

# THE LNC NEWSLETTER

PRESENTED BY:  
**Medical-Legal Interface**

## PATIENT NON-COMPLIANCE

Sarah McLain RN CLNC

December 2004  
Volume 4, Issue 3

### Inside this issue:

<b>Malnutrition in the Elderly-Fact of Life or Treatable Condition (Part Two)</b>	<b>2</b>
<b>Patients Undergoing Surgery During Pregnancy</b>	<b>4</b>
<b>Medical Terminology Resources for the Legal Profession</b>	<b>5</b>

Non-compliance is a problem that has plagued medicine since its advent. Non-compliance occurs when a patient does not follow the advice of his or her physician. Do we really want compliant patients who blindly obey whatever we command of them, or do we want patients who better understand their conditions and both comprehend and agree with our advice? Patients who we might call "concordant." It is estimated that lack of concordance costs the health care industry over a billion dollars in hospital expenditure, loss of productivity at work and medico-legal issues. Concordance itself is a wide ranging scope of possibilities. It ranges from a routine GP visit to a patient on strict warfarin therapeutic monitoring. Since both these patients have seen the doctor, they may be called concordant. However, the consequences of non-concordance will have different severities in each case. Similarly, non-concordance ranges from a patient who does not take one aspirin a

a day to a patient who fails to continue with triple therapy for HIV treatment.

What factors are involved in non-concordance? Perhaps there is a lack of effort on the part of the physician to explain the situation to the patient causing the patient to ignore the doctor's advice. If a patient is unable to grasp the full extent of the disease he/she is less likely to be motivated and may simply be overwhelmed with all the information. Perhaps physicians, due to time constraints, have a tendency to speed through technicalities of treatment, relying on the patient to pick up some of the slack by educating themselves. Depending on factors such as level of education and resources, this may occur; however, one must keep in mind that it may not.

Where does one draw the line as far as doing too much? Physicians are in a position of ultimate responsibility and their words have a resounding  
Cont on p 2

## Medicine Means Never Having To Say You're Sorry?

Robert Morrison, RN BSN

My mother spent years trying to teach me the basic principle, and now that I am a parent I often find myself giving the same lecture. When you hurt someone or act rude toward another person you have to say "I'm sorry." Of course, the other side of that is that the other person follows with "I forgive you." One of the problems I face is when my children see the other person not following an apology with a statement of forgiveness. The "real world" often seems reluctant to express regret, either because they don't expect the other side to do likewise or they think they will appear at fault if they do. This also makes a person appear not to care, even if they do.

That leads us to discuss the reasons most often cited for filing, or threatening to file, a medical malpractice suit. Insurers blame the greedy lawyers and plaintiffs, the legal profession blames greedy insurers, and politicians blame everyone. It is undeniable that the ability to sue for damages plays an important role in improving medical care and maintaining social order. After all, no profession can operate at peak efficiency if it has no threat of repercussion and is not accountable to anyone. However, the concept of the "frivolous" lawsuit benefits no one.

Electronic and literature searches have indicated

that the reason that most suits are filed, or threatened, is anger and a perceived lack of information, not greed. The proportion of such suits is estimated at 70-80% by some sources. In other words, the problem appears to be the non-willingness to communicate. Given the fact that the majority of suits are dropped or settled, and the vast majority of litigated cases are found for the defense, damaged plaintiffs cannot be universally described as "out for a buck." The odds of that happening are too small to make this true.

This is confirmed by my own experience. How many times have I sat in a client's office listening to the potential plaintiff describe their experience? They are upset about the believed breach of standard. They suffer from the damage done to themselves, or their family member. But what are they angry about, to the point of assuming the role of adversary? The lack of "owning up to the mistakes," or a perceived lack of caring. One such family member submitted a medical record that they had reviewed page by page, with numerous notes, highlights and comments in the margins. The statements were clearly angry and voiced significant pent-up emotion. It made it difficult to concentrate on the medical information.  
Cont on p. 3

## PATIENT NON-COMPLIANCE

Continued from page 1

impact on patient decisions. However, freedom of choice allows the patient to choose therapy he sees fit and to omit what he feels as unnecessary despite understanding the dire consequences. One cannot legally make a patient adhere to a certain treatment even if the consequences of not doing so could be fatal: for instance, a woman who abuses alcohol during her pregnancy despite doctor's advice. It would seem to be ethical to take action against this individual, but legally there is little that a doctor can do to save the life of the unborn child. A "good" doctor should know his or her limits and utilize resources by working within these limits.

