Limb Loss… Who Is Really to Blame?— The Patient? The Physician? The System?—Part 2

The author explores the causative factors.

BY KENNETH REHM, DPM

Editor's Note: *This is the second part of a two-part article.*

In the first part of this article (Nov/Dec '21) we discussed the main points: that in spite of many readily available state-of-the-art, innovative, evidence-based diagnostic and therapeutic approaches that could be used to minimize risk factors, their implementation, utilization and compliance are disappointedly less than optimal, thereby increasing the burden of potential limb loss. In part 2 we'll delve deeper into the specific mental, emotional and psychological conditions unique to the person with diabetes; the dynamics of the relationship between doctor and diabetic patient; and a highly challenging future in which the medical profession is likely to be subjected to far more administrative and bureaucratic controls than was conceivable even a few years ago.

As we continue from Part I, it bears emphasizing that the higher the quality of communication which exists between doctor and patient, the more successful the therapeutic experience is,[2] especially as it relates to persons with diabetes. Essential to fostering this level of interrelating, the physician needs to be keenly aware of the patient's affect; and what is really behind what they are, or are not, saying. It is relevant to note that specific mental, emotional and psychological conditions, unique to the person with diabetes, have to be understood if effective communication with the patient is to take place.[3]

What are these distinctive behavioral patterns? First off, fluctuations in blood sugar can trigger rapid changes in mood and other mental symptoms such as fatigue, inability to think clearly, and anxiety. Additionally, a condition called *diabetes distress*, an emotional response to the various burdens of living with diabetes and self-management, can show up as stress, guilt, frustration and a feeling of being overwhelmed and burnt out. Also, denial and depression are both common threads of the diabetic experience.4 Similarly, when someone experiences loss of protective sensation they mentally block out of their consciousness the existence of that body part, offering rationale for non-compliance and the lack of desire to care for one's wounds.[5,6]

Further, neuropathy and small vessel disease of the brain can each pose significant challenges in a person's ability to communicate, which can be very subtle. This can be a very taxing

situation, even for the most astute of practitioners; but the physician must be aware of these limitations if they are to develop optimal rapport with their patient.[1,7,15]

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Additionally, a patient's inability to process the onset of a chronic disease often hampers the healing connection that's needed with their physician; and likely diminishes the desired curative results. It is incumbent upon the provider, therefore, to be astute, perceptive and sensitive to the patient's struggles, and to offer a breakthrough opportunity to the patient. Frequently, upon discovery of their diagnosis, anxiety, depression and anger consume the patient. These emotional components of the diabetic experience can be devastating. One minute you identify as being

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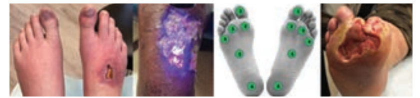

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"normal". Then you are told *you are diabetic*. Your identity is jilted and this insult to the psyche finds its home in emotional turmoil. It can be very destructive to label a person by their disease for just that reason.[7,8] (Figure 1)

Figure 1: Guiding Principles Quoted Directly From The Use Of Language in Diabetes Care And Education[8]

Expert Voices

It is through the voice of experts in the therapeutic experience of persons with diabetes that we learn how to thwart the emotional turmoil that often plays havoc with the personal relationships of those affected with diabetes, including that which they have with their doctor.[10]

Karen Kemmis, R.N., of the Association of Diabetes Care and Education Specialists, deplores the practice of calling a person by a disease or disorder, contending that this is not a good way to develop rapport with your patient.[9] She maintains that a person should always be referred to as a person with diabetes (PWD) and not a *diabetic*. Ms Kemmis, also a physical therapist and education team leader at the Joslin Diabetes Center Affiliate at SUNY Upstate Medical University, uses her communication skills as a diabetic educator to ask questions that ultimately empower patients to exercise, helping them function better in the everyday world, engendering a positive impact on their lives.[12]

To these issues the late Dr. David Viscott, esteemed psychiatrist, affirmed his mantra: "Having emotional stress is related to not being able to identify the source of pain and the expression of these feelings is therefore blocked. If someone can help another person understand what they're feeling and get them to communicate any underlying emotional pain, then the patient will be able to reframe their experience in a way that healing can take place." Dr. Viscott had a profound belief that this scenario should be the keystone to *any* therapeutic relationship.

