

Volume 27

Number 2

Summer 2016

THE JOURNAL OF
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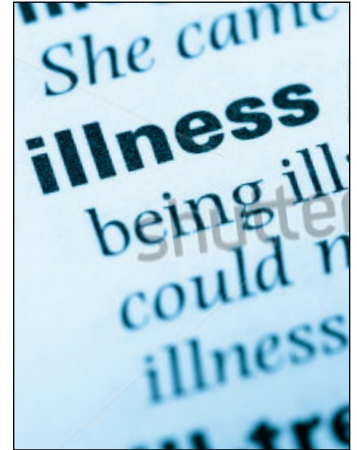
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8
AN LNC PRIMER: SCREENING AND INVESTIGATING POTENTIAL MEDICAL MALPRACTICE CASES

Elizabeth K. Zorn, RN, BSN, LNCC; Stephen G. Schwarz, Esq.

15
ANATOMY OF A MEDICAL MALPRACTICE DEMAND LETTER

Peter I. Bergé, JD, PA

24
DEMONSTRATIVE EVIDENCE: INSTRUCTION AND ETHICAL PERSUASION

Mindy Cohen, RN, MSN, LNCC

32
DAY-IN-THE-LIFE: VIDEO AS EVIDENCE

Kelly Deutsch

35
DEMONSTRATIVE EVIDENCE: SPECIALTY TIMELINES

Alicia Luke, RN, LNCC

40
MEDICAL DEFINITIONS: TERMS, ABBREVIATIONS, ACRONYMS AND SYMBOLS

Ann M. Peterson, RN, EdD, MSN, FNP-BC, LNCC



- 02 Manuscript Review Process
- 03 Article Submission Guidelines
- 04 From the President
- 06 From the Editor
- 14 Test Your Screening Skills





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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.

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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 *Journal of Legal Nurse Consulting* as a benefit of membership. Subscriptions are available to non-members for \$165 per year. Back issues are available for free download for members at the Association website and \$40 per copy for non-members subject to availability; prices are subject to change without notice. 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, *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 refereed 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, 6th 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
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- Include a 100-word abstract and keywords on the first page
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- All photos, figures, and artwork should 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)

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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.

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Susan Carleo
RN, CAPA, LNCC

President, AALNC

A Message from the President

Dear AALNC Members,

When I attended my first American Association of Legal Nurse Consultant's Forum eight years ago I remember looking at and admiring the President and the Board of Directors. I wondered how I could become one of them someday. I wanted to be "up there."

I was impressed by how warm and friendly the successful women I met were. They would talk and offer suggestions to help me with my independent practice. I felt a positive connection. They inspired me to come back each year for more education, networking and inspiration.

And it was more than this. I was the only legal nurse consultant in my town. I had an independent practice with my own office in my house and I worked with attorneys on my own but after that Forum I was never alone, with the best support system any legal nurse could have. All year I stayed in touch with the contacts I made, the webinars I attended, and the educational opportunities available. New York's Chapter closed but I still felt connected to AALNC.

Each year I met new people and reconnected with the nurses I knew. One of them, Abbie Citron from California, suggested I think about being a PACU expert since I work in the PACU. I had not considered this, because I loved the independent part of my practice. About a month later an attorney needed a PACU expert. I reviewed the case and since then have been deposed and to trial several times on PACU cases. Accepting this case opened up a whole new field for me. Thank you, Abbie.

Every year when the Forum's over and I wait for my plane I write down 20-30 new ideas I learned. These are a list of great suggestions to work on in the coming year for my business and myself. During the year I check them off one by one as I accomplish them. Attending the Forum motivates me for a whole year.

I volunteered for AALNC because I wanted to become more a part of this amazing organization of successful LNCs. Volunteering was a new experience for me. I learned how AALNC functions and I realized it is all in the hands of creative and dedicated volunteers. Through volunteering, once again I saw my practice grow. I can say without a doubt that becoming a member of AALNC and volunteering were some of the best things I've done. As I've volunteered my way up the chain of command on the Board of Directors I have experienced the same support and encouragement I did when I first joined.

I am very pleased, honored and proud to be the 2016-2017 AALNC President. I'm excited about this coming year and I'd like to share some of our plans with you.

“The best preparation for tomorrow is doing your best today.”