Many strategies that deal with patient education, support and empowerment have been proposed to overcome non-concordance. More often physicians are going to great

lengths to make sure that patients know how to take their medications correctly. A common strategy is to educate patients on monitoring blood sugar levels in the case of diabetics, on nutrition, and giving contact numbers for existing support groups. These measures help put the patient at ease about therapy and enable them to get much needed emotional support. A more drastic strategy includes patients visiting wound-care facilities for diabetics, visiting victims of DUI's (driving under the influence of alcohol or drugs) in intensive and coronary care units so that these patients can see the dire consequences of their non-concordance. Other physicians have given ultimatums to their patients stating that if they don't follow their advice for successful treatment then therapy would be terminated and there would be little point to come back. This strategy

aims to either scare the patient into concordance, make him comprehend the gravity of the situation (impending death), or drive him to another doctor who may have better luck.

The impact of doctor-patient interactions as they relate to non-concordance is of paramount importance to the health-care industry. As medical students, it is highly prudent to evolve strategies on how to bridge any gaps that impact on this interaction. We are in prime position to create a paradigm shift in the future of healthcare practice. The internet, TV and radio all offer modalities of communication which allow us to encourage patients to selectively use as current, informative resources for better health. It is logical to argue that a more informed patient will prove to be a more concordant, happier and healthier patient.

## Malnutrition in the Elderly-Fact of Life or Treatable Condition (Part Two)

Pattie Patterson RN, LNCC, CLCP

Last month the discussion was about ways to determine malnutrition, specifically in the elderly. This month we will look at ways to help to reverse this problem as well as some of its causes.

Several medications have been suggested for the treatment of anorexia and weight loss in older persons. These medications include:

- Megestrol acetate
- Oxandrolone
- Testosterone
- Cyproheptadine
- Dronabinol
- Metoclopramide

Megestrol acetate has been used successfully to stimulate appetite and promote weight gain in patients with AIDS and cancer. Megestrol acetate, dosed at 160 mg daily, was shown to prevent nutritional deterioration in older males with head and neck cancer

receiving either radiation or chemotherapy. Administration of megestrol acetate to elderly malnourished nursing home residents resulted in mild weight gain but was associated with a variety of side effects including delirium, megacolon, edema and congestive heart failure.

Growth hormone has been shown to stimulate weight gain in severely malnourished older patients. Growth hormone is extremely expensive, however, and treatment for more than six months has been associated with a variety of side effects including arthralgias, carpal tunnel syndrome, and gynecomastia. The use of growth hormone to treat intensive care unit patients with severe malnutrition resulted in increased mortality. Oxandrolone, an oral anabolic steroid with potent anabolic activity and minimal androgenic activity, was shown to have a positive

impact on weight gain in patients with AIDS and alcoholic hepatitis. Nandrolone, another anabolic steroid, improved nutritional status in patients with renal failure. Testosterone increased muscle strength and decreased leptin levels in older persons. In another study, it decreased fat mass and increased muscle mass.

Metoclopramide, a prokinetic agent, has been used to treat early satiation and anorexia. It was also found to stimulate appetite in persons with anorexia caused by the cancer-associated dyspepsia syndrome. Its use, however, may result in dystonic reactions and worsening of parkinsonian symptoms. Cyproheptadine, an antiserotonergic agent, has been shown to have a mild

Cont to p 3

## Medicine Means Never Having To Say You're Sorry?

Continued from page 1

It also pointed to the primary reason for filing the suit. They were looking for information and clarification.