Figure 2: David Viscott Interview with Dr. Kenneth Rehm For Feeling Good Television 1989

Also, in reference to the disadvantaged segment of the population who by virtue of their life's circumstances have no motivation, inspiration, impetus or incentive to do what they intuitively know they should do to improve their lives, Dr. Viscott says: *"If you have nothing to lose…you have nothing to lose."* That is in essence the patient saying: "it doesn't matter what I do, It's not going to help anyway." This is the badge of a despairing attitude, planting the seeds of a self-fulfilling prophecy. It speaks directly to the defeated feeling of having a chronic disease like diabetes, and the incapability of a person to take control of their life and develop an optimistic, compliant lifestyle with a heathier positive outlook toward life. Like other authorities on the subject, he maintains that it is important to show patients that they have value in their life; and the trick to accomplishing this is to discover, and have the patient acknowledge, what is often a glaringly simple emotional block. This removes the destructive anger which is overshadowing all the good things in this person's life, potentially transforming a very toxic situation into a powerfully positive and productive experience. (Figure 2)

One of the iconic gurus of the podiatry profession was sagacious in his advice, offering it up much before the rigors of scientific research

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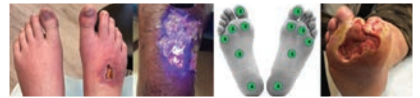

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showed it to be valid. Robert P. Levoy, author of *The $100,000 Practice and How to Build It*, in his many lectures to podiatrists in the 1960's famously quoted Theodore Roosevelt when he said: *"People don't care how much you know until they know how much you care."* Levoy emphasized that this sentiment was key to a podiatric physician having a successful and efficacious relationship with their patients who have diabetes. Talking to the podiatry group, he expounded, "They are scared of you telling them they're going to lose their leg when they come into your office, but if they know you care about them, they will feel less vulnerable. He went on to say, *"always sit down"* when you're in the treatment room. This act alone improves communication, cultivates trust and creates a more valuable experience for the patient. Levoy also encouraged "self-disclosure" on the part of the doctor, as a means of displaying openness. This inspires the patient to reveal more of themselves, providing essential information that's needed to formulate an exacting and astute diagnosis and treatment plan, and speaks to being a better doctor. Levoy opines that these recommendations, when put into place, are the keys to building a solid and trusting doctor-patient relationship.

Another trailblazer, the esteemed Dr. Philip Gardner (Figure 3) spoke at an introductory assembly at the California College of Podiatric Medicine. He emphasized four pivotal precepts for being a successful doctor:

1) Always have a high index of suspicion, that is, when you hear hoof beats, don't always think of horses. Think of zebras as well.

2) Ask the right questions and use your examining skills to lead you to the right answers. Use your sense of smell, sight, touch and hearing.

3) Know that you are *not* here to treat foot problems, but you *are* here to treat *people* who have foot problems.

4) He quoted Sir William Osler when he said: *"Listen to your patient, he is telling you the diagnosis."*

Dr. Paul Brand (Figure 4), the quintessential luminary in the field of diabetic foot medicine, promoted the concept to his students that they should be an advocate for patients who suffer from loss of protective sensation using the following principles as a framework:[5,6]

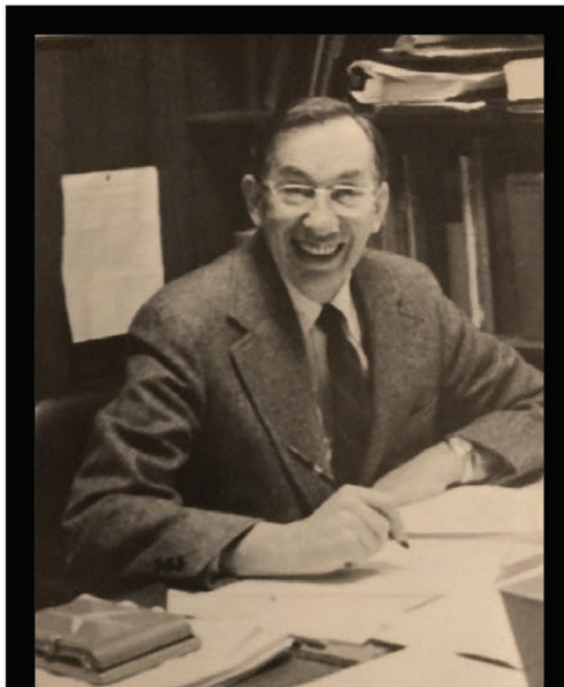

Figure 3: Dr. Philip Gardner, Dean of Podiatric Medicine CCPM
From Yearbook 1976: CALCANEOUS

1) Think about the person, not just the foot.

