

COMMON DENOMINATOR IN PODIATRIC MALPRACTICE

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The incidence of medical malpractice has dramatically escalated in the past 25 years in the United States. Because of this tremendous increase in litigation, the practice of medicine has been significantly affected. One reason for this change can be traced to the post World War II growth of this country and the urbanization of our society. The quest for "Narcissistic" goals has altered the basic morals and value structure of the average American citizen. Where our fathers had been imbued with the "work ethic", it seems our current society is fraught with the concept of "why work if you can get it for nothing". However, overall growth, prosperity, progress, and equality, has provided the average American the opportunity to prosper both educationally and financially to a greater extent than his or her predecessors. Unionization, civil rights, and free and open education has hopefully made this country a better place to live. However, the physicians of this informed society must deal with greater levels of criticism and scrutiny than ever before.

There are some real and hard facts that we must accept if we are to continue to practice medicine. Medicine as it was in the 1940's and 1950's will never return. The era of cost containment, HMO's, and PSRO's are here to stay. The age of computerized medicine has increased paperwork and red tape by ten-fold. A good portion of this paperwork is geared toward protecting the physician from the medical malpractice lawsuit. The advanced manual and claims statistics from PICA (Podiatry Insurance Company of America) place "poor record keeping", and insufficient documentation as a major factor in "plaintiff awards" and pretrial settlements. Documenting "what you do" seems to be as important as "how you do it".

A well-documented, meticulous chart which is legible gives the "good counselor" an idea what type of individual he is confronting. Financial payment schedules and office visit charges should not dominate the chart, and should not be part of the medical record. A separate section of the chart should be designated for fees and reimbursements. In 15 years of reviewing records the author has advised insurance carriers to "settle the case"

when the medical record cannot support the diagnosis and treatment considerations advocated by the doctor.

Claims and allegations by patients of improper treatment are credited as the primary area of question in the majority of law suits (70.45%). Whereas "poor results" are listed as the major reason for litigation in 6.49% of liability cases. (Chart A). Lack of informed consent (24.03%), fee disputes (1.30%), and fraud (.65%) are some of the non-technical allegations made by plaintiffs and their attorneys.

CHART A

Claims and Allegations by Patients

Claims and Allegations:		
Improper treatment	217	70.45%
Other	180	58.44%
Improper surgical		
Technique	173	56.17%
Lack of informed		
Consent	74	24.03%
Post-op infection	62	20.13%
Pain	61	19.81%
Misdiagnosis	41	13.31%
Unnecessary surgery	37	12.01%
Poor result	20	6.49%
Error in Medication	5	1.62%
Fees dispute	4	1.30%
Fraud	2	0.65%
Breach of Contract	1	0.32%
Guarantee	1	0.32%

CHART B**Claims Due to Complications of Procedures Performed**

Claim-Complications:		
Other	258	83.77%
Infection	79	25.65%
Amputation	36	11.69%
Nerve Damage	16	5.19%
Delayed Healing	12	3.90%
Disfigurement	6	1.95%
Non-Union	4	1.30%
Floppy Toe	3	0.97%
Recurrence	3	0.97%
Cock-up Deformity	3	0.97%
None	2	0.65%
Numbness	2	0.65%
Varus	1	0.32%
Coma/Death	1	0.32%
Allergic reaction	1	0.32%

In evaluating these allegations, your defense is dependent upon the medical record, and your ability to defend it is their sole vehicle for counterattack.

Informed consent, no longer means "boy, we're going to fix your" As an intern the author can clearly recall a general surgeon taking a 90 year old patient's hand and "helping" her sign the consent for her cancer surgery after she was already sedated. Consent is now "informed consent", in the patient's own words and in a simple and direct way. Hallux valgus repair with metaphyseal osteotomy may not be acceptable, and could possibly be replaced with hallux valgus (great toe deviation) and bone cutting with screw or internal wire use for stability. Risk factors must be clearly spelled out in the operative consent and may include infection, non-healing bone, anesthesia-related problems, and death.

