

Podiatric Surgeon, Mr B
Medical Centre

A Report by the
Deputy Health and Disability Commissioner

(Case 15HDC00645)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011, Mr A was involved in an accident and suffered multiple fractures to his right foot. Mr A underwent treatment with physiotherapist Mr D and returned to work in July 2012.
2. In October 2013, Mr A was experiencing bilateral heel pain and sought treatment from Mr D, podiatrist Mr F, and general practitioner Dr G. Unfortunately, Mr A's heel pain continued. Dr G referred Mr A to podiatric surgeon Mr B.
3. On 21 July 2014, Mr A consulted with Mr B, who diagnosed Mr A with bilateral plantar fascia. Mr B scheduled Mr A for plantar fascia release surgery on both feet (bilateral fasciotomy).
4. On 7 August 2014, Mr B performed plantar fascia release surgery on Mr A's right foot. Following this, Mr A attended two postoperative consultations with Mr B. On 22 August 2014, Mr A told Mr B that for the previous week his foot had been painful while at work.
5. On 26 August 2014, Mr B performed plantar fascia release surgery on Mr A's left foot. Following this, Mr A returned for several postoperative consultations with Mr B. Mr A continued to experience heel pain and, on 20 February 2015, he made the decision not to consult with Mr B again.

Findings

6. By failing to perform adequate investigations prior to undertaking bilateral fasciotomy and failing to ensure that the first surgical procedure had been successful before proceeding with the second surgical procedure, Mr B did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Recommendations

7. The Deputy Commissioner recommended that, should Mr B seek to resume practice as a podiatric surgeon in New Zealand in the future, the Podiatrists Board of New Zealand review his competency prior to issuing a practising certificate.
8. The Deputy Commissioner recommended that, should Mr B resume practice as a podiatric surgeon in the future, he engage a mentor in podiatric practice to be present during the first six months of his practice. The mentor is to be endorsed by the Podiatrists Board of New Zealand.
9. The Deputy Commissioner recommended that Mr B provide a written apology to Mr A for breaching the Code. The apology is to be sent to HDC within three weeks of the date of the final report being issued, for forwarding to Mr A.

Complaint and investigation

10. The Commissioner received a complaint from Mr A about the services provided to him by podiatric surgeon Mr B. The following issues were identified for investigation:
- *Whether Mr B provided Mr A with an appropriate standard of care between July 2014 and February 2015.*
 - *Whether Medical Centre 1 provided Mr A with an appropriate standard of care between July 2014 and February 2015.*
11. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the powers delegated to her by the Commissioner.
12. The parties directly involved in the investigation were:
- | | |
|------------------|----------|
| Mr A | Consumer |
| Mr B | Provider |
| Medical Centre 1 | Provider |
13. Information was also reviewed from:
- | | |
|------------------------|---------------------|
| Dr C | Orthopaedic surgeon |
| Mr D | Physiotherapist |
| Mr E | Podiatrist |
| Physiotherapy provider | |
| Medical Centre 2 | Medical centre |
| Medical Centre 1 | Medical centre |
- Also mentioned in this report:
- | | |
|------|------------------------------|
| Mr F | Podiatrist |
| Dr G | General practitioner |
| Mr H | Podiatrist |
| Ms I | Physiotherapist |
| Dr J | Director of Medical Centre 1 |
14. Independent expert advice was obtained from podiatric surgeon Mr Robert Hermann¹ (**Appendix A**).

¹ Mr Robert Hermann has a doctoral degree in health science.

Information gathered during investigation

Mr B

15. At the time of these events, Mr B was registered with the Podiatrists Board of New Zealand, and his scopes of practice were listed as “podiatrist” and “podiatric surgeon”. Mr B trained as a podiatric surgeon, and has a doctoral degree in podiatric medicine. Mr B no longer practises. At the time of these events, Mr B provided treatment for feet and ankle problems.

Medical Centre 1

16. Medical Centre 1 leased a consultation room to podiatrist Mr H. Mr H entered into a license agreement with Mr B that allowed Mr B to use the room for consultations. Mr B performed surgery in an operating room that he leased from a separate company.

Mr A — Background

17. In 2011, Mr A was involved in an accident and suffered multiple fractures to his right foot, fractures to two bones in his forearm, and a compression fracture to his lower spine. Mr A had time off work and underwent rehabilitation with physiotherapist Mr D. In July 2012, Mr A returned to work.
18. In October 2013, Mr A presented to Mr D with bilateral heel pain,² which came on with standing and became more painful after the cumulative standing that was required for his role at work. The pain was becoming progressively worse over time.
19. Mr A consulted with Mr D on 30 June 2014 and 14 July 2014, and was given exercises to do. Mr D documented that there were positive Tinel signs³ in Mr A’s medial⁴ heel, and his analysis was “neural tissue dysfunction⁵ mimicking plantar fascia⁶”. Following his consultations with Mr D, Mr A presented to podiatrist Mr F, who assessed Mr A and reviewed his orthotics.⁷ However, unfortunately the bilateral heel pain continued.
20. In June 2014, Mr A’s pain became worse, and his general practitioner, Dr G, referred him to Mr B. Dr G documented in the referral letter: “Plantar fasciitis? Pain in heels since Oct 2013 No problems while on holiday but standing on spot at work causes pain.” Dr G stated in the letter that previously Mr A had received treatment from a podiatrist.

First consultation — 21 July 2014

21. On 21 July 2014, Mr A consulted with Mr B at Medical Centre 1. Mr B did not receive or request clinical documentation from Mr D or Mr F. Mr B documented in

² Pain in the heels of both feet.

³ Tinel’s sign is a way to detect irritated nerves by use of palpation.

⁴ Middle.

⁵ Neural tissue is the primary tissue of the nervous system.

⁶ The plantar fascia is the flat band of tissue that connects the heel bone to the toes. The plantar fascia supports the arch of the foot by acting as a “bowstring” to connect the ball of the foot to the heel.

⁷ Moulded pieces of rubber, leather, metal, plastic, or other synthetic material that are inserted into a shoe to provide support.

the clinical notes from this consultation that Mr A had been experiencing “sharp pain on palpation, origin plantar fascia ...”.