H. Jackson Brown, Jr.

In 2016-2017 we plan to:

- Continue to associate with nursing specialty organizations to share speakers and promote legal nurse consulting.
- Actively seek speaking opportunities with attorney organizations.
- Complete the final phase of our online course.
- Begin work on the Principles & Practice 4th Edition.
- Transform Nominations to a year-round process.
- Support our new Scope and Standards Committee to update, revise, and finalize our 2006 Scope & Standards document.
- Communicate that AALNC is the premier professional organization for every LNC seeking education and networking.
- Advertise our LNC Locator as the place for attorneys to find LNCs and nurse experts.

Our strategic goals to support our core demographic, experienced LNCs, include:

- Assuring that our products and services meet their needs.
- Providing them education on new and emerging trends in litigation.
- Communicating with them using current, relevant methods.
- Demonstrating the value of their board certification to potential clients
- Marketing LNCs/LNCCs to the legal community.

Thank you to all our volunteers, chapters and members. I appreciate your help and support very much while we move forward.

I am so excited to be standing “up there” as I dreamed all those years ago. Please feel comfortable contacting me if you have questions or suggestions about AALNC.

Sincerely,



Susan Carleo, RN, CAPA, LNCC
President AALNC



Wendie Howland
MN, RN-BC, CRRN,
CNLCP, LNCC

Editor, JLNC

Editor's Note

Welcome to the June 2016 *JLNC*. You're looking at a wonderful collection of ideas and techniques to make your work stronger, more persuasive, more valuable to your clients. One of the things I value most about serving as editor is the opportunity to learn about things I wouldn't otherwise have occasion to see. I hope you enjoy this issue with as much enthusiasm as we do when we put it together.

As I write this, I've just returned from a wildly successful AALNC Forum that was packed with great ideas, knowledgeable speakers, fun vendors, lots of chocolate and ... bowling! I talked to so many aspiring and new legal nurse consultants who wanted to come to play on the Journal (there's a reason we don't call it work), and connected with old friends and people who feel like old friends. Susan Carleo's President's Note nearby reminds us that we were all new once, owing owe our successes and expertise to colleagues and mentors.

I was pleased to present a brief look at the Journal; the slide show of past covers drew some chuckles and some sighs. The earliest *JLNC* I have is 1993's volume 4, 23 years ago. It describes the Association's Fourth Annual Conference in Chicago, has a complete listing of all members, and ran an ad for a proprietary LNC certificate program. Now, of course, technology! Listing our membership on our website is just a matter of electrons; our webinars and the LNCC set the standard for legal nurse consulting education and certification. Technology also allows the Journal to have much more appealing look with color pictures, graphics, and live links. We review submissions to assure that our Journal is useful to any nurse interested in legal nurse consulting, from aspiring to novice to expert. It was terrific to see so many past and present *JLNC* committee members and authors rise for well-deserved applause. We have been, and are still, your Journal.

We're planning an issue for next year (sooner than you think!) of articles all by first-time nurse authors; we have people eager to help them develop their ideas and get them into shape. Of course, you don't have to wait. Shoot me a quick email to get started now! Perhaps next April your smiling face will be up on the screen as the author of the best article of the year!

Finally, although no one stood when Susan called to recognize any founding members of the association present, I was struck by the palpable sense of institutional memory in the hall. I met several past presidents who graciously shared their perspectives on how issues have evolved over time. I found myself more than once sitting at a table just listening quietly. Read the Executive Board's goals thoughtfully; be prepared to help the profession march forward. Every single person on those committees is just like you: a legal nurse consultant who wants to help others succeed at what we love.

Remember that new people look to us. Let them know that they and the organization have much to be thankful for. Like Newton, we see far by standing on the shoulders of giants.

Wendie A. Howland

Wendie A. Howland
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Sapling said to have come from the apple tree that inspired Newton to consider gravitation.

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An LNC Primer: Screening and Investigating Potential Medical Malpractice Cases

Elizabeth K. Zorn, RN, BSN, LNCC
Stephen G. Schwarz, Esq.

Keywords: Medical malpractice, screening, investigating

Medical malpractice cases are difficult, time-consuming, and expensive. Non-meritorious and even equivocal cases are vigorously, and rightly, defended. However, plaintiff firms do not generate revenue on non-meritorious claims, so they must recognize claims that are likely to fall short on liability, causation, or damages.