Other alleged incidents resulting in malpractice litigation are consequences of infection (20.13%), persistent pain (19.18%), and misdiagnosis (13.31%). All too often, the doctor is trying to placate the angry and upset patient by down-playing the possibility that the surgery could have resulted in a postoperative infection. When in doubt, get cultures and sensitivities, gram stains, and consultations with infectious disease, vascular surgery,

CHART C**Claims Due to Treatment Rendered**

Claim-treatment		
Other	354	114.94%
Surgery	252	81.82%
General care	153	49.68%
Bunion/HAV	100	32.47%
Osteotomy	90	29.22%
Arthroplasty	42	13.64%
Neuromas	31	10.06%
Tenotomy	24	7.79%
Capsulotomy	22	7.14%
Nails	19	6.17%
Sesamoids	16	5.19%
Ulcerations	13	4.22%
Bone Spurs	11	3.57%
Implants	9	2.92%
Fracture	8	2.60%
Calluses	5	1.62%
Non-surgery	5	1.62%
Tourniquet	4	1.30%
Warts	4	1.30%
Partial Osteotomy	3	0.97%
Arthrodesis	3	0.97%
Injections	2	0.65%
Multiple		
Procedures +4	2	0.65%
Anesthesia with		
Tourniquet	2	0.65%
Soft Tissue	2	0.65%
Ambulatory		
Surgery (MIS)	1	0.32%
Metatarsal		
Heads-Multiple	1	0.32%
Arthrotomies	1	0.32%
Falls	1	0.32%

internal medicine, and other outside sources as indicated. These individuals will ensure that the patient receives the best possible care and demonstrates to the patient your concern for their condition.

Open claim statistics of PICA as of August 1989, lists a host other complications (83.77%) as major factors in litigation (Chart B). Podiatric surgery, (81.82%) although the largest affiliated area of malpractice for our profes-

sion, is not alone as the sole causative agent. General care (49.68%), injections (.65%), anesthesia with tourniquet (.65%), and falls (.32%), are other listed reasons in the plaintiffs complaints (Chart C).

The following cases will illustrate important points to consider.

CASE HISTORY #1

I.F., a 37 year old obese female, presented with a chief complaint of chronic pain involving her right heel. The patient states she began having heel pain two years prior to presentation. Past medical history included hypertension for ten years, non-insulin dependent diabetes mellitus for 4 years controlled by diet, and hypothyroidism for two years. Her medications included Tenormin and Synthroid with no allergies to medications. The patient's diagnosis was acute inferior calcaneal bursitis, acute plantar fasciitis and inferior calcaneal spurs (Fig. 1A, 1B). Treatment included strapping and padding of the right foot. The patient returned to the office one week later with minimal relief of pain. Injections of 2% carbocaine plain with 2 mg of hexadrol was then performed with strapping and padding. The patient was seen for a period of two years with recurrent pain of her right foot treated with injections, oral medications, and orthotics. The patient was very non-compliant with her oral medication and the use of her orthotics. It was also suggested that the patient try to lose some weight. She was very resistant to this suggestion. At this time the patient elected for surgical intervention. A complete surgical workup was performed with the CBC, UA, and Chem 24 within normal limits. She was gait trained by physical therapy and briefed on the protocol of the surgery to be performed. She was told that she may not experience any relief for one year's time following surgery.