22. Mr B told HDC: “[Mr A] had sharp pain (which means he winced and withdrew immediately on palpation, origin (proximal portion)⁸ of ... plantar fascia, bilateral. Palpation and manipulation did not elicit symptoms elsewhere.”
23. Mr A told HDC that he had not taken NSAIDS⁹ for his foot pain prior to his consultation with Mr B, and that such an option was not offered to him during his consultation with Mr B.
24. When asked whether Mr B discussed NSAIDS with Mr A, Mr B responded to HDC: “I did not document the prior use of NSAIDS (e.g. ibuprofen, naproxen, diclofenac) by patient [Mr A]. I do not record everything discussed.”
25. Mr B diagnosed Mr A with bilateral plantar fasciitis¹⁰ and arranged for his nurse to schedule Mr A to receive bilateral plantar fascia release surgery on both feet (also known as a bilateral or plantar fasciotomy). Plantar fascia release surgery involves cutting part of the plantar fascia to release tension and relieve inflammation. Mr B documented in Mr A’s notes: “[Discussed] cortisone injections, [Mr A] not interested ‘just masks it’. [Discussed] procedure, [complications].”
26. Subsequently Mr B wrote to Dr G, informing him: “[S]ince orthotics haven’t helped, and [Mr A] doesn’t want Kenacort injections [steroid injection],¹¹ we will do a plantar fasciotomy in the near future.” Mr B also wrote to Mr A’s place of work, informing his employer that Mr A would require “at least a 4 week period of time off work for recuperation”.
27. Mr B told HDC: “[Mr A] was first seen by podiatrist [Mr F] in October 2013 and given orthotics for plantar fasciitis. He was treated conservatively, unsuccessfully, for 11 months before I did surgery in August 2014.”
28. Mr A told HDC that Mr B informed him that he would require two weeks off work for each foot, and that there was a 95% success rate for full recovery.

First surgical procedure — 7 August 2014, right foot

29. On 7 August 2014, Mr B performed plantar fascia release surgery on Mr A’s right foot at Medical Centre 2. Mr B obtained signed surgical consent from Mr A prior to the surgery. Mr B documented that local anaesthesia was used, and the foot was prepared prior to the procedure. He noted that he incised the plantar fascia and separated the bowstringing plantar fascia from the surrounding structures. He also recorded that the “plantar fascia was noted to be released of tension”, and that the “arch was supple without bowstringing fascia”. Mr B documented that subsequently

⁸ Near the centre of the heel.

⁹ Nonsteroidal anti-inflammatory drugs.

¹⁰ Inflammation of the plantar fascia.

¹¹ A corticosteroid that is used to treat pain caused by inflammation of the joints or tendons.

the wound was dressed and Mr A was placed in a postoperative shoe and provided with written postoperative instructions, and that a postoperative visit was arranged.

First postoperative consultation — 15 August 2014

30. On 15 August 2014, Mr A had his first postoperative consultation with Mr B. Mr B documented that Mr A was very pleased, and had reported that his foot felt better already. Mr B also documented that he had sprayed second skin (a first-aid spray) over the wound and applied a dressing.

Second postoperative consultation — 22 August 2014

31. On 22 August 2014, Mr A had his second postoperative consultation with Mr B. Mr B removed the sutures and documented that Mr A told him that his foot had been painful for the previous week while at work. Mr B noted that Mr A would return in one week's time for surgery on his left foot.

Second surgical procedure — 26 August 2014, left foot

32. On 26 August 2014, Mr B performed plantar fascia release surgery on Mr A's left foot. Mr B obtained signed surgical consent from Mr A prior to the surgery.
33. Mr B told HDC:

“On the day of the second surgery, [Mr A] was full weight bearing on the previous foot, so that he could use crutches post op[eration]. If he wasn't capable of full weight bearing on the first foot done, we would have delayed the second surgery.”

34. Mr B documented that local anaesthesia was used, and the foot was prepared prior to the procedure. He noted that he incised the plantar fascia and separated the bowstringing plantar fascia from the surrounding structures. He also recorded that the “plantar fascia was noted to be released of tension”, and that the “arch was supple without bowstringing fascia”. He documented that subsequently the wound was closed with sutures and dressed, and Mr A was placed in a postoperative shoe and provided with written postoperative instructions, and a postoperative visit was arranged.

Postoperative consultation — 1 September 2014

35. On 1 September 2014, Mr A met with Mr B for a postoperative consultation regarding his left foot. Mr B documented that Mr A told him that he felt okay, but also felt that he would need significant time off work. Mr B also noted that Mr A had got the bandage wet, and that he redressed the wound with skin spray. Mr B documented that he would remove the sutures on Mr A's left foot in one week's time, and issued a medical certificate stating that Mr A would be unfit for work until 22 September 2014. The medical certificate included Mr B's name and the company name “[Medical Centre 1]” on the letterhead.

Postoperative consultation — 8 September 2014

36. On 8 September 2014, Mr A met with Mr B for another postoperative consultation. Mr B removed the sutures in Mr A's left foot. Mr B then issued Mr A with a medical

certificate stating that he was unfit for work for the time being and would be re-evaluated on 26 September 2014.

Postoperative consultation — 26 September 2014

37. On 26 September 2014, Mr A met with Mr B for another postoperative consultation. Mr B documented that Mr A felt good but had bilateral pain at his Achilles insertion,¹² which he noticed mostly in bed at night. Mr B then issued Mr A with a medical certificate stating that he was unfit for work for the time being and would be re-evaluated in eight weeks' time.
38. Mr B told HDC: “[Mr A] had a new pain at the back of his heels, he indicated the Achilles tendon insertion.” Mr B stated that “the diagnosis was compensatory Achilles insertional pain, right.¹³ [Mr A] was instructed to only continue normal activities, and avoid running, jumping, walking uphill.”

Postoperative consultation — 7 November 2014

39. On 7 November 2014, Mr A met with Mr B for another postoperative consultation. Mr B documented: “[Mr A] only has pain in posterior heel¹⁴”, and “slight pain on palpation, Achilles [bilateral]”. Mr B noted that he demonstrated range of motion exercises¹⁵ for Mr A. Mr B told HDC that the exercises he demonstrated were ankle dorsiflexion¹⁶ exercises.
40. Mr B then issued Mr A with a medical certificate stating that he was able to return to work at seated duties, and it was anticipated that he would be able to return to full standing duties in three to six months' time.

Referral to physiotherapist Ms I — 12 January 2015

41. On 12 January 2015, Mr B sent a referral to physiotherapist Ms I,¹⁷ stating that the previous week he had received an email from Mr A informing him that his condition had not improved since November 2014. Mr B asked Ms I to review Mr A and see whether she could assist him, as Mr A had developed bilateral insertional Achilles pain. Mr B said he believed that Mr A might be experiencing “compensatory overuse from favouring the heel pain”.
42. Mr A consulted with Ms I on numerous occasions. On 26 January 2015, Mr B documented that he had telephoned Ms I, who told him that she had seen Mr A twice and that there was some improvement. In contrast, Mr A told HDC that he received no improvement following his sessions with Ms I.