Experienced medical malpractice attorneys reject most medical malpractice inquiries. Although there is no central repository of statistics, at our firm we reject 90 to 95% of all potential malpractice cases because we don't believe there was any negligence or don't believe we can prove it. This is remarkable because lawyers, judges,

physicians, and other professionals make most of these referrals, not claimants. However, most lawyers and physicians truly do not understand how difficult it is to succeed in a medical malpractice case.

Clients often say that a healthcare provider advised them to seek counsel. Typically, this is in the setting of a poor or unexpected outcome in which there may or may not have been malpractice. Providers rarely know the legal and other standards for proof and are not necessarily qualified to render an off-the-cuff opinion, especially if they have not even reviewed the medical records; these same providers are often unwilling to speak to the attorney about

it. Although a referral from the medical community can be a factor, it should not be the sole basis for proceeding with an investigation. Comments from providers about a potential legal claim may be misunderstood or even the result of acrimony between two providers. Endorsements from subsequent treating doctors or well-meaning nurses are unreliable in predicting the success of a claim.

ROLE OF THE LNC IN INITIAL SCREENING

Highly skilled and experienced trial attorneys who have spent years in the trenches learning the medicine and the art of trial work are best qualified to

handle medical malpractice cases. Legal nurse consultants are tremendously valuable in this work, and nowhere more than in screening cases. However, attorneys should never entirely delegate this responsibility to legal nurse consultants (or anyone else). Screening cases is an interdisciplinary process involving medicine, science, law, and often economics. Attorneys who fully delegate the screening decision to non-lawyers of any background do so at their peril.

At our firm, both a nurse and an attorney review all potential medical malpractice claims. For those we reject outright, the client receives a letter from the attorney explaining that we will not investigate their potential claim. Usually we tell them the reasons for this in very general terms. We remind them that a SOL applies and encourage them to seek the advice of another attorney “who may feel differently about your potential claim.” It is very important from a legal risk management standpoint to let clients know that our decision not to investigate their claim is our judgment and does not mean they have no case.

LNCs can assist the attorney in several ways to screen cases effectively including:

- Developing a good medical malpractice intake form that includes essential information. At our firm, the nurses created both the original intake form and a detailed client questionnaire for those cases we agree to investigate.
- Training paralegals or secretaries to take initial information from prospective clients. We train them to obtain the essential information without spending too long on the phone.
- Reviewing potential claims so the attorney can decide whether to accept the case for investigation. This is a great opportunity for the lawyer

to learn medicine from the LNC and for the LNC to learn about the legal standards from the attorney.

- Getting additional information from the client for the attorney to reach a decision. This is a perfect role for the LNC; nurses are adept at taking medical histories.
- Conducting a quick literature review. A quick literature review may indicate that a surgical complication is fairly common, decreasing the chances of proving negligence.
- Drafting the letter to the client a summarizing facts supporting or rejecting a case for the attorney’s review and signature.
- Helping the attorney process new client intakes timely, important both for public relations and risk management. If the attorney declines to investigate a case, the client should have time to seek other counsel well before the SOL expires.

CONSIDERATIONS FOR INITIAL SCREENING

Always remember all the elements of a viable medical malpractice claim. If the case involves catastrophic injuries but liability is not good or causation is unlikely, the attorney could spend a lot of money working the case up and getting it reviewed all for naught. This said, though, it is important to be very careful and thorough in cases involving very serious injuries. The consequences of a wrong call and rejecting a catastrophic injury case are worse than in rejecting a case that someone eventually settles for \$75,000.

One of the first questions to ask is, “How is this case likely to be defended?” Playing devil’s advocate early on is safest. The client has likely not told you everything, potentially purposely, but just as often because he or she is unaware of certain medical

data buried in the records that may contradict the theory of liability. We try to be sympathetic to potential clients but cynical about their claims until convinced otherwise. Some have said that good judgment comes with experience, and experience comes from bad judgment. Nowhere is this truer than in plaintiff malpractice claims.

