LETTER TO THE EDITOR

The American College of Clinical Wound Specialists (ACCWS) Rebuttal to the Recent NPUAP Pressure Ulcer Definition (July 2016)

As healthcare professionals dedicated to the care of patients with wounds, including those patients with wounds secondary to pressure, it is with the utmost concern that we bring the new classification proposed by the National Pressure Ulcer Advisory Panel (NPUAP) to your attention. The field has only recently been unified with the current terminology and now the new classification proposed creates confusion and frankly, is unnecessary and incorrect. Wound care providers understand that pressure wounds are due to ischemic injury as a result of a myriad of issues, including but not limited to mechanical pressure, shear, friction positioning/re-positioning, the prodromal issues surrounding end-of-life, death and the dying process and/or skin failure. Furthermore, the proposed “pressure injury” terminology is not listed as a diagnosis in the current/new ICD 10 coding and does not capture the breadth that the current acceptable term, pressure ulcer, does.

Wound care providers; nurses, physical therapist, physicians and other health care professional have only recently integrated protocols, policy and procedures to protect patients, educate families and care givers, and teach healthcare students regarding the appropriate definitions of stage I, II, III or IV pressure ulcerations as well as such terms a deep tissue injury.

The proposed use of pressure INJURY will not only confuse health care professionals, it has the potential to negatively impact providers who are dedicated to wound care. Plaintiff attorneys will be armed with inaccurate jargon to help convince juries that an injury or insult was inflicted upon a patient intentionally. This ultimately increases exposure of all providers for potential law suits and may cause the number of talented providers to dwindle, just as was observed with those physicians who were skilled

obstetricians when malpractice policies reached record highs.

In all areas of healthcare the United States is the world leader; why is it necessary to follow European and Australian recommendations? Additionally, doctors in Europe pay only approximately \$200 a year for malpractice, whereas in the U.S., providers pay upwards of \$20,000 or more in annual malpractice premiums. We live in a highly litigious country which ultimately drives up healthcare costs overall. Europe and Australia do not have this burden.^a

Neither was there a publicized request for consensus or comment among wound care societies or providers on the decision to change criteria and definitions, nor was any of this criteria change opinion evidence based. There seems to be a disconnect between the NPUAP and the rest of the active wound care community.

It has also been noted that several practitioners who sit on the NPUAP board of directors, and drafted these changes, make their living as plaintiff expert witnesses. This is a clear conflict of interest, is self-serving and could be construed as blatant fraud. In addition, it has been discussed that these changes in terminology were put forth without a vote or a proposal.

Major organizations in the United States such as Kindred Health Network, Select and others have already issued a statement that they will not be applying the new classifications.

The Board of Directors of the American College of Clinical Wound Specialists, along with our colleagues, and the majority of the other wound care organizations, kindly request that NPUAP rescind this most recent decision.

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The Board of the American College of Clinical Wound Specialists

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^a <http://www.pbs.org/newshour/rundown/health-costs-how-the-us-compares-with-other-countries/>; http://m.amednews.com/apps/pbcs.dll/article?aid=/20100503/profession/305039938&template=mobile_art