Pressure ulcers and litigation

In the past, relatives and patients appeared to accept that pressure ulcers were an inevitable result of chronic conditions and reduced mobility. Now they are viewed as evidence of a failure to provide a reasonable standard of care and action can be brought against those responsible, for compensation.

Implications of the Human Rights Act 1998
Since 2 October 2000, UK citizens have had the right to bring an action to the European Court of Human Rights in respect of any alleged breach of their rights as contained in Schedule 1 to the European Convention of Human Rights, 1951. The articles which appear to relate directly to the issue of tissue viability are Articles 2 and 3. Article 2 states that everyone's right to life shall be protected by law. In some cases pressure ulcers and tissue damage are so severe that they can cause the death of a patient. In such cases it could be argued that the failure to provide a proper standard of care has led to the death of the patient and is, therefore, a breach of Article 2. Clearly, to succeed it would have to be shown that there was gross negligence in the care of the patient and a link between the failures in care and the death of the patient. This may be extremely difficult, and therefore action under Article 3 may be preferred.

Article 3 gives a right not to be subjected to torture or to inhuman or degrading treatment or punishment. Most practitioners would probably agree that, in the worst cases, failures to prevent the occurrence of tissue breakdown could be seen as inhuman or degrading treatment. There has not been a case where the human rights articles have been invoked in litigation relating to pressure ulcers, but it would seem that there is no reason that such an argument should not succeed.

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The same logic could be used against an NHS trust in relation to the standards of care provided. The trust has a statutory duty to provide reasonable health services, and failures to fulfil this duty by causing pressure ulcers could be seen as a breach of Article 3.

Accountability Human rights arguments are likely to be accompanied by other forms of legal action. Cases relating to a serious pressure ulcer could, in certain situations, form evidence for a manslaughter charge. It would have to be shown that the individual or individuals responsible were guilty of the most appalling gross negligence causing the death of the patient. However, difficulties in establishing personal blame are likely to make such a criminal prosecution rare.

What is becoming increasingly likely is the possibility of patients and relatives suing in respect of pressure ulcers and claiming compensation. This may begin as a complaint, but these frequently lead to litigation. The claimant would have to prove that a duty of care was owed, that there was a breach of this duty and that this breach caused the pressure ulcers and the claimant is, therefore, entitled to compensation.

Causation A claimant has to establish, on a balance of probabilities, that the harm suffered by the patient was a reasonable, foreseeable consequence of the breach of the duty of care. In cases involving tissue viability, it may be easy to establish that the patient has suffered increased pain and hospitalisation as a result of a pressure ulcer. However, it is more difficult to establish that the patient’s death was caused by the ulcer and a specific breach of the duty of care. Often the patient is ill and in a weak, vulnerable situation and therefore death may be caused by an underlying condition that is exacerbated by a pressure ulcer, but not caused by it.

Standards of care The traditional way of determining the standard of care in relation to an action for negligence is to apply the Bolam test. This comes from a case (Bolam v. Friern Hospital Management Committee, 1957) in which the judge said: ‘The standard of care expected is the standard of the ordinary skilled man exercising and professing to have that special skill.’

In order to establish what would be the reasonable standard of care in individual cases, expert evidence is provided to the court. The House of Lords has emphasised that experts should be reasonable and responsible in giving this expert opinion (Bolitho v. City and Hackney Health Authority, 1997). Recent reforms of civil procedure have made it clear that the experts owe a duty to the court and that, where possible, both sides should agree on a particular expert or experts. The opinion of the expert would be based on current research on clinically effective practice and on current thinking as shown in approved text books.

National Institute for Clinical Excellence NICE recommendations and guidance will have a major impact in determining what is considered to be
reasonable practice. NICE provides levels of evidence to support its recommendations. It has published guidelines on pressure ulcer risk management and prevention (NICE, 2001) and in this grades its recommendations from level 1 to 3. (Level 1 recommendations are based on generally consistent findings in a majority of acceptable studies; level 3 has limited scientific evidence where research does not meet all the criteria for acceptable studies).

Interestingly the only level 1 recommendation in its pressure ulcer guidelines is that risk assessment tools should only be used as an aide-memoire and should not replace clinical judgement.

Using guidelines It is important to question whether published guidelines have to be followed. Whether guidelines are appropriate depends upon the circumstances of the individual patient and there may be occasions where there need to be modifications in the application of the guideline to ensure that reasonable care was taken of the patient’s safety.

Hurwitz (1998) provides a useful view of the legal implications of guidelines, policies, protocols and procedures. He discusses the circumstances where it is negligent not to follow guidelines and those situations where it is negligent to follow the guidelines absolutely. Professional judgement is required and circumstances must be documented when guidelines are not entirely appropriate.

High standards of documentation Sound standards of record-keeping are essential as part of the duty of care to the patient.

If there is a dispute about the cause of a pressure ulcer, then the patient’s records will be extremely important in determining whether there was a risk assessment of the patient’s condition, and whether it was followed by a treatment plan which, the records show, was properly implemented. If advice is sought from others, for example the tissue viability nurse specialist, this should also be recorded.

It is also essential that if there are adverse incidents and conditions then others should be able to learn from these lessons. This is why a return should be made to the National Patient Safety Agency.

Changing standards It is a personal and professional requirement of any health practitioner to ensure that they keep up to date with changing standards. The Bolam Test is useful since it applies the reasonable standards applicable at the time of any incident, rather than the standards at the time that a court hearing takes place which may be many years later. Thus the Bolam Test implicitly recognises that standards change with the development of research and knowledge.

Perhaps in future, particularly in rural areas, it may become a reasonable requirement that telemedicine is available to obtain expert opinion on wound healing, but this will require the establishment of standards for the practice for telemedicine (Stanberry, 1998).

The Future On 12 June, 2002 the Public Accounts Committee (PAC) of the House of Commons published a report into the handling of clinical negligence claims in England. It criticised the present system which showed a systematic lack of compassion in dealing with patients who claim to have suffered through negligence. It found that patients who had suffered injury through negligence of the NHS often faced a long and difficult process to pursue their claims. This PAC report follows the report of the National Audit Office (2001) which stated that almost £4bn should be set aside to meet known and estimated liabilities. A high proportion of this sum is spent on the legal costs, not on the actual compensation to patients.

In the light of the NAO report, the Department of Health announced in July 2001 that it was setting up a committee under the chairmanship of the chief medical officer of health to consider a new scheme for compensation for clinical negligence. The intention is for a white paper to be published, setting out the government’s reforms for obtaining compensation within the NHS. Suggestions for change include:

■ A no-fault liability system;
■ Structured settlements so that patients receive periodic payments (These are already legally possible but the NHS Litigation Authority does not favour them);
■ A scheme for fixed tariffs for specific injuries (comparable to the Criminal Injury Compensation Scheme or the Vaccine Damage Payments Scheme);
■ Greater use of mediation to resolve disputes.

Conclusion There is no doubt that we are now in an era of ‘compensationitis’. There is no reason to suppose that the field of wound healing and tissue viability is exempt from the possibility of litigation and arguments that human rights have been breached. It is clear that practitioners must ensure that they follow the reasonable standards of care and use guidelines with professional discretion. At the same time it would appear that the time has come to test out a system of no-fault liability combined with mediation in order to save legal costs, reduce the impact of litigation and ensure more funds go to patient care.