Postoperative consultation — 2 February 2015

43. On 2 February 2015 Mr A met with Mr B for a postoperative consultation. Mr B documented:

¹² Point where the Achilles tendon is connected to the heel bone.

¹³ Pain located in the Achilles insertion.

¹⁴ The back of the heel.

¹⁵ Range of motion exercises are done to preserve flexibility and mobility of the joints.

¹⁶ Dorsiflexion is backward flexion (bending) of the hand or foot.

¹⁷ Ms I has a doctoral degree in physical therapy.

“6 [months] [postoperative] plantar fascia release [bilateral]. [H]as a vague pain, medial, lateral, plantar and posterior heels, and Achilles [bilateral]. [C]an walk without pain, but standing with shoe heel counter pressure or lying on couch or in bed hurts his heel, Achilles. [I]ncision area, mid arch, [asymptomatic] [bilateral]. [Patient] has been trying his orthotics again, past 3 days, not sure if they help.”

Postoperative consultation — 20 February 2015

44. On 20 February 2015, Mr A consulted with Mr B again. Mr B documented:
- “[Patient] states worse than before [surgery] (‘to be honest’) ... Has aches and soreness, plantar medial heels and up into achilles [bilateral] ... no pain on palpation, neg tincl sign, posterior tibial nerve, arch [surgery] site, Achilles [bilateral].”
45. Mr B documented a diagnosis of “possible calcaneal oedema?”¹⁸, and a treatment plan to “cont[inue] with physio care”. Mr B then issued Mr A with a medical certificate, which stated that Mr A would require limited standing duties at work.
46. Mr B told HDC: “[S]ince [Mr A’s] pain had changed once again, as a differential I contemplated calcaneal bone marrow oedema¹⁹ as contributing to his symptoms; but with the symptoms being bilaterally symmetrical, this appeared unlikely. Since conservative treatment of minimising activity and time are preferred for this diagnosis, I continued his medical certificate for 4 weeks.”
47. Mr B told HDC that he informed Mr A that “his stated symptoms were varied and atypical, and not consistent with clinical findings”. Mr B told HDC: “I reminded [Mr A] that before surgery I couldn’t palpate the bottom of his heels without eliciting significant sharp pain, and that although he still had symptoms, they were nothing like before surgery.”
48. Following this visit, Mr A was dissatisfied with the care provided, and chose not to make any further appointments with Mr B. Mr A sought assistance from other providers.

Further information from Mr B

49. Mr B told HDC: “There is a wide variation in how people heal, pain threshold and the perception of pain. Early ambulation²⁰ is beneficial for healing. In [Mr A’s] case, and the nature of his work, meant that we had him stay off work for longer after the second surgery, returning him to partial duties.”

Further information from Mr A

50. Mr A stated: “[Mr B] told me he had no explanation for why my feet were not healing, and that I may need to look at changing my lifestyle, both in and outside of work.”

¹⁸ Fluid retention in the heel.

¹⁹ A condition where fluid is found within the heel bone.

²⁰ A technique of postoperative care in which a patient engages in light activity as soon as possible after an operation.

Further information from Medical Centre 1

51. The Director of Medical Centre 1, Dr J, told HDC that he became aware of Mr H's license agreement with Mr B only in July 2014. Dr J stated:

“As [Mr B] was in no way connected with [Medical Centre 1] and was at all times contracted by [Mr H], we did not seek to have him removed.”
 52. Dr J told HDC that, once he became aware of Mr B using the name “[Medical Centre 1]” on his medical certificates, he asked Mr B to remove the reference on his letterhead. Dr J also told HDC that Mr B's name was not advertised anywhere on the premises, or on the Medical Centre 1 website.
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Responses to Provisional Opinion

53. Mr A had no further comments regarding the “information gathered” section of the provisional opinion.
 54. In response to the provisional opinion, Mr B made various submissions which have been considered and changes have been made where relevant.
 55. Mr B also told HDC:

“Under general anaesthesia, which many foot surgeons prefer, we almost never do bilateral cases in separate sessions. We do them on the same day. The risk of general anaesthesia, the post-operative recovery, and even the additional cost are prohibitive to doing the procedures on separate occasions.”
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Opinion: Mr B — Breach

Diagnosis of plantar fascia and plan for surgery

56. Mr A first consulted with Mr B on 21 July 2014. Mr A presented to Mr B with a nine-month history of foot pain and previous podiatric treatment. Mr B palpated Mr A's plantar fascia, which resulted in Mr A feeling a sharp pain. Mr B told HDC: “Palpation and manipulation did not elicit symptoms elsewhere.”
57. Mr B diagnosed Mr A with bilateral plantar fasciitis, and scheduled bilateral plantar fascia release surgery.
58. My independent expert advisor, podiatric surgeon Mr Robert Hermann, considered that the initial assessment by Mr B was adequate to make an initial diagnosis of plantar fasciitis. However, Mr Hermann advised that the assessment was not of an adequate standard to substantiate performing plantar fascia release surgery, and that this was a moderate departure from an accepted standard of care.

59. Mr Hermann advised that, in his view, in light of the information available to Mr B at the time, including Dr G's letter outlining the nine-month history of pain and podiatric treatment provided previously, as well as the reports of pain caused by standing on the spot, Mr A was likely to have been suffering from something more than plantar fasciitis.

60. Mr Hermann advised:

“Most patients tend to receive a significant (50% or more) reduction in symptoms in the first 3 months of conservative treatment especially with the use of prescription orthosis.²¹ In [Mr A's] case the pain was unresponsive to orthotic therapy and physiotherapy. This was suggestive that neural involvement was likely to be contributing to the pain ...”

61. Mr Hermann said that Mr B's notes have a “lack of detailed description of both [Mr A's] subjective complaints of bilateral heel pain and [Mr B's] objective findings”. Mr Hermann stated:

“There was also no description of the severity of pain when it occurred and if it improved at all during the day. Further, [Mr B's] clinical notes failed to indicate if he had asked [Mr A] if his heel pain was affecting his sleep or if there was pain when non weight bearing. The presence of sleep disturbance and pain when non weight bearing are also indicators that nerve involvement is occurring in addition to plantar fasciitis.”

