Dodging the Medical Malpractice Bullet

Follow these steps to minimize your risk of getting sued.

Mark Terry

Mark Terry is a freelance writer, editor and author. He writes mostly about medicine, health and biotechnology. His latest novel, Dirty Deeds, involves identity theft and Internet crime. He lives with his wife and sons in Michigan.

Steps to Minimize Your Risk of Getting Sued

Let's come right out and say it: some podiatrists deserve to be sued. They screw up. It's not just a little screw-up, but a big one, one that through negligence or incompetence leads to harming a patient.

Then there's the rest of you, podiatric physicians just doing your job as well as you can, keeping your patients at the front of your thoughts and at the center of your practice. No matter how good you are, there might be a medical malpractice lawsuit bullet with your name inscribed on it, too. Is there a way to dodge that bullet or get that bull's-eye off your chest?

The Dirty Dozen

Bob Goldstucker, Esq., an attorney with the Atlanta, GA law firm of Knoll & Miller, serves as the national malpractice counsel for the Podiatry Insurance Company of America (PICA), and has defended over 550 podiatrists over the last 25 years. He regularly gives speeches around the country citing his "dirty dozen," categories of podiatric medicine in which most medical malpractice suits occur. The twelve categories are:

1. Non-healing ulcers. In this area, says Goldstucker, "the bottom line is, we follow the patients for ages, the wound won't heal, the wound gets infected, the patient gets osteomyelitis…" and the result is eventual amputation.

2. Jumping into invasive or surgical procedures without conservative care. Although Goldstucker cites an example of treating plantar fasciitis with surgery instead of conservative care, he notes, "if you never should have done the procedure in the first place because conservative care might have worked, and you didn't try it, that's a problem."

3. Lack of conservative care for bony procedures. Less common than for soft-tissue procedures, Goldstucker says that, "It's purely indefensible if the allegation also includes that conservative care wasn't tried."

4. Mid-foot and rear-foot procedures. They are complicated to perform. Says Goldstucker, "When they go bad, the training of the physician becomes an issue. The fourth category is doctors perhaps don't have the training or background to undertake really complex treatment."

5. Bunions gone bad. Says Goldstucker, "Bunion complications or bunion surgery is probably one of the most common things we see."

6. Complex regional pain syndrome, or CRPS. Because CRPS can be difficult to diagnose, or is confused with complications from other procedures, the podiatrist may wait too long to treat for CRPS. "The window of opportunity to treat CRPS closes quickly," says

Goldstucker. Oftentimes the physician takes a wait-and-see approach instead of being "willing to turn it loose and get a consultation sooner."
7. Misidentifying or mishandling a malignant tumor. Goldstucker describes this scenario involving synovial cell sarcoma: "It's so rare that it doesn't come on the radar screen and the chance to diagnose and treat it passes and the patient dies or the patient loses her leg, and the allegation is, 'Why didn't you do a culture biopsy or an MRI for synovial cell sarcoma?'"
8. Poor surgical technique on simple procedures. "This could be the result," says Goldstucker, "of lack of training or due to sloppiness or to not getting interoperative X-rays, or just poor surgical technique."
9. Tarsal tunnel syndrome, or TTS. Goldstucker notes that TTS is often diagnosed using conduction nerve testing, which, "When done properly, will miss 7 to 10% of TTS patients." In those cases, the physician may diagnose with sciatica or nerve entrapment and focus on surgery. "If the pain still persists," says Goldstucker, "their diagnosis is brought into question because they did an insufficient differential diagnosis to rule out other possible causes."
10. Unnecessary surgery. "There are conditions that require surgery," says Goldstucker, "that aren't apparent on X-ray, and in that case the need for the surgery needs to be very well-justified in the chart. They'll just never document in enough detail the signs and conditions which warrant the surgery."
11. Mishandling of infections. "I think," says Goldstucker, "we have a generic infection issue with culturing where there's no need to culture, which creates problems; not culturing when there is a need to culture—there is drainage and you're not culturing, which creates a problem; and inappropriate antibiotic coverage."
12. Failure to recognize underlying vascular disease or vascular compromise. "Not recognizing ischemic compromise is very, very common," says Goldstucker.

