



PERFORMANCE UNDER PRESSURE

The Legal Side of Pressure Ulcer Prevention

Among the tools of the healthcare trade are medicines, dressings, instruments, nutritives and durable equipment. The tools of the legal trade are words. When these two professions meet, it's words that become the focus of attention. The outcome of a medical litigation is highly dependent on the words used in a care setting, arguably as important as the care delivered itself.

The concept of the importance of words in a clinical setting was discussed at the Medline "Prevention Above All" conference in Washington, D.C. by Kevin W. Yankowsky, JD, a partner in the Health Law–Health Litigation department of Fulbright & Jaworski LLP and Caroline Fife, MD, CWS, Director of Clinical Research at the Memorial Hermann Center for Wound Healing and Associate Professor–Division of Cardiology at the University of Texas Health Science Center. They explained the potential for trouble when words are turned against their original user.

Perhaps nowhere is a facility's choice of words more important than in the policies and procedures it creates and expects its employees to follow. "The road to litigation is paved with well-intentioned policies," explained Mr. Yankowsky. "Policies and procedures are kept in libraries by plaintiff's attorneys. They're shared electronically online." The implication is that a facility's own policies may be used to support a judgment against itself and its workers. Though policies and procedures are not law, a skillful lawyer can hold them up as standards. Because they're the facility's own words, they can be very powerful.

“Never”

In their single-minded pursuit of improved clinical care, policy drafters often fail to consider the legal implications of words they choose to insert in policies. Even more dangerously, they often fail to appreciate the plain, common sense meanings lay people give to those words when they are jurors in a professional liability trial.

For example, *never*, *always*, *equal*, *complete* and *immediately* are absolute words. Absolutes should be used cautiously, as they imply a binary, black or white, yes or no state. Suppose one particular two-hour turn of a bariatric resident over a four-day period was not done until three hours had passed. If your policy stated that residents with certain risk factors for pressure ulcers **must** be turned every two hours, have you delivered substandard care because of that one incident?

Actually, this scenario captures two potential problems – the imperative *must* and the implied linkage between a policy and standard of care. In nearly all jurisdictions, jurors in a healthcare liability lawsuit will be asked to

decide whether the “standard of care” was violated. Typically, “standard of care” in a medical legal context is unique to each resident, very factually specific and generally no more than what would be reasonable care under the same or similar circumstances.

However, a policy incorrectly identified as the definition of the standard of care can fundamentally change this important question. When a policy is labeled the “standard of care” a jury can be asked to simply consider whether or not every exact detail of the policy, as written, was followed. Put another way, the focus shifts to whether the policy was strictly adhered to instead of whether clinically appropriate care was delivered.

A policy should be a guideline that recognizes the uniqueness of each resident, which allows the sound judgment of the healthcare team to be exercised and provides flexibility in implementation. When “standard of care” is too closely bound to a policy, the answer to policy adherence is too closely bound to the assessment of appropriate care.



“Stage”

The word stage means a point in a progression or series of events. When we think of stages, we usually consider them moving through a usual set order, such as stages of development or grief. Staging a pressure ulcer, however, does not fit with that widespread understanding of the term.

“There is the misconception that if you have a stage 3 or 4, it must have begun as a stage 1,” Dr. Fife explained. “Therefore it follows that had it been identified at stage 1, the stage 4 would never have happened. If that’s true, the fact the stage 4 is there must mean that there was negligent care.”

All of these assumptions are false. The current NPUAP (National Pressure Ulcer Advisory Panel) pressure ulcer staging system indicates only the depth of tissue damage at the time the ulcer is assessed – it implies nothing about progression. Furthermore, our current understanding of how stage 3 and 4 ulcers develop is that they form from the inside out, the way an apple rots. As a result, tissue damage has already occurred at the level of the muscle by the time skin changes are apparent.

When communicating with residents and their families about pressure ulcers, using the staging system, while clinically correct, may be more confusing than helpful. Spending time to educate them – about the development of wounds from the inside out, about the skin as an organ that can fail and about the healing process may save you from trying to educate a jury later on those same points.

Of course, you should only answer questions appropriate to your clinical expertise and specific knowledge of the resident’s case. Otherwise, a three-part response is called for: Acknowledge the question and its importance, name the person who can address their question, and promptly notify that person by calling them or leaving them a detailed message—and note the action in the chart.

“[silence]”

One of the most dangerous words in precipitating litigation may well be no words at all.

“We really need to think about...what drives residents to attorneys,” explained Mr. Yankowsky. “Sometimes it’s greed. Certainly sometimes it’s grief. Sometimes it’s anger. Most of the time...it’s a search for answers.”

Two typical scenarios lead to litigation. The first is a resident or family who had questions that were simply not answered. The second is a question that was answered incompletely, inappropriately, unhelpfully or dismissively.

“If you don’t provide the answers, your adversary will,” Yankowsky cautioned, “and once they go to the plaintiff’s attorney, the game’s up. You’re past the point of being able to prevent the legal risk.”

The role of the apology is a topic of debate. Apologizing is not new; it has been almost universally taught in homes and classrooms and liberally applied on sporting fields and in department stores. In a clinical setting, though, it is a relatively new phenomenon.

Current thinking is that this practice may be efficacious, but words can be tricky when attached to an apology. Unintended and unexpected messages may be communicated. A nurse wishing to communicate sympathy by saying, “I’m sorry,” may mean, “I’m sorry this has happened to you,” but the resident may **hear** an admission of guilt for substandard care. Like many good treatments, apologies must not be dispensed without cautious, conscious consideration.



Prevention Above All

Preventative medical care and preventative dentistry are concepts we understand conceptually and whose effectiveness we can prove empirically. The concept of preventative legal care for healthcare facilities and practitioners is not as widely adopted. Understanding the potential pitfalls of simple words and responding appropriately is one

facet of a comprehensive preventative legal care approach. Far from being an underhanded way of deflecting blame for poor healthcare, it is an open and honest way to improve healthcare while preventing litigation that is preventable and protecting oneself against litigation that may be unpreventable. ■

Available beginning March 22, 2010

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Kevin Yankowsky is a partner in the health law litigation group of Fulbright & Jaworski L.L.P.'s Houston office. A true trial lawyer, Kevin's trial practice encompasses virtually all types of civil litigation facing the healthcare industry. In addition to his extensive courtroom experience, he advises on Joint Commission investigations, hospital committee and medical peer review matters.

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