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Malpractice and Podiatry: Navigating the Waters

Our experts discuss this vital
medical-legal issue.

BY MARC HASPEL, DPM

Malpractice may well be the most fearsome word in the medical lexicon. As is often the case, beyond the ultimate control of a practicing physician, events may transpire that lead to circumstances resulting in alleged malpractice. From there, an unforgiving medical legal system takes over, putting the physician at both financial and reputational risk. There are realistic factors to consider when discussing the area of malpractice. First and foremost is the selection of a malpractice insurance carrier, which will be intimately involved in handling a malpractice claim. Other considerations are patient risk avoidance, knowledge of local state scope of practice acts, as well as the utilization of appropriate practice management routines, all of which can help reduce the likelihood of a malpractice occurrence.

Podiatry Management Magazine has invited a panel of medical legal experts to advise on issues surrounding malpractice. Their insights should



be helpful in navigating what is quite simply an “ever-threatening dark cloud” above the heads of today’s medical practitioners. Joining this panel:

Richard Boone, Sr., JD has vast experience as a malpractice defense attorney for podiatrists in several different jurisdictions. He also represents podiatrists before state licensing boards, credentialing committees and in reimbursement disputes with Medicare and private insurers.

Anthony Heller is a partner at Heidell, Pittoni, Murphy and Bach, who has been defending podiatrists and other healthcare practitioners for nearly forty years. He is a graduate of Fordham Law School and teaches trial advocacy in law school programs.

Lawrence Kobak, DPM, JD is a partner at Kern Augustine Conroy and Schoppmann, the general counsel to both the New Jersey Podiatric Medical Society and the Medical Society for the State Of New York.

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He is the director of the firm's Office of Professional Medical Conduct (OPMC) and Office of Professional Discipline (OPD). He was in podiatric medical practice for 26 years.

Isidore Steiner, DPM, JD, MBA, graduated from Temple University School of Podiatric Medicine; University of Detroit Law School, Magna Cum Laude; University of Colorado, MBA in Health Administration; Residency, Straith Memorial Hospital. He is a diplomat of the American Board of Podiatric Surgery since 1985 and a fellow of the American College of Foot Surgeons.

Ross Taubman, DPM is the president and chief medical officer of the Podiatry Insurance Company of America (PICA). Prior to joining PICA in 2011, Dr. Taubman was in private practice for 26 years in Maryland. He is a former President of the Maryland Podiatric Medical Association and served as President of the American Podiatric Medical Association from 2008-2009.

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Q *PM: What factors should a podiatric physician consider when selecting a malpractice insurance company?*

Taubman: There are many issues that should be considered. Not all carriers provide the exact same coverage in exactly the same manner. The following is a short list of issues which one may want to factor into the decision-making process of which company to choose. Among these are: defense counsel (especially in podiatry, which requires experienced counsel to obtain the best results), experienced internal staff to handle podiatric-specific problems, risk management programs and resources that are specific to this profession, carrier coverage features such as 'consent to settle' clauses and comprehensive administrative defense coverage for other types of government actions.

Kobak: First and foremost, the podiatrist must consider the company's financial stability. Having practiced podiatry back in the 1980s

when two of the malpractice insurance companies went out of business, I would only use a company that was part of my state's insurance pool. If the podiatrist's state has an insurance pool, it will only let financially able insurance companies participate. This will ensure that the podiatrist will indeed have the coverage when it's needed. Also, the podiatrist should check the prospective company's Moody rating. I would also consider a company only if the company cannot force the podiatrist to settle a

the A.M. Best Company's web page. A.M. Best publishes ratings of the financial strength of the various insurance companies and is considered very reliable.

The second thing one should consider is the company's commitment to the podiatry malpractice market. As Mr. Heller mentioned, historically, a number of companies have entered the podiatry market and then exited very soon thereafter, leaving their policy holders scrambling for a new carrier. For one's own comfort, one

A.M. Best publishes ratings of the financial strength of the various insurance companies and is considered very reliable.—Boone

case without consent. I recommend that the DPM carefully read the terms of the carrier's coverage before signing on the dotted line.

Heller: The most important factor to consider is the insurer's experience in the specialty. Avoiding the necessity to change carriers from time to time is beneficial as the expense of purchasing "tail" or "nose" coverage is high. From time to time, an insurer that has not previously written podiatric malpractice insurance enters the field only to find that it does not belong there and has entered the marketplace without sufficient knowledge or experience to properly price the product and to make a profit. The result is that it leaves the market and forces their former insured clients to find new coverage and often to buy "tail" or "nose" coverage. Hence, the cheapest first year premium is sometimes not nearly cost-effective over the term of several years, let alone the long run.

