CASE CLOSED

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IN THIS CASE...

the podiatric physician's aggressive surgery on a minor could not be supported.

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PATIENT AND CONDITION

The claimant was nine years old at the time of her initial treatment with the insured podiatric physician. Her parents reported she had been experiencing pain in both feet for one year. The pain was specific to the ankle, mid-foot and rear foot bilaterally. The claimant rated her pain as a six on a scale of one to 10. She reported walking, exercising and running aggravated her pain.

TREATMENT

Based upon physical examination and X-ray findings, the insured diagnosed bilateral calcaneal-navicular coalition and discussed treatment options with the parents.

Three weeks later, the claimant returned with her parents for a surgery consultation. The insured planned to perform surgery consisting of excision of tarsal coalition with transposition of the extensor digitorum brevis muscle belly bilateral. The insured obtained the parents' informed consent and the surgery was performed three days later.

The claimant returned for her initial post-operative visit on post-op day four. The insured noted that the wounds were healing well. The claimant was to continue non-weight bearing.

The claimant continued to return for regularly scheduled post-operative visits. The insured noted her pain to be gradually resolving and her incisions were healing well. At three weeks post-op, the insured instructed the patient to gradually increase weight bearing with assistance. He dispensed surgical boots and recommended physical therapy.

Two weeks later, the claimant's parents took her to an urgent care facility due to the development of pressure sores on the right heel and the lateral aspect of the left foot. The patient also had some swelling and drainage at the surgical incision sites. The urgent care physician ordered an MRI. The MRI report stated that osteomyelitis could not be ruled out. Therefore, the physician referred the patient to the local hospital emergency department for possible admission for IV antibiotics. The ED physician did not think the claimant had osteomyelitis, so she was discharged with oral antibiotics.

At her six week post-op visit, the claimant presented in a wheelchair and reported throbbing pain rated six out of 10, consistent with the previous grading, during physical therapy. The claimant stated she still couldn't put weight on her feet. The claimant's parents reported the urgent care visit. The insured noted the blisters caused from pressure were healing. The insured reviewed the MRI and felt the infection did not involve the bone.

The claimant returned for her initial post-operative visit on post-op day four. The insured noted that the wounds were healing well.

At her eight week post-op visit, the claimant reported reduced pain while at physical therapy, but she still could not put weight on her feet and keep her balance. She was still using a wheelchair. The insured noted wound dehiscence 1 cm along the proximal aspect of the surgical incisions on each foot with drainage. He prescribed Augmentin and instructed the patient to return in two weeks. However, the claimant never returned.

INJURY

The claimant subsequently sought care from an orthopedic surgeon who noted neither of the surgical wounds had completely healed, but there was no purulence, induration or erythema. The claimant had diminished sensation along the distribution of the superficial peroneal nerve with palpable

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tenderness of the left foot. The orthopedic surgeon noted significant obliteration of the cuboid, left foot, which he thought could be possible lytic osteomyelitis versus over-resection of the cuboid. He performed exploratory surgery on the left foot. During the surgery, he noted that about 70 percent of the cuboid had been previously removed. Bone specimens and cultures were taken and antibiotic beads were employed.

Six weeks later, the claimant underwent another surgery for autogenous bone grafting to replace the defect at the interface between the calcaneus and the cuboid, left foot.

There was never any evidence of osteomyelitis.

The claimant had satisfactory healing of the bone graft which was confirmed with CT imaging. However, about a year later she began to experience recurrent pain on the right foot. It was felt that recurrence of the coalition had occurred and the claimant underwent surgery to remove the additional bone. The right foot healed, but the claimant continued to complain of pain in the left foot.

Six months later, an Evans calcaneal osteotomy and peroneus brevis and Achilles tendon lengthening were performed on her left foot. The claimant continues to complain of pain and swelling in her left foot and ankle and has, and will continue to have, significant limitations.

ALLEGATIONS

- Negligent removal of otherwise healthy bones in the left foot, leaving a major defect in the cuboid and calcaneus.

DEFENDING THE CLAIM

During the discovery process, the defense enlisted podiatric experts to review the case. Based upon the medical records, they agreed:

- The diagnosis made by the insured and the decision to perform corrective surgery on both feet was appropriate.
- A review of films taken after the insured's surgeries indicate there was appropriate and adequate bone resection of the right foot.

However, there was a huge, unnecessary amount of bone removed from the left foot. Bone resection included 1 cm of the anterior calcaneus, a huge portion of the cuboid and portions of the navicular, as well as the talus laterally. The excessive resection was not recognized or described postoperatively by the insured. Additionally, pre-operative X-rays did not justify the need for such radical bone resection, and the insured did not describe the need for radical bone resection in his operative report or his progress notes.

OUTCOME

The defense team, including the insured podiatric physician, agreed that there was significant exposure to the insured. The defense podiatric experts could not support the left foot surgery performed by the insured, and the claimant was a very sympathetic minor with significant damages. Mediation ensued and the claim was resolved via negotiated settlement.

RISK MANAGEMENT POINTERS

- **Document your justification** for treatment or procedures performed in the patient's medical record prior to the initiation of treatment or performance of procedures.
- **Accurately and thoroughly describe** the surgical procedure performed in the operative report, and include any unanticipated anatomical findings, your rationale for performing any deviation from the planned procedure, and any unanticipated outcomes.
- **Promptly document** any unexpected outcome or undesirable result in the patient's medical record and notify the patient of the unexpected outcome or undesirable result. Provide the patient with an objective, factual description of the event, a sincere acknowledgment of regret for the unfortunate nature of the event and a plan for continued care and treatment. Please note that acknowledging regret and showing empathy are not the same as admitting liability. Empathetic statements should not be about admitting fault or liability, but rather about connecting with the patient and expressing regret for the patient's discomfort and/or predicament. Do not admit liability or blame others for the outcome, and do not speculate about the cause of the result. While there are no guarantees, honestly acknowledging and addressing an unanticipated outcome and offering benevolent statements and gestures can help minimize patient anger and open lines of communication. This, in turn, may prevent the filing of a lawsuit.

You are encouraged to become familiar with your state's laws regarding apologies or benevolent gestures as the provisions vary from state to state. You may consult the PICA Risk Management or Claims Departments for guidance prior to offering benevolent statements or gestures.

– Barbara Bellione, RN, CPHRM, ARM
Director of Risk Management