THE SOUL OF FOOT MALPRACTICE CLAIMS

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I. Introduction

The screening evaluation of a podiatric and orthopedic medical malpractice case is not always as straightforward as it might appear. Many practitioners who are experienced in medical malpractice often fail to appreciate the peculiarities of cases pertaining to this area of the anatomy. This paper will help the practitioner to become aware of some of those fine distinctions and allow them to better evaluate foot medical malpractice cases during the client case screening process.

II. The Plaintiffs to Avoid

The first thing that the counselor must do is evaluate the potential plaintiff. Certain plaintiffs with foot injuries should be avoided. Although it is often wise to encourage a plaintiff to return to work and become productive – which shows the jury that they are taking responsibility for themselves and not blaming every shortcoming in their life on the doctor – there is a precarious balancing act that such a plaintiff must undertake.

In fact, watching the client walk is the first and often telling indicator of veracity. The foot acts as the locomotion for the body. An injured plaintiff's ability to walk, run, move, and act independently is often diminished through injury or disease to the lower extremity. Therefore, a plaintiff who appears outwardly to be functioning normally while claiming to be in constant pain may not be credible to a jury. Even a history of multiple treatments by multiple doctors may not sway a jury who sees with their own eyes what appears to be a normally functioning plaintiff.

The first example would be a plaintiff who claims to be in chronic foot pain following a foot surgery or injury, yet goes to your office wearing high-heel shoes. This plaintiff probably should be avoided.

The second example is a case in which our plaintiff allegedly suffered chronic neuropathic foot pain following foot surgery, such that she required a handicap license plate. The defense videotaped her doing three minutes of low impact aerobics. Despite her testimony to the jury that before surgery she could do several hours of high impact aerobics and after surgery, even taking

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narcotic analgesics, the pain only allowed her to do low impact aerobics for a few minutes, the jury thought that she lacked credibility.

The third example is a client who suffered foot pain due to a nerve which was inadvertently cut during foot surgery. She had constant pain, even after a subsequent second surgery which found the nerve to be lacerated. However, during the three-year period of the case litigation, she moved from the area and we learned that she was working as a clerk and sitting at a desk. Usually that would be a good sign of the client taking responsibility and moving on with her life. However, she was working as a deputy sheriff. The fact that she had to complete the police academy, including the physical training and the obstacle course, meant that we had to settle the case for a much lesser value because we felt the case could not go to a jury. The perception that anyone who can complete the police academy must not have foot pain was too powerful to take a chance with the jury.

Look at the client's lower extremities and visualize the injuries which are alleged. We all know that a picture is worth a thousand words and alternatively, a normal looking leg or foot can be total silence.

Finally, during the screening process one should identify whether or not the client is a smoker. Simply because a client is a smoker does not mean that the client should be avoided as much as it means that one should expect the defense to blame any foot injury on the client's own actions – their smoking.

III. The Defendants

Once you decide that the plaintiff is acceptable, you next have to decide who to sue. When one thinks about lower extremity medical malpractice, one often thinks about a podiatrist as a defendant. However, podiatrists only provide about thirty-seven percent of the foot care in the United States.[1] Many other specialties also provide foot care and therefore, the potential defendant can come from various specialties.

The reader is referred to the article "Targeting the Achilles Heel of Podiatric Medical Negligence"[2] which appeared in the April 1996 issue of TRIAL magazine for insight into podiatric medical negligence. It was written by Charles Fenton who is also a podiatrist and an attorney and who is a member of the Footlaw.com.

Probably the next most common defendant in foot medical negligence cases is an orthopedic surgeon. A very interesting dichotomy develops in foot medical negligence cases when foot surgery performed by an orthopedic surgeon, even a foot orthopedist, is concerned. In the medical arena, an orthopedic doctor, who by definition possesses the M.D. degree, is seen to have much more medical training to deal with foot problems, especially after a complication following foot surgery by a podiatrist. However, it often appears as if the orthopedic surgeon is held to a lesser standard of care when defending a medical negligence case. Although the podiatrist is often held to a higher standard of care, it seems that the old joke that if two bones are in the same room that they will heal becomes the standard of care for the orthopedic defending a claim of improper foot surgery.