It is this finding that has given rise to the Sorry Works! program that is now in place around the country. The concept started with a VA hospital in Kentucky in 1987. The basic premise is simple. When a mistake is made, the providers and hospital administrators sit down with the patient and family, explain the situation in full, apologize for mistakes that were made, and offer financial settlements up front if they believe that the providers violated standards of care. Not all situations result in such offers. After all, sometimes the medical team does everything right and the patient still suffers. The hospital realized such significant savings in litigation and settlement expenses that they realized that they had found something big.

This program was later instituted at the University of Michigan, which reported a drop in the number of malpractice suits by 50% and a drop in litigation expenses by two-thirds, according to the Associated Press. It is set to begin on a "try and see" basis in Illinois this year in two hospitals. The results will be analyzed to see how the program affects rising insurance and litigation expenses.

The primary goal of the Sorry

Works! program is to reduce the anger and perceived accountability problems that often flare up during meetings between hospitals and doctors, and injured patients. Patients and/or their family members are encouraged to have legal counsel to represent them and full disclosure is made to all. This allows the family to know exactly what happened and make an informed decision regarding their legal options. In the event that the hospital or physician is at fault, the injured parties often accept lower settlements than they would have demanded in court. It also appears to have a positive impact on the rate of medical errors in the facilities that have tried it.

Just talking about this program would be enough to induce cardiac arrest in many hospital administrators, not to mention physicians. For many years the conventional wisdom is that the medical community should disclose nothing that could implicate them in any pending or possible litigation. Unfortunately, this often feeds the anger felt by the patient or family member. It also places the patient and their physician on opposite sides of a bitter dispute.

For the plaintiff's attorneys, the "us against them" mentality also poses a problem. In order to evaluate the merits of a potential claim, the attorney (and

their LNCs, of course!) need to know exactly what happened. In an adversarial situation the only way to determine the course of events is to file suit to force the other side to produce their records. This creates time and financial expenses that are totally unnecessary. If all parties could sit down and discuss the situation, examine the records, and diffuse the anger then everyone involved could spend their time on tasks that must be done.

We can all agree that there is enough rancor in the world today. While it is not possible to placate everyone, and there are many situations that both parties feel they are in the right, it is possible to stop looking at all bad medical outcomes as potential war. Allowing the parties to interact up front, providing full and unhesitating disclosure and expressing sympathy for the injured party can go a long way toward achieving this. Efficiency, after all, is not so much what you get done as what you eliminate that is unnecessary. This may not be the best program to use, but the concept is vital. Reduce the emotion and improve the quality of the work performed and we all benefit.

## Malnutrition in the Elderly

Continued on page 2

positive effect on appetite in malnourished adults. Duranabinol (tetrahydrocannabinol) is an antiemetic that promotes food intake. It has been shown to promote mild weight gain in patients with cancer or AIDS and stimulate weight gain when administered to patients with Alzheimer's disease. Adverse effects include euphoria, somnolence, and fatigue.

In cases where metabolic demand exceeds what can be met by oral intake alone such as with cancer cachexia or

with mechanical problems as with esophageal obstruction, endotracheal intubation, neuromuscular disease, or orofacial surgery, a tube feeding may be indicated. Access to the gut is achieved by a nasogastric (NG) or nasointestinal tube, or a percutaneous gastric (PEG) or percutaneous intestinal (PEJ) tube. Aspiration of gastric content is the most serious complication of feeding tubes, and is very common, even with aspiration precautions. As much as 40% of deaths related to tube feeding are due to aspiration pneumonia, with aspiration

occurring in 44% of patients with NG tubes, and 56% of patients with PEG tubes in a long-term care setting. Duodenal tubes do not provide added protection against aspiration. In fact, a false sense of security with feeding tubes that traverse the pylorus may lead to relaxation of reflux precautions, increasing the risk of aspiration. Medications that decrease the lower esophageal sphincter or delay gastric emptying must be avoided if possible.

Tube feeding      Cont on p 5

## Patients Undergoing Surgery During Pregnancy

Jan Aken RN IBCLC LNC

The following guidelines may be helpful when reviewing a medical malpractice suit involving a pregnant woman who has undergone a surgical procedure during her pregnancy.

