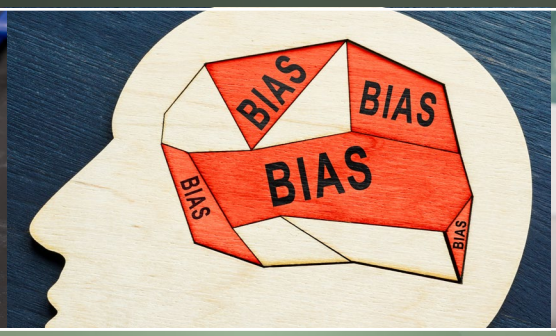
Volume 34
Number 2
Summer 2023

THE JOURNAL OF Legal Nurse Consulting



IN THIS ISSUE:

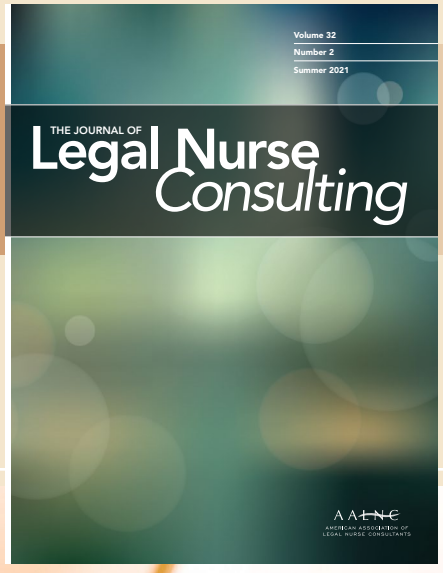
You can earn
CE CREDITS

• • •

Details inside!

AALNC
AMERICAN ASSOCIATION OF
LEGAL NURSE CONSULTANTS

This Journal Could Advance Your Legal Nursing Career!



CONTINUING EDUCATION IN THE *Journal of Legal Nurse Consulting*

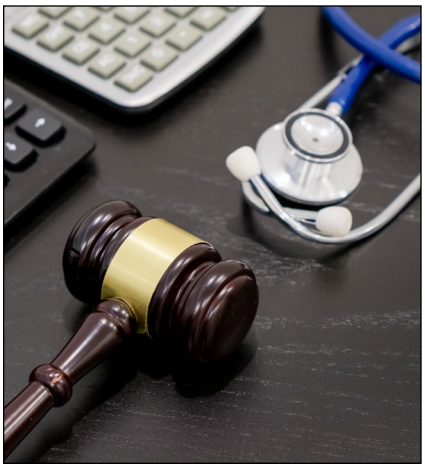
Earn Continuing Education credit(s) on select article(s) by following a few simple steps provided at the end of the article(s).

AALNC is accredited with distinction as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

For questions, contact **info@aalnc.org**.

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

THE JOURNAL OF
Legal Nurse Consulting
Volume 34 | Number 2 | Summer 2023



Did you know the highlighted articles above can earn you CEs? Follow the instructions listed inside to secure yours. *The Journal of Legal Nurse Consultants* provides **CE approved manuscripts** to help you stay current and relevant to your profession.

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

American Association of Legal Nurse Consultants
330 North Wabash Ave., Suite 2000
Chicago, IL 60611
877/402-2562 | 312/321-5177
Fax: 312/673-6655
E-mail: info@aalnc.org
Web site: www.aalnc.org

PURPOSE

The purpose of the *Journal* is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

MANUSCRIPT SUBMISSION

The *Journal* accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

MANUSCRIPT REVIEW PROCESS

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

The Journal of Legal Nurse Consulting is the official publication of the American Association of Legal Nurse Consultants (AALNC) and is a peer reviewed journal. Journal articles express the authors' views only and are not necessarily the official policy of AALNC or the editors of the journal. The association reserves the right to accept, reject or alter all editorial and advertising material submitted for publication.

The content of this publication is for informational purposes only. Neither the Publisher nor AALNC assumes any responsibility for any injury and/or damage to persons or property arising out of any claim, including but not limited to product liability and/or negligence, arising out of the use, performance or operation of any methods, products, instructions, or ideas contained in the material herein. The reader shall assume all risks in connection with his/her use of any of the information contained in this journal. Neither the Publisher nor AALNC shall be held responsible for errors, omissions in medical information given nor liable for any special, consequential, or exemplary damages resulting, in whole or in part, from any reader's use of or reliance on this material.

The appearance of advertising in the *The Journal of Legal Nurse Consulting* does not constitute a guarantee or endorsement of the quality or value of such product or of the claims made for it by its manufacturer. The fact that a product, service, or company is advertised in *The Journal of Legal Nurse Consulting* shall not be referred to by the manufacturer in collateral advertising. For advertising information, contact JLNC@aalnc.org or call 877/402-2562.

The Journal of Legal Nurse Consulting (ISSN 2470-6248) is published digitally by the American Association of Legal Nurse Consultants, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611, 877/402-2562. Members of the American Association of Legal Nurse Consultants receive a subscription to *The Journal of Legal Nurse Consulting* as a benefit of membership. Back issues are available for free digital download at the Association website. Non-members can purchase a digital subscription to current year issues and archives for $65 per year. Prices are subject to change. Back issues more than a year old can be obtained through the Cumulative Index to Nursing & Allied Health Literature (CINAHL). CINAHL's customer service number is 818/409-8005. Address all subscriptions correspondence to Circulation Department, *The Journal of Legal Nurse Consulting*, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611. Include the old and new address on change requests and allow 6 weeks for the change.

ARTICLE SUBMISSION

The Journal of Legal Nurse Consulting (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The *JLNC* follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: http://publicationethics.org/resources/code-conduct.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

INSTRUCTIONS FOR TEXT

- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 7th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Include a 100-word abstract and keywords on the first page
- Write the manuscript in third person only. If you feel an exception is warranted for the topic of your manuscript, please contact the Editor to discuss.
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

INSTRUCTIONS FOR ART, FIGURES, TABLES, LINKS

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art should be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

INSTRUCTIONS FOR PERMISSIONS

The author must accompany the submission with written release from:

- Any recognizable identified facility or patient/client, for the use of their name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned

GENERAL INFORMATION

Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

The author, not the Journal, is responsible for the views and conclusions of a published manuscript. The author will assign copyright to *JLNC* upon acceptance of the article. Permission for reprints or reproduction must be obtained from AALNC and will not be unreasonably withheld.

This publication may include digital hyperlinks to external resources. AALNC does not oversee, manage, or operationalize third party management of these external resources. If you encounter any issues with an external hyperlink provided, please contact the external source directly for assistance.

Lisa Mancuso,
BSN, RN, CCRN, CLCP, LNCC

President, AALNC

President's Update

I hope you will forgive me for a personal message this quarter (and I promise I'll get back to business with our next issue of *JLNC*).

My husband, Col. Martin Spellacy (US Army, Ret.), was diagnosed with pancreatic cancer in January. This is still a diagnosis filled with dread—as a medical and nursing community, we don't often hear about positive outcomes associated with this disease. My own sister's husband died of pancreatic cancer five years ago. I took care of him when he was dying; I can never "unsee" the devastating effects of pancreatic cancer on the human body.

Immediately after Martin was diagnosed, I joined multiple online support groups and swiftly left them as I read one terrible tale after another. I knew my "people" weren't going to be online.

I won't bore you all with the details of the past few months, but on March 21st, Martin had surgery at Massachusetts General Hospital in Boston. (Shout out to the best possible care! The team at MGH exceeded my expectations.) At the time I'm writing this, I can say to the best of our knowledge, Martin is cancer-free. (In the wise words of Mary Flanagan, our immediate Past President, "A chance to cut is a chance to cure.") Martin is facing 10 years of surveillance before anyone else will say he's cured, but we can handle that.

2023 has brought many health challenges to our AALNC membership. I obviously cannot disclose those difficulties, as they are not my stories to tell. However, I can assure you, readers, that when we call AALNC your "professional home," this is so true. The AALNC community has supported me (and others dealing with health and personal issues) in every possible way. I went from profound despair to cautious hope with each conversation I had with AALNC members.

I want to offer a public "thank you" to everyone who sent cards, emails, text messages, phone calls, flowers, soup, cookies, ice cream, and bottles of wine (again, Mary Flanagan!) to support me and Martin. It means more than you will ever know. I received an amazing care package filled with magazines, colored pencils, "foul language" coloring pages, motivation notes, etc., that made me laugh and helped pass the time in the hospital. (JP and NM, you know who you are!) AALNC members who I have never met sent us wonderful, distracting novels. Maybe we need to start an AALNC book club?

Many of you sent me a list of television shows to get lost in. Before Martin's diagnosis, I rarely watched TV. I can now say I have "binged" on programs. (Bridgerton; Schitt's Creek; Downton Abby—how did I miss all these delightful shows?) My point is that the AALNC community knew what I needed, even though I had no idea myself, and I'm grateful.

Continued on page 33

"Not all of us can do great things. But we can all do small things with great love."

– Mother Teresa

Editor's Note

Shawna M. Butler,
DNP, JD, RN, CPHRM

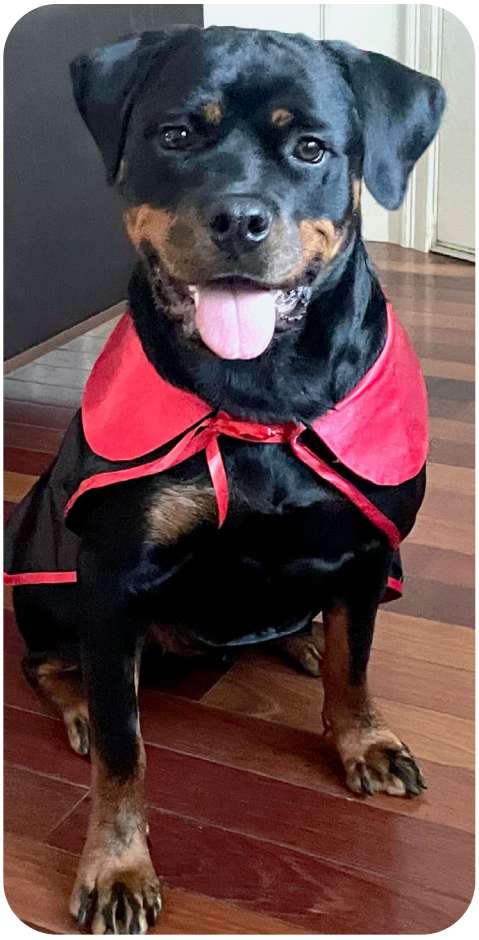
Editor, JLNC

Dear Readers and Colleagues,

Many of us struggle to find balance in our modern complex society. We follow the news and hear about tragedies and traumas locally and globally. It can be hard to find a way to allow ourselves to enjoy the pleasures in life without feeling guilty about the challenges many are experiencing all over the world along with all of our obligations. We can and should do things to help others within our capacity. This could be volunteering, donating to a cause we care about or helping our community members where they may need it. We have to do this within reason while also caring for ourselves. As healthcare clinicians we are also at risk of burnout. I have been reviewing ways to prevent and manage burnout. I ended up finding some help in an unlikely place.

This may sound sort of silly, but I sometimes watch my dog. My dog seems so content. She acclimated well into our home shortly after being rescued. She was found last year wandering around at about 1 year old and was never claimed. We were lucky to adopt her shortly after. I think we can learn a lot from our pets.

Have you ever noticed the way our pets act when happy or when stressed? When they are happy, they may wiggle, they may jump, they wag their tails. They exhibit their joy without any inhibition. They show love without shame or embarrassment. When dogs are stressed or overwhelmed, they may lick their lips, bark or whine, they may cower, hide in a corner or go to their bed, crate or their "safe space". Cats may purr or rub against their humans. These actions actually display strong coping mechanisms. I find myself admiring the way my dog, Raven, handles life events. She lets out a big sigh when she needs a release. She may play joyously and raucously and then suddenly drop down and go to sleep. I wish I could take a page out of Raven's "playbook". When she is tired, she rests. When she is playful, she plays. We could all really learn something from our pets. Remember to take some time to take a break today and if you have a pet, take a play out of their book!



Please see a gratuitous photo of my beautiful (I am not biased at all) Rottweiler Raven for your viewing pleasure.

Thank you,

Shawna Butler

Shawna M. Butler, DNP, JD, RN, CPHRM

When A Certified Nurse Aide's Actions Contribute to Litigation

Jessica Lewis, RN

Keywords: CNA, scope of practice, unlicensed personnel, RN oversight, medical malpractice

Certified Nurse Aides (CNAs) are a key part of the care of residents in nursing homes. Their actions, though overseen by Licensed Practical Nurses (LPNs) and Registered Nurses (RNs), can be a factor in an incident resulting in a lawsuit against the facility. This article will discuss the requirements of a CNA program, qualifications to enter the program, and some issues that may cause an incident to occur. The author will use her home state of Connecticut (CT) as a template. Each state will have a Board of Nursing as well as agencies that monitor CNA programs and survey nursing homes. Also, each state has its own regulations that need to be reviewed by the legal nurse consultant (LNC) working on a case involving CNAs and their Scope of Practice.