POSSIBLE REASONS FOR REJECTING A CASE OUTRIGHT

There are several general justifications for immediately declining to investigate a potential medical malpractice claim:

- **Conflict of Interest:** Conflicts can be legal (e.g., the firm has represented a potential defendant before) or personal (e.g., a defendant is the friend or treating doctor of a firm member or employee). Most plaintiff malpractice firms also do general personal injury cases. Many current clients are being treated by orthopedic surgeons or pain management specialists. Suing any of these physicians for malpractice may not technically be a conflict of interest, but it is not in the interest of the personal injury client to sue his treating physician for malpractice.
- **Expired or limited Statute of Limitations (SOL):** SOL rules vary by state, type of case, and whether it involves a minor. Due to the complex nature of the continuous treatment doctrine or discovery exceptions, it’s not always possible to determine the SOL without first reviewing medical records and sometimes conducting legal research. If the care took place in a state other than where the attorney practices, alarms should go off immediately; research must be done before making any commitment to investigate. We were recently asked to review a legal malpractice case against an attorney in New York who took a case on behalf of a former



client's minor child who moved to Pennsylvania and received medical care in Delaware. He did not know that Delaware has a particularly ungenerous statute of limitations for minors, resulting in the legal malpractice claim alleging improper legal representation resulting in harm to the client's case.

Even if the SOL has not expired, the deadline may not allow enough time to investigate the claim thoroughly before suit must be brought. This is undesirable, because the attorney may decide not to take the case, leaving the client with insufficient time to find another lawyer willing to bring the case. The attorney may be forced to bring a case she does not believe has merit just to preserve the SOL to prevent subsequent legal malpractice action.

We prefer not to accept a case for investigation with less than six months before the SOL runs because it typically takes several months to obtain the pertinent medical records and an expert review. However, if the case appears strong, it may be worthwhile to mobilize firm resources to evaluate the case and file the documents in a short timeframe to preserve a client's legal right to bring a claim.

- ♦ **Limited damages:** It doesn't make sense to spend \$20K to pursue a claim in which the potential recovery is only \$50K. Most plaintiff firms

have a minimum "damage threshold" range, anywhere from \$25K to \$500K or more, depending upon the firm. Also, the attorney must consider whether there are any third-party liens that must be satisfied, such as workers comp, Medicaid, or Medicare, which could consume most of the net proceeds if they can't be reduced.

Determining potential economic recovery involves assessing:

- ♦ Physical/emotional pain & suffering
- ♦ Functional limitations
- ♦ Economic damages (lost wages, liens, out of pocket medical expenses)
- ♦ Loss of enjoyment of life

Attorneys may also want to research prior awards in the same state and venue for similar injuries, including outcome of appeals related to inadequate or excessive awards. If the defendant's conduct constituted gross negligence, this may increase the settlement value since the insurance carrier may feel it's too risky to take the case to trial, especially a case with significant damages.

Litigation when the cost may exceed recovery include those involving:

- ♦ only minor injury
- ♦ no permanency or significant functional limitation

- ♦ a very brief period of conscious pain and suffering, or none at all
- ♦ a decedent who was very old or very young and had no one relying on him or her for support (in states where wrongful death damages are limited to financial loss)

Although there are always exceptions, it very difficult to find economical justification for cases like these. This is especially true in New York State, with its very restrictive wrong death statute that does not permit distributees of an estate any monetary recovery for emotional harm suffered from the death of a loved one.

Clients often tell us that "it's not about the money," or they "don't want the same thing to happen to someone else." We gently remind them that the only reason to sue is to recover money for injury from improper care, not to punish or sanction a provider or undo what has been done. People who truly feel this way are much better served by filing a complaint with the appropriate state Licensing Board, which will cost the client nothing and can (although rarely) result in suspension or removal of the provider's license.

- ♦ **No legal cause of action:** When a potential defendant has immunity or the plaintiff cannot establish a duty between the plaintiff and the potential defendant, a suit is not viable. Some states do not recognize a cause of action for wrongful birth/life, which precludes a failed tubal ligation claim, for example. Prisoners who are injured through malpractice while in prison must prove "deliberate indifference," which is often impossible.
- ♦ **No liability or causation:** The attorney must prove departure from the standard of care, damages,

and a causal link between them. Damages must be enough to offset the cost of litigation. Even egregious medical errors do not support a good malpractice case without these elements. The worst possible outcome does not overcome failure to prove departure from the standard of care. Typically we analyze first what appears to be the hardest of these elements to establish. If the liability looks promising we will choose first to analyze causation, coming back to liability only if we are satisfied that a reasonable causation claim can likely be established.