62. Mr Hermann said that he strongly recommends that a clinical record include “a summary of previous treatment, reports and outcomes”. He stated that if any further clarification is required to assess how a patient's condition has responded to previous treatment, that information should be sought from previous providers.

63. I accept Mr Hermann's advice. In my view, accurate diagnosis is essential prior to performing surgery. In light of Mr A's nine-month history of pain, his response to conservative treatment, and the observations made and reported by Dr G, I consider that further investigations, including consideration of potential neural involvement and likely response to fasciotomy, should have taken place prior to Mr B recommending plantar fasciotomy to Mr A.

64. I consider that Mr B did not perform an adequate assessment to determine whether fasciotomy was appropriate treatment.

Surgical procedures

65. I note that Mr Hermann advised that the technique utilised by Mr B during the surgical procedures on both Mr A's left foot and right foot was appropriate and done with due care. I accept this advice, and am not critical of Mr B's surgical technique.

²¹ A brace, splint, or other device serving to support the limbs or spine or to prevent or assist relative movement. In this case, orthotics had been used previously to support Mr A's feet.

66. However, in his operative reports, Mr B did not document how much of the plantar fascia was released. Mr Hermann advised that this should have been documented.

Decision to proceed with second surgery

67. Mr B performed a plantar fasciotomy on Mr A's left foot on 26 August 2014, less than three weeks after the procedure performed on his right foot (7 August 2014).
68. After the first procedure, Mr B documented in his two-week postoperative consultation with Mr A that Mr A told him that his foot had been painful for the previous week while at work. Mr B noted that Mr A would return for surgery on his left foot in one week's time. While Mr Hermann is not critical of the technique Mr B used in conducting the surgery, Mr Hermann advised: "Providing the second surgery less than three weeks after the first surgery was too soon to know if the first surgery had been successful and [whether] the use of fasciotomy was appropriate for [Mr A]." Noting the record of right foot pain at two weeks after the first surgery, Mr Hermann told HDC:

"It would have been more prudent to have waited at least 4 to 6 weeks to ensure that the first surgery had been successful before proceeding to the second surgery."

69. Mr Hermann advised HDC that Mr B's decision to proceed with the second surgical procedure without ensuring that the first surgical procedure had been successful was a significant departure from accepted standards.
70. In response to the provisional opinion, Mr B told HDC:
- "Under general anaesthesia, which many foot surgeons prefer, we almost never do bilateral cases in separate sessions. We do them on the same day. The risk of general anaesthesia, the post-operative recovery, and event the additional cost are prohibitive to doing the procedures on separate occasions."
71. This statement was provided to Mr Hermann for review. Mr Hermann told HDC that this comment has no bearing on the advice that he provided to HDC.
72. I remain of the view that Mr B performed the surgery on Mr A's left foot prematurely. Mr B should have waited until it was clear that the initial surgery on the right foot was successful, and that the use of fasciotomy was appropriate for Mr A's presenting problem, before undertaking the second surgery.

Conclusion

73. By failing to: perform adequate investigations prior to undertaking bilateral fasciotomy and ensure that the first surgical procedure had been successful before performing the second procedure, Mr B did not provide services to Mr A with reasonable care and skill. Accordingly, I find that Mr B breached Right 4(1) of the Code.

Opinion: Medical Centre 1 — No breach

74. Medical Centre 1, at the time of events, leased a consultation room to podiatrist Mr H. Mr H entered into a license agreement with Mr B that allowed Mr B to use the room. Medical Centre 1 Director Dr J told HDC that the medical centre became aware of Mr H's license agreement with Mr B only in July 2014. Dr J stated: "As [Mr B] was in no way connected with [Medical Centre 1] and was at all times contracted by [Mr H], we did not seek to have him removed."
 75. Dr J told HDC that, once he became aware of Mr B using the name "[Medical Centre 1]" on his medical certificates, he asked Mr B to remove the reference on his letterhead. Dr J also told HDC that Mr B's name was not advertised anywhere on the premises, or on the Medical Centre 1 website.
 76. I have considered the nature of the relationship between Medical Centre 1 and Mr B, and accept that there was no employment or agency relationship. As a result, Medical Centre 1 is not liable for the care provided by Mr B to Mr A.
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Recommendations

77. I recommend that if Mr B seeks to resume practice as a podiatric surgeon in New Zealand in the future, the Podiatrists Board of New Zealand review his competency prior to issuing a practising certificate.
 78. I recommend that if Mr B resumes practice as a podiatric surgeon in the future, he engage a mentor in podiatric practice to be present during the first six months of his practice. The mentor is to be endorsed by the Podiatrists Board of New Zealand.
 79. I recommend that Mr B provide Mr A with a written apology for breaching the Code. The apology is to be sent to HDC within three weeks of the date of the final report being issued, for forwarding to Mr A.
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Follow-up actions

80. Mr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Podiatrists Board of New Zealand, and it will be advised of Mr B's name.
81. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

82. The Director of Proceedings decided not to issue proceedings.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from podiatric surgeon Mr Robert Hermann:

“Thank you for your email dated 15 September 2015 in which you have requested an opinion on the above matter. I have read and agree to follow the Commissioner’s Guidelines for Independent Advisors.

Qualifications

I am a podiatric surgeon and qualified for Fellowship of the Australasian College of Podiatric Surgeons (ACPS) in 1991. The ACPS Fellowship is recognised by the Podiatry Board of Australia (PBA) as a qualification for the purposes of registration as a specialist surgeon. I am also endorsed by the PBA to prescribe from a national list of Schedule 3, 4 and 8 medicines according to State legislature in the practice of podiatric surgery.

I qualified as a podiatrist in 1985 with an Advanced Diploma in Science (Podiatry) from the South Australian Institute of Technology. My experience includes 9 years in general podiatry and 23 years in reconstructive podiatric foot and ankle surgery.

I received a Graduate Certificate in Research Methodologies from the University of South Australia in 2005. Currently I am completing a professional doctorate at the Queensland University of Technology.

Due for completion in late 2016 this research will see the development of the first foot and ankle web based surgical audit tool. The objective of this research is to improve the quality and safety of foot and ankle surgery provided in Australia.

The referral instructions provided are:

Provide an opinion as to the following questions regarding [Mr B’s] practice in managing [Mr A].

1. Was [Mr B’s] initial assessment of [Mr A] of an adequate standard?
2. Was the diagnosis of bilateral plantar fasciitis reasonable?
3. Assuming the diagnosis of plantar fasciitis was reasonable, do you believe bilateral fasciotomies were appropriate?
4. Were the fasciotomy techniques used by [Mr B] appropriate and undertaken with due care and skill?
5. Was the postoperative care of an appropriate standard, specifically should referral to another practitioner have occurred before 5 February 2015?
6. Any other comments regarding [Mr B’s] care of [Mr A].