2) Praise the wonder of what the patient with insensitive limbs have left, that is the part of them that remains healthy and whole.

3) Have empathy for your patients and feel the pain that your patients are having.

4) There but for the grace of G-d go I, it could be you.

5) Know that each person wants to be listened to, respected, understood, appreciated and accepted.

6) Access the ability to get inside your patient's mind to help them build a new self-image of value, significance and pride.

7) Each person wants desperately to be able to have confidence, understanding, clarity and trust in what the doctor is saying; as well as the goals and outcome of the visit.

8) Pain is a gift no one wants. If you lose sensation in a limb, to that person that limb doesn't exist. The wise practitioner will reacquaint the patient with their foot and establish it as something worth preserving. Make them want to save their foot.

9) The reasons for non-compliance and/or non-adherence should be considered part of the disease process; and is just as important to address that issue as it is to treat the other manifestations of the disease.

Dr. Lawrence Jay Jaffe (Figure 5), a San Diego psychiatrist whose expertise is anxiety and depression in aging adults states: *"Learn to direct your attention on what's good in your life and not what's wrong with it. Acknowledge the part of you which does not have disease and don't let labels define who you are because this detracts from your healing energy and focus."*[10]

Carrying out these captivating words of true wisdom, of course, requires an astute physician with communication and listening skills, backed up by an ample knowledge base, genuine caring, compassion and curiosity. This modus operandi is not carried out in a vacuum. The physician must have adequate resources available and be able to spend ample time with the patient, albeit not inefficiently, to offer the optimum, most complete and ethical care possible.

Regrettable Transformative Changes in Healthcare

This is a great prescription, if the practitioner is in private practice or otherwise has the luxury of incor-

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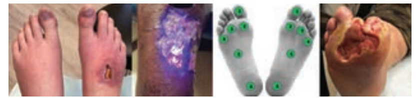

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porating these measures into their workflow process. Nevertheless, it is becoming more and more difficult to provide quality patient-centered care, where the most important aspect of that care should always be the patient. Yet, more likely than not, the doctor is part of a corporatized medical practice which is, by nature, designed for efficiency and profit, and not aimed at providing services that are in the best interests of the patient's health.

According to the International Journal of Health Services,[11] large corporate health care firms are seeking to reorganize the way their health care services are delivered. This metamorphosis is driven by growing cost-containment pressures from government and health insurers representing major businesses. Medical management information systems are generating an increasing number of financially motivated utilization management software interventions that are designed to restrict costly measures in the practice of medicine. This technology is advanced for the purpose of monitoring practitioners' clinical decisions in order to improve the productivity of physicians and other health care personnel. As this trend continues, decision making authority shifts from previously autonomous physicians to corporate health care managers; and the medical profession is likely to be subjected to far more administrative and bureaucratic controls than was conceivable even a few years ago. These transformative changes will undoubtedly bias against individualized patient care. We have a system in turmoil and the payor system is calling the shots, often to the detriment of patients with diabetes.

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The solution offered here is to eliminate the abusive bureaucratic waste that is part and parcel of our healthcare system as it exists today. Renewed efficiency can create the dollars needed to offer a high standard of care and other vital resources to those who currently cannot afford it, enabling those that would unnecessarily lose their legs now to keep

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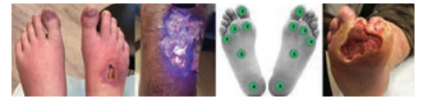

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them and keep them healthy in the future.[14]

The physician, whether M.D., D.O, or D.P.M., with his knowledge, insight, focus and compassion, is the professional that is inimitably and uniquely equipped to deal with these challenges and must serve as a major impetus for change, now! If the medical profession forfeits this short window of opportunity, its members will become mere sheep in this bureaucratic herd.