Boone: The first thing one should always consider is the financial strength of the company issuing the policy. If one is paying one's hard-earned dollars for the premium, one needs to know that the company will be around when it is needed. My suggestion is for the podiatric physician to go online and research

would want a company that has been dealing with podiatrists for a good long while and looks like it's in the podiatry market for the long-term.

The third thing one should consider is the company's particular expertise in handling podiatric malpractice claims as stated earlier. I personally have represented just about every type of healthcare provider that exists, and claims against the various professions all require different handling;—especially true when dealing with a provider who is not an M.D. If I were a podiatrist being sued, I'd like to know that my insurance company understood who I am and what I do for a living. Not all of them do.

There are other technical issues which are also somewhat important—for instance, the company's underwriting policies, especially if the podiatrist has had a few prior claims. Whether it is an admitted carrier in one's particular state is also of interest. Finally, consider whether it can provide the podiatrist with other types of liability coverage as well as professional liability.

In the final analysis, professional liability insurance is not a place to go looking for a cheap bargain on the Internet. I recommend spending a little time to research the company before committing.

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Q *PM: What signs identify a patient who is at-risk to file a malpractice action?*

Steiner: I find it simple to identify such a patient. If the patient is very unhappy with a surgical outcome, if the patient says it was a failure, if the patient believes that the pain will never go away, if the patient has contacted a lawyer but has not decided whether or not to proceed, if the patient is always complaining about the way the foot looks, if the patient is non-compliant, if the patient is rejecting physical therapy as well as other modalities such as bone stimulation, if the patient is discussing the surgical outcome with a primary care physician, or if the patient wants the primary care physician to review the x-rays to determine what went wrong, are all clear signs of someone at-risk to file a malpractice action.

Heller: Identifying a current patient who is at risk to file a lawsuit requires a combination of uncompromising objectivity and attention to detail. One needs to determine whether the surgery or treatment result was less than desirable and whether communication with the patient has been open, honest, and realistic. Other factors to consider include whether the patient came in complaining about prior doctors, whether the patient was on mood-altering medications, whether the patient was complaining of pain or lack of mobility that seems out of proportion to the practitioner's objective findings, and whether insurance reimbursement was denied to the patient by a health insurance plan.

Boone: As I have so often told my clients, the most common mistake that a podiatrist can make, which leads to malpractice cases, is poor patient selection. Unfortunately, there is no single sign that indicates whether a patient is likely to sue. Almost any patient is a potential plaintiff if the outcome of the patient's surgery is dismal enough and if the plaintiff feels that the podiatrist

did not do a proper job. Having said all of that, a problem patient almost always exhibits some warning sign which, if perceived and acted upon, would have averted disaster. Therefore, even though there is no single way to discern the potential plaintiff, there are some interesting common threads which I have seen in podiatry malpractice plaintiffs over the years. Some of them are as follows:

A patient who takes a lot of psychotropic medications. Of course, a patient with emotional problems may

folks. More importantly, I feel they should be re-evaluated and started all over from the beginning—I would try to understand why they suddenly decided to have right now what was originally recommended a long time ago. More importantly, I think it wise to make sure that these patients still need what was originally recommended.

Kobak: The obvious answer to this question is the patient who talks about having already sued a health-care provider. I would also be leery

Identifying a current patient who is at risk to file a lawsuit requires a combination of uncompromising objectivity and attention to detail.—Heller

have foot pathology and is entitled to treatment. As was just mentioned, however, and for reasons that I cannot identify, an inordinate number of the plaintiffs in cases I have handled in the past were popping pretty heavy doses of mood-altering medications. I recommend making sure to inquire about such medicines before doing surgery. If the history reveals such medications, I recommend proceeding with a lot of caution in planning and performing surgery.

A patient with unrealistic, or what I would call "non-clinical" objectives is a risk. Every malpractice case begins when the patient's objectives and desires for the surgery are not met. A patient who seeks surgery for cosmetic reasons, for one example, is especially prone to getting unsatisfactory results. If the patient isn't undergoing the procedure because the foot hurts badly, then I recommend being wary of doing any procedure on that patient.

A patient who disappears for long periods and then re-appears requesting surgery that was recommended months ago, is also a risk. A large number of my plaintiffs have had an initial consultation, perhaps a few palliative treatments, and then disappeared for several months only to reappear later requesting the surgery my client recommended months before. I recommend being very careful with these

of the patient who has been to several doctors for the same medical problem. Additionally, I recommend being leery of patients who dictate what the treatment should be. That is a clue that the patient does not value the professional's opinion. Contrary to popular opinion, by the way, lawyers often make excellent patients.