For each of the above questions advice is requested as to:

1. What is the standard of care/accepted practice?
2. If there has been a departure from standard of care or accepted practice and how significant a departure?

3. How peers would view the matter?

The information provided and considered for this opinion include: Health and Disability Commissioner (HDC)

1. Background regarding the matter
2. [Mr A's] complaint to the HDC ([date])
3. [Mr B's] response to [Mr A's] complaint (6/7/15)
4. Letter to [Mr E] (podiatrist) (5/6/15)

[Mr B] (podiatric surgeon)

1. Clinical notes and work certificates (17/7/14 to 20/2/15)
2. Letter of referral from [Dr G] to [Mr B] (17/7/14)
3. Letter from [Mr B] to [Dr G] (28/7/14)
4. Letter from [Mr B] to [Ms I] (12/1/15)
5. Consent for right plantar fasciotomy and operative report (7/8/14)
6. Consent for left plantar fasciotomy and operative report (26/8/14)

Mr D (physiotherapist)

7. Assessment notes for 30/6/14, 14/7/14
8. Return to Work Plan (24/4/15)
9. [Mr E] (podiatrist)
10. Clinical notes (2/3/15 & 12/3/15)
11. Diagnostic ultrasound report by [radiologist] (9/3/15)
12. [Dr C] (orthopaedic surgeon)
13. Letter to the HDC (8/7/15)
14. Letter to [Dr C] from [orthopaedic surgeon] (23/3/15)

Opinion

The initial assessment by [Mr B] of [Mr A] was of adequate standard to make an initial diagnosis of plantar fasciitis but was not of adequate standard to substantiate performing a fasciotomy. This is a moderate departure from accepted practice. This view is based on a review of [Mr B's] clinical notes. There is a lack of detailed description of both [Mr A's] subjective complaints of bilateral heel pain and [Mr B's] objective findings. In addition, no assessment of both the subjective and objective findings in conjunction with information from other practitioners is evident in [Mr B's] clinical notes.

The documentation provided for this report points to a number of factors that [Mr A] was likely to be suffering from something more than only plantar fasciitis. These points are listed below:

1. [Mr A's] letter of complaint to the HDC states that the chronic heel pain had been present for nine months before he sought consultation from [Mr B].
2. [Dr G's] letter (17/7/14) to [Mr B] stated that [Mr A] had been in pain since October 2013 (nine months) and that podiatric treatment (orthotic therapy) had already been provided.
3. [Mr D's] assessment notes of 30/6/14 state that [Mr A's] pain was sharp, stabbing after 15 minutes of standing. He also found signs of nerve entrapment (positive Tinel's sign) on the same date of consultation and again on 14/7/14.

The three points above suggest that [Mr A's] heel pain had become chronic because it had been present for longer than 3 months. Most patients tend to receive a significant (50% or more) reduction in symptoms in the first 3 months of conservative treatment especially with the use of prescription orthosis. In [Mr A's] case the pain was unresponsive to orthotic therapy and physiotherapy. This was suggestive that neural involvement was likely to be contributing to the pain. The Tinel's sign described in [Mr D's] clinical notes refers to the application of light percussion over the course of a nerve branch.

If such an examination produces paraesthesia (strange sensations) and/or pain along the course of the nerve away from the point of percussion, nerve entrapment is likely to be present.

In the case of chronic heel pain percussion is applied along the course of the posterior tibial nerve from 5 cm proximal to the medial malleolus (ankle bone) to the medial arch. [Mr D] found a positive Tinel's sign on 2 separate occasions, the heel pain had not responded to any great degree to orthotic or physiotherapy and standing for only 15 minutes caused significant pain. Most patients with plantar fasciitis report pain on weight bearing after rest that eases after a few minutes of weight bearing but slowly gets worse as the day progresses.

The above findings are all indicators that nerve involvement may have been involved in [Mr A's] case. [Mr B's] clinical notes do not report an examination of the posterior tibial nerve as described above. There was also no description of the severity of pain when it occurred and if it improved at all during the day. Further [Mr B's] clinical notes failed to indicate if he had asked [Mr A] if his heel pain was affecting his sleep or if there was pain when he was non weight bearing. The presence of sleep disturbance and pain when non weight bearing are also indicators that nerve involvement is occurring in addition to plantar fasciitis.

Bilateral fasciotomy was not the appropriate treatment and this is a significant departure from accepted practice. This view is based on the previous examination by [Dr G] and [Mr D] that from his clinical notes appears to have not been

appreciated by [Mr B]. In addition, there was a lack of additional assessment to rule out nerve involvement and the likely response of symptoms to fasciotomy.

Although [Mr A] refused to have a steroid injection there is no indication within the clinical record that a course of non-steroidal anti-inflammatory drugs (NSAIDs) was recommended, tried or contraindicated due to patient sensitivity or intolerance. This omission in treatment options is difficult to appreciate and NSAIDs most definitely have a place in the management of chronic heel pain but appear to have been not discussed or offered to the patient.

The literature describes that conservative treatment of plantar fasciitis usually provides a clinical response within the first 6 weeks (Thomas et al, 2010 p4). If after a program of conservative treatment pain persists as in the case of [Mr A] then surgery is a reasonable consideration (Thomas et al, 2010 p2 & 11). However, an accurate diagnosis is essential prior to selecting the most appropriate procedure to address the cause of heel pain.

In the management of chronic heel pain like [Mr A's] case the likely cause of nerve involvement is thought to be due to the long standing inflammation of the plantar fascia. The inflamed plantar fascia causes constriction of fibrous tissue to which it is connected and also surrounds the medial and lateral branches of the posterior tibial nerve as it travels from the medial ankle into the arch of the foot. The anatomical structure that surrounds the medial and lateral branches of the posterior tibial nerve form a protective tunnel and is called the porta pedis. It is the constriction of the porta pedis that causes neural pain that can be associated with chronic plantar fasciitis.

As the majority of heel pain cases tend to respond well to non-surgical management the use of imaging such as X-ray, ultrasound and occasionally MRI is usually only indicated prior to performing surgery. However surgical management of chronic heel pain patients where imaging provided no additional information can also be reasonable. In my experience of providing foot and ankle surgery for 23 years I have managed many such cases in which imaging did not provide additional information. [Mr B] is correct when he stated that the diagnosis of heel pain is often based on clinical findings.