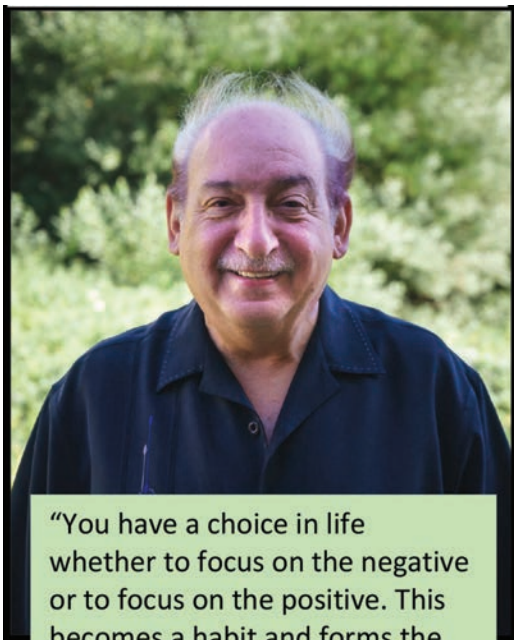
It's not that patients are off the hook here—as discussed above, they must want to be healthy and prevent their disease more than anyone else does. Patients need to be motivated, knowledgeable, self-reliant and accountable for the outcome that they deserve as well as an active participant in their own healthcare. They must realize that their well-being is in their own hands and that they are the captain of their own ship. But we as healthcare providers must be their navigators and be there for them, to educate, inspire and help our patients help themselves before the onset of a costly critical event or chronic condition. The system needs to support this model and favor a preventive and quality care approach.

"Always find something beautiful about your patient's feet, and tell them. It will make them feel whole again." ...Dr. Paul Brand

Figure 4: Dr. Paul Brand Lecturing At Gillis W. Long Hospital Carville Louisiana 1993

Conclusion

To summarize: we have discussed many permissive factors that are part of the clinical mosaic which contributes to limb loss in a person with diabetes. These factors include those that are overt, such as loss of protective sensation, peripheral vascular disease, uncontrolled blood sugar, lack of regular medical and foot exams and improper footwear, among a host of other traditionally considered risk factors. There are, however, other covert dynamics that influence a person's vulnerability for impending limb loss, which include racial, genetic, lifestyle and psychologic factors, among others, that when addressed can alter the pathway that would ordinarily lead to diabetic complications. The solutions reside in the same compartment that houses a patient's motivation, activity level, habit, hygiene, nutritional status, emotional resilience, culture, and thought process as well as their belief system. These factors should always be considered as part of a provider's plan of care when the goal is lower extremity amputation prevention.



"You have a choice in life whether to focus on the negative or to focus on the positive. This becomes a habit and forms the lens with which you look at life" ...Dr. Lawrence Jay Jaffe

Figure 5: Dr. Lawrence Jay Jaffe, MD Psychiatry Physician

This discussion has a presented a case where accountability for a preventive stance lies not only with the patient, but also with the doctor and the system—and all three working in concert and mutually supporting the other's perspective. Each is codependent on the others, but independently has the ability to change for the better. Experts do assert, however, that the physician is ultimately responsible for patient outcomes; and must operate on a different level, take the higher road, if you will, and effectively meet the needs of the patient, thereby providing the highest standard of care possible. He must take a stand in defense of his patient, consigned to improve the system that is currently choking any chance of truly quality healthcare.[13] Modern medicine has indeed reached the tipping point of complexity, where physicians must be leaders that pilot the field of medicine back to a pathway that cultivates a healthy body, mind and spirit.[16] Otherwise, all we are doing is paying into a system that advocates fake healthcare.

Finally, if you want to assign blame, let's acknowledge that the patient, the doctor and the system are all to blame for the high prevalence of lower extremity amputations in people with diabetic foot disease. Things must change, though. It's a high mountain to climb and not an easy path, especially for those at risk for losing their legs. After all, if we always do what we've always done, we will get what we always got; and will not *procure a cure* for our sick healthcare system. **PM**

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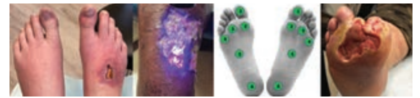

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Dr. Rehm is a Diplomate, ABPS, Board Certified in Limb Preservation And Salvage