MALPRACTICE COUNSEL

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Finger Nearly Cut Off in Accident

A 19-year-old man fell at work while carrying several glass jars. The jars shattered and severely cut his right hand in three places, including his thumb, ring finger, and little finger.

The plaintiff went to an Indiana ED. His little finger had been nearly cut off and was hanging by a patch of skin in the back. Blood was pouring out of the wound. The physician sutured the wound, covered it with gauze, and ordered the application of a pressure dressing to hold the gauze in place.

The plaintiff claimed that the physician told him not to touch the dressing for two days and that the dressing had no opening through which he could watch for vascular compromise of the wound site. The plaintiff also claimed he was given no instructions regarding what to do in the event of swelling.

The man's mother called the hospital when her son continued to experience pain. She was told to increase his pain medication and not to loosen the dressing.

The plaintiff developed an ischemic injury to the tip of his little finger. The injury caused him to lose an ROTC scholarship.

The plaintiff claimed that he should have been instructed to watch for swelling and have been given a way to check for vascular compromise. The plaintiff also claimed that the wound was bandaged in a way that cut off the blood supply to his finger. The plaintiff additionally argued that hospital personnel failed to properly respond to his complaints of pain.

The defendants denied any negligence, disputing the nature and extent of the injury and arguing fault by the plaintiff.

Outcome

According to published reports, a defense verdict was returned.

Comment

The information provided in this case is confusing: The initial presentation sounds like a near-complete amputation of the fifth digit, but the bad outcome is only an ischemic injury to the "tip of the little finger." It is critical to know the location of the finger laceration to comment on the appropriate management.

Assuming it was actually just a fingertip injury, normally one of two pathways is followed. If the fingertip injury is small (ie, 1 cm or less) and there is no exposed nailbed or bone, management can entail application of a nonadhesive dressing, with daily dressing changes. If the injury is large (ie, $>$ 1 cm), or there is exposure of bone or nailbed, consultation with an orthopedic, hand, or plastic surgery specialist is frequently necessary.

As this case illustrates, it is important that wound appearance be checked daily. Similarly, increasing wound pain may be the first sign of a complication (eg, ischemic injury, infection) and necessitates re-evaluation. **FLC**

Failure to Obtain Timely Orthopedic Treatment Results in Below-Knee Amputation

The plaintiff, age 60, was involved in an automobile accident and struck his knees on the dashboard. He underwent arthroscopic surgery. The plaintiff subsequently developed a deep vein thrombosis (DVT), and warfarin was prescribed.

Six weeks later, the plaintiff went to a Michigan ED on a Saturday with complaints of leg pain. He was treated and released. He returned to the ED the next day and was evaluated by Dr B., an emergency physician. Dr B. ruled out a DVT and suspected the plaintiff was experiencing compartment syndrome of the lower left leg. Dr B. contacted the plaintiff's treating orthopedist, who insisted it was likely a DVT and advised the defendant to call for a vascular consult.

The vascular surgeon agreed with Dr B. that the plaintiff's symptoms were caused by compartment syndrome. Dr B. again contacted the plaintiff's treating orthopedist, who refused to come to the hospital or admit the plaintiff for treatment.

The plaintiff was admitted through his treating family physician so that a stat orthopedic consult could be ordered. The plaintiff underwent emergency fasciotomies to treat his leg, but eventually underwent a below-knee amputation.

The plaintiff claimed that he was in the ED on the day in question for four to six hours. Within two hours, Dr B. had ruled out a DVT, and an ultrasound showed

a large hematoma in the calf, which led to a diagnosis of compartment syndrome. The plaintiff claimed that Dr B. could have called the on-call orthopedic surgeon, which would have resulted in timely surgery and eliminated the need for the amputation.

The defendant claimed that the plaintiff had an assigned orthopedist at the time of his presentation and that Dr B. was obligated to contact the plaintiff's treating orthopedist. Dr B. maintained that he had properly diagnosed the plaintiff's condition and that the compartment syndrome had been present a day earlier.

Outcome

According to a published account, a defense verdict was returned.

Comment

One of the more difficult challenges in emergency medicine is to convince consultants and/or primary care physicians to do the right thing—which usually means admitting or at least seeing the patient. The emergency physician in this case made the correct diagnosis early on. The problem was that the treating orthopedic physician did not want to see his/her patient. While a collegial approach is always best, sometimes the situation warrants a more aggressive interaction as we serve as the patient's advocate.

In cases of compartment syndrome, a patient will normally complain of pain out of proportion to the injury and frequently be resistant to narcotic analgesics. As the pressure in the closed space continues to increase, parasthesias (often described as a burning sensation) and impaired motor function can occur. The presence of a pulse in no way excludes the diagnosis of compartment syndrome, as lack of a pulse can be the last sign to develop. Management is timely surgical fasciotomy to reduce the pressure within the compartment. This case is unfortunate in that it resulted in the loss of a leg, but it was not due to any action or inaction of the emergency physician. **FLC**

Failure to Diagnose Fractured Leg After Fall

The plaintiff, in her mid-70s, was entering a supermarket when she slipped and fell, injuring her leg. She was taken to a local hospital, where she was seen by Dr P. An x-ray revealed evidence of a nondisplaced fracture. The plaintiff claimed that she was not told of the fracture and was discharged home.

At home, the plaintiff was helped from the car by her husband. Her fracture became displaced and comminuted when the plaintiff began to place weight on the leg. The plaintiff subsequently underwent surgery and was hospitalized for several days. She required recuperation in an assisted-living facility for several more weeks. The plaintiff claimed that she should never have been released home.

Dr P. claimed that he relied on the radiologist, Dr V., who reviewed the x-rays and reported no fractures. Dr V. denied giving such a report to Dr P.

Outcome

According to published reports, a jury found Dr P. 85% at fault and the plaintiff 15% at fault. The jury awarded $260,000.

Comment

Even when an emergency physician initially is told by the radiologist that there is no fracture, if the findings are not documented in the medical record—preferably with a written preliminary report from the radiologist attached—the emergency physician may later find that legally, he/she has "no leg to stand on." **NF**

Woman, Not Properly Triaged, Dies From Cardiopulmonary Arrest

A 45-year-old diabetic woman was brought to a hospital ED with severe hyperglycemia. She died of cardiopulmonary arrest. The plaintiff claimed that the decedent was not properly triaged as "urgent" and that she was not properly monitored.

Outcome

According to a published account, a $4 million verdict was returned.

Comment

It is sometimes difficult to seriously consider a diag-

nosis that is not typically associated with a certain age-group or gender—in this case, a woman who might be of child-bearing age.

At triage, there is often a need to rapidly evaluate patients under less-than-ideal conditions, which may not allow for careful consideration of other factors such as the effects of diabetes on pain and the cardiovascular system. If "down triaging" such a patient results in a prolonged wait for a more thorough evaluation, it may be too late afterward to address the more serious possibilities. **NF**

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