My approach to deciding if surgery is indicated and what procedure to provide in managing chronic heel pain involves 2 additional steps not taken by [Mr B]. Firstly, in such cases a diagnostic low dye strapping is first applied and the patient advised to wear their orthosis and non-flat soled shoes for all weight bearing. The patient is reviewed 48 hours later.

If the patient reports a 50% or greater improvement in their pain, I advise the use of an instep fasciotomy. Secondly if the diagnostic strapping provides less than a 50% improvement in symptoms over 48 hours, imaging is ordered and clinical reassessment occurs. Then a determination as to if entrapment of the posterior tibial nerve branches, the presence of a plantar heel spur or systemic disease (e.g. rheumatoid arthritis) is the cause of the heel pain is made. The use of diagnostic strapping after 3 months of non-surgical treatment is an excellent method to

determine if an instep fasciotomy is indicated or further investigation and other procedures are required. This is because a positive response to diagnostic strapping as described above even in cases like [Mr A's] which are suggestive of nerve involvement usually have a favourable outcome from instep fasciotomy. That is to say I will recommend to patients to have an instep fasciotomy in cases of early nerve involvement with no imaging findings present but only if the strapping provides a significant improvement in their pain within 48 hours. In such cases however patients are always informed that should their pain not settle over the 3 months following surgery then neurolysis (surgical decompression) of one or more posterior tibial nerve branches will be required.

The first fasciotomy technique used by [Mr B] appears from his operative report to have been appropriate and undertaken with due care. However, the operative report does not describe how much of the plantar fascia was incised. As described on page 220 of the article (Woelffer et al 2000) cited by [Mr B] the recommendation is to only incise two thirds or the central band of the plantar fascia. This is because incising more than two thirds of the plantar fascia is thought to cause long standing pain in the joints of the outside of the foot. Unfortunately, [Mr B's] operative report does not detail how much of the plantar fascia was incised. The lack of detail in the operative report represents a minor departure from accepted practice.

The second fasciotomy technique for the left foot was performed in the same manner as the first technique and likewise omitted to describe how much of the plantar fascia was released. Of more importance is the description of right foot pain at 2 weeks after the first fasciotomy noted in [Mr B's] clinical record of 22/8/14. It would have been more prudent to have waited at least 4 to 6 weeks to ensure that the first surgery had been successful before proceeding to the second surgery.

This is because even with a good outcome from instep fasciotomy patients can have some discomfort in the heel and the site of surgery for 4 to 6 weeks after surgery.

If after this time the vast majority of pain has not settled it would not be wise to proceed to providing the same surgery to the other foot. Providing the second surgery less than three weeks after the first surgery was too soon to know if the first surgery had been successful and the use of fasciotomy was appropriate for [Mr A]. This would be considered a significant departure from accepted practice.

Recommendations

For the purpose of quality improvement, the following recommendations are made for [Mr B] when managing patients with chronic plantar fasciitis.

1. Note the outcome of examination and treatment of other practitioners who have already managed the patient and how it may influence the diagnosis and treatment plan.

2. Note the type, location, duration and pattern of pain and what exacerbates it.
3. Offer and record in the clinical note the use of NSAIDs.
4. Thoroughly examine the neural structures such as the posterior tibial nerve and note findings in the clinical record.
5. Apply and note the outcome of diagnostic strapping prior to deciding to perform an instep fasciotomy.
6. Order imaging if diagnostic strapping fails to provide at least a 50% reduction in pain over a 48 hour period.
7. Wait for 4 to 6 weeks after the first surgery and monitor that the vast majority of postoperative surgical and preoperative heel pain is resolved before proceeding to instep fasciotomy of the other foot.

Thank you for requesting my advice in the matter. Please inform me if any further advice is required.

Yours faithfully

Dr Rob Hermann — Podiatric surgeon (registered specialist)

References

Thomas et al (2010). 'The Diagnosis and Treatment of Heel Pain: A Clinical Practice Guideline—Revision 2010' *Journal of Foot and Ankle Surgery* 49: 1–19

Woelffer et al (2000). 'Five Year Follow-up Results of Instep Fasciotomy for Chronic Heel Pain' *Journal of Foot and Ankle Surgery* 39(4):220"

The following further expert advice was obtained from podiatric surgeon Mr Robert Hermann:

"Thank you for your email dated 11 July 2016 in which you have requested further advice regarding the above matter. ... The referral instructions provided are:

Review a letter from [Mr B] dated 6 June 2016 and consider if my original report of 5 November 2015 should be revised. The letter provided from [Mr B] to [HDC] is dated 10 June 2016 and this correspondence has been assessed as new information for the purposes of this report.

I have been asked to comment on any aspect of the care provided to [Mr A]. Further I have been requested to advise if a conflict exists in the evidence by advising in the alternative. Specifically, where care is found to be appropriate if scenario a) was correct and where it is appropriate if scenario b) was correct.

The information provided and considered for my original opinion has been reviewed again and includes:

Health and Disability Commissioner (HDC)

1. Background regarding the matter
2. [Mr A's] complaint to the HDC ([date])
3. [Mr B's] response to [Mr A's] complaint (6/7/15)
4. Letter to [Mr E] (podiatrist) (5/6/15)

[Mr B] (podiatric surgeon)

1. Clinical notes and work certificates (17/7/14 to 20/2/15)
2. Letter of referral from [Dr G] to [Mr B] (17/7/14)
3. Letter from [Mr B] to [Dr G] (28/7/14)
4. Letter from [Mr B] to [Ms I] (12/1/15)
5. Consent for right plantar fasciotomy and operative report (7/8/14)
6. Consent for left plantar fasciotomy and operative report (26/8/14)

[Mr D] (physiotherapist)

1. Assessment notes for 30/6/14, 14/7/14
2. Return to Work Plan (24/4/15)

[Mr E] (podiatrist)

1. Clinical notes (2/3/15 & 12/3/15)
2. Diagnostic ultrasound report by [radiologist] (9/3/15)

[Dr C] (orthopaedic surgeon)

1. Letter to the HDC (8/7/15)
2. Letter to [Dr C] from [orthopaedic surgeon] (23/3/15)

Peer reviewed literature

Published article concerning management of plantar heel pain and surgical release of the plantar fascia. These articles are cited in the body of this report and listed in the reference section.

