Pressure ulcers in Australia: patterns of litigation and risk management issues

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Abstract

Unexpected outcomes or adverse events in the field of medicine have always existed and will continue to do so. Litigation for particular types of errors is increasing, perhaps not because health care professionals make more mistakes, but because consumers of health services are better informed and have come to expect outcomes which are reasonable and realistically achievable. However, it must be recognised that even state of the art medicine or faultless health care cannot cure all disease conditions nor save all lives. Delivering good health care involves not only the knowledge of science but the application of the art of good judgement. Despite this, there are still adverse outcomes or medical errors which should not occur. A medical error may be described as an unintended act (either of omission or commission) or an act that does not achieve its intended purpose [1].

This article examines some of these concepts and how they interface with the prediction and prevention of pressure ulcers. The article will examine, in particular, civil litigation patterns in this area, specific areas of legal exposure for practitioners and how the AWMA *Standards for Wound Management* [2] ('the Standards'), provides clinicians with the opportunity to deliver sound risk management principles in the prevention and management of pressure ulcers.

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Introduction

It is now recognised, both internationally and nationally, that good risk management in the area of health care can significantly impact upon claims trends [3]. Overseas experience has borne this out by demonstrating over a period of time that structured risk management strategies and programmes can lead to a reduction in claims costs and frequency. These patterns are relevant not only to medical practitioners insured through private insurers, but also staff employed by public health entities who are indemnified under government schemes [4].

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As guidelines [5] and treatment [6] options for the potentially life threatening condition of pressure ulcers become more refined, arguably the practitioner's legal exposure increases. The availability of clinical practice guidelines and standards enable closer examination of the requisite legal standard of care and any possible departure from this.

Growing claims numbers and costs in medical negligence are not reflected in the area of pressure ulcers; historically this has not been considered an area of 'high risk' for either medical or nursing staff. This is surprising given that pressure ulcers are now considered to be predictable and possibly preventable [7]. It is no longer acceptable to assume that pressure ulcers are the inevitable result of ageing or long hospital/nursing home stays [8]. Any increase in litigation in this area should inevitably lead to a greater focus being placed on improving standards of care, which should in turn result in improved quality of service delivery [9].

The development of pressure ulcers in a patient should always be viewed as an adverse outcome of treatment. With any adverse outcome, whether based in negligence or not, there is always an opportunity to litigate. There is no reason why any patient, whether placed in a nursing home or admitted to hospital, should sustain unnecessary pressure

ulcers. Yet anecdotal evidence suggests that patients continue to be sent to hospitals with necrotic limbs following minimal treatment in private residences or nursing homes. Conversely, many patients not considered to be at risk are sent home with pressure ulcers acquired in acute hospitals.

Cumulative Australian data on pressure ulcers suggest that the prevalence [10, 11] and incidence of pressure ulcers [12] in the acute care sector is high. This has been found to be equally so in a domiciliary setting [13]. Whilst data on the morbidity and mortality of pressure ulcers in Australia are scarce, they are known to have been the primary or secondary cause of death in 1293 cases between 1997 and 2000 [14].

Recognition of adverse outcomes also provides significant opportunity to alter systems and practices such that they lead to an improved standard of clinical care in the future. This opportunity should never be diminished or discouraged in any health care setting.

When examining the prevention of pressure ulcers, one is often faced with the paradox of false economies. For example, the cost of modern dressings and pressure relieving mattresses, although relatively expensive, will still be less costly than remedial treatment or successful litigation, not to mention the unnecessary medical, social and emotional consequences for the patient [15].

Current litigation patterns

Litigation against individual health care providers and health care institutions for pressure ulcers has been commonplace both in the US [16] and the UK [17] for some time. Litigation in Australia, however, is uncommon, although there is no reason why this should continue to be the case.

Trends overseas, particularly in the US, have been quite different to those in Australia. While litigation in the US involving pressure ulcers has not always attracted high payouts, this pattern has gradually changed [8].

In respect of Australian cases, a patient did succeed against both her treating doctor and the Sydney Hospital for a range of breaches of standards of care. The incident occurred in 1986, but was not heard by the Supreme Court of New South Wales until 1994. Mrs Gwen Ford was admitted to a Sydney hospital and, over a period of time, sustained serious muscle loss following the development of a pressure sore which was not treated promptly. Mrs Ford was awarded $630,000 in damages, a rather significant settlement for that time [18]. Aside from highlighting that large awards of damages are possible in Australia for pressure sore cases, this case also demonstrates that litigation may involve an individual, an institution or an employee for whom an institution is vicariously liable.

Given that civil litigation is increasing in Australia, one must ask the obvious question – why do patients not litigate once they have developed serious pressure ulcers? While it is not the intention in this paper to examine this question in any depth, one can only surmise that the majority of patients in this category are elderly, have an organic brain disorder or dementia (whereby medical decisions would have been delegated to a third party) and live alone; hence, any proceedings in negligence would need to be commenced by a third party. Assessment of damages in civil cases include non-pecuniary loss (pain and suffering, loss of amenities, disfigurement and scarring and aggravated and exemplary damages), cost of carers and assistance and loss of earning capacity. If any of these heads of damages were to be applied to an elderly patient in Australia, the result may be that awards for damages may not be very high.

While the practice does occur in the US, Australian courts tend not to award aggravated or exemplary damages. To demonstrate the seriousness with which US courts consider damages resultant from poor nursing home care, general personal injury cases produce punitive (aggravated/exemplary) damages in only 5% of cases, compared with the figure of 20% for nursing home ligation [8].