CNA programs are generally offered at community colleges, vocational schools and sometimes to high school seniors as part of their curriculum. The Department of Public Health (DPH) requires a number of hours be dedicated to classroom instruction on subjects such as skin care, bathing, and feeding residents. What follows is what generally occurs in training programs, there may be minor differences from program to program, but it exhibits the basic type of training that occurs. There is a simulated laboratory experience where the instructor demonstrates various skills, e.g. ambulating residents safely and applying Personal Protective Equipment (PPE). The students then do a return demonstration. The students must show proficiency in the skills to progress to clinical experience in a nursing home, caring for residents under the supervision of an instructor who is an experienced

LPN or RN. During the hands-on training, students initially shadow a CNA, then proceed to work in pairs, before independently caring for residents. The instructor regularly observes the students during the care. At the end of the rotation the instructor will write an evaluation. Upon successful completion of the internship and a passing academic grade, the student takes a state certification exam. The exam is composed of both a written and skills exam where the instructor observes the student performing skills. Students must pass both the written and skills portions.

To qualify for a CNA program, students must have some college credit or pass a math and English test. Students are medically screened due to the nature of the work. They must have a physical exam and a Tuberculosis (TB) test. Pregnant students must be cleared by their obstetrician and the program will honor restrictions such as a student lifting no more than ten pounds.

When caring for residents, CNAs follow a detailed, individualized written care plan written by a registered nurse. This care plan is generated from the physician orders on the admission of the resident. Almost all residents are admitted from a hospital after an illness or injury. The hospital will forward the resident's medical history and pertinent information to a nursing home rehab center. Transfer will be arranged from the hospital, and the nurse caring for the patient will report the patient's history and course of hospital stay to the nurse who will assume care of the resident. Upon arrival, the new resident will be assessed by the multidisciplinary team consisting of nursing, occupational and physical therapy, speech therapy, and the facility physician. Orders regarding diet, medications, and mobility are put in place and a care plan that delineates these is prepared for the CNA, particularly in regard to mobility (such as the need for a walker or mechanical lift) and diet along with dietary and fluid consistency (such as when a pureed diet is needed, and fluid requires thickening to enhance swallowing to prevent an aspiration pneumonia). Failure to adhere to these instructions can result in serious and immediate harm to the resident. For example, a choking incident can occur if the resident is fed solid food and has swallowing difficulty due to a stroke. A CNA is expected to report any issues to the nurse. Reddening of the skin, poor appetite, and complaints of pain are examples. Not following guidelines may lead to an incident. A CNA must not perform actions not taught in CNA training, such as medication administration. Facilities must provide in-service training on new equipment or specialized care residents need.

CNA actions can result in a lawsuit or Department of Public Health (DPH) citation. These are separate, and one may or may not lead to the other. A nursing home may be cited during an annual inspection for an infraction, but if a resident was not harmed obviously there would be no lawsuit. If a resident is harmed in some way, it may result in a citation or more seriously, be considered a Sentinel Event if it results in permanent injury or death of a resident. An article that recounted an incident in a Syracuse nursing home illustrates these points: a resident, a woman with dementia, walked to the bathroom unassisted. Due to her dementia, she didn't call for assistance. While returning to bed she fell, and in an unusual set of circumstances caught the tie of the hospital-type gown on the doorknob, hanged herself, and was found deceased. The article goes on to report that the facility had been previously cited for a number of infractions. And since these fortunately did not result in harm there was no litigation. While conducting the investigation, it was found the CNAs had not read the care plan and were unaware the patient was not supposed to walk unassisted (Briggs, 2021, May 11). Unfortunately, a person with dementia may not remember to ask for assistance, but it might have made staff more aware to check on this lady more frequently if they read the care plan and realized she might attempt to walk on her own. In essence, CNAs and their training are critical to the care of residents. If their training is inadequate or the CNA does not follow the principles taught to them, it can result in serious harm to the resident.

In Connecticut, The Nurse Aide Registry (The Nurse Aide Registry, CT) monitors hours worked, and facilities verify certification. CNAs must be certified to work in facilities but may function in a companion role in homecare settings even when not certified. In homecare, one CNA may use a Hoyer lift; in a facility, two caregivers are always required.

The pandemic slowed training and testing of CNAs. Training was problematic when it came to infection

CNA actions can result in a lawsuit or Department of Public Health (DPH) citation. These are separate, and one may or may not lead to the other. A nursing home may be cited during an annual inspection for an infraction, but if a resident was not harmed obviously there would be no lawsuit.

control. Unfortunately, this happened at the worst possible time. Stopgap measures were instituted such as an 8-hour video course and hiring people with the expectation they would become certified within a year. There has been a real backlog to catch up with students needing to be tested, as well as training and testing of students who were able to enter classes given after "lockdown". One issue: the training program was waiting for DPH approval to train students entirely on campus with no hours in a facility. The approval came through many weeks later.

Another consideration is the setting in which a CNA works. A caregiver working in the home does not necessarily need to be state-certified. Connecticut home health agencies are regulated by the Department of Consumer Protection. These homecare agencies are only allowed to work with clients with very basic needs. One example is Pansey Homecare. Its co-owner Mr. Francis describes his practice this way: "I look for quality people. You can train them on skills." Mr. Francis offers mini trainings and is pleased with results. In person and online options are offered, and compliance is monitored. He has an agency liaison make visits to check that the caregiver is performing properly. Some organizations utilize systems where the participants can print certificates of completion.

Medication administration is another aspect of care related to setting and training. CNAs and caregivers referred to as direct caregivers can be certified in medication administration by an RN. Examples of settings in Connecticut are juvenile detention, assisted living, residential care for children, and group homes. Direct caregivers can give oral medication and possibly some injections such as vaccines. What a caregiver is authorized to do would need to be verified by individual situations, with regards to the state the caregiver works in and the setting. State Boards of Nursing and Departments of Health would be possible agencies to check regarding state regulations. This allows medication to be administered conveniently by on-site staff. However, in group homes, assisted living, juvenile detention, and other residential care there is limited contact with licensed caregivers such as RNs and LPNs.

Licensed staff generally have less face-to-face contact with licensed caregivers. Direct care staff in group homes, for example, are not licensed nurses or CNAs. They only receive basic training from the organization in charge of the group home. Another consideration is that when a skill or responsibility is added, there is a risk of something untoward happening. In one instance, a CNA working in an assisted living facility administered insulin (a medication used to control a diabetic's blood sugar) to a patient. Fortunately, the correct dose was given and no harm came to the patient. Insulin potentially could cause dangerously low blood sugar (hypoglycemia). It is not generally in CNA scope of practice to administer insulin and the incident was reported to the administrator. Follow-up actions may involve a report to the state's DPH if the incident resulted in patient harm, but the CNA will certainly be retrained in practicing only within their scope.

CNAs are a cornerstone of resident care in any setting. It is imperative to train, screen, and look for integrity and compassion in caregivers. Here are three examples of situations that can occur:

Case Study One

During 2022 in Texas, two staff members were caught on camera beating a resident in his 80s. The family was initially told he had fallen. Video shows two employees of Solidago Health and Rehabilitation dragging Cornelio Salinas across the floor, hitting, and kicking him, and then tossing him on the bed.

His family said facility staff told them he fell and had to go to the hospital. "You never think it's going to happen to one of your family members," his grandson, Lizandro Solis, said. "It's sad." The family installed the camera after Salinas complained of staff members mistreating him. Salinas is now in the hospital with bruised eyes and wearing a neck brace. The incident was reported to the Texas City Police Department. (click2houston.com)

Case Study Two

[An incident witnessed personally by the author while working with CNA students is recounted here.]

A CNA used a standing lift on a resident (which requires ability to partially bear weight) instead of a Hoyer lift in which a resident is lifted in a sling attached to the lift. There were other caregivers present who supported the resident's weight and positioned the wheelchair under the resident to prevent a fall. This was reported to the Director of Nursing Services by the author and the CNA was suspended. Follow-up and retraining is recommended in this type of incident.

Case Study Three

A story in the "New Britain Herald" in March 2021 reported a homecare atten-

dant (not a certified CNA as homecare workers do not have to be certified) gained Power of Attorney from her client and obtained her credit cards, then used them to pay her own expenses and make lavish purchases. This resulted in the attendant's incarceration.

These are examples of physical abuse, neglect, and financial abuse that can result in litigation and citations to the facility.

CONCLUSION

A legal nurse consultant reviewing a case in which there is CNA involvement should check the policies of the facility involved. These must comply with local state agencies such as the Department of Health or the state Board of Nursing and be written in accordance with the state's Nurse Practice Act or regulations governing the profession. These will determine if the CNA acted appropriately within their scope of practice.

REFERENCES AND RECOMMENDED READING

Briggs, Steven. (2021, May 11). *Elderly Woman Hangs Herself Due to Alleged Neglect by Nursing Home Staff*. Scrubs Magazine. https://scrubsmag.com/elderly-woman-hangs-herself-due-to-alleged-neglect-by-nursing-home-staff/

Certified Nurse Aide (CNA) Training Programs – Connecticut https://uwc.211ct.org/certified-nurse-aide-cna-training-programs-connecticut/

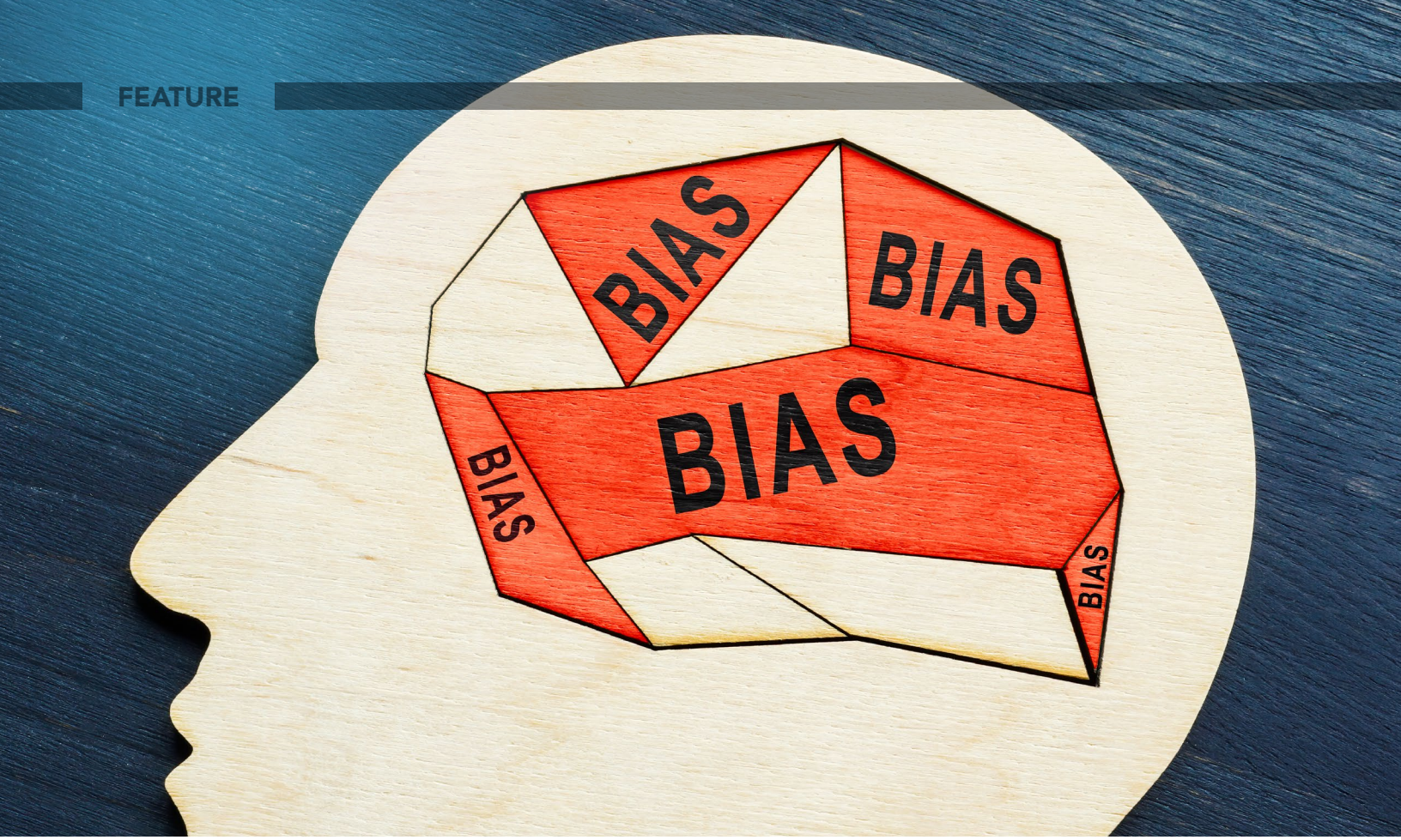
https://www.click2houston.com/news/local/2022/10/04/caught-on-video-elderly-man-allegedly-abused-by-texas-city-nursing-home-employees/

The Nurse Aide Registry, CT https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Nurseaide/Nurse-Aide-Registration

What to Expect During & After CNA Training https://www.registerednursing.org/certified-nursing-assistant/training/

Jessica Lewis, RN is a graduate of State University of New York at Farmingdale and received a Bachelors in Psychology from Charter Oak State University in Connecticut. She worked as an Emergency Room nurse and a substitute school nurse, as well as in inpatient psychiatric nursing. She has many years experience in long-term care and taught Certified Nursing Assistants for community colleges for 10 years.