Response to [Mr B's] letter of 10 June 2016

Current status of [Mr A]

In his letter [Mr B] states on page 1, paragraph 1 that after discussing [Mr A's] progress with [Dr G], '... I am happy to learn that [Mr A] is better; he is at work full time, and able to stand without pain in his job for half his shift as an airport security officer.' My view on this comment is we do not have an objective opinion regarding the current status of [Mr A's] foot pain. To my knowledge no current

examination and report has been produced that quantifies [Mr A's] status and supports [Mr B's] position on the matter. [Mr B] appears to have come to his conclusion based on a conversation with [Dr G]. Although it indeed appears [Mr A] is better than before surgery he is still not been able to return to normal work activity. Specifically, he is unable to stand for his entire shift. Given that almost 2 years have elapsed since the last surgery one would have expected [Mr A] would have returned to his full pre-heel pain level of work activity. Given he is employed as an airport security officer it is assumed that having the ability to be comfortable weight bearing for the entire shift is the objective following surgery. Based on the information provided this does not appear to be the case. Given nerve entrapment is likely to have been present prior to surgery it is not surprising that [Mr A] is not able to perform at his full capacity while at work and remain weight bearing all day.

[Comment relating to other providers not relevant to this report has been redacted.]

Dr Hermann's personal routine

[Mr B] believes that my protocol of using diagnostic strapping to assist in deciding whether to perform an instep fasciotomy is outside accepted practice and not supported by the Clinical Practice Guideline. Further, [Mr B] believes that the use of diagnostic strapping in the manner described is my 'personal routine'. It appears that [Mr B] has misunderstood my previous report and how it applies the concepts of the Clinical Practice Guideline.

Pathway 2 on page 52 of the Clinical Practice Guideline actually states that in tier 1 strapping should be used in addition to a number of other non-surgical modalities to treat plantar heel pain. If the patient has unsatisfactory improvement they should progress to tier 2. Orthotic therapy is part of the treatment regime used in tier 2. If a patient does not improve satisfactorily after utilising the treatment modalities in tier 2 they then progress to tier 3 which includes fasciotomy.

The Clinical Practice Guideline also recommends on page 56 that tier 1 be utilised for 6 weeks, tier 2 for 6 months and then treatment considerations should include surgery in tier 3 (Thomas, Christensen et al. 2001). It is important to realise that practice guidelines such as the one considered in this report represent a framework in which clinical decisions are made. Like any such framework there is always variations in how patient symptoms present and the time over which such symptoms respond to treatment methods. Likewise, there can be variation as to how long the treatment modalities for each tier are followed. For example, if a patient receives no symptomatic relief at all from treatment modalities in tier 1 and 2 they should then progress to tier 3 sooner than 6 months. While such an outcome is not common it does occur.

In the case of [Mr A] he has received 11 months of tier 1 and 2 treatment prior to seeking treatment from [Mr B]. In such a scenario it is quite reasonable to use diagnostic strapping to decide if the fascia is the cause of most of the pain or if some other factor such as nerve entrapment is also involved. Diagnostic strapping

is very unlikely to provide any significant relief of heel pain when the fascia is not the cause. This is especially the case if orthosis have already been used by the patient for an extended period of time as was the case with [Mr A]. So in fact the recommendation to use diagnostic strapping before proceeding to tier 3 treatment modalities such as surgery is an adjunct to the Clinical Practice Guideline. It is not a deviation from it as suggested by [Mr B]. That is to say it adds to the information used to decide if an instep fasciotomy is the appropriate surgical technique to use. Therefore, the recommendation to use diagnostic strapping and closely monitor a patient's symptomatic response before deciding to perform surgery actually builds on the recommendations of the Clinical Practice Guideline document.

In my previous report I have stated that if after 3 months of non-surgical treatment a patient has failed to improve to any meaningful degree then I use diagnostic strapping to assist in deciding if an instep fasciotomy is indicated. This statement was to illustrate the above point that variation in the time frames applied using the 3 tier treatment protocol are reasonable and can be justified.

This means that some patients may well take 6 months before surgery should be considered. Likewise, other patients may receive very little or no benefit from tier 1 and 2 treatments. In such cases it is prudent to move forward to tier 3 and consider surgery. In other words, all patients are different in their symptomatic presentation and response to treatment. It is because of this individual patient variation that clinical guidelines time frames are modified. If such modifications were not considered, then some patients will be placed through more pain than they need to suffer.

In the way described above my recommendation on using diagnostic strapping to assist in decision making before proceeding to an instep fasciotomy is not contradictory as claimed by [Mr B]. In addition, I do not practise unnecessary surgery for heel pain.

Specifically, I operate on less than 5% of the heel pain cases I treat. Therefore, [Mr B's] statement that I perform unnecessary surgery is not based on fact.

Lack of response to conservative treatment suggests nerve involvement.

On page 3, paragraph 6 of [Mr B's] letter he states the literature provided in my last report did not support my view that a lack of symptomatic improvement with conservative treatment was suggestive of nerve involvement in [Mr A's] case. On page 53, paragraph 3 the Clinical Guideline states 'Localised nerve entrapment of the medial calcaneal or muscular branch of the lateral plantar nerve may be a contributing factor.' (Thomas, Christensen et al. 2001). In addition, on page 52 of the Clinical Guideline the pathway 2 diagram documents at the last level that if unsatisfactory improvement occurs following tier 1 and 2 treatment modalities (i.e. the treatment that [Mr A] had received prior to surgery) then alternative causes of heel pain such as neurogenic conditions should be considered in pathway 4 (Thomas, Christensen et al. 2001).

Further, Fishco states in paragraph 3 of page 66 that, ‘When heel pain is not eradicated by nonsurgical modalities, it is necessary to rule out less common causes of heel pain, including calcaneal stress fractures, tumours, infection, systemic arthritides, and nerve entrapment of the first branch of the lateral plantar nerve.’ (Fischo, Goecker et al. 2000). Therefore, the literature does support the view that neurological causes of heel pain should be ruled out before proceeding to surgery in cases of recalcitrant heel pain.

Releasing more than 2/3 of the plantar fascia

On page 6 and 7 of [Mr B’s] letter he questions my recommendation that when performing an instep fasciotomy no more than 2/3 of the plantar fascia should be released in order to prevent joint pain at the lateral (outside) aspect of the foot. He further suggests there is no literature to support my view on this point.