Getting in Over Your Head

Goldstucker believes the biggest reason podiatrists are the target of lawsuits is, "getting in over their heads. My view on this subject," he says, "is that practicing outside their comfort area or outside their areas of expertise transcends every one of these categories."

Consenting Adults

Gordon D. Tresch, Esq., an attorney with the Buffalo, NY firm of Feldman, Kieffer & Herman, does podiatric defense work for the American International Group, Inc., (AIG) insurance company across the state of New York. He believes one of the major things to make a podiatric practice susceptible to a medical malpractice lawsuit "is to have an inadequate informed consent form." Tresch suggests three things a podiatrist should consider when designing a consent form.
1. Get specific. "List any of the reasonable risks of the procedure specifically," says Tresch. "That would be number one, because a lot of practitioners have informed consent forms that say nothing more than 'I've been warned of all reasonable risks and alternatives' with nothing else there." This can lead to a "he said/she said" dispute should evidence be presented in court. Says Tresch, "Aim specific in terms of the risks; as far as alternatives are concerned, make sure reasonable alternatives have been reviewed."
2. Sign early. "I think it's probably a good idea," says Tresch, "to have the informed consent form signed before the day of surgery." He cites cases where patients have signed

immediately before surgery, then claim to not remember signing, perhaps because they were under anesthesia at the time. "Silly stuff," says Tresch, "but if it's signed before the day of surgery you avoid that kind of retroactive disagreement between doctor and patient."

3. A picture is worth a thousand words. "I like the informed consent that has a diagram of the foot," says Tresch, "giving the doctor the chance to circle or identify specifically what area is being proposed, what they agreed to. And then, have a spot for the patient to initial." He goes on to suggest written consent on one side of the consent form, with the foot diagram on the back.

A. Douglas Spitalny, DPM, a Peoria, IL podiatrist who regularly consults in podiatric malpractice cases and analyzes podiatry practices for risk management, agrees. "Consent forms were all really shoddy with most of the cases we saw. They were very ambiguous."

"If you can't win a case on medical deviation," says Tresch, "the plaintiff's lawyer or the patient's lawyer will try to get you through the back door on informed consent. I think that goes a long way toward avoiding that whole claim."

Tresh also suggests, with the ease of digital photography, that podiatrists should consider taking a photograph or Polaroid of the patient's malady. "Years ago," he says, "podiatrists used to take photographs and keep them in the chart. Then they got away from it. If there's any question at all or the condition of the foot is quite extreme and you're really doing something to offer somebody some help and it's not a slam dunk, it's an optional procedure … I think photographs are a big help."

Talk the Talk

The entire area of informed consent may more accurately fall under the category of communication, whether between the physician and the patient or between the physician and him- or herself. Says Spitalny, "I think the biggest problem in the majority of cases that I've reviewed was communication."

Poor Charting

There were only a few cases where standard care was the problem, but charting was an issue in all of the cases I've ever covered."

Tresh agrees, saying, "I can't stress enough, the more specific and better your notes are, the more you're likely to withstand scrutiny five years later when someone's in dispute questioning what happened on any particular day."

With electronic medical records cropping up everywhere, clean, consistent documentation should be the norm, not the exception. "They're more particular," says Tresch. "And more specific. And you can read them." He notes that legibility doesn't have to be an issue. "If the doctor can read the notes, and it's there in some fashion, it's okay. It's not that the patients have to be able to read it, but the doctor has to be able to read his own handwriting. But sure, I think legibility is better than illegibility."

Goldstucker says, "The bad result is what triggers the malpractice action, not bad charting. Once the malpractice actually starts, the bad charting is an important issue, but that's not what triggers it."