She can be contacted at jjlewis.rn@gmail.com



When Words Wound:

Stigmatizing Language in the Electronic Health Record

Marilyn McCullum, BSN, RN, CEN

Keywords: stigmatizing, language, charting, electronic health record, EHR, bias, implicit bias, stigma, credibility, stereotype, documentation, chart, patient care, hidden bias, empathy, emotional regulation

Stigmatizing language elicits implicit bias. In patient documentation, use of stigmatizing language may permeate future clinicians, attorneys, legal nurse consultants, and even juries. Providers should look carefully at their documentation and use of quotations to ascertain whether the documentation is painting an objective, truthful narrative of the patient's medical situation.

From a young age, children are taught the effect their words have on other people. Negative words, such as, "stupid" and "cripple," are discouraged because of the stigma placed on the person to whom that language is directed. Using language meant to publicly demean a person due to a specific characteristic or behavior exhibited is stigmatization. Using stigmatizing language in the electronic health record (EHR) can contribute to implicit bias. Implicit or hidden bias is when certain attitudes and/or stereotypes regarding people occur automatically and unintentionally, affecting judgments, decisions, and behaviors. Implicit bias may be exhibited not only by the writer of the medical note but also by the subsequent people who read the chart, such as follow-up clinicians, specialists, and even legal nurse consultants (LNCs).

Language is ever evolving. Just a few decades ago, before the disease became known as AIDS, it was known by the moniker GRIDS, which stood

for Gay-Related Immunodeficiency Syndrome. Though the terminology did change, the original term created a stigma regarding the homosexual community, which still impacts the care of many HIV and AIDS patients.

"Retard" and "cripple" are two words that were once acceptable to use. In today's time, however, these words have been deemed stigmatizing, and they are no longer appropriate descriptors. Research has also shown that people prefer not to be defined by their disease. Terminology is always evolving and progressing, so while referring to a patient with sickle cell anemia as a "sickler" was once permissible, it is now regarded as a pejorative. The same is true for referring to a person with asthma as an asthmatic and a person with diabetes as a diabetic.

When a medical professional uses stigmatizing language in the EHR, the repercussions may last for years, impacting that individual's care in a cascading effect. When stigmatizing language is used, the implicit bias of the writer is exhibited. However, an interesting phenomenon occurs when subsequent providers, medical professionals, and even laypeople read the stigmatizing language. Without ever meeting the patient, the subsequent readers absorb this implicit bias and, in turn, develop preconceived notions regarding the patient before they meet the individual. Their clinical judgments, decisions, and behaviors are affected solely based on reading a stigmatizing entry by a different clinician, and this bias may negatively affect the patient's care.

People have a disease; they are not their disease. In 2018, a randomized controlled vignette study was conducted to determine how negative versus neutral language in a hypothetical patient with sickle cell anemia would influence the providers who read the narrative note (Goddu, 2018). Two vignettes were written about a hypothetical patient, a person with sickle cell anemia, and the clinically relevant information was kept identical in both scenarios. However, one narrative was written in neutral language, and the other narrative used stigmatizing language. The providers who read the stigmatizing language adopted a negative attitude about the patient and opted to order less analgesia than those who read the neutral language, even though the clinically relevant information was the same. Repeated similar studies have been done, exhibiting that bias can and is perpetuated through EHR, affecting clinicians' attitudes and decision-making.

What is stigmatizing language? Stigmatizing language in medical charting is grouped into five negative language categories: questioning credibility, disapproval, stereotyping, difficult patient, and unilateral decisions (Park, 2021).

Questioning the patient's credibility is exhibited when the writer demonstrates their disbelief of the patient either by implying that the patient lacks sufficient cognitive ability to remember and/or accurately convey information or by doubting the patient's sincerity. It may be manifested through words such as *insists* and *claims*. For example, writing that, "the patient insists that her pain is still a 10/10," indicates that the writer is questioning the patient's assertation of their pain level. A tactic known as "scare quotes" is also used by writers to cast doubt on what the patient is saying. For example, writing that, "the patient states she takes oxycodone daily for her 'fibromyalgia,'" indicates a dubiousness towards the diagnosis of fibromyalgia and calls into question the patient's ability to accurately relay her medical information.

The second harmful language category is disapproval, which encompasses the writer's sense that the patient has poor reasoning and poor decision-making. This tactic is usually employed to convey that the patient is being unreasonable. One example that the writer charted, "counseled that there is no evidence for this, but the patient has strong beliefs otherwise (Park, 2021)." In this example, the patient is construed as being stubborn and resistant to the writer's counseling, and the patient's strong beliefs are false. A patient may be nonadherent to their prescribed treatment for a plethora of reasons, and it is possible to document this in a non-disapproving way. For example, charting that the patient "has not been taking their insulin," is neutral language. It may even be converted to positive language if the writer adds what barriers the patient has inhibiting them from taking their medication as prescribed. However, the language becomes stigmatizing when qualifiers are added to convey disapproval. "She neglected to follow up with physical therapy because, 'it is too much work,' but requests hydrocodone, which she states has worked in the past," includes qualifiers that indicate the provider's disapproval of the patient's actions.

Stereotyping is the third negative language category. Quoting African American Vernacular English (AAVE) and incorrect grammar are ways to stereotype a patient in the EHR. Using quotes in this way is unnecessary and serves only to stereotype the patient

When a medical professional uses stigmatizing language in the EHR, the repercussions may last for years, impacting that individual's care in a cascading effect.

as a lower socioeconomic class, as "the relationship between socioeconomic status, race and ethnicity is intimately intertwined" (American Psychological Association, 2017). Documenting, "I been so tired, doc, so doggone tired," and "my head was painin' me," are examples of stereotyping the patient, as the use of these quotes only serve to belittle and portray the patient as uneducated.

The fourth negative language category is the difficult patient, when the writer attempts to suggest that the patient is belligerent, ignorant, or otherwise willfully noncompliant by use of details with questionable clinical significance. For example, tactics such as *this seemed to pacify him*, and *the patient was adamant that*, illustrate the patient as being onerous or troublesome. Clinicians may attempt to paint the patient as burdensome, such as describing how a patient "refuses" to take a medication instead of stating they *declined* to take a medication, a distinction that displays two very different patient attitudes towards the medication they did not take.

Unilateral decision is the last negative language category, and this is when the writer takes a paternalistic standpoint over the patient and attempts to assert their authority. Examples of such documentation include, "I instructed him to..." and "I impressed upon her the importance of...," and these statements imbue the clinician/patient relationship with a power dynamic in which the writer takes an authoritative role and places the patient in a submissive/childlike role. This language emphasizes clinician authority over the patient instead of describing a clinician/patient relationship in which the patient has some control over their healthcare decisions.

When stigmatizing language is present in the EHR, the patient suffers, as illustrated in the following hypothetical situation.

The patient, Jane, goes to an emergency room (ER) for a sickle cell anemia crisis via ambulance. She is sent to triage by the charge nurse, who had read the ER provider's narrative note from her last visit two weeks prior. That note stated, "Jane, a frequent flyer to this ER who comes in about every week or so, returns with what she claims to be another sickle cell crisis. She was hanging out with her friends at McDonalds when the pain started in her left hip. She says, "only narcs help," and requests Dilaudid by name. She is narcotic-dependent and states her pain was not relieved by the narcotics she took at home already. Her boyfriend is laying in the bed with her and requests a bus token to get home."

The triage nurse receives a verbal report from the charge nurse, who states, "she's a frequent flyer and only likes Dilaudid." The triage nurse decides to bump the patient to the bottom of the list of who needs to be triaged.

It takes three hours for Jane to be triaged. When she finally sees a doctor, that provider had read the same note that the charge nurse had read. The doctor orders a small initial dose of analgesia and oxygen, but she fails to follow up with the patient. The patient asks for additional pain medication, but the nurse fails to relay this information to the provider because of her bias against substance abusers. The nurse's ex-boyfriend had been an intravenous (IV) drug abuser, and the nurse has negative preconceived notions about people who request opioid pain medications by name.

The patient's pain is uncontrolled for several hours despite multiple requests for additional pain medication. The provider reassesses Jane at the end of her shift, where she finds Jane writhing in bed complaining of shortness of breath and chest pain. The nurse reassesses her vital signs for the first time since triage, and Jane is febrile at 103.8 degrees Fahrenheit. Further studies are ordered, and Jane is ultimately diagnosed with acute chest syndrome and requires hospitalization.

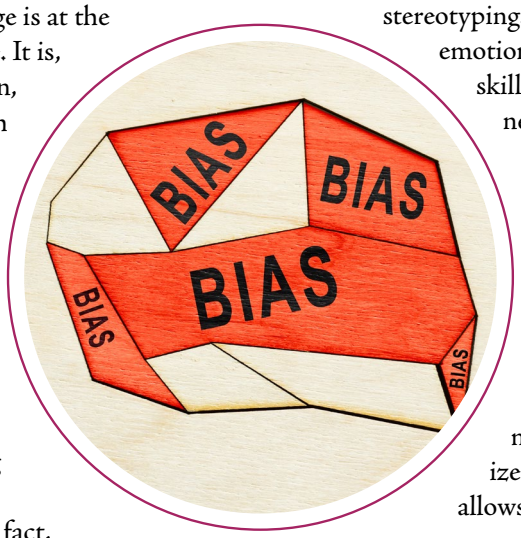
In this hypothetical situation, the delay in the standard of care is clearly illustrated by each participating clinician who had read the stigmatizing narrative note of the provider who had treated Jane two weeks ago. This transmission of bias being propagated through EHR is concerning, and clinicians must be diligent in not only charting in neutral language but in parsing out the bias that may occur when reading a past narrative that includes stigmatizing language.

Attorneys, paralegals, and LNCs who review medical charts also need to be aware of the implicit bias that may occur when they review medical records. The bias in the hypothetical case was transmitted from the provider who treated Jane two weeks ago to the clinicians who cared for Jane that day, and it is not improbable to say that bias may continue to be transmitted when a medical record is screened for merit. Those who review medical records must be cautious to not allow implicit bias to form, potentially skewing the facts of the case in front of them.

Stigmatizing language may continue to perseverate in the legal process through Defense Medical Examination providers, expert witnesses, judges, and jury members. Bias resides in all individuals,

Those who review medical records must be cautious to not allow implicit bias to form, potentially skewing the facts of the case in front of them.

and by using stigmatizing language, clinicians may impact the patient's chance at a fair trial. Language is a powerful weapon, and it is not overreaching to assume that stigmatizing or demeaning language potentially changes the course of a patient's future medical care and/or legal case. "Language is at the heart of human life. It is, and has always been, the means by which we construct and analyse [sic] what we call reality (Jarad, 2004)."



Changing how clinicians document is important, but it is a daunting task that will take years to change. In fact, studies looking into stigmatizing language in physician charting have shown that the negative language markers increase from medical students to residents. This hints at an ethical erosion perpetuated through the "hidden curriculum" in medical school (Goddu, 2018). Tackling how to mitigate negative language in the EHR has proven difficult, as even the practice of quoting the patient, which is often encouraged in medical school, evokes strong sentiments. Some clinicians feel that quoting a patient is an empathetic practice while others feel it serves only to reveal certain socioeconomic statuses within the narrative. Before quoting a patient, clinicians should ascertain if the quote is providing relevant clinical information and nurturing compassion versus stigmatizing the patient and perpetuating bias.

Until rigorous education on how to appropriately and neutrally document is in place, negative documentation will exist, so it is important to recognize and confront implicit bias. To mitigate implicit bias and provide health equity, the Joint Commission recommends three tactics: empathy via perspective-taking, emotional regulation, and partnership-building skills. Approaching others with empathy can produce positive reactions during the exchange, thus inhibiting bias and reducing stereotyping. Having strong emotional regulation skills can assist in negating implicit bias. The ability to create positive reactions with others by learning to view the individual less by their individual attributes and more by generalized social structures allows one to create a more empathic interaction.

When clinicians learn to work as a team with their patients, they begin to see the patient as someone with whom to collaborate in working towards a common goal.

Knowing what triggers one may have is another important aspect of abolishing implicit bias. Learning to work through those triggers and having open, honest discussions with other people regarding each other's biases can break down the barriers in health equity, thus paving the road for a more unprejudiced, objective, and fair healthcare society in which patients feel free to seek medical care without retribution or bias.

REFERENCES

American Psychological Association. (2017). Ethnic and racial minorities & socioeconomic status. *American Psychological Association.* https://www.apa.org/pi/ses/resources/publications/minorities

Ball, J. W. (2015). Chapter 1: The history and interviewing process. Seidel's Guide to Physical Examination. St. Louis, MO: Elsevier.

