Risk Management: Working with Podiatrists

Asking Anesthesiologists to Perform or Counter-Sign the Surgical History & Physical

The following information is provided by Preferred Physicians Medical to provide you with an outline for discussions about issues that arise while working with podiatrists and other non-physician providers. Preferred Physicians Medical strongly encourages anesthesia practices to address such situations carefully and consider any specific legal concerns that may be unique to your particular jurisdiction. The information provided below is an edited version of research in this area that has been compiled by PPM over the last several years. Statements of law and legal opinion should be carefully reviewed in light of more recent statutory enactments and case law. Also, different standards may apply depending on the jurisdiction in which you practice.

What Liability Concerns are Raised by Working with Podiatrists?

At the outset, this is a common question that a number of groups have struggled to address. In some facilities, anesthesiologists are being asked to "co-sign" the Surgical H&P along with the podiatrist. In other facilities, anesthesiologists are being requested to actually perform the Surgical H&P. In both scenarios, PPM believes that such involvement will increase your group's liability exposure. For this reason, PPM recommends that anesthesia practices carefully consider whether or not to participate in or perform the Surgical H&P. For those groups that are inclined to undertake this responsibility, these anesthesia groups should implement steps to minimize the liability exposure presented.

Performing a Surgical H&P or co-signing the Surgical H&P requires an anesthesiologist to conduct a more complete history and physical than is normally conducted by anesthesiologists for the purpose of determining if the patient is an appropriate candidate for anesthesia. By counter-signing the Surgical H&P or performing the Surgical H&P, the anesthesiologist is also making a determination that the patient is an appropriate surgical candidate. This requires a more complete understanding of the surgical issues involved and the potential surgical complications that may arise. In discussing this issue with a number of anesthesia practice groups, PPM has found that many anesthesiologists were unaware that they were taking on this responsibility and many quite frankly have indicated that they do not feel qualified to evaluate these surgical issues.

In addition to concerns related to the Surgical H&P, anesthesia groups should also be aware that practicing along-side any non-physician provider presents a higher exposure than practicing with another physician. In general, in cases where the anesthesiologist is the only physician present, plaintiff attorneys will typically allege that the anesthesiologist has a greater duty to second guess and/or intervene in the medical care being provided by non-physicians. Also, it is not unusual for podiatrists, and other non-physician providers, to have different insurance requirements. If your practice facility allows podiatrists to carry lower limits than those required of the anesthesiologists, plaintiff attorneys are more likely to name the anesthesiologist and to view him/her as a deep pocket. Our experience indicates that a significant disparity in the insurance coverage limits will distort the allegations and focus more attention on those health care providers with the most insurance coverage available.

Litigation Experience

With respect to the types of claims that can occur, PPM's in-house attorneys reference several lawsuits that have arisen in anesthesia practices where anesthesiologists are working with podiatrists. In one PPM case, a patient undergoing a routine bunionectomy developed gangrene that resulted in multiple amputations eventually requiring a below knee amputation. Details of this case are enclosed for your review and help to illustrate the concerns presented.

PPM's in-house attorneys stress that in undertaking the obligation to perform the Surgical H&P, the involved anesthesiologist must have a clear understanding of the responsibility that the facility is placing on them. In our view, this responsibility should be clearly articulated in a facility protocol. All too often in our litigation it is obvious that individual anesthesiologists have not appreciated the responsibility placed on them in this situation. We have enclosed another article outlining a typical case of podiatric malpractice; in this case there is no indication who performed the Surgical H&P.

Standard of Care

PPM's in-house attorneys also note that in a court of law, a physician who undertakes the role of a specialist (in this case a surgeon) will be held to the same standard of care as that specialist. In other words, anesthesiologist performing Surgical H&Ps must do so in a manner that meets the standard of care that would be expected of a surgeon. For example, in performing podiatry cases it is not unusual for the plaintiff to retain an orthopedic surgeon to review the adequacy of the Surgical H&P. Based on a number of the podiatric cases we have reviewed, PPM would, for example, expect an orthopedic surgeon to testify that it is important to evaluate the patient's circulation, check the pedal pulses, examine the extremity and determine whether the patient presents a higher risk of post-surgical complications or infections.