Taubman: Anyone can file a malpractice action, but it is being increasingly noted that good communication between the physician and patient may be a component in the mitigation of a malpractice claim. A patient's perception of the quality of care provided by the physician and managing the patient's expectations may be dependent upon the quality of communications. Certainly, communication is a two-way street. Not only must the physician adequately inform the patient of the patient's progress, but the physician must also provide the patient with the opportunity to adequately communicate experiences, questions, and needs.

Q *PM: Given various states' scope of practice laws, how do gray areas in those laws influence defending malpractice lawsuits?*

Kobak: A treatment in the gray
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area might weigh towards settling the case. For example, if a podiatrist was treating the hyperuricemia systemically, as opposed to just its local pedal manifestations, that could bring up the issue of a failure to refer. Assuming that the plaintiff's damages turned on the systemic treatment, the gray area would factor into a possible settlement. I think it is worthwhile to remember that a podiatrist who practices in those gray areas is practicing near the precipice. That is a very dangerous place to be.

Heller: I agree. While podiatrists are usually familiar with scope of practice in our jurisdiction, the envelope is often pushed: wound care in a center where the patients are routed to podiatry with wounds above the ankle; hyperbaric oxygen treatment supervised or administered by podiatrists for issues that are not within scope; aggressive surgery that is beyond a limited below-the-ankle scope. Although out of scope or gray area procedures may still be defended as having been properly done, they may pose issues for insurance coverage.

Boone: Alleged violations of scope of practice laws almost never give rise to the malpractice cases by themselves. No podiatrist whom I have ever represented has been sued for exceeding the state's scope practice law. Scope of practice issues have usually factored into malpractice cases I have handled in two ways: what I call the turf war cases and the determination of the qualifications of expert witnesses.

Turf war cases arise when the subsequent treating physician (usually, but not always, an orthopedic surgeon) convinces the patient that the post-operative complication occurred because the podiatrist "didn't have any business doing that kind of surgery", or similar derogatory statements. The best way to deal with those cases is to recognize them for what they are and, then, demonstrate convincingly that the accuser is just simply wrong.

The other type case involves expert witness qualifications and becomes a little more complex. These days, we are seeing all sorts of other practitioners who are trying to cross the line and give opinions about podiatry. Wound care nurses, for example, are trying to testify against podiatric physicians about the standards of care for wound treatment (especially in nursing home cases). In those cases, I work to establish that the standards of care are different.

Taubman: A malpractice carrier may provide scope of practice coverage to its policyholders, meaning coverage applies, as indicated in the

type of bunion the patient has, and any other general information about bunion deformities. The A stands for alternatives. The podiatrist should delve into the various alternative treatments that are available; it does not have to be exhaustive, but unless the situation is life or death, the patient should have a choice. One of the alternatives should be no treatment. Finally, the R represents the risks. The risks should be reviewed with the patient. Unless there is a history of allergy to local anesthesia, death is not a reasonable risk of the local anesthesia when performing a nail matrixectomy. Still, it is better

If a podiatrist was treating the hyperuricemia systemically, as opposed to just its local pedal manifestations, that could bring up the issue of a failure to refer.—Kobak

insuring agreement of the policy, to any claim based upon or arising out of any act, error, or omission within the scope of practice of podiatric medicine in the state in which the insured is licensed. The podiatrist must be aware of that doctor's own state's scope of practice to be sure that the insurance carrier will afford coverage for the physician's acts. Incidentally, state scope of practice reviews and documentation can be found on the APMA website.

Q *PM: What elements are involved in obtaining proper informed consent, and to what detail of risk must the patient be informed?*

Kobak: First of all, informed consent is a process, not a piece of paper. The signed consent form evidences the process; it is not the process. The process should begin as soon as a diagnosis is made. I like the acronym, "G.A.R." G is for the general considerations of the diagnosis, such as explaining to the patient, in understandable terms, for example, what a bunion is, what

to find out prior to the procedure or treatment if the patient does not really want that plan of care. I warn not to oversell any procedure by understating the reasonable risks. An informed patient is less likely to sue the podiatrist.

Steiner: Our office is very knowledgeable regarding informed consent. Our scheduler makes sure that the consent pages are thoroughly filled out. A back assistant then sits with the patient to make sure that every area in the consent form is filled out, and that the patient understands the procedures that the doctor will be doing. Both our own longer consent form, along with the hospital consent, are used. If the patient has more questions, the back assistant has the doctor review the consents with the patient. Pictures are also drawn on the consent forms to help patients better understand the procedures being done. We also have a wall board which shows the areas where the surgery will take place. We also have the patient sign off on a long list of potential complications.