What is required for a patient to succeed in negligence?

In Australia, for there to be a finding in negligence, there must also be a finding of fault. The law aims to put the patient back in the same position as they were immediately before the adverse event/damage occurred. A patient must satisfy the court on the basis of probabilities that:

- The defendant owed the patient a duty of care.
- The defendant breached that duty.
- The breach caused loss or injury (damage).
- Such damage was not too remote a consequence of the original breach of duty.

In the case of pressure ulcers, the patient would need to establish that the 'pressure ulcer' was indeed that, and not due to some underlying disease process which meant that ulcers in some form were inevitable and not as a result of poor nursing or medical care [8]. It is possible in such a scenario that damages may be awarded but discounted to reflect the possibility that the condition would have manifested itself in any event, perhaps at a later time.

Medical, nursing and allied health staff should be reminded of other possible areas of recourse for a patient inflicted with a pressure ulcer. Health care professionals may find themselves the subject of an Ombudsman's investigation, a complaint before the Medical or Nurses Board, the subject of

a complaint before the Health Care Commissioner (this may vary from State to State) or even involved in a coronial investigation.

Health care professionals are also reminded that Freedom of Information legislation enacted in each State and the *Privacy Act (Cth)* 1988 and its amendments dictate that, with some exceptions, patients are able to request access to their medical record; this quite rightly enables the patient (or approved third parties) to identify any anomalies or deficits in their clinical care.

Application of risk management principles and the AWMA Standards [2]

Generally speaking, sound risk management principles are demonstrated in a number of ways. The relationship which develops between the health care provider and the patient/family is pivotal and cannot be underestimated when adverse outcomes occur. It is well understood that patients and their families litigate for reasons other than the desire for handsome monetary settlements [9]. Similarly, "if a patient is generally happy with the medical service provided by their regular practitioner, then there may be a tendency to overlook minor incidents with a view to affirming and continuing a positive relationship" [19].

The Standards enunciate the delicate balance as mentioned previously between the knowledge of science and the application of good judgement; "The Australian Wound Management Association Inc. believe that all people with or who are likely to develop a wound are entitled to receive personalised care and management that is supported by current validated research" [2].

While all of the Standards have some relevance to clinical risk reduction, this paper will briefly discuss Standards 1, 2 and 5.

Standard 1: Collaborative practice and interdisciplinary care

Just as good communication between the health care provider and patient can reduce litigation, so too can good communication among members of a health care team. For too long, adverse outcomes have been viewed in terms of 'individual error' instead of recognising that a 'system error' may be the key to such poor outcomes.

When an incident occurs you should ask: 'What does this tell us about our system,' then ask, 'What does this tell us about the individual' [20]?

Standard 2: Professional practice

This Standard ensures that all relevant legislation, codes of practice, clinical practice guidelines and organisational policies are complied with.

From a clinical risk management perspective, this Standard achieves two things. It extends the first Standard by confirming the importance of health care professionals working as a team; by doing this and adhering to sound organisational guidelines and policies, staff are less likely to become involved in unexpected outcomes, or to feel 'blamed' when an adverse outcome does occur.

Standard 2 also recognises the value of clinical practice guidelines. While there is a divergence of opinion as to the role which clinical practice guidelines play in reducing medico-legal exposure, legal observation suggests that where clinical practice guidelines are available, failure to adhere to them may be regarded as 'less than reasonable', unless there are compelling clinical grounds not to adhere to the guidelines [21].

In medico legal terms, 'reasonable' refers to the duty placed upon a medical practitioner to exercise reasonable care and skill in the delivery of medical advice and treatment [22].

In *Maloney v Commissioner for Railways NSW* [23], Barwick CJ noted "It is easy to overlook the all important emphasis placed upon the word 'reasonable' in the statement of the duty. Perfection or the use of increased knowledge or experience embraced in hindsight after the event should form no part of the components of what is reasonable in all the circumstances".

Standard 5: Documentation

The quality and clarity of medical records is an essential ingredient in good risk management and, more often, a successful legal defence. The importance of clear, legible and contemporaneous medical records are considered by many to be the cornerstone of clinical risk management.

The absence of documentation in the medical record of over 80% of people with a pressure ulcer in a recent national multi-centre study would suggest that compliance with this Standard is poor [24].

This Standard confirms not only the importance of consistent and legible medical records but of the necessity of obtaining informed consent from the patient in every aspect of assessment and treatment of pressure ulcers.

Medical indemnity insurers for both the public and private sectors have begun channelling increased time and resources into risk management programmes. The development of these Standards supports good risk management, even though it is acknowledged that they were developed to ensure the highest standards of clinical care. The importance of these Standards lie in the fact that they reinforce the belief that risk management should not be seen as an adjunct to good clinical care but as an integral part of the process.

Clinical practice guidelines and standards provide a template for what health care providers must aim to work within. The more frequently a system's approach is used in the medical

setting, the less likelihood of an adverse even occurring or the health care professionals involved feeling alienated and unsupported.

Conclusion

If we are to expect that litigation in this area will follow overseas trends, then it is likely that the frequency will increase. However, health care professionals are well placed to avoid the likelihood of litigation by adhering to current clinical practice guidelines for pressure ulcers and standards for wound management. These documents represent good risk management strategies as well as ensuring the quality of clinical care remains high.

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