1. All fetal/ monitoring should be done by a skilled OB nurse who can interpret the results and act accordingly
2. Operating room Anesthesiologist should consult with the attending Obstetrician prior to the case.

### **RELEVANT information:**

Safest time for surgery during pregnancy is the 2<sup>nd</sup> trimester: 14-26 weeks, because:

1. Out of time period of teratogenicity /Spontaneous Abortion (1<sup>st</sup> trimester)
2. Prior to time when uterus is likely to contract (3<sup>rd</sup> trimester)

### Drugs:

1. Check with reference: Freeman & Griggs, Drugs in Pregnancy & Lactation
2. Narcotics are safe and should be administered, as they would be if patient were not pregnant.
3. Vasopressors that decrease uterine blood flow (i.e. epinephrine decreases uterine blood flow,) should be avoided. Ephedrine does not diminish uterine blood flow and can be used.

### CRITICAL POINTS:

1. Patient should have pre-op cervical exam.
2. Pregnant patients are considered "full stomachs" and should receive Alka Gold(neutralize the stomach acid on call to operating room.
3. After 20 weeks should have positioning during procedure with uterus displaced off Vena Cava and aorta.
4. Hypotension should be avoided.

### **Procedure:**

1. Monitoring (usually done if patient is greater than 24 weeks)
  - a. Preoperative:  
Obtain a 20-30 minute electronic fetal monitor strip in holding area of the operating room or on the patient's unit.
  - b. Intraoperative:
    - i During abdominal surgery, fetal monitoring can be done by getting a Doppler attachment gas sterilized. It is then applying in a sterile fashion to the abdomen after prepping the abdomen.
    - ii Intraoperative monitoring can reveal variant fetal heart rate patterns associated with the following:
      - Hypotension
      - Cord compression
      - Manipulation of the maternal brain
      - Hypothermia
  - c. Postoperative:
    - i Postoperative Fetal/Monitoring should begin immediately in the PACU and extend continuously until the patient is recovered.
    - ii After discharge from the PACU, intermittent post operative monitoring is usually ordered by the obstetrician (i.e. 30 minutes, every 4- 12 hours)
    - iii Observe closely for preterm contractions since increased uterine activity is common post-op regardless of location of surgical site.
2. Logistics/Emergencies:
  - a. If the patient is greater than 25 weeks, the possibility of emergency C/S during surgery or immediately post-op
    - i A C/S cart should be ordered for the OR and kept nearby during the procedure.
    - ii) Have a C/S cart sent to the OR.
    - iii) As needed, an OB resident should be designated as the person to call stat should an emergency ensue. A system for getting them stat to the OR or PACU should be established between the nurse monitoring the patient and the OB resident.
    - iv) The anesthesiologist covering the PACU should be aware of the patient's pregnancy. The risk of crash cesarean section is extremely low. Ideally, an operating room should be used for the crash cesarean section rather than trying to move the patient to Perinatal Services.
    - v) The following to the preoperative area:
      - Fetal monitor, extra paper, belts, gel, etc.
      - Alka Gold for preoperative administration
      - Indocin suppository (50 mg.)
      - Terbutaline (with TB syringe for SQ use)

**WE WISH YOU AND  
YOURS THE MERRIEST  
CHRISTMAS AND A  
HAPPY, JOYFUL AND  
PROSPEROUS NEW  
YEAR!**

## Medical Terminology Resources for the Legal Profession

Maggie Driscoll BSN RN CCRN CLNC

It's not unusual for the legal nurse consultant to receive the occasional email or phone call from the frustrated legal assistant asking us to decipher the meaning of an abbreviation or unusual medical term. We are happy to answer the questions: what does "xyz" mean? Sometimes the answers to those questions are not found in medical terminology books or in our favorite online resource, but are unique to the profession and its different specialty areas around the country. Many times the writing is so poor that only a medical professional can determine the word's meaning and sometimes not even then!