Bickley, L. S. (2013). Chapter 1: Overview: Physical examination and history taking. Bates' Guide to Physical Examination and History Taking. Philadelphia, PA: Wolters Kluwer Health.

Confront Implicit Bias in Healthcare. (2021). *Lamar*. https://degree.lamar.edu/online-programs/healthcare/rn-to-msn/combating-implicit-bias-in-nursing/

Feudtner, C., Christakis, D. A., & Christakis, N. A. (1994). Do Clinical Clerks Suffer Ethical Erosion? Students' Perceptions of their Ethical Environment and Personal Development. *Academic Medicine, 69*(8), 670–679. https://doi.org/10.1097/00001888-199408000-00017

Goddu, A., O'Conor, K.J., Lanzkron, S. et al. (2018). Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record. *Journal of General Internal Medicine, 33*(5), 685–691. https://doi.org/10.1007/s11606-017-4289-2

Hafferty FW, Franks R. (1994). The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education. *Academic Medicine, 69*(11):861–871.

Jarad, N. I. (2004). Language: A Powerful Weapon of Mass Deception. *English Language & Literature Studies, Vol. V, No. II.*

O'Conor KJ, Lanzkron S, Haywood C Jr, Beach MC. (2016). Implicit Bias and Stigmatizing Language in Medical Records of Patients with Sickle Cell Disease. *Society of General Internal Medicine Annual Meeting.*

Park, J., Saha, S., Chee, B., Taylor, J., & Beach, M. C. (2021). Physician Use of Stigmatizing Language in Patient Medical Records. JAMA network open, 4(7), e2117052. https://doi.org/10.1001/jamanetworkopen.2021.17052

Joint Commission. (2016). Implicit bias in health care. *Quick Saf, 23, 1-4.*

Marilyn McCullum, BSN, RN, CEN is the owner of McCullum Legal Consulting in California. She is an emergency room expert witness and an LNC consultant with experience in trauma and emergency medicine. She was a travel nurse for several years, giving her the unique opportunity to work in a variety of hospitals across the nation. She is presently working as a Spanish-English bilingual bedside nurse. She can be contacted at McCullumLegal@gmail.com.

What Do We Owe People Living With Dementia?

Setting Ethical Priorities for a Standard of Care

Julia Parker, RN-BC Gerontology, BSN, PhD

Keywords: Dementia, Alzheimer's, Lewy-body, Dementia care, Memory care, Dementia standards of care, autonomy, dignity, patient-centered care, restraints, safety, monitoring

As the population of people living with dementia grows in the United States, facilities and care providers need to work within a coherent ethical foundation. The principles of autonomy, welfare and dignity create an ethical basis for dementia care. These ethical priorities can be implemented through use of person-centered care, anticipation of needs, nursing/medical oversight, freedom from restraints, training, and adequate staffing.

This activity is designed to provide an overview of the ethical priorities for a standard of care for people affected by dementia.

Upon completion of the learning activity the learner will be able to:

a. Identify dementia risks in aging population and vulnerability in health care settings
b. Identify principles of autonomy, welfare, and dignity that create an ethical basis for dementia care
c. Describe ethical priorities that can be implemented through use of person-centered care, anticipation of needs, nursing/medical oversight, freedom from restraints, training, and adequate staffing

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until July 1, 2025.

To receive CE credit, read the article and pass the CE test online at https://www.aalnc.org/Resources/The-Journal-of-Legal-Nurse-Consulting

CEs are free to members during the membership year and can be purchased as a 4-issue subscription of $65/year for non-members.

As the United States (U.S.) population ages and treatment of acute and chronic disease expands the lifespan, more people are living with dementia in their elder years. Alzheimer's disease is the most common form of dementia. However, dozens of other known causes exist, the most prevalent being vascular dementia, Lewy-body dementia, frontal-lobe dementia, and chronic traumatic encephalopathy as a result of brain injuries. More than 6.5 million Americans age 65 and older are living with Alzheimer's disease alone, and this number is projected to be 13.8 million by 2060 (National Institute of Health, 2022). (Varelius, 2006; Varelius, 2006) While the rate of dementia in people over age 65 is declining, the rapid growth in our older population means that we still have more people living with dementia in the United States and a growing demand to address the needs of this population (Langa, Larson, & Crimmins, 2017).

Overall, dementia risk increases as people age. About 3% of adults between ages 70 and 74 have dementia. The percentage of the population affected by dementia grows to 22% of adults between 85 and 89 years old and 33% of adults age 90 and over (Population reference bureau, 2022).

VULNERABILITY

Due to their difficulties communicating and remembering details of their own care and situation, individuals with Alzheimer's disease, dementia, and the myriad of other diseases that cause cognitive, emotional, and motor changes are some of the most vulnerable, defenseless, and easily victimized people in our society. Healthcare facilities and health care professionals providing dementia or memory care must be held to high ethical standards that include safe, secure care, allowance for personal preferences, and maintenance of human dignity. Appropriate care of the growing population living with dementia must start with understanding the ethical duties to these vulnerable adults.

PHILOSOPHY OF CARE

People living with dementia deserve humane treatment that promotes their autonomy, welfare, and dignity. These ethical standards relate to nursing standards and human rights. The crux of the challenge is balancing autonomy with safety and dignity.

- Autonomy is self-governance, the ability to act freely and make one's own plans. Autonomy can be considered along a spectrum based on an individual's ability to weigh decisions, risks, and possible outcomes. Therefore, autonomy is not an absolute but a continuum (Varelius, 2006).
- Welfare (or beneficence) invokes the duties of kindness and charity. Healthcare workers are bound to the moral imperative to do what is in the best interest of their patients or clients (Kinsinger, 2009). Nurses have focused on beneficence throughout the development of the profession (Haddad & Geiger, 2022). Specifically, in dementia care, the welfare of people living with dementia includes maintaining safety.
- Dignity is the inherent worth of all people. The resident bill of rights for long-term care includes the right to be treated with respect and dignity (Center for Medicaid and Medicare Services, 2022). The duty to treat people with dignity includes maintaining hygiene, promoting self-reliance, maintaining privacy, addressing people in a respectful manner, reducing insults to their sense of themselves, and treating symptoms such as pain, agitation, inappropriate behaviors, and incontinence (Kennedy, 2016).

STANDARDS OF CARE

How do we translate philosophy into practice? Healthcare providers, nurses, and long-term care facilities should apply this ethics-based philosophy for care of people with dementia. Standards of care of people with dementia should be drawn directly from the ethical standards of autonomy, welfare, and dignity.

AUTONOMY

People living with dementia have the right to as much autonomy as possible in their care. They should be given the opportunity to make decisions as they are able and to continue to live in ways that reflect their wants, needs, and desires. Autonomy can be a mix of former preferences and current preferences. Caregivers should ensure they are allowing people to continue to be themselves.

Sometimes the desires of loved ones will conflict with the desires of a person with dementia. For example, a mother may choose to drink soft drinks every day, and a son, who focuses on healthy foods, may insist that his mother only drink water. Preferences of the person with dementia must take precedence over preferences of the loved ones.

Additional steps toward maintaining autonomy can be achieved through long-term autonomy or plans and preferences made prior to the onset of dementia. While an individual may no longer be able to assert his or her preferences clearly as dementia progresses, health care providers, facilities, and families should pay close attention to previous statements regarding care. These may take the form of written material, previously documented statements regarding care, living wills, or resuscitation orders.

WELFARE

Nurses, doctors, caregivers, and residential care facilities have a duty to ensure the welfare of individuals with dementia. These ethical foundations, welfare and autonomy, can appear to be in conflict. People living with dementia frequently have difficulty with problem-solving and so will make unsafe choices. So, the duty of providing autonomy can feel contradictory to the provision of welfare especially when it comes to safety.

Care providers specializing in dementia care must maintain a balance: allowing for the most independent decision-making possible while creating a safe environment to protect the patient is welfare. This balance requires three precious resources in dementia care: time, training, and staffing. For example, a resident wants to leave the confines of his memory care facility and go for a walk. He is a little unsteady on his feet, is wearing a thin shirt in the cool autumn weather, and cannot remember directions. The ethic of autonomy seems in direct conflict with the ethic of welfare. However, with appropriate time, training and staffing, care facilities can ensure that the resident can safely exercise his autonomy. If a trained caregiver can redirect him to put on a jacket and wait a few minutes, both of his rights can be met by having a staff member walk with him and help direct him back to his dementia care facility safely. If this option is not possible, then the resident's autonomy and safety are compromised. He is unable to walk outside when he wants to, he may slip out of the facility unattended, he may become agitated and labeled as a problem patient, an elopement risk, and even an aggressive patient if he is angry enough about not being able to exercise his autonomy.

Balancing autonomy and welfare may be a fine line, but it can be done, and it is the responsibility of ethical care of people with dementia. Appropriate time, staffing, and training will allow for the autonomy AND welfare of people living with dementia.

SUPPORTING DIGNITY

In long-term care, all individuals have a right to dignity. With dementia, a person's sense of dignity or their ability to read social cues may diminish. Knowing important factors in a person's pre-dementia life is key to maintaining dignity. If a resident lived her adult life footloose and fancy free in tie dye t-shirts, sweatpants, and no bra, then she should be able to continue that life even if she does not quite recall it. If another resident had impeccable manners and looked elegant every day, she should be able to continue that life, even if she no longer knows to change her shirt if it has soup on it.

Again, we may see that autonomy and dignity can conflict. If a resident is too hot and strips off her clothes in the dining room, is that not her right to do what she wants? Yes, but, a trained staff will know that this is not a resident's former way of life, so they can assist her to a private place to put on lighter clothes that better meet her needs and maintain her dignity.

Another example, in later stages of dementia, a person may not be able to use utensils and may eat only with his or her hands. We can surmise that most adults do not eat all foods with their hands and go about with sauce-stained digits and food crumbs in their laps. So, how do we balance their autonomy and dignity? A trained staff and flexible dementia program would provide a person who now eats with their hands with meals that are more

Additional steps toward maintaining autonomy can be achieved through long-term autonomy or plans and preferences made prior to the onset of dementia.

easily eaten with hands – not a bowl of chili, but perhaps a chili dog, not a pile of buttered peas, but some carrot and celery sticks.

THE GUIDELINES THAT BALANCE AUTONOMY, WELFARE AND DIGNITY

Dementia is a disease that attacks people's insight. People with Alzheimers, Lewy-Body dementia, vascular dementia, frontal lobe dementia and other diseases often do not know the extent to which their mind and behavior have been altered. In some ways, a lack of self-awareness can be one of the few blessings of this disease. However, if a person is unaware of their rights and the ethics of treatment, what do we owe them? People working in the healthcare fields owe treatment that ensures autonomy, welfare, and dignity. As dementia progresses, sufferers may not be able to stand up for or articulate their own rights. Thus, professionals have a duty to uphold them.

Five elements of dementia care in any setting support the ethics of care. These foundations for actions and policies will ensure that people with dementia receive appropriate ethical care and treatment when they may not be able to advocate for themselves:

- Person-centered care
- Anticipation of needs
- Nursing/medical oversight
- Freedom from restraints
- Training and adequate staffing.

PERSON-CENTERED CARE – THE KEY TO AUTONOMY

People living with dementia maintain their own emotions, understanding, preferences, and abilities. Therefore, person-centered care, informed by an understanding of disease processes, is the basic requirement of dementia care. Person-centered care can be developed using a variety of resources that may help the care plan designer understand the unique characteristics of an individual. This can be done within the context of usual human needs – shelter, hunger, thirst, movement, clothing, rest, cleanliness, social interaction, and intellectual engagement.

People living with dementia maintain their own emotions, understanding, preferences, and abilities. Therefore, person-centered care, informed by an understanding of disease processes, is the basic requirement of dementia care.

The first source of information in person-centered care should always be the individual with dementia. Interviewing and observing someone with dementia will create the foundation of a care plan. Ask preference questions directly to the individual in need of care and give them time to answer. Often, the nurse assessor needs to explain this process to family or loved ones. Loved ones may want to interject in an interview or assessment if they feel like the person with dementia gives insufficient or inaccurate answers. Loved ones need to know that they will have their turn to provide input.

If these assessments are conducted in a person's home, the assessor can use clues to help determine the likes and dislikes of an individual who may have trouble expressing themselves. For example, are their diplomas on the walls or technical books in the bookcases? Does the person suffering from dementia repeat certain colors in their home or wardrobe? Is music central to the home? Is there a particular sports team's paraphernalia in the home? Are there certain types of snacks or drinks in the home? Are their clothes comfortable or formal?

Once an interview and assessment has been conducted with the person in need of care, then the assessor can move on to family, caregivers, and friends. The assessor can use their input to determine how the environment and care can be tailored to the unique characteristics of the person with dementia.

Person-centered care requires attention to preferences and abilities as they existed in the past, exist in the present, and change throughout the lifespan. In a healthcare workplace culture of computer forms and drop-down boxes, care plans still should be created in a more open format that allows description of patients as real people that may not fit into prescribed boxes. Information can be gathered from the individual with dementia, their history, and from loved ones. If a person lives in a residential care facility, staff members may become good sources of information regarding preferences and abilities as time passes. For example, an attentive caregiver will know that one resident likes to be in the garden in the afternoon and hates black coffee. The caregiver will also know that this resident has more trouble walking in the evenings and needs more assistance than earlier in the day.