PROBLEMATIC PLAINTIFF CASES

Though all cases must be evaluated on their own merits, the following may present particular hurdles:

- Cosmetic surgery cases when the client's primary complaint is dissatisfaction with the cosmetic outcome. A jury may not be sympathetic to a plaintiff who undergoes an elective cosmetic procedure and then doesn't like the result.
- Psychiatric cases when the client alleges wrong diagnosis or treatment. These are quagmires with large volumes of records created over many years and numerous diagnoses and treatments. It's difficult to establish improper care and that different care and treatment would likely have resulted in a significantly better outcome.
- Cases when the client has a litany of complaints about many aspects of their care, including care rendered by multiple providers. While some may be valid, it is not likely that most resulted in a worse outcome. Also, it may be difficult to convince a jury that multiple providers provided substandard care.

- Clients who are (or were) non-compliant or otherwise partially responsible for their injuries, e.g., a heavy smoker complaining of a fracture nonunion or a delay in diagnosis and treatment of smoking-related lung cancer.

SURGICAL COMPLICATIONS

There are three general possibilities; the injury:

- Resulted from a clear departure of accepted standards of care, such as transecting a major nerve or some other operative "misadventure"
- Was mostly likely not due to improper care but a known risk that could occur even with proper care
- Was possibly due to improper care but this would likely be difficult to establish

In these cases, the attorney and LNC must establish the likely mechanism of injury and how proper surgical technique or other care would likely have prevented the complication. Proving such cases almost always requires an outcome that could not occur without a surgeon's or other documented error.

LACK OF INFORMED CONSENT

Specific rules related to informed consent vary by state. In general, physicians, advanced practice nurses, and other providers must discuss with the patient the reasonably foreseeable risks, benefits and alternatives of a proposed procedure or treatment.

The plaintiff must prove that the client did not receive proper informed consent and that she (or in some states a "reasonable person") likely would not have undergone the procedure or treatment had she been properly informed. Find evidence of informed consent discussions in multiple sources: the consent form, the operative note,

a hospital progress note and/or the provider's office record.

Plaintiff firms rarely take cases in which the only claim is lack of informed consent because it can be difficult to prove all the required elements of the claim. However, this element may be included in cases alleging other types of improper care.

MEETING WITH CLIENTS

For those claims deemed worthy of investigation, it is very important for the attorney and LNC to meet with clients, and sometimes family members, to review their version of the events and obtain a complete medical, social, educational, and employment history. (See Conklin, et al.) Your standard client questionnaire will be helpful.

The medical history should include:

- Significant underlying medical conditions
- Related family history
- Unrelated hospitalizations
- Name and address of primary care physician(s) back at least 10 years
- Current medications
- The names addresses of all providers who have treated the client for the related injuries
- All hospitalizations for treatment of related injuries
- Any entities that may assert a lien, such as Medicare, Medicaid, workers compensation, and supplemental or ERISA health insurance.

The social history should include:

- Tobacco, alcohol and recreational drug history
- Treatment for substance abuse
- Treatment for mental health issues
- Prior involvement in litigation
- Criminal history
- Educational background
- Employment history



View additional screening memos online at AALNC.org.

- Information regarding dependents
- Social media platforms
- Whether the client is in bankruptcy proceedings (any recovery in a medical malpractice claim would be considered an asset)

In a death case, obtain the following:

- Was an autopsy done? If so, where?
- Has someone been appointed to represent the estate?
- Preliminary assessment of pecuniary loss (e.g., lost wages, pension, etc)

Gather relevant information about liability, causation, and damages and assess the client's personality. The attorney should also explain the investigation process, the general legal requirements in that state for commencing a claim, and the litigation process, including costs. Put a summary of this meeting into the file.

COLLECTING MEDICAL RECORDS

The process for doing this varies. At our firm, the LNC identifies the relevant records/diagnostic films and provides a list of those records (with complete addresses) to the person who generates the letters requesting medical records. Some firms use a records retrieval service. Be sure to have a reminder system to follow up on those records not received timely. Also, an LNC should review the records as they come in to ensure they are complete.

Preliminary review of relevant medical literature (journal articles, medical textbooks, practice guidelines)

This is not exhaustive. It's a means to understand the general conditions,

procedures and/or standard of care issues, etc., to help you frame your questions to the medical and nursing expert(s) better.

MEDICAL RECORDS REVIEW AND SUMMARY

It's more efficient to review medical records all at once. This can take from a half hour to many hours, depending upon volume and complexity. While some attorneys still prefer hard copies in tabbed three ring binders, EHR in PDF means that most firms must learn to navigate, bookmark, and highlight digital materials. Many now use an electronic case management system, such as Case Map, to create chronologies, highlight important deposition testimony, and organize case issues. After record analysis, the attorney decides whether to recommend to the clients proceeding with an expert review.