Many other specialties can become defendants in a foot medical negligence case. For example, a radiologist may be negligent for failure to identify a foot fracture on an x-ray, especially if the treating doctor relies upon the radiologist-written report and does not have access to the actual

films. Additionally, a plastic surgeon who treats a tendon and skin laceration of the foot, but fails to identify and treat an underlying foot fracture may be negligent. An anesthesiologist and anesthetist may be liable for areas within their own purview during foot surgery.

Other practitioners who treat the lower extremity and may be potential defendants include general/family practitioners, internists, chiropractors, emergency room physicians, infectious disease doctors, vascular surgeons, general surgeons, neurologists, physical therapist and physiatrists, pain management doctors, emergency room doctors, and just about any specialty, with perhaps the exception of an OB/GYN and a psychiatrist. Of course no list of potential defendants would be complete without including the facility where the services were rendered, such as the hospital, outpatient facility, nursing home, or office/professional corporation. The negligence of those entities can be either vicarious or primary. For example, we are currently pursuing a claim against a hospital under primary negligence for allowing the doctor to perform Achilles tendon surgery when the doctor was never granted the privileges for such a procedure.

As in all cases, it is incumbent to analyze the insurance coverages which a defendant may have to allow for funding of a successful litigation. Unfortunately, those practitioners who specialize in lower extremity care, treatment, and surgery, despite the discipline, often maintain extremely limited insurance coverages. It is common for a doctor to maintain $100,000/300,000 coverage limits. As we all understand, the economics of medical malpractice litigation often precludes accepting cases which such limited insurance coverage. Therefore, selecting the proper case, and litigating the same with fiscal restraint, often is the norm.

IV. The Top Ten

With apologies to David Letterman, we will provide our top-ten list of medical negligence areas of the foot that the counselor should strongly consider pursuing when undergoing the case screening process.

Number Ten: Synovial Sarcoma

Synovial sarcoma is a rare, malignant tumor which can initially present in the foot. Although it is a rare tumor, it appears that there are many current cases arising involving synovial sarcoma in the foot. Because synovial sarcoma in particular, and malignant soft tissue tumors in general, are rare in the foot, most practitioners do not think tumor when presented with a soft tissue mass. Proof in these cases often mimics a breast cancer failure to diagnose case in that these cases often hinge on the causation issue of proving that if the diagnosis had been made in a timely manner that the outcome would have been different (the client would have survived or would not have lost their leg).

Number Nine: Wrong Side Surgery

Despite wide spread publicity of wrong side amputation cases, wrong side surgery continues to be a major battle that the medical community faces. While a wrong side amputation is devastating to the client, a wrong side bunion surgery is much less devastating. A defendant foot surgeon who operates on the bunion of the wrong foot is likely to argue that the patient needed the procedure on that side, so what is the big deal. No real harm so no real foul. Of course the big deal is the un-bargained for surgery on the wrong foot. Wrong side surgery is easily prevented if the surgery will simply write a big “no” on the non-operative side during the pre-operative phase.

Number Eight: Infections

Infections account for a disproportionate number of foot claims. Infection, in and of itself, even after foot surgery, is not medical negligence. The main causes of action in foot infection cases involve either a failure to make a timely diagnosis of infection or failure to treat properly.

Number Seven: Diabetic patients

Next to infections, claims involving diabetic patients account for the most foot claims. Diabetic patients present several unique medical risks, including poor circulation, nerve damage, and lowered ability to ward off infections. For those reasons and many others, the physician has a higher level of duty when treating theses patients because they are considered "high risk" patients being more prone to infection and amputation. The defense will often claim that the injury was the client's own fault for failure to properly monitor and control their sugar level.

Number Six: Tarsal tunnel surgery

Tarsal tunnel syndrome is of the ankle what carpal tunnel syndrome of the wrist. Many foot surgeons decline to perform tarsal tunnel surgery because of the high incidence of poor results and malpractice claims associated with tarsal tunnel release surgery. However, the proof may be difficult in these cases because very often there is a paucity of objective clinical data in the medical record to support the patient's claim of chronic pain.