ANTICIPATION OF NEEDS

Caregivers, whether professional or family, should be able to anticipate the needs of someone with dementia. Basic human needs of thirst, hunger,

elimination, clothing, shelter, and socialization can be anticipated to ensure the comfort and safety of the person with dementia. In a recent case in Washington, a non-verbal woman with Lewy-body dementia was attempting to stand on her own early in the morning. Staff shut off her alarm and had her sit back down. Five minutes later she fell while trying to stand again. No documentation

records that a staff member offered her the toilet, a drink, or food. In a deposition, the opposing counsel asked me how the nurses were supposed to know what she needed. The answer was simple: Nursing staff should have used their own un-affected cognition, training, and understanding of human nature to know that when someone wakes in the morning, they generally need the toilet, a drink, to eat breakfast or other common morning routines. When a patient with dementia cannot articulate their needs, it is the responsibility of health care staff to anticipate those needs. If staff do not anticipate needs, then the welfare of people with dementia suffers.

NURSE AND MEDICAL OVERSIGHT

Nurse and medical provider oversight is critical to monitoring the welfare of people with dementia. Nurses and medical practitioners (physicians, nurse practitioners, physician assistants) understand signs and symptoms of impending health problems, use of medications, adverse effects of medications, and disease processes. This global understanding of the various disease processes that exacerbate dementia creates an excellent foundation to watch for changes that are occurring and for care, treatment or medication changes that need to be made. As a person progresses through the dementia disease processes, a nurse should be aware of new needs and the potential need to change care plans, assistive devices, and medications. Practitioners should be able to take feedback regarding changes in symptoms and create appropriate plans for adjusting medications, making suggestions of changes in care, providing referrals, and discussing end-of-life care.

FREEDOM FROM RESTRAINTS AND OVER-MEDICATION

Long gone are the days of tying people into their wheelchairs for safety. However, one of the greatest risks to autonomy is still restraint. Dementia-related behaviors such as wandering, agitation, and falls are still used as

excuses to restrain people with dementia. Most of these are now chemical restraints, but they can also take the form of constant intervention from a harried staff or family member to interfere with the autonomy of individuals with dementia in the name of welfare or safety. The frequent use of anti-anxiety medication such as lorazepam, off-label use of anti-seizure medications such as Depakote, and the use of anti-psychotics such as Risperidone and Seroquel, show the desperate attempts of families and facilities to control the behavior and limit the autonomy of people living with dementia (Aigbogun, Stellhorn, Hartry, Baker, & Fillit, 2019) (Oliveira, Blanco, & Ali, 2022).

Behavioral intervention plans should be the first line of defense for difficult dementia-related behaviors. Behavioral intervention plans document antecedents to a behavior (what was happening before) and what techniques for intervention work or fail. When followed, behavior plans are a very effective way to deduce the meaning behind a behavior and what interventions might help.

For example, a resident is wandering into other rooms at midnight and waking other residents. She is then getting into shouting matches with other residents and becoming aggressive because she thinks they are in her house. Care staff have tried helping her to the toilet at night, but it has not changed her wandering behavior. An evening nurse notices that she does not eat much dinner and starts offering her a sandwich before bed, the resident then is able to start sleeping during the night instead of wandering around looking for a kitchen. This is a safer and better outcome than starting the resident on an anti-psychotic or anxiolytic at night to calm her. The simple behavioral intervention of feeding the resident a nighttime snack meets her needs and eliminates the intrusive, and aggressive behaviors.

AN ETHICS-BASED WAY FORWARD

Preserving autonomy, welfare, and dignity takes time and understanding. People living with dementia at home or in residential facilities suffer when under-trained or over-taxed caregivers try to do more than they are able. Residential facilities for people with dementia are usually licensed under assisted living facilities and specialized memory care assisted living facilities. Each state has different requirements for training and staffing. However, these minimum requirements do not always meet an ethical standard of care. Training and staffing levels are the key to meeting the standards maintaining autonomy, welfare, and dignity for people living with dementia.

At first, the standards for the ethical treatment of people with dementia may feel contradictory and difficult to obtain, but the duty to people living with dementia can be met with time and attention. Vulnerable people deserve ethical care whether or not they are aware of it. Health care workers, physicians, nurses, and care facilities have a duty to provide ethical care to people who have diminished cognitive abilities, difficult emotional needs, and changing physical needs as they progress through the dementia process.

REFERENCES

Aigbogun, M. S., Stellhorn, R., Hartry, A., Baker, R. A., & Fillit, H. (2019). Treatment patterns and burden of behavioral distrubances in patients with dementia in the United States: A claims database analysis. *BMC Neurology, 19*(1), 33.

Center for Medicaid and Medicare Services. (2022). *Your rights and protections as a nursing home resident.* Retrieved 2023, from https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf

Haddad, L. M., & Geiger, R. A. (2022, August 22). *Nursing Ethical Considerations.* Retrieved 2023, from StatPearls Publishing: https://www.ncbi.nlm.nih.gov/books/NBK526054/

Kennedy, G. (2016, January). The importance of patient dignity in care at the end of life. *Ulster medical journal, 85*(1), 45-48.

Kinsinger, F. S. (2009, April). Beneficence and the professional's moral imperative. *Journal of Chiropractic Humanity, 16*(1), 44-46.

Langa, K. M., Larson, E. B., & Crimmins, E. M. (2017). A comparison of the prevalence of dementia in the united states in 2000 and 2012. *JAMA Internal Medicine, 177*(1), 51-58.

National Institute of Health. (2022, April). *Alzheimer's disease facts and figures.* Retrieved 2023, from Alzheimers dementia: https://pubmed.ncbi.nlm.nih.gov/35289055/

Oliveira, I., Blanco, M., & Ali, M. (2022, April 7). *Antipsychotic medication prescribing in long term care facilities increased in the early months of Covid-19 pandemic issue brief.* Retrieved 2023, from https://aspe.hhs.gov/reports/antipsychotic-use-ltcfs-early-months-covid-19-pandemic

Population reference bureau. (2022). *Fact sheet U.S. dementia trends.* Retrieved 2023, from https://www.prb.org/resources/fact-sheet-u-s-dementia-trends/

Varelius, J. (2006). The value of autonomy in medical ethics. *Medical healthcare philosophy, 9*(3), 377-388.

Julia Parker, RN-BC, PhD is an experienced geriatric-nurse and elder care leader with a reputation for passionate and intelligent advocacy for elders and their families. In addition to years of nursing experience, Julia is board certified in geriatrics through the American Nursing Credential Center and has participated in extensive training through the National Council of Certification of Dementia Practitioners, the Alzheimer's Association, the Washington and Oregon Health Care Associations, and the American Association of Legal Nurse Consultants. Julia works as a nurse administrator, a legal nurse consultant and expert witness.

Julia is the author of *Navigating Elder Care* and has written professional articles for McKnight's Senior Living and Idaho Nurse. She lives in Moscow, Idaho with her family, enjoys time outdoors and in her close-knit community.

Organizational Process to Publication:

A Starter Guide for Legal Nurse Consultant Authors

Marc Gayol EdD, MSN, MPH, MBA, RN
Nina Beaman EdD, MSN, MHP, RN

Keywords: Journal article, authorship, writing for publication

Legal Nurse Consultants have vast experiences and insights worthy of publication. Authoring a professional manuscript involves writing content about a topic within the guidelines set forth by a publisher. Manuscripts go through several stages before, and each step has a specific set of requirements that must be satisfied. This article covers initial guidance for article submission.

Journal writing requires content knowledge and strong writing skills including grammar usage, sentence structure, and proper content organization. New writers may face some challenges. This article intends to assist Legal Nurse Consultants (LNCs) in shaping their unique insights into the written word that can be published. The discussion focuses mostly on articles in journals as the primary form of publication for most LNCs. This article guides how to choose an acceptable venue while introducing the various journal types and status measures and examines the numerous rules that journals demand writers adhere to, such as length and citation style. The purpose of this article is to introduce some initial considerations about the process of publication and offer guidance for a prospective author.

PROCESS OF AUTHORSHIP

Although the author may base a journal article on a previous essay, thesis, dissertation, or DNP project, the authored journal article must be written specifically for the journal selected rather than as an academic paper. Use of previously published work, even by the author, can be considered self-plagiarism. Editors usually check for plagiarism and originality (Harris, 2019).

It is important to only use facts that can be proven, rather than including opinions that are not supported with evidence, as journals will fact-check the article before publication. Data should be supported with modern (usually within the past 5 years of publication) references and cited/referenced as the journal requires. Any ideas or data that are not the author's, must be cited and referenced. It is better to use peer-reviewed scholarly sources from the university or hospital library, than 'grey literature' like Google Scholar or Google (Fowler, 2020).

Journal guidelines should be followed (usually published in the journal itself) regarding the use of tables, illustrations,

and organization of the manuscript. An example of a typical article structure may include sections such as Title, Authorship, Abstract, Keywords, Introduction, Materials and Methods, Results, Discussion, Conclusion, Acknowledgement, and References (Nayak, 2020). The title should not have jargon but instead should use a title that will attract the reader. The abstract should concisely summarize the article, as it is the preview that may attract the reader to read the entire article. Keywords should be selected broadly, to maximize the potential for retrieving the article in a database. The thesis of the article, such as a legal strategy, should flow continuously through the introduction, design, results, discussion, and conclusion. References should be in the form the editor of the journal requested. Content, even if interesting, may be rejected if improperly organized. Following these guidelines to the letter provides consistency across the journal in its entirety.

TIPS FOR SUBMISSION TO A JOURNAL

To assure a good match between the manuscript and the journal, the author must review not only the guidelines for writing given by the journal editor but also should also peruse the previous issues of the journal to understand what topics the readers of that journal prefer to read about. Selecting a journal that is appropriate for a specific journal article will not only make the journal article more likely to get approved but also more likely to be of interest to the readers of that journal.

It is important to select peer-reviewed journals and avoid submitting to predatory journals. Predatory journals are usually open-access journals that exploit new authors by charging publishing fees to authors without providing services offered by legitimate open-access journals, such as promotion in databases (Harris, 2019). Someone always pays for publication in a journal. Frequently, it is the subscriber to the journal or the member who pays a membership fee. In those cases, the author is usually not paid for the article but may receive a copy of the article for free and a letter indicating that the article was published. In the case of open-access journals, the author is expected to pay to have the article published. Non-predatory journals will have clear information about any fees that the author pays upfront to become published in the journal and what the author will receive for the fees.

Further, a reputable journal will use a peer-review process with reputable reviewers that review the submitted manuscripts. Mikhail (2022) suggested that good reviewers be knowledgeable about the journal mission and author guidelines, well-informed in the literature, able to give clear suggestions for improvement, are empathetic, know when to decline reviews that are out of their areas of expertise, respond promptly, declare potential conflicts of interest, and maintain confidentiality. Sometimes a manuscript is rejected as inappropriate for the journal, but often the author is asked to make changes based on peer feedback. An author should heed the feedback and resubmit if encouraged to do so. If the manuscript is rejected completely, the author should seek publication in another journal.

CONCLUSION

The LNC frequently works in legal settings other than those typically associated with nursing direct care settings. The experiences of LNCs are distinct because they work in settings where the legal and medical worlds converge. These experiences are enlightening and valuable to convey through publications, particularly about current best practices. With the help of this article, LNCs can better express their distinctive thoughts through authorship and use the tips provided to begin their journey toward journal publication.

REFERENCES

Fowler, J. (2020). From staff nurse to nurse consultant. *British Journal of Nursing, 29*(20), 1215.

Harris, M. (2019). Writing for refereed journals. *Pennsylvania Nurse, 74*(1), 22-25.

Mikhail, J. (2022). Top 10 traits of an excellent JTN peer reviewer. *Journal of Trauma Nursing, 29*(5), 227. https://doi.org/10.1097/JTN.0000000000000667

Nayak, C. (2020). Writing and publishing research articles: A panoramic view. *The Homeopathic Heritage, 46*(9), 41-47.

Dr. Marc Gayol is a double board-certified registered nurse in both Nursing Education (CNE) & Public Health (CPH) and is the current Dean of Nursing & Health Sciences at Aspen University. Dr. Gayol has a particular interest in assisting and supporting immigrants and other vulnerable populations who are often unable to access healthcare and educational services. He is active on the Board of Directors with the Florida Nurses Association (FNA) and is politically involved in state and national movements in support of universal healthcare and policy reform to increase access to comprehensive, culturally-sensitive education and healthcare services. Dr. Gayol can be reached at: marcos.gayol@aspen.edu.