The surgery was performed without complications. The procedures included excision of the inferior calcaneal spur of the right foot and a plantar fasciotomy. The patient was told to remain non-weight bearing with crutches and a surgical shoe and to return to the office in three days. She was given Keflex 500 mg (one tablet two times a day) and Tylenol with codeine #3 for pain. The patient returned to the office three days after the surgery with the wound appearing dry, with well-coated wound margins, and no erythema. Mild edema was noted. Her chief complaint was that her foot "still hurts" the same as prior to surgery. The patient states that she cannot use the crutches, and therefore, she has been walking on the foot since the day of surgery. She was told to return in one week, to remain non-weight bearing, to apply cold compresses, elevate the leg, and to continue with the pain medication as needed. The patient returned 3 weeks

later after two appointment cancellations. There was dehiscence of the incision with erythema of the wound margins, but without drainage. The area of dehiscence was approximately 2 cm by .5cm. Cultures and sensitivities were performed. The patient again admitted that she was not using her crutches or her orthotics as indicated. She was placed on betadine soaks and garamycin cream.

She returned two weeks later with decreased pain upon ambulation and with apparent partial healing of the dehiscence. She complained of intense pain upon weight bearing without relief from pain medication.



Fig. 1A. Preoperative radiograph, oblique



Fig. 1B. Preoperative radiograph, lateral

At this time the patient was not seen by her doctor for follow up care. The patient sought legal advice from her lawyer due to the complication of the wound dehiscence. The case was settled out of court for \$75,000.00.

CASE HISTORY #2

M.R. is a 56 year old white female who presented with a chief complaint of bilateral foot pain located at the 1st and 2nd metatarsophalangeal joints. The patient was in good health, taking no medications, and had no allergies. The only previous surgery was a tubal ligation ten years prior to presentation. The patient has experienced pain for the past five years increased upon ambulation and prolonged standing. The patient has been treated conservatively by another podiatrist with orthotics and anti-inflammatories with little relief. She was not satisfied with her results and sought treatment elsewhere. Upon physical examination she had mild pain of the 1st metatarsophalangeal joint throughout the range of motion with pain of the dorsal medial exostosis bilaterally. The second metatarsal head was painful upon palpation plantarly with a diffuse tyloma. Radiographs were performed (Fig. 2). Modified McBride bunionectomies, Akin osteotomies, and chevron osteotomies of metatarsals 2-5 were performed bilaterally. The patient was released the same day from the surgery center with an oral analgesic, anti-inflammatory medications, and full weight bearing with Darby shoes. She was told to return to the office in one week.

Follow up visits continued for a period of eight weeks. The patient continued to have pain upon ambulation. Radiographs taken two weeks postoperatively demonstrated displaced osteotomies of the 2-5 metatarsals bilateral with recurrent hallux valgus. The patient was told that this type of pain was normal and for her to continue with the pain medications and walking shoes. Six weeks postoperatively, radiographs showed increased deformities of both feet. Twelve weeks postoperatively, the patient continued to have severe pain of the metatarsal heads upon weight bearing with increase deformity of the 1st ray (Fig. 3).

The patient was very upset with the results and sought legal counsel. The case was settled out of court for \$250,000.00.

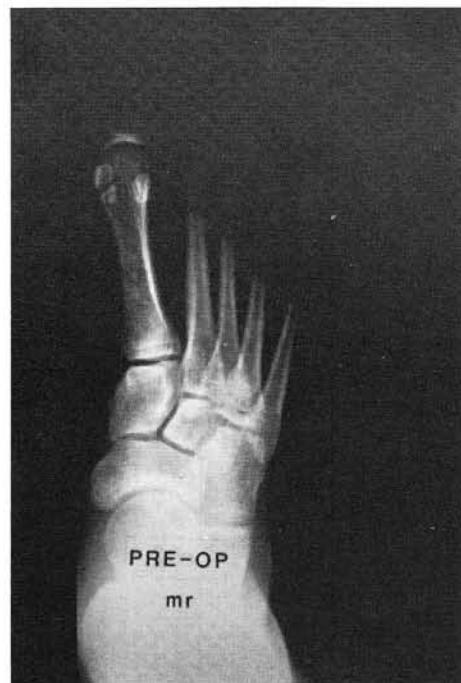


Fig. 2. Preoperative radiograph



Fig. 3. Postoperative radiograph 6 weeks with displaced osteotomies of metatarsals 2-5.