Number Five: Heel surgery/plantar fasciitis

Heel pain is one of the main ailments that foot physicians treat. Although up to ninety percent of heel pain patients never need to have surgery, claims resulting from injuries following heel-related surgery appear to be disproportionate. One of the main reasons is that the heel is a highly innervated area and injuries involving nerve damage or outright nerve severing, with the resultant chronic pain, predominate this area

Number Four: Non Union

A bony non-union is by definition a surgical or traumatic fracture which has not healed after six months. Between six weeks and six months post-incident, the process is called a delayed union. The claim may involve either failure to diagnose the delayed union or failure to treat it properly and hence the condition progresses to the non-union. In some instances the development of the delayed union itself may result from surgery which was performed negligently. Non-union ranks high on our list because the jury can see with their eyes the non-union on x-rays. Lay people expect bones to normally heal.

Number Three: Hallux Varus Deformity

Hallux varus deformity is a big toe which looks like a monkey foot. The big toes points away from the second toe and there is a big gap between the first and second toe. In such cases, use of closed footgear can be very painful if not outright impossible. Hallux varus results at times from over-aggressive bunion surgery correction. Although the development of Hallux varus does at times occur even following properly performed bunion surgery, because of the cosmetically unpleasing

result that the jury can see with their own eyes, this type of case and post-surgical case is one that should be visited.

Number Two: RSDS

Reflex Sympathetic Dystrophy Syndrome (a.k.a., Chronic Regional Pain Syndrome) is a highly debilitating condition that can develop following foot surgery or trauma. Just like infection, the development of RSDS is not usually in and of itself negligence, but the failure to diagnose or to treat the disease timely and properly may be negligent. The results can be devastating for the client. In evaluating these cases, one should accept cases in the tertiary stage where the client is actually disabled and be leery of clients in stage one or early stage two. In an effort to avoid claims of failure to diagnose, physicians have labeled may patients with chronic pain as RSDS, when in fact they may simply suffer with chronic pain. The case should be evaluated to weed out a client which may improve and return to work.

Number One: Amputation

Most, but not all cases, involving amputation should be accepted. A lay jury just does not expect an amputation to develop from proper medical care, especially if that amputation develops soon after elective foot surgery.

V. Emerging Issue

The current emerging issue in lower extremity medical negligence involves claims resulting from cosmetic foot surgery. As reimbursements from insurance companies continually diminish, especially for elective foot surgery, many foot surgeons are beginning to promote and advertise cosmetic foot surgery. By definition, cosmetic foot surgery is not covered by insurance plans, so the fees that the foot surgeons demand are greater than what they receive when such services are covered by insurance. Cosmetic foot surgery generally involves foot surgery which is done in the absence of pain to create a different appearance to the foot, even when deformities are absent. Cosmetic foot surgery is evolving from current medical practices in Manhattan. Ladies are being targeted to have foot surgery in order to re-shape the foot to be able to fit into stylish ladies shoes, i.e., high heel pointed shoes.

As the pressure for increased revenues affects foot surgeons, podiatrists, orthopedists, and plastic surgeons alike, cosmetic foot surgery is likely to spread from Manhattan to Los Angeles and everywhere in between. Many people undergoing cosmetic foot surgery may eventually be unhappy with the results and may present to your office seeking explanations and wanting to know their rights.

VI. Conclusion

The foot medical negligence case is unique in several factors. The foot is the body's method of ambulation. The damages must be demonstrable to the jury generally as an impairment to function and ability to ambulate, whether that impairment is due to pain, deformity, or loss of limb. While lower extremity medical malpractice cases are interesting and can be economically gratifying for your client, they have many pitfalls which require continuing expert analysis in the medical field.

Endnotes

[1] American Podiatric Medical Association, American Podiatric Medical Association maps & Graphs: Summary of Information on Foot and Ankle Problems, Foot Care, and Podiatric Physicians I (1995).

[2] Fenton, Charles, "Targeting the Achilles Heel of Podiatric Medical Negligence," TRIAL, April 1996, pp. 40-47.