Dr. Sloan Gordon, DPM, a Houston, TX podiatrist who regularly acts as a legal expert in defense of podiatrists, lists a number of things that podiatrists should be concerned about. "Number three," he says, "which is the most important and maybe belongs at number one, is to have outstanding record keeping. I think that, having looked at quite a few lawsuits for

lawyers in my career, the one thing that always stands out, whether it's perceived truth or not, is it seems that the doctors that keep really good records that are legible or typed and carefully thought out--in other words, you can read the thought process--those doctors appear to practice very good medicine."

Holler For Help

Gordon suggests that podiatrists should not be shy about seeking outside experts or suggesting they get second opinions. "If you have a patient with vascular disease, you should be ordering the diagnostic testing, but you should also probably be consulting with an interventional cardiologist or a vascular surgeon or someone you trust to get a better picture of what's going on with the vascular system. I think that appropriate consultations are important."

Goldstucker agrees. "If they would just doubt themselves more in finding consultation more readily; if they would hold onto the patient shorter rather than longer; if they bring somebody else in to consult, if they would do those things it would truly eliminate a bunch of this malpractice because it's geometrically more difficult to sue two doctors than to sue one or to sue three than to sue one." He adds, "That would be the single best way to reduce malpractice risk."

One podiatrist, Dr. X, who regularly consults in medical malpractice lawsuits, but did not wish to be named for this article, says, "Don't be afraid to use second opinions." Dr. X notes that patients get a tremendous amount of feedback from family members, neighbors and friends on what they should do if there is a question about medical care or a bad result. "But if you have already sent the patient for another opinion, it gives the patients a way to argue with family and neighbors that, 'Well, my surgeon sent me to see somebody for a second opinion and this is what we decided and what we agreed upon.' It's a way to defuse that particular situation."

Failure To Communicate

Every person interviewed for this article stated that failure to communicate with your patient is one of the biggest problems leading to a medical malpractice lawsuit. Says Spitalny, "Communication is multi-factorial. Patient-doctor communications, as far as instructions for care, are always a problem. In just about every case I've studied, the patient said, 'The doctor never listened. I go in, say three things, the doctor says, 'Yeah, I know what your problem is.' So there were a lot of patients irritated with the physicians. Listening skills were a real problem."

A happy patient," says Tresh, "is less likely to sue a doctor. Demeanor is everything."

Dr. X chimes in with a corollary to treat your patients nicely: "Don't send surgery patients to collection." If they had a bad result and you send them to collection for a few hundred dollars, that could be the impetus to send them to an attorney.

Spitalny agrees. "Don't tick off your patient. The majority of cases that got brought up were because a fellow podiatrist or orthopedic surgeon openly criticized the original surgeon, and that's what led patients to seek lawyers. Just because a patient didn't like their outcome, it's not necessarily malpractice." Spitalny also lists eight qualities that he looks for when evaluating a practice. They are:

1. Honesty

2. Candor

3. Openness
4. Integrity
5. Compassion
6. Professionalism
7. Calmness
8. Decisiveness

"Nine times out of ten," says Spitalny, "when things go awry, it's because one of these eight qualities was breached. Of those eight qualities, every case I analyzed had flaws in at least one, and sometimes half of them. They aren't necessarily breaches of standard care, but they're things that cause questions or doubt in a patient."

Dodging the Bullet

Sometimes you need your gut instincts to guide you. Says Tresch, "If you have a patient that you know is just trouble, and you can feel it, it's intuitive, or, if you have a noncompliant patient, I think the best thing to do is discontinue treating." Document the compliance carefully, give plenty of time to find alternate care, even "give them the name of the local podiatry association so it doesn't look like you're dropping the patient, but get yourself out of there, because it's only going to get worse, and you're kind of asking for it."

Goldstucker rounds it out. "If they would give consultations earlier and earlier; if they would always try conservative care and document dealing with transient conditions—infections and vascular problems, to really document the chart; those three things would really have a great impact on the number of medical malpractice lawsuits."

Finally, a note of hope from Dr. Gordon. "I think that physicians who practice prudently, particularly in today's litigious climate, and practice defensive medicine, will triumph in the end, and avoid malpractice lawsuits."