Given the concerns discussed above, PPM routinely encourages caution in undertaking the additional responsibility for counter-signing or performing Surgical H&P. Based on these concerns, many anesthesia practices have declined to participate in these arrangements. Anesthesia groups wishing to take this position may want to suggest asking the patient's primary care physician to perform the Surgical H&P (like anesthesiologists, many primary care physicians may have similar reservations).

Anesthesia practices that wish to undertake this responsibility should take appropriate steps to minimize their liability exposure including the following:

1. The anesthesia practices should request that the facility develop a detailed protocol specifically outlining the responsibility for completing the Surgical H&P for Podiatric cases. Having a written protocol will eliminate the finger pointing that frequently occurs in this type of litigation as various parties attempt to avoid responsibility for an adverse outcome.
2. Those responsibilities outlined in the facility protocol should then be effectively communicated to all members of the anesthesia group that will participate in cases involving podiatrists. It is important for the anesthesia practice to ascertain that those anesthesiologists undertaking responsibility for counter-signing or performing the Surgical H&P understand the obligation and each anesthesiologist participating feels qualified to do so.

In PPM's experience, it is not unusual for there to be a significant division among the members of an anesthesia group with regard to this issue. Some members may believe they have the requisite skill and training, while others do not. In anticipation of future litigation, it is exceedingly important that any policyholder undertaking this responsibility be prepared to testify favorably regarding his skill and training to complete the Surgical H&P. It would be exceedingly difficult to defend an anesthesiologist who testified that he/she only performed the Surgical H&P as a matter of convenience, or because it was required by his/her practice group. Over the years both our in-house attorneys and underwriters have discouraged groups from going down this path if there is not consensus within the group.

3. Anesthesia groups undertaking this responsibility are encouraged to develop and utilize a detailed Surgical H&P form that will help focus attention on the broader nature of their role and the specific concerns presented. Given some of the cases we have reviewed, we would suggest that the Surgical H&P for podiatry cases include specific space for checking and noting the patient's history for diabetes and other circulatory problems, a space for evaluating the patient's pedal pulses and a space to note any wound care issues. We would also encourage the anesthesia group to work closely with the podiatrist with whom they work to identify other areas of concern that should be routinely addressed in completing a Surgical H&P.
4. Anesthesia groups working with podiatrists should ascertain whether or not podiatrists and other non-physician providers are required to carry the same limits of insurance coverage as physicians in the facility. To the extent there is disparity, anesthesia groups are encouraged to work with PPM to promote insurance parity.

Conclusion

In the end, the decision to counter-sign or perform the Surgical H&P for podiatric cases should be undertaken carefully. Anesthesia groups should appreciate the additional exposure presented and either refuse to accept it, or in the alternative implement procedures to help minimize the risks presented. Your group's decision in this regard is a factor in our underwriting process, and to the extent your anesthesia practice undertakes this role, our underwriters will look at the details surrounding its implementation.

Bunionectomy Leads to Below Knee Amputation: Podiatrist Settles for $200,000 Policy Limits; Anesthesiologist Settles For Confidential Amount

02/28/2001 PPM Settlement

Facts: The plaintiff, a 49 year old female, with a history of obesity, hypertension, congestive heart failure, arthritis, peripheral vascular disease, total knee replacements was scheduled for a bunionectomy. Patient was under the care of a podiatrist. Pursuant to the surgicenter requirements, the anesthesiologist performed the surgical history & physical for patients under the care of a non-physician surgeon.

Evidence presented during discovery suggested that the patient had previously experienced infection and difficulty with wound healing following an earlier knee replacement. The orthopedic surgeon who performed the knee procedure denied the presence of an infection, but admitted treating the patient with antibiotics. A dermatologist who had seen the patient shortly before her bunionectomy noted concerns regarding healing of the knee incision and suspected possible infection or peripheral vascular disease. In light of this history, a podiatrist (not the podiatrist named in this litigation) referred the patient for Doppler studies to rule out possible vascular concerns, these tests were never conducted. Prior to the bunionectomy, the patient was seen by the podiatrist who noted that he discussed the risks and benefits of surgery and checked the patient's pedal pulses. The patient denied that the podiatrist checked her pedal pulses.