The good news is that in addition to your favorite legal nurse consultant, there are great resources available for the legal professional to quickly locate and interpret medical terminology:

### Text Resources

- Medical Terminology: A Systems Approach, 4th Ed. Barbara Glys, Mary Ellen Wedding
- Medical Acronyms, Eponyms & Abbreviations by Marilyn Fuller Delong, R.N.
- Dorland's Illustrated Medical Dictionary
- Taber's Cyclopedic Medical Dictionary

Many of us are now finding that the online search is a more convenient way of researching information. When utilizing the World Wide Web it is important to remember that while there is a lot of accurate reliable information available at our fingertips, it can also be a source of misinformation. Websites that are more likely to provide quality information generally have the following information: contact information, statement of adherence to quality standards, date material was written, placed online, updated and with references.

### Online Resources

- Medical Dictionary: <http://cancerweb.ncl.ac.uk/omd/>
- Medline Plus medical dictionary and encyclopedia: <http://www.nlm.nih.gov/medlineplus/mpplusdictionary.html>
- Free online medical spell check: <http://www.medical-spell-checker.com/>
- Comprehensive medical resource (fees required): <http://www.stedmans.com/>
- Hyper-dictionary that includes English, computer and medical dictionaries: <http://www.hyperdictionary.com/medical>
- Lab testing: <http://www.labtestsonline.org/>  
[http://web2.airmail.net/uthman/lab\\_test.html](http://web2.airmail.net/uthman/lab_test.html)  
<http://pathcuric1.swmed.edu/PathDemo/nrrt.htm>
- Cardiology and open heart surgery terms: <http://www.musc.edu/chp-clin/ect/glossary.htm#A>
- Acronym finder: <http://www.acronymfinder.com/>
- Pharmaceutical and medical abbreviations: <http://www.medilexicon.com/>
- Physical therapy acronyms and abbreviations: <http://physicaltherapy.about.com/cs/medreference/a/rehabacronyms.htm>
- Ophthalmology Abbreviations: <http://www.med.cmu.ac.th/dept/eye/abbrev.pdf>  
<http://www.uiowa.edu/~c067111/pdf%20documents/abbreviations.pdf>

Online search engines can also be a valuable source for deciphering words where the spelling is unclear or where the terminology is very specialized.

Some favorites include:

- Includes multiple search engines: <http://www.freeality.com/>
- A metasearch engine with visual interface: [http://www.kartoo.com/en\\_in\\_dex.htm](http://www.kartoo.com/en_in_dex.htm)
- The Librarian's Index to the internet: <http://lii.org/>
- The world's biggest search engine: [www.google.com](http://www.google.com)  
Google is widely considered

the best general search engine available. For more information on how to better utilize Google for research, an online tutorial is available at:

<http://www.lib.berkeley.edu/TeachingLib/Guides/Internet/Google.html>

Still stuck? Call an experienced legal nurse consultant. We are always happy to assist our clients with terms that are difficult to interpret!

## Malnutrition in the Elderly

Continued from page 3

candidates must be selected carefully. Similar concerns surround the use of central or peripheral parenteral feeding. Parenteral feeding should be limited to relatively brief periods of time or be restricted to individuals with a nonfunctional gut. It is of benefit in acute management of pseudomembranous colitis, acute pancreatitis, or a severe flare-up of Crohns disease to rest the gut while recovery occurs. Metabolic parameters and electrolytes must be monitored closely. Parenteral nutrition has no place in the management of chronic age-related malnutrition.

Malnutrition in the elderly is a common problem albeit under diagnosed and when diagnosed is often undertreated. Early detection is the key to management and treatment of malnutrition.

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## Medical-Legal Interface

**Pattie Patterson RN, LNCC CLCP**  
**Legal Nurse Consultant-Certified**  
**Certified Life Care Planner**  
**6501 Galaxie Road**  
**Richmond, Va. 23228**

Phone: 804-262-2991

Fax: 804-266-5701

Email: [leglnurs@bellatlantic.net](mailto:leglnurs@bellatlantic.net)

*“We get to the heart of your  
case.”*