Dr. Nina Beaman is certified in four different distinct areas. She is a National League for Nursing Certified Nurse Education, holds a certificate as an AANC Psychiatric Mental Health nurse, is an NCC certified Ambulatory Women's Health Nurse, and is an AAMA Certified Medical Assistant. She also actively serves as a Medical Reserve Corps volunteer. Dr. Beaman is the Chief Nurse administrator at Aspen University and has been in academia, served in leadership positions for professional boards and associations as well as a practicing nurse in a variety of venues for over 20 years. Dr. Beaman can be reached at: nina.beaman@aspen.edu

Wernicke's Encephalopathy:

Increase in Malpractice Claims

Emma J. Patterson MD FRCS FACS FASMBS

Keywords: Wernicke's encephalopathy, Wernicke-Korsakoff's syndrome, Thiamine deficiency, Medical negligence, Bariatric surgery, Hyperemesis gravidarum, Vitamin B1

Wernicke's encephalopathy is an acute neuropsychiatric syndrome resulting from thiamine (vitamin B1) deficiency. This can occur within just two weeks of reduced food intake or persistent vomiting. Delayed diagnosis or inadequate treatment or Wernicke's leads to permanent neurologic deficiencies, the Wernicke-Korsakoff's syndrome with permanent deficits in memory and executive functions.

Commensurate with the rise in the number of bariatric surgery procedures over the last two decades the number medical malpractice cases of postoperative Wernicke's is rapidly increasing. This article focuses on the cause, diagnosis, treatment and consequences of delayed treatment of Wernicke's encephalopathy.

INTRODUCTION

Wernicke's encephalopathy is an acute neurologic syndrome caused by thiamine (vitamin B1) deficiency, first describe by Carl Wernicke in 1881. Alcohol use disorder and bariatric surgery are the most common etiologic factors associated with Wernicke's in the United States, but it can occur in any patient with a nutritional deficiency state such as hyperemesis gravidarum, intestinal obstruction, sepsis, hemodialysis and malignancy.

Wernicke's is a clinical diagnosis which may present with the classic clinical triad of confusion, eye signs, and gait ataxia, or difficulty walking (Figure 1), although all three signs are present in only 16% of patients (Galvin, 2010). Clinical signs can be subtle and gradually progressive. Because the low prevalence is low, the diagnosis is often missed, and treatment is delayed, inadequate, or absent. Estimates suggest that only about 15% of Wernicke's cases are diagnosed before death (Sinha, 2019).

Without prompt treatment, patients are left with serious permanent neurological deficiencies due to irreversible damage to the brain and nerves. With prompt

treatment, the clinical results can appear miraculous, with patients who could not get out of bed begin walking again within a few doses of intravenous thiamine.

DIETARY THIAMINE

Thiamine is an essential vitamin, meaning that humans don't synthesize it and must therefore, obtain it from food or vitamin supplements. Some foods that are high in thiamine include seafood, pork, legumes, whole grains, nuts, seeds and vegetables. The adult daily requirement of thiamine is 1.1 to 1.2 mg daily. Since the human body stores very little thiamine, only 30 to 50 mg, and the half-life is short at 9 to 18 days, a person can have their thiamine stores depleted in as short at 2-3 weeks of restricted nutrition. After a few weeks of thiamine deficiency, Wernicke's encephalopathy then rapidly ensues and can lead to irreversible brain damage (Marrs, 2021).

THIAMINE FUNCTIONS AND PHYSIOLOGY

Thiamine is critical for the growth, maintenance and function of cells and maintenance of the myelin sheath of neurons. The myelin sheath insulates the axon of the neurons and speeds electrical conduction, and it also protects the nerve fibers. Ingested free thiamine passes through the intestinal wall and into erythrocytes, where it is converted to the bioactive form of thiamine, thiamine triphosphate (TTP). Blood carries TTP to the liver, heart and muscles, and TTP passes through the blood-brain barrier to enter the cerebrospinal fluid (CSF) and then diffuses into the brain (Ota, 2020).

Thiamine also has a crucial role in cellular energy production (ATP), via the Krebs cycle, and TTP is a necessary cofactor in aerobic respiration, where oxygen is used to produce energy and release carbon dioxide (Sinha, 2019). These biochemical reactions take place in the cells' mitochondria, capsule-shaped organelles that are thought to have evolved from primitive bacteria. Mitochondria are tiny organelles in the cellular cytoplasm that are the powerhouses of the cell, as they help turn the energy we take from food into the energy that the cell can use (Ota, 2020).

This activity is designed to increase understanding of Wernicke-Korsakoff's syndrome among healthcare professionals to help prevent future cases of the devastating and permanently disabling condition and aid LNCs with record review for litigation of cases related to Wernicke's encephalopathy.

Upon completion of the learning activity the learner will be able to:

a. Recognize the etiology and pathophysiology of Wernicke's and the signs and symptoms in the clinical setting with options for prevention and treatment.
b. Identify common themes in cases of Wernicke's encephalopathy after bariatric surgery.
c. Identify some common pitfalls in malpractice claims involving Wernicke's encephalopathy.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until June 1, 2026.

To receive CE credit, read the article and pass the CE test online at https://www.aalnc.org/Resources/The-Journal-of-Legal-Nurse-Consulting

CEs are free to members during the membership year and can be purchased as a 4-issue subscription of $65/year for non-members.

WERNICKE'S ENCEPHALOPATHY PATHOPHYSIOLOGY

Since thiamine is a co-factor in the Krebs cycle, disruption reduces ATP production, which results in shunting to glutamate production, free radical production and neuroexcitotoxicity, which results in cell death. Thiamine deficiency also impairs myelin sheath maintenance, so nerves and areas of the white matter of the brain break down, which results in neurologic dysfunction, such as the classic Wernicke's triad of confusion, blurred vision and gait ataxia (Figure 1).

If treated promptly, symptoms and signs can be completely reversible within a matter of days. However, if not promptly and adequately treated, permanent neurologic impairment can result, such as weakness, impaired balance, blurred or double vision, and permanent deficits in memory and executive functions (Wijnia, 2022).

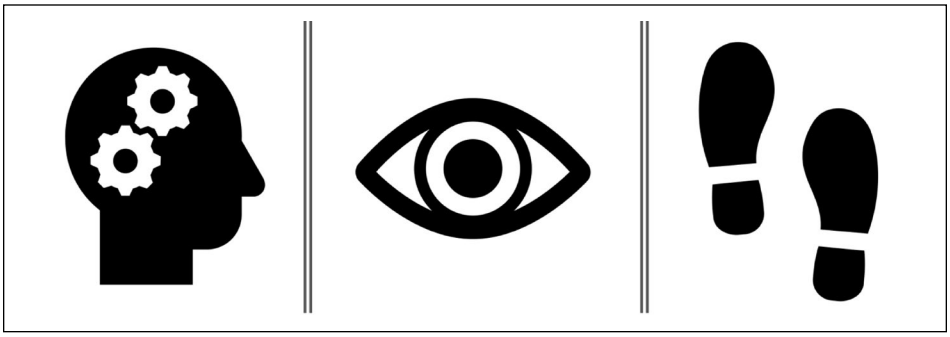


Figure 1: Graphic of the classic clinical triad in Wernicke's encephalopathy: confusion, eye signs and ataxia.

Primary prevention prevent disease in susceptible people	Ensure thiamine intake, food, fortified foods and vitamin supplements.
Secondary prevention treat early when subclinical	Give iv thiamine to high-risk patients i.e., banana bag with 100 mg iv thiamine daily.
Tertiary prevention reduce the severity of disease	High dose iv thiamine 500 mg iv q 8h for three days.

Table 1: Primary, secondary and tertiary prevention measures for thiamine deficiency and Wernicke's encephalopathy.

MEDICAL CONDITIONS WITH INCREASED RISK OF WERNICKE'S

The most frequent cause of thiamine deficiency is decreased physiologic access to thiamine, such as from dietary deficiency after bariatric surgery, or with anorexia nervosa, fasting, alcohol abuse, malnutrition, or a lack of thiamine in total parenteral nutrition (TPN). Thiamine deficiency can also result from prolonged vomiting such as in hyperemesis gravidarum, pyloric stenosis, or in patients undergoing chemotherapy. Other causes of thiamine deficiency include decreased absorption from the small intestine, such as in Crohn disease, ulcerative colitis, or after gastric bypass surgery (Wijnia, 2022).

Increased metabolism of thiamine or excess losses can also lead to deficiency, such as with dialysis, hypermetabolic states such as sepsis, burns, trauma, hyperthyroidism or certain rapidly growing cancers. Rare causes of thiamine deficiency are decreased storage capacity such as chronic liver failure, or impaired cellular utilization of thiamine such genetic, heritable dysfunctions in transketolase (Galvin, 2010).

PREVENTION OF THIAMINE DEFICIENCY AND WERNICKE'S ENCEPHALOPATHY

Wernicke's encephalopathy is a low-frequency but high-severity condition, therefore the most appropriate clinical approach is prevention, much like the approach to prevention of postoperative venous thromboembolism (VTE), another low-frequency but high-severity condition.

A small dose of thiamine is indicated to prevent deficiency, but once there are signs of deficiency, high doses of thiamine are required for effective treatment of Wernicke's encephalopathy. This is analogous to prevention of VTE with low-dose blood thinners, but once a VTE is confirmed, much higher doses of blood thinners are needed for treatment, in order to prevent permanent disability and possibly death.

From a public health perspective prevention of thiamine deficiency can be considered under the usual paradigm of primary, secondary and tertiary prevention as described in Table 1. Primary, secondary, and tertiary prevention can be accomplished with food fortification, food stamps and vitamins; medium-dose intravenous thiamine (banana bag); and high-dose iv thiamine, respectively.

CLINICAL PRESENTATION AND DIAGNOSIS OF WERNICKE'S

Patients with Wernicke's frequently present to the Emergency Department with alcohol dependence, post bariatric surgery, hyperemesis gravidarum, vomiting after chemotherapy, or after hospitalization for sepsis. Early symptoms are vague and non-specific, such as weakness, mood changes, mental fuzziness and memory deficits, along with loss of appetite, food intolerance and vomiting (Wijnia, 2022).

Wernicke's is a clinical diagnosis, and the classic clinical triad consists of confusion, eye signs, and ataxia, which may be present as an abnormal or a complete inability to walk (Figure 1). Since all three signs are present in only 16% of patients, reliance on the classic triad would result in missed or delayed diagnosis, often resulting in malpractice claims (Galvin 2010),

While Wernicke's encephalopathy can present as coma or decreased level of consciousness, the symptoms are often described disorientation or withdrawal, including indifference and inattentiveness (Table 2). As thiamine deficiency progresses ocular abnormalities and ataxia develop, primarily with stance and gait. Unlike alcoholic cerebellar degeneration, patients

History of Present Illness	Constitutional	sleep disturbance, weight loss, weakness, confusion
	Gastrointestinal	loss of appetite, nausea, vomiting, diarrhea
	Neurologic	blurry vision, trouble walking, tingling extremities
Past Medical History		cancer, hyperthyroid, sepsis, fever, pregnancy
Past Surgical History		bariatric surgery, trauma
Physical Exam	Constitutional	lethargy, tachycardia
	Gastrointestinal	vomiting, dry heaving
	Neurologic	nystagmus, ataxia, disorientation, weakness

Table 2: Clinical presentation of Wernicke's encephalopathy: history of present illness, past medical and surgical history and physical examination

with Wernicke's encephalopathy have no upper limb ataxia. Oculomotor abnormalities may include palsies, unequal pupils, retinal hemorrhage, papilledema, and a common physical examination finding is lateral gaze nystagmus (Sinha, 2019).

Wernicke's encephalopathy is not only underdiagnosed, but also undertreated and overlooked that it's a clinical emergency. Wernicke's is diagnosed clinically, by history and physical, and must be treated emergently, in a similar fashion to stroke, myocardial infarction or pulmonary embolus. Delay in treatment and undertreatment leads to worse outcomes including permanent neurological deficits, seizures and possibly death (Kohnke, 2021).

The Caine Criteria for diagnosis of Wernicke's came from a classical histopathological paper (Caine, 1997). Diagnosis of Wernicke's encephalopathy, requires two or more of the following and has a sensitivity of 85%:

1. Dietary deficiency
2. Eye signs e.g., lateral gaze nystagmus on physical examination
3. Cerebellar signs e.g., ataxia
4. Mild memory impairment or altered mental state.

Using these diagnostic criteria for Wernicke's of two or more of above positive, the sensitivity is 85% and specificity is 99%. If the diagnosis is suspected, treatment should start immediately with intravenous thiamine. Prior to treatment, a whole blood thiamine level can be drawn and sent to the laboratory as a confirmatory test, but these results are usually not available for several days, and treatment should be started immediately based on a clinical diagnosis of Wernicke's using the Caine criteria (Kohnke et al, 2021).

The best diagnostic test is a trial of treatment with high-dose iv thiamine, as symptoms will usually rapidly improve in 1-2 days, even before the blood test result comes back several days later. Early recognition and clinical diagnosis of Wernicke's is vital, as prompt treatment can restore gait, ocular and cognitive function and prevent permanent disability.

Radiologic imaging is also confirmatory, and treatment should be initiated prior to any imaging. CT scans are not diagnostic and MRI of the brain with contrast has a low sensitivity (53%) and high specificity (93%), so the scan will be normal in almost half of the patients who have Wernicke's encephalopathy (Galvin, 2010).