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Boone: Informed consent laws tend to vary from state to state, so there's no uniform answer to this question which is applicable nationwide. Nevertheless, there are a few general rules which are applicable everywhere. First, an informed consent is not obtained just because the patient has signed a consent form. The form is merely documentation of the consent which you have already received from the patient. Accordingly, in order to have an informed consent, there must be a true meeting of the minds. To obtain an informed consent, the patient must be given enough information so that the patient understands, to the best of the patient's ability, what the treatment plan is, what the risks are, and the outcome to be expected from the surgery. It is essential that the patient understand what is going to be done and accepts both the benefits and the possible consequences. Both the doctor and the patient have to have a meaningful understanding of the entire process. Moreover, this means that both parties fully understand what is going to occur and agree to it. The good news is that if that level of understanding is truly achieved, a podiatrist will more than

Q **PM:** *How do questionable practice behaviors involving the podiatric staff—in terms of poor filing habits, inappropriate patient communication, and harsh billing habits—contribute to malpractice?*

Steiner: Most receptionists are trained to avoid poor filing habits. Unfortunately, there are receptionists who are lazy and do indeed have

involving the staff—such as the loss or misfiling of x-rays, the failure to properly keep appointment records, missing chart entries, the provision of medical advice by unqualified personnel, and disclosure of privileged information—all may affect compliance with standard of care, patient satisfaction, and violation of law. Practice behavior, good or bad, reflects on who the practitioner is as a person. Tolerance of inappropriate or incompetent

Legally, the podiatrist is always responsible for any harm which may come to a patient as the result of some action by the staff.—Boone

poor filing habits. Oftentimes the receptionists need to be re-trained by the office manager. Likewise, if there has been inappropriate patient communication by the receptionists, the office manager should immediately suspend those employees. This is HIPAA-protected information.

Actually, there are worse actions a receptionist can display—such as participating in harsh billing habits. This can cause a patient to bring up issues about why are they still getting bills for copays and deductibles. A

behavior by staff is often viewed by a patient as indivisible from the practice options selected by the doctor.

Boone: I agree wholeheartedly. Stated simply, the podiatrist and the staff are one in the same.

Legally, the podiatrist is always responsible for any harm which may come to a patient as the result of some action by the staff. It's called vicarious liability, and the concept is alive and well in the podiatric medical world.

More importantly, the staff is most often the real communication interface between the physician and the patient. If the staff makes a patient feel unwelcome or feel treated without proper care, then it is the doctor who made the patient feel that way. Thus, the doctor must demand that the staff obtain and exercise the same high standards to which the doctor has committed.

A patient may get angry even though everything is being done according to Medicare guidelines.—Steiner

likely never have a malpractice claim from that patient.

Although the legal standard for what constitutes enough detail may vary from state to state, in reality, there is no difference. There is really no universal measurement of what is enough information in an informed consent. Regardless of a state's standards, the podiatrist always has to give the patient sufficient information to make the patient happy, or at least accepting, of the surgical outcome, whatever it may wind up being. If that is done properly, there will always be informed consent.

patient may get angry even though everything is being done according to Medicare guidelines.

Finally, there are receptionists who are dispensing medical advice, not only on the phone, but also to friends, old patients, and disgruntled past employees. This too is a HIPAA violation and can result in criminal prosecution.

Heller: Office practice behavior, no matter who is responsible for it, if it leads to patient dissatisfaction, will increase the likelihood of a patient filing a lawsuit. Questionable behavior

Taubman: I also agree that any deviations from the standard of care related to the actions of the staff could be potential areas of malpractice risk. Similarly, it is imperative that the staff be appropriately and adequately trained to address these risks. Many patients will evaluate the quality of the podiatric care they receive not only by the outcome of their treatment, but also by how they are treated by the physician and the office staff. Inter-

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personal skills of the staff have a direct impact on patient satisfaction, and poor patient satisfaction can lead to lawsuits. Each podiatry office should have a working system to track diagnostic test results, referrals, missed appointments, and patients requiring follow-up. The manner in which billing and collection is handled is also critical for the success of the practice and patient satisfaction.