Interestingly 2 peer review articles that have been reviewed by both [Mr B] and I in the course of this matter do support my view. Specifically Fishco (page 68, paragraph 6) has reported that, ‘It is already widely accepted in the literature that after aggressive fasciotomy, lateral column pain is a common complication secondary to abnormal joint function and subsequent jamming.’ (Fishco, Goecker et al. 2000). In addition, Woelffer (page 222, paragraph 5) found, ‘Murphy and associates believed that this strain was more easily avoided if only 1/3 of the fascia was released rather than the entire fascia. With the instep plantar fasciotomy procedure reviewed in this article, only the central band of the fascia is transected’ (Woelffer, Figura et al. 2000). [Mr B] also states that the Woelffer article does not mention releasing 2/3 of the plantar fascia. However, on page 220 of the Woelffer article are 4 pictures that clearly show an incision placed at the medial aspect of the arch (Woelffer, Figura et al. 2000). This anatomical location is where the central band of the plantar fascia is most easily located during surgery.

In addition, the article does state that the central band of the fascia should be released. It is important to realise that the plantar fascia is comprised of a larger medial and smaller lateral band. The medial band comprises 2/3 of the width of the plantar fascia and is often called the ‘central band’. So releasing the central band is the same as releasing 2/3 of the plantar fascia.

However, the omission in [Mr B’s] operative report was that he did not describe how much of the plantar fascia was released. The amount of fascia released is not described in numerical value (i.e. 2/3) or in words such as the central band. Therefore, given the literature recognises the complication of lateral (outside of the foot) joint pain can occur if too much fascia is released the lack of detail in [Mr B’s] operative report is a minor departure from accepted practice.

Length of time between procedures

On Page 8 of [Mr B’s] letter he suggests that there is no literature to support the concept that bilateral instep fasciotomies should not be performed within at least 4 to 6 weeks of each other. However, the literature documents that complication rates following instep fasciotomy are not insignificant.

Over 5 years of following a cohort of patients Woelffer found a complication rate of 9.4%, Urovitz documented 20% in an 18 month follow up and Fishco followed patients for 20 months after surgery and reported 42% had complications (Fishco, Goecker et al. 2000, Woelffer, Figura et al. 2000, Urovitz, Birk-Urovitz et al. 2008). This means that most patients require a longer period than 2 weeks before a clinician can be certain they have recovered enough to have surgery on the opposite foot. I have performed more than 100 of these procedures. In my experience all patients take between 4 weeks and up to 12 months to completely settle and return to normal activity. Further [Mr B's] clinical notes of 22 August 2014 documents that [Mr A] still had right foot pain at 2 weeks after his first surgery. It was on the evidence just described that my report found performing the second surgery only 2 weeks after the first was a significant departure from accepted practice.

Summary

1. There is no objective data to suggest [Mr A's] heel pain as completely resolved. The fact that he cannot remain weight bearing for his entire shift at work suggests he still has ongoing heel pain 2 years after surgery.
2. Point one reinforces the notion that nerve entrapment may still be present.
3. [Comment relating to other providers not relevant to this report has been redacted.]
4. The suggestion to utilise diagnostic strapping after non-surgical treatment has failed to provide significant relief and before proceeding to surgery is valid and it enhances application of the 3 tier approach to treating heel pain described in Thomas' Clinical Guideline document.
5. Nerve involvement should be excluded by further investigation in patients with heel pain who do not response to tier 1 and 2 treatment modalities.
6. Operative reports for instep fasciotomy should document both the placement of the incision and quantify how much and what aspect of the plantar fascia is released.
7. When treating bilateral heel pain with the instep fasciotomy the procedures should be staged at least 4 to 6 weeks apart. My preference is to wait 12 weeks based on my experience using this procedure.

The findings of my previous report are all still valid. The suggestion that the clinical record should include a summary of previous treatment, reports and outcomes is strongly recommended. Analysis of such data should form part of the assessment and treatment plan in such patients. Further the suggestion to document offering the patient, where appropriate, use of non-steroidal anti-inflammatory medicine always has a place in the management of patients with heel pain.

Thank you for requesting my advice in the matter. Please inform me if any further advice is required.

Yours faithfully

Dr Rob Hermann — Podiatric surgeon (registered specialist)

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The following further expert advice was obtained from podiatric surgeon Mr Robert Hermann:

“Thank you for your email dated 1 February 2017 in which you have requested clarification about this matter.

You have asked if the advice I have provided should be changed because it has been established that [Mr B] did not receive any additional information regarding previous treatment of [Mr A] other than the initial referral letter from [Dr G]. In addition, [Mr F] and [Mr D] have confirmed that they did not provide any further documentation (about any consultations or treatment they provided) to [Mr B].

The information you have provided does not significantly change my opinion on the matter under review.

History taking is an integral part of patient management and should always include questions about previous treatment. Such questions should include how patient symptoms have responded to previous treatment. [Mr B] was aware that [Mr A] had received podiatric treatment prior to providing consultation because it is detailed as such in [Dr G’s] referral letter. Even when a referral letter does not provide much detail about previous treatment it is incumbent on any healthcare practitioner to seek clarification from the patient. Such clarification should include questions about what treatment has been provided and when. In addition, symptomatic response to previous treatment over time should be ascertained by asking the patient. If further clarification is required to assess how a patient’s condition has responded to previous treatment and/or the exact detail of the treatment provided, then additional information should be sought from previous providers of care. The process described above is very important if a surgeon is to appropriately decide to provide surgical management.

Further it is important to note [Dr G’s] referral letter states ‘... standing on the spot at work causes pain’. Although this statement could not be considered diagnostic when considered in isolation it is suggestive of nerve entrapment. This is especially the case considering [Mr A] had failed to improve with orthotic therapy.

As explained in my previous 2 reports and cited in the literature the vast majority of patients response very well to non-surgical management of heel spur syndrome. In those patients that symptoms are not significantly improved by non-surgical management nerve entrapment must be considered as a possible or even likely cause of symptoms.

It is acknowledged that had [Mr B] received all clinical notes from previous healthcare providers it may well have assisted his assessment of the patient’s condition. However, the fact remains that [Mr A’s] symptoms had not improved with non-surgical management. When such a clinical outcome occurs during the management of heel spur syndrome careful assessment and differential diagnosis is required to ascertain the involvement or otherwise of nerve entrapment.

Such determination can only be based on a careful clinical examination and thorough taking of the clinical history and symptomatic response of the condition to previous treatment.

In summary, the fact that [Mr B] had only received the information contained in [Dr G's] letter of referral and nothing from other providers of care to [Mr A] does not alter my opinion on the matter.

Thank you for requesting my advice in the matter. Please inform me if any further advice is required.

Yours faithfully

Dr Rob Hermann (Podiatric surgeon — registered specialist)”