Typical MRI Findings of Wernicke's Encephalopathy are that T2-weighted images show bilateral and symmetrical hyperintensity in the: medial thalami, hypothalamus, mammillary bodies, periaqueductal area and tectal plate. FLAIR images demonstrate hyperintensity in the same lesions more obviously than T2-weighted images, since they provide better contrast as the CSF appears dark. The most distinctive neuroimaging findings of acute Wernicke's are cytotoxic edema and vasogenic edema (Jung et al, 2012).

PREVALENCE OF THIAMINE DEFICIENCY AND WERNICKE'S IN THE UNITED STATES

Fortification of flour began in 1940 in the United States and was broadly and voluntarily adopted. Breakfast cereals and infant formulas are now also fortified with thiamine (Whitfield, 2021). Data from the National Health & Nutrition Examination Survey (NHANES) from 2015-2016 showed that 99% of people who ate ready-to-eat cereal (fortified with thiamine) met their nutrient intake recommendations, whereas 11% on non-eaters of cereal failed to meet their recommended daily intake of thiamine (Zhu, 2019).

Historically, the reported prevalence of Wernicke's is 0.4 – 2.8 per 100,000 population, but the incidence is likely underestimated (Flynn et al, 2015). Autopsy data suggest that Wernicke's is not actually rare, but under diagnosed, even in high-risk patients, since the prevalence of Wernicke's in autopsies of patients with alcohol dependence is as high as 12.5%. In a prospective study of 262 psychiatric inpatients, 12% had Caine-positive WKS and 17 (53%) of those used alcohol (Lin, 2019). Some experts report the post-mortem prevalence of WKS to be as high as 1-2% of the population (Dingwall, 2022, p. 1134).

A study of ICU patients reported that only 20% of patients with Wernicke's on autopsy had received a clinical diagnosis before their death, and only 10% of patients exhibit all three of the classic triad of physical signs of eye signs, ataxia and confusion. Even more concerning was the finding that 30% of patients with Wernicke's encephalopathy in the ICU presented with coma, which can have many alternative explanations in the ICU as sepsis, hypoxia, stroke, intoxication and medication-induced sedation (Flannery, 2016).

WERNICKE'S AFTER BARIATRIC SURGERY

The author's personal clinical and medicolegal experience with Wernicke's is in patients whose food and thiamine intake is limited after bariatric surgery. A systematic review of Wernicke's after bariatric surgery was published in 2008 and described 104 cases of Wernicke's after gastric bypass or other procedures, in which 90% of patients reported frequent vomiting lasting a median of 21 days, and 94% were admitted to hospital within six months of surgery. Brain MRI showed lesions characteristic of Wernicke's in 47%, and 49% of patients had an incomplete recovery. Memory deficits and gait problems were common sequelae (Aasheim, 2008).

A recent review of 118 cases of Wernicke's encephalopathy after bariatric

surgery described that the latency between bariatric surgery and onset of symptoms was 2-3 months, and vomiting was again the most common symptom, in 87% of patients. Ataxia was present in 85%, altered mental status in 76%, and eye movement disorders in 74%. The full triad was present in 54%, significantly higher than the 16% previously reported from autopsy studies (Oudman, 2018).

The implications of these studies are that bariatric surgery training programs should include education on the possible nutritional complications of weight loss surgery. Thiamine administration is advisable in all patients readmitted or reporting frequent vomiting after a bariatric procedure as a simple, safe, inexpensive, and efficient preventive measures. Severe vomiting is not normal or expected after bariatric surgery, therefore investigation is warranted and Wernicke's must be considered.

WERNICKE'S COMPLICATING HYPEREMESIS GRAVIDARUM

Hyperemesis gravidarum is a pregnancy complication characterized by severe nausea, vomiting, weight loss, and possibly dehydration. A published review of 49 cases found that the mean gestational age when Wernicke's manifested in pregnancy was at 14.3 +/- 3.4 weeks, and pregnancy loss rate attributable to Wernicke's was 47% (Chiossi et al, 2006).

Clinical presentation included symptoms of confusion in 63%, ocular symptoms in 57%, and memory loss in 61%. Physical examination signs included ocular signs in 96%, ataxia in 82%, and deterioration of consciousness in 53%, and the classic clinical triad of eye signs, ataxia, and confusion was present in 47% of patients. Complete remission occurred in 28% of patients.

A more recent systematic review of Wernicke's developing with hyperemesis gravidarum yielding 146 case studies reporting on 177 cases and found that pregnant WE patients became thiamine depleted between 10-15 weeks of gestation, had been vomiting for a median of 7 weeks and had lost 12.1 kg. Unfortunately, treatment with subtherapeutic thiamine dose was common (63.6%), pregnancy loss occurred in 50%, and maternal death in 5% of cases (Oudman, 2019).

TREATMENT OF WERNICKE'S ENCEPHALOPATHY

A high index of suspicion is necessary for any low frequency, high severity disease such as Wernicke's. Treatment is emergent and must be initiated immediately, generally as a hospital inpatient since intravenous thiamine is necessary three times a day, along with serial neurologic exams and nutrition therapy. Treatment requires high-dose parenteral thiamine, which promotes passive diffusion across the blood-brain barrier. If not treated acutely, brain damage, institutionalization and mortality may result (Lin, 2019).

The brain and peripheral nerves are prone to cell death and dysfunction in thiamine deficiency, therefore Wernicke's needs to be treated as the emergency it is, with a similar sense of urgency as patients suspected to have a stroke, myocardial infarction or pulmonary embolism.

The Royal College of Physicians also produced guidelines recommending 250 m iv once daily when used prophylactically and 500 mg three times daily for presumptive diagnosis of WKS including acute WE, for three to five days. Oral thiamine administration is inadequate for WE and WKS due to poor absorption from the gastrointestinal tract (Thomson, 2002). Importantly, if hypomagnesemia is present, patients may fail to respond to parenteral thiamine (Wijnia, 2022).

A randomized trial that studied the effect of variable intramuscular (IM) thiamine doses on working memory in patients with alcohol dependence, and they found that 200 mg IM daily for 2 days was significantly more effective than a 5 mg IM dose (Ambrose, 2001).

The European Federation of Neurological Societies (EFNS) clinical guidelines recommend high-dose intravenous thiamine, 200 mg iv every eight hours for three days or until there is no further clinical improvement in signs and symptoms of Wernicke's. They also acknowledge that even higher doses may be required (Galvin, 2010).

The most recent Cochrane review on prevention and treatment of WKS due to excess alcohol consumption was published in 2013 and concluded that evidence from randomized controlled trials was insufficient to guide clinicians in determining the dose, frequency, route or duration of treatment for prophylaxis against or treatment of WKS due to alcohol abuse (Day, 2013).

In a prospective study of 262 psychiatric inpatients, 32 (12%) had Caine-positive WKS, and only half of those currently used alcohol. Treatment with high-dose intravenous thiamine (1200 mg on day

A study of ICU patients reported that only 20% of patients with Wernicke's on autopsy had received a clinical diagnosis before their death, and only 10% of patients exhibit all three of the classic triad of physical signs of eye signs, ataxia and confusion.

one and 200 mg on days 2-4) resulted in clinically significant neurocognitive improvement (Lin, 2019).

A more recent randomized, controlled clinical trial aimed to study several dosages of thiamine for secondary (asymptomatic at-risk) and tertiary prevention (symptomatic) of Wernicke's patients with alcohol use disorder. The parenteral dosages studied were: 100 mg daily, 100 mg three times a day (tid), or 300 mg tid for 3 days in the asymptomatic at-risk patients. Dosages studied in symptomatic patients were either 100 mg tid, 300 mg tid, or 500 mg tid. The results of this study showed no clear benefit of high dose thiamine over intermediate or lower doses of thiamine, over the short time intervals examined, for the prevention and treatment of cognitive abnormalities related to WKS. However, several study limitations temper the interpretation of these findings, including a high dropout rate of 41% which limited the power of the study to detect differences between treatment groups (Dingwall, 2022).

Based on the current available literature, it's this author's opinion that, given the excellent safety profile of thiamine, potential overtreatment is preferred over undertreatment to prevent prolonged or persistent neurocognitive impairments

WERNICKE-KORSAKOFF'S SYNDROME

Korsakoff's syndrome (KS), often called Wernicke-Korsakoff's syndrome (WKS), is a chronic neuropsychiatric disorder from thiamine deficiency that follows untreated or undertreated Wernicke's encephalopathy. Patients with WKS suffer from a wide range of severe comorbid physical and psychiatric complaints, which limit their ability to perform activities of daily living and negatively affect their social functioning. Up to 25% of patients with WKS require long-term institutionalization (Van Dam et al, 2020)

Tragically, 80% of patients with untreated Wernicke's encephalopathy progress to Korsakoff's syndrome characterized by severe cognitive, behavioral and emotional disorders (Sinha et al, 2019). People with KS often suffer from antegrade and retrograde amnesia, persistent deficits in learning, and confabulation (where they fill in the blanks by fabricating memories). Most patients with Korsakoff's also have deficits in executive functioning, organization, planning and cognitive flexibility, which is essentially dementia. Common behavioral problems include depressive symptoms, impaired self-awareness, agitation and aggression (Draper et al, 2011).

WERNICKE'S MEDICAL MALPRACTICE CLAIMS

Published cases of Wernicke's encephalopathy have more than doubled over the last twenty years, and the number of Wernicke's medical negligence claims has seen an "alarming increase" after bariatric surgery, as described in a risk alert published by the Texas Medical Liability Trust in 2016. Common allegations in these cases include failure to prevent, diagnose and adequately treat thiamine deficiency. The diagnosis of Wernicke's is clinical, by history and physical examination, and is often missed, delayed, or undertreated, which can lead to permanent neurologic damage.

A group comprised primarily of past Presidents of the American Society for Metabolic and Bariatric Surgery (ASMBS) recently published their findings of a closed-claims registry of 175 malpractice claims arising in patients after bariatric surgery procedures in 2006 through 2014. The most frequent reasons for claims were death (27%), leak (17%), bowel obstruction (8%), technical error (7%), wound infection or dehiscence (7%), bleeding (6%), perforation of the gastrointestinal tract (6%) and nutrient deficiencies (5%) (Morton, 2022).

A physician or advanced practice provider in almost any specialty could be named in a Wernicke's claim, since the potential causes are so wide-ranging. Some common medical specialties named are Emergency Medicine, Internal Medicine, Gastroenterologist, Oncologist, Neurologist, and Pediatric Medicine. Common surgical specialists named in a Wernicke's case are Bariatric Surgery and Obstetrics.

EXPERT PEARLS

In the author's personal clinical experience treating several cases of Wernicke's after bariatric surgery and as a testifying expert witness in several other cases, there are some common themes in these case reviews:

- Poor food intake and rapid weight loss.
- Vomiting but normal gastrointestinal studies (x-ray and endoscopy).
- Multiple trips to the Emergency Room, eventually by ambulance (since they can't walk).
- Family member is advocating for them as they can't advocate for themselves anymore.
- Multiple physicians miss the diagnosis: emergency medicine, bariatric surgeon, hospitalist

The author has also identified some common pitfalls in malpractice claims involving Wernicke's:

- Blaming the patient for their weakness and vomiting.
- Labelling the patient noncompliant with their diet after bariatric surgery.
- Misconception that a patient with thiamine deficiency is cachectic.
- Subconscious bias that a morbidly obese patient is not malnourished.
- Failure to do a thorough neurological exam, especially eyes, gait, and mental state.
- Failure to consider the diagnosis of Wernicke's.

- Delay in treatment while awaiting lab result of whole blood thiamine (takes 4-5 days).
- Health care team reassured by normal head CT or brain MRI (only 50% sensitive).
- Failing to recognize that vomiting is both a cause and effect of Wernicke's.
- When Wernicke's is diagnosed, it is usually undertreated.

DISCUSSION

The incidence of Wernicke's encephalopathy and related medical negligence litigation have simultaneously and significantly increased over the past two decades, commensurate with the increase in bariatric surgery, a significant risk factor for Wernicke's due to reduced nutrition.

Although the etiology and pathophysiology of Wernicke's is a standard part of any medical school curriculum, it's often a diagnosis that is missed across many medical specialties. Given the safety of high-dose intravenous thiamine and weighing the potentially serious morbidity of delaying treatment of Wernicke's, a low threshold for rapid treatment should be widely adopted.

Wernicke's encephalopathy can occur in as little as two weeks of thiamine deficiency, is diagnosed clinically and requires urgent empiric treatment with high-dose intravenous thiamine. With appropriate early treatment, the symptoms and signs of Wernicke's usually completely resolve. Unfortunately, most patients with acute Wernicke's encephalopathy progress to the chronic Wernicke-Korsakoff's syndrome, are permanently disabled and unable to live independently.

While there is some work to be done to determine the optimal dosage of thiamine to treat Wernicke's encephalopathy, in order to have the biggest public health impact and prevent the most harm, our focus in needs to be on prevention on the primary, secondary and tertiary levels. Prevention and treatment of Wernicke's encephalopathy with thiamine is safe, effective and inexpensive, yet vastly under prescribed.