Q *PM: How has the expansion of EMR impacted podiatric malpractice, both negatively and positively?*

Steiner: There is a belief that EMR can reduce medical errors. Unfortunately, there is too much dependence on EMR, which could result in small mistakes that can turn into medical errors. *The New England Journal of Medicine* has found out that there is over-reliance on simple EMR functions such as copy and paste, which leave a long list of individual errors. Using computers runs the risk of bugs, viruses, and other malware. Also, there is a risk for the physician regarding medical malpractice. The risk of errors increases the risk of medical malpractice sometimes. Generally, the print medical

everything (metadata) is now able to be tracked; in other words, one can tell when that entry was actually made, and, therefore, is problematic for malpractice defense. Copy and paste entries from preceding

times for automating or simplifying the data entry. That can cause problems. Such routines have a tendency to make every chart look like every other chart. They also make it a lot easier to add treatments that really

Copy and paste entries from preceding chart visits without proper editing or scrutiny are rampant and create meaningless entries, reducing the validity of the chart and the credibility of the doctor.—Heller

chart visits without proper editing or scrutiny are rampant and create meaningless entries, reducing the validity of the chart and the credibility of the doctor.

Boone: I could probably do a three-hour seminar on the impact of electronic medical records on malpractice cases. Here are a few salient points: first, the good: EMR prevents malpractice claims. Ultimately, malpractice cases begin based on a review of a chart by a plaintiff's lawyer looking for some reason to sue. Sloppy, illegible hand-written records are an invitation to litigation. Electronic medical records, done reasonably correctly, just look better and are less

weren't done. That will be a problem. It's easy to become sloppy when charts are all hand-written, but electronic records give rise to a new and different kind of sloppiness. Accurate and truthful entry of the patient data is mandatory, whether the records are on paper or in a computer database.

Kobak: Absolutely there are two sides to this story. On the negative side, charts tend to be longer, but full of fluff and inconsistencies. Prior examination and history are often repeated despite interval changes being noted later in the note. Too often, charts read like every box had to be checked off in order to complete the note. Longer does not always mean better. The quality of the note supersedes the length of the note. With EMR, however, everybody has equally good handwriting, which makes for a decrease in mistaken orders and prescriptions. When EMR is used to write a quality note, it increases the quality of medicine being practiced by the podiatric profession.

A physician should provide clear and honest communication with the patient and/or the patient's family regarding the facts surrounding the unexpected outcome, showing compassion and concern for the patient.—Taubman

record oftentimes bears no resemblance as to what doctors are looking at when they made clinical decisions at the time of treatment.

Heller: The positives of EMR are that charts are more readily understood; no deciphering of handwriting is necessary. Also, some programs contain prompts for testing that encourage more thorough evaluation. The negative is that ev-

likely to draw criticism.

Now the bad: EMR causes malpractice claims. This can happen in two ways. First, electronic medical records make it much easier to detect medical errors and omissions. An error or omission in a hand-written chart is bad. The same error in an electronic chart sticks out like a sore thumb. Second, there is the problem of automation. Many electronic records programs have built-in rou-

Q *PM: How should a podiatrist approach a post-op patient who has a poor surgical result?*

Taubman: Patients may suffer unexpected outcomes, such as surgical complications, that may or may not be the result of malpractice. A physician should provide clear and honest communication with the pa-

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tient and/or the patient's family regarding the facts surrounding the unexpected outcome, showing compassion and concern for the patient. A physician is encouraged to become familiar with the state's laws regarding apologies or benevolent gestures as the provisions vary from state to state. It is also important to become familiar with the disclosure policies and procedures at all hospitals where privileges have been granted.

Steiner: I recommend that the physician be very empathetic to the patient with complications, expressing regret for the patient's pain and providing the patient with an objective, factual description of the problem without accepting blame. In fact, the physician should not blame anyone for the problem, but should relate feeling bad regarding the patient having pain or a poor result. Always, I recommend sitting down with patient and family to review the problems and working out together a plan for continued care and treatment.

Heller: Hopefully, the possibility of a poor result was mentioned in the informed consent discussion, but in any case, the podiatrist should be honest and forthcoming regarding the facts. Without apologizing, unless such is required by the occurrence of an avoidable mistake, options to correct the problem should be given, including the referral to a specialist if necessary. Medical records should be provided when requested, and reasonable cooperation should be made with second opinion practitioners.

Kobak: The answer to this question starts back in the pre-operative process of informed consent. One should not look to hide the obvious. A podiatric physician is not going to convince a patient that a crooked toe is straight or that something that hurt, does not hurt. That will only succeed in reducing the doctor's credibility in the patient's eyes. Once that credibility is lost, the physician is in trouble. Rather, I recommend explaining to

the patient, in plain language, what is occurring and what can be done or not be done to help. Also, I believe in believability. If the doctor is not believable, the patient will leave. All questions posed by the patient must be answered, even if the doctor cannot do so directly. The patient should not be rushed, and the doctor should not ever give the impression of preferring to be elsewhere while talking to the patient. It's a simple

matter of remaining in control of the situation. **PM**



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