On the day of surgery, the CRNA and the Anesthesiologist conducted the pre-anesthesia exam and the Anesthesiologist performed the surgical H&P. The Anesthesiologist did not check the patient's pedal pulses and it was disputed that the Anesthesiologist and CRNA noted the unhealed knee wound. The Anesthesiologist made no entries in the medical records that indicated the open wound was noted during the surgical H&P, except for an entry in the record made approximately a year later when the Anesthesiologist was asked by the facility's risk manager to review the records. Two podiatry residents who participated in the case performed a "Podiatry H&P" and noted the open wound and an absence of pedal pulses. Conflicting testimony was provided by a podiatrist who performed the surgery who indicated pulses were checked and by a nurse who indicated that pulses were detectable only by Doppler.

The defendant podiatrist performed the bunionectomy and followed the patient during three uneventful post operative office visits. Several weeks later, the patient was referred to a wound treatment specialist who diagnosed gangrene. Patient was admitted to a local hospital and a femoral popliteal bypass was performed. Continued deterioration of the patient's foot led to an amputation of the patient's toe, followed by a partial amputation of the foot and then a complete amputation of the foot and eventually a below knee amputation.

Damages: Medical bills totaling $236,759 were submitted along with estimates of future medical care ranging from $595,000 to $830,000. Additional damages were claimed on behalf of a mentally disabled, epileptic child. Loss wages of approximately $375,000 to $475,000 were claimed despite the fact the patient hadn't been employed for some time.

An expert witness hired by the patient claimed that the Anesthesiologist was negligent in the performance of the surgical history & physical. Specifically the Anesthesiologist's failure to conduct an adequate H&P, a failure to note concerns with the open wound or to specifically check the patient's pedal pulses contributed to the outcome. This expert testified that there was confusion among the health care providers regarding the responsibility for evaluating the patient for surgery, but that as the only "attending medical doctor," the anesthesiologist had the ultimate responsibility for determining whether the surgery should have been performed.

Result: The defendant podiatrist settled the case for his policy limits of $200,000. The anesthesiologist and the patient entered into a confidential settlement agreement.

Surgery to Type II Diabetic With Failure to Prescribe Antibiotics Leads to Osteomyelitis, Amputation of Toe and Portion of Foot. (Pennsylvania)

11/15/2005 Pennsylvania Jury Verdict Reporter

Surgery to Type II Diabetic With Failure to Prescribe Antibiotics Leads to Osteomyelitis, Amputation of Toe and Portion of Foot. (Pennsylvania)

Facts: The plaintiff, a type II diabetic, claimed the defendant podiatrist performed surgery to her right foot at a time when her diabetes was out of control and negligently failed to prescribe prophylactic antibiotics. As a result, the plaintiff alleged she developed osteomyelitis, which required amputation of her small toe and a portion of her foot. The defendant contended that the time was optimal for the plaintiff's surgery and that her care met the required standard in all respects.

The female plaintiff was 41 years old at trial. She was admittedly a poorly compliant and poorly controlled type II diabetic. The plaintiff was treated by the defendant for an ulcer on the little toe of her right foot. The plaintiff contended the foot ulcer was decreasing in size over the course of several months and there were no infections other than upon original presentation. The plaintiff introduced her medical chart from the defendant's office as an exhibit. The plaintiff contended the chart erroneously listed her as having recurrent infections and incorrectly stated that the plaintiff's primary care physician had placed her on antibiotics.

The defendant performed an arthroplasty to surgically remove bone in the plaintiff's toe, which he contended was contributing to the foot sore. The plaintiff was not placed on antibiotics and developed an infection and osteomyelitis. The plaintiff underwent amputation of the little toe and top of her foot. A second surgery involving skin grafting from her thigh was also performed. The plaintiff's expert podiatrist testified the defendant should not have performed the surgery because the plaintiff's diabetes and blood sugar level were not under control at that time. This expert testified the defendant should have at least prescribed prophylactic antibiotics to prevent infection.

The plaintiff missed six months from her employment as a data entry clerk with a church. The defendant's podiatrist testified the plaintiff's surgery was warranted and that elective podiatric procedures are routinely performed on diabetic patients. This expert opined there was no deviation from the standard of care pre-operatively, intra-operatively or postoperatively. The defense maintained that the plaintiff's ulcer was improving, conditions were optimum for the surgery and her subsequent infection developed in the absence of any negligence. The defendant's expert also opined that the plaintiff would be able to function normally, with no limitations with the use of molded orthotics.

Result: The jury found for the plaintiff in the amount of $215,000.

Plaintiff's Expert: Jeffrey Yale, DPM, Ansonia, Connecticut Defendant's Expert: Vincent Muscarella, DPM, Philadelphia, PA.