Our current challenge, and the author's personal mission, is to apply this knowledge gleaned from clinical experience and reviewing malpractice claims to raise awareness about WKS among health professionals and the public at large in order to help prevent future cases of this devastating and permanently disabling condition.

REFERENCES

Aasheim ET. Wernicke encephalopathy after bariatric surgery: A systematic review (2008). *Ann Surg., 248(5): 714-720.* https://doi.org/10.1097/SLA.0b013e3181884308

Ambrose M, Bowden S, Whelan G. Thiamin treatment and working memory function of alcohol-dependent people: preliminary findings (2001). *Alcohol Clin Exp Res., (25)1: 112-116. PMID: 11198705.*

Caine D, Halliday G, Kril J and Harper C. Operational criteria for the classification of chronic alcoholics: identification of Wernicke's encephalopathy (1997). *Journal of Neurology, Neurosurgery, and Psychiatry, (62): 51-60.* https://doi.org/10.1136/jnnp.62.1.51.

Chiossi G, Neri I, Cavazzuti M et al. Hyperemesis gravidarum complicated by Wernicke encephalopathy; background, case report, and review of the literature (2006). *Obstet Gynecol Surg, 61(4): 255-268.* https://doi.org/10.1097/01.ogx.0000206336.08794.65

Day E, Bentham P, Callaghan R et al. Thiamine for prevention and treatment of Wernicke-Korsakoff Syndrome in people who abuse alcohol (2013). *Cochrane Database Syst. Rev. (7):CD004033.* 10.1002/14651858.CD004033.pub3

Dingwall K, Delima J, Binks P et al. What is the optimum thiamine dose to treat or prevent Wernicke's encephalopathy or Wernicke-Korsakoff Syndrome? Results of a randomized controlled trial (2021). *Alcohol Clin Exp Res., (46): 1133-1147.* https://doi.org/10.1111/acer.14843

Draper B, Karmel R, Gibson D et al. Alcohol-related cognitive impairment in New South Wales hospital patients aged 50 years and over (2011). *Australia & New Zealand J Psychiatr., 45(11). 985-992.* https://doi.org/10.3109/00048674.2011.610297

Flannery A, Adkins D, Cook A. Unpeeling the evidence for the banana bag: Evidence-based recommendations for the management of alcohol-associated vitamin and electrolyte deficiencies in the ICU (2016). *Critical Care Medicine., (44)8: 1545-1552.* https://doi.org/10.1097/CCM.0000000000001659

Flynn A, Macalusco M, D'Empaire I et al. Wernicke's encephalopathy: Increasing clinician awareness of this serious, enigmatic, yet treatable disease (2015). *Prim Care Companion CNS Disord., (17) 3.* https://doi.org/10.4088/PCC.14r01738

Galvin R, Brathen G, Ivashynka A, et al. EFNS guidelines for diagnosis, therapy and prevention of Wernicke encephalopathy (2010). *European Journal of Neurology., (17): 1408-1418.* https://doi.org/10.1111/j.1468-1331.2010.03153.x

Jung Y-C, Chanraud S, Sullivan E. Neuroimaging of Wernicke's Encephalopathy and Korsakoff's Syndrome (2012). *Neuropsychology Review., (22): 170-180.* https://doi.org/10.1007/s11065-012-9203-4

Kohnke S and Meek C. Don't seek, don't find: The diagnostic challenge of Wernicke's encephalopathy (2021). *Annals of Clinical Biochemistry., (58)1: 38-46.* https://doi.org/10.1177/0004563220939604

Lin S, Leppla I, Yan H et al. Prevalence and improvement of Caine-positive Wernicke-Korsakoff syndrome in psychiatric inpatient admissions (2019). *Psychosomatics, (61): 31-28.* https://doi.org/10.1016/j.psym.2019.08.002

Marrs C and Lonsdale D. Hiding in plain sight: Modern thiamine deficiency (2021). *Cells., (10) 2595.* https://doi.org/10.3390/cells10102595

Morton JM, Khoury H, Brethauer SA, et al. First report from the American Society of Metabolic and Bariatric Surgery closed-claims registry: prevalence, causes, and lessons learned from bariatric surgery medical malpractice claims (2022). *SOARD. (18): 943-947.* https://doi.org/10.1016/j.soard.2022.04.004

Ota Y, Capizzano A, Moritani T et al. Comprehensive review of Wernicke Encephalopathy: Pathophysiology, clinical symptoms and imaging findings (2020). *Japanese Journal of Radiology, (38): 809-820.* https://doi.org/10.1007/s11604-020-00989-3

Oudman E, Wijnia J, Oey M et al. Wernicke's encephalopathy in hyperemesis gravidarum:

A systematic review (2019). *Eur. J. Obstet. Gynecol. Reprod. Biol., (236): 84-93.* https://doi.org/10.1016/j.ejogrb.2019.03.006.

Oudman E, Wijnia J, Oey M et al. Wernicke-Korsakoff syndrome despite no alcohol abuse: A summary of systematic reports (2021). *J. Neurol. Sci. 2021, 426, 117482.* https://doi.org/10.1016/j.jns.2021.117482

Oudman E, Wijnia J, van Dam M et al. Preventing Wernicke encephalopathy after bariatric surgery (2018). *Obesity Surgery, (28): 2060-2068.* https://doi.org/10.1007/s11695-018-3262-4

Sinha S, Kataria A, Kolla B, et al. Wernicke Encephalopathy – Clinical Pearls (2019). *Mayo Clin Proc., 94(6): 1065-1072.* https://doi.org/10.1016/j.mayocp.2019.02.018

Texas Medical Liability Trust (2016). Risk alert and closed claim study: Wernicke's encephalopathy after bariatric surgery. https://hub.tmlt.org/tmlt-blog/risk-alert-and-closed-claim-study-wernickes-encephalopathy-after-bariatric-surgery.

Thomson A, Cook C, Touquet R and Henry J. The Royal College of Physicians report on alcohol: guidelines for managing Wernicke's encephalopathy in the accident and emergency department (2002). *Alcohol and Alcoholism, (37)6:513-521.* https://doi.org/10.1093/alcalc/37.6.513

Van Dam M, van Meijel B, Postma A, Oudman E. Health problems and care needs in patients with Korsakoff's syndrome: A systematic review (2020). *J Psychiatr Ment Health Nurs., 27: 460-481.* https://doi.org/10.1111/jpm.12587

Whitfield K, Smith T, Rohner F et al. Thiamine fortification strategies in low- and middle-income settings: a review (2021). *Ann. N. Y. Acad. Sci., (1498): 29-45.* https://doi.org/10.1111/nyas.14565

Wijnia J. A clinician's view of Wernicke-Korsakoff syndrome (2022). *Journal of Clinical Medicine, (11) 6755.* DOI. https://doi.org/10.3390/jcm11226755

Zhu Y, Jain N, Vanage V et al. Association between ready-to-eat cereal consumption and nutrient intake, nutritional adequacy, and diet quality in adults in the National Health and Nutrition Examination Survey 2015-2016 (2019). *Nutrients, (11)12: 2952.* https://doi.org/10.3390/nu11122952

Dr. Emma Patterson is board certified in General Surgery in both Canada and the USA and has focused her practice on bariatric surgery in Portland, Oregon, since completing her fellowship in Advanced Laparoscopic Surgery at Mount Sinai Medical Center in New York City in 2000. She has served as a testifying expert witness in general and bariatric surgery all over the US for the past 18 years.

She is internationally recognized as a leader in bariatric surgery for her outstanding surgical skills, teaching abilities, and clinical research track record. Dr. Patterson was a key surgeon contributor in the NIH-funded LABS consortium, and she served on the ASMBS Executive Council from 2010 to 2013. Dr. Patterson has published 20 book chapters and more than 50 peer-reviewed papers, including articles in prestigious journals such as the New England Journal of Medicine and the Journal of the American Medical Association.

AALNC 2023 Annual Forum

AALNC's Annual Forum kicked off in Louisville, KY on Thursday afternoon, where attendees took advantage of 2 half-day workshops. This was followed by an evening networking session - time to kick back, enjoy adult beverages and live music, and network with so many legal nurse consultants. Friday and Saturday were packed with breakout and general sessions, more networking, our Awards Ceremony & our fun annual Passport to Prizes.

See you next **April 18-20, 2024** at the **Omni William Penn in Pittsburgh!**

"Amazing, amazing, amazing experience and opportunity!"
– Jennifer Hous

"AALNC's Annual Forum is the necessary retreat to help every LNC reflect on their goals and establish their path forward."
– Laura Averette

"Whether you are a just starting out or have been doing legal nurse consulting for years, you HAVE to attend the Annual Forum. The presentations and in-person networking has been an invaluable tool in growing my business." – ***Kysa Douglas***

"I have been an LNC for over ten years. This was the first time I attended the AALNC forum. I found this experience to be invaluable!" – ***Deborah Lord***

"As a novice LNC…this conference has boosted my confidence in myself and in my business." – ***Kayla Logsdon***

"The Forum is the place to go to meet your colleagues, share common experiences and build relationships to share referrals. Regardless of your medical legal experience, you can not help going away with your head filled with knowledge and your spirit buoyed by being part of an amazing community of colleagues!" – ***Becky Czarnik***

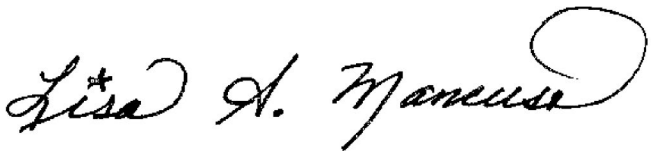
"This conference is a must attend for legal nurse consultant. The breadth of knowledge in the room was phenomenal."
– ***Tina Baxter***

President's Update *continued from page 4*

Our association management team, likewise, has been so uplifting and supportive. Prayers from many different religious traditions were offered up for Martin. It is gratifying to experience diverse faith and to feel included.

When I joined AALNC in 2010, I expected to take part in exceptional education and networking. I knew if I "worked" my relationships within the organization, I would probably get some cases and learn a few things along the way. What I didn't expect was that these LNCs would become such close friends.

If you are new to AALNC, I want to let you know you have found your professional community. If you have been here for a while, you already understand. AALNC is not the biggest organization I belong to, but without a doubt, it's the organization with the biggest heart.



Lisa Mancuso, BSN, RN, CCRN, CLCP, LNCC
35 Hill Street | Holliston, MA 01746
Mobile: 508-446-3664 | Office: 774-233-2943
lmancuso@mancusomedlegal.com

AALNC Continuing Education Opportunities

https://www.aalnc.org/Education

AALNC offers a monthly Webinar series, extensive online courses, and holds an annual Legal Nurse Consulting Educational and Networking Forum. Each educational offering attests to AALNC's commitment to delivering our members and constituents with quality education related to diverse and dynamic topics within the field of legal nurse consulting.

AALNC Webinar Series presents informative, educational content on important LNC topics based on clinical Issues, LNC Practice Issues, and LNC Business Issues. Individuals can access live, interactive webinars each month or access a number of on-demand webinars. Upcoming webinars include:

- **June 7, 2023: Adobe Pro for the LNC**
- **July 12, 2023: LCP, MSA, MCP – What's the Difference?**
- **August 2, 2023: Intro to Software: Best Practices for the LNC**

As an AALNC member you can watch these and previously offered webinars on-demand anytime throughout the year.

Looking for other resources?

Check out the AALNC education resources available at https://www.aalnc.org/Resources/Education-Resources

July 24 – 28, 2023 – LNC Awareness Week

Join your AALNC community in our annual celebration week this July!

- Multiple CE opportunities for both the novice and experienced LNC
- Tips and Tricks for LNC Success
- Get involved with your LNC Community

Friday, September 8, 2023 – LNC Jumpstart

Join us for a live, virtual workshop this September

- Network with experienced LNCs and new LNC peers
- Registration opens soon – stay tuned for more information!

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

Your Legal Nurse Consulting Professional **Home**

EDUCATIONAL RESOURCES

Free access to our foundational *The Legal Nurse Consulting: Scope and Standards of Practice* as well as access to the *Journal of Legal Nurse Consulting* archives, current issues, and current year *Journal* CNE.

WEBINARS

Each year, all 10 webinars presented will be free to members in both live and on-demand formats.

COMMUNITY

Attend the AALNC Annual Forum and volunteer with AALNC to network with likeminded LNCs and other legal and nursing professionals. Access our Career Center and the LNC Locator to get your name out there.

MEMBER SAVINGS

Enjoy member only discounts on all AALNC educational products, including the LNCC® credential, the only ABNS legal nurse consulting recognized certification.

SHARED INTEREST GROUPS

Access to online communities for members to have a central place for conversation and sharing about common interests related to their LNC career.

BELONGING

AALNC is the professional home for all Legal Nurse Consultants, whether you are just getting started in your practice, or have been an LNC for many years. Welcome home!

AFFINITY PROGRAM

Access to exclusive discounts from vendors you use every day for your practice.

Join today at **https://www.aalnc.org/Membership/Member-Benefits**.