IDENTIFYING EXPERTS

Most states require that an Affidavit of Merit (AOM) to file a medical malpractice complaint. Even if this is not required, it makes no sense to get involved in an expensive and time-consuming claim without a qualified expert opinion that there is a good basis for doing it. A qualified expert can talk you out of getting involved a case you can't win. An unqualified one will likely hold up poorly under intense cross-examination.

The initial steps involved in obtaining an expert review are:

- Identify the specialty (ies).
Remember that liability

and causation may require different experts.

- Identify potential experts. Most firms maintain a list of experts used in the past. Find new experts via:
 - Looking in the medical literature
 - Experts used in the past
 - Treating team
 - Expert services and individuals (LNCs, physicians) who find experts for a fee
 - Networking
 - Internet searches
- Contact and interview the expert. The expert must be comfortable with the issues, able to do a timely review, and willing to commit to a thorough job. Someone who wants to put his feet up on his desk and pontificate without reviewing the records will not help you. Find out how often the expert has testified and what percentage of his income derives from expert work.
- Research regarding education, training, professional activities (including publication history), clinical appointments, and licensure status (including any history of prior censure). Review the expert's CV and other qualifications. It is also important to retain experts with active clinical practices and to avoid "professional witnesses."

We think it is very important to tell experts you want an objective opinion on the merits. Lawyers can always find an expert to say almost anything, but such a witness will not do well, especially on cross-examination. Make sure that the expert has no personal conflict with any of the defendants. Avoid an expert who testifies only for plaintiffs or only for defense; this could invite inferences of bias.

Sometimes a treating physician will meet with their patient's attorney to give the attorney an "off the record" opinion on the merits. While this can be helpful,

it may be hard to judge if that physician is “circling the wagons,” has an axe to grind with a potential defendant, or is so sympathetic to the patient as to have lost objectivity. Providing off the record opinions can be helpful, but be cautious. It is easy to give an opinion knowing it will not be subject to scrutiny. Remember that many medical and nursing providers are not knowledgeable about legal standards.

PACKAGE TO EXPERT

Send an organized package of materials to the expert. This will take the expert less time to review thoroughly and therefore cost you less. It doesn't make sense to pay an expert to organize records or, worse, to worry that the expert has missed something. We typically send an organized set of bookmarked EMR (hard copies if the expert is not comfortable with digital records), relevant diagnostic imaging on CD, a summary of the facts, and a list of questions for the expert to consider. We may also include a time line or chronology for reference.

Anything an attorney sends to an expert may be discoverable, especially anything that the expert relied upon in forming opinions. Do not send a letter to an expert that appears to be “leading” the expert to form certain opinions, or a timeline including editorial comments. Letters to experts should be factual and timelines/chronologies should include only excerpts from the medical records, not comments that suggest the direction of the desired opinion.

CONFERENCING WITH EXPERT AFTER REVIEW

The attorney must understand the facts, medical issues, relevant anatomy and physiology, and standard of care/causation issues before the conference. Depending upon the complexity of the issues, this discussion can take 30 minutes to more than two hours.

Ask for the basis for the opinions to make sure that it will hold up under cross-examination.

Some attorneys record and transcribe these conferences. Others summarize the substance of the expert's opinions.

SUMMARY

An attorney must consider the strength of the expert's review on both liability and causation, whether the damages (assuming liability) will offset the cost of litigation, and how a particular client is likely to be perceived by a jury in deciding to proceed with a suit.

Effective screening is critical to obtaining favorable outcomes. It is a methodical process involving immediate rejection of nonviable claims and thoughtful analysis of those claims deemed to be worthy of investigation. Skilled LNCs play a crucial role in assisting attorneys to screen and investigate potential medical malpractice cases effectively. 🍷

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Stephen G. Schwarz, has been the managing partner of Faraci Lange, LLP since 1995. He focuses his legal practice on personal injury and business litigation, including medical malpractice, serious auto accident cases, product liability and toxic tort and environmental contamination cases in both state and federal courts. He has been awarded

Martindale-Hubbell's highest rating and is listed in the personal injury law, medical malpractice and product liability sections of the The Best Lawyers in America directory. Stephen has been named Best Lawyers Lawyer of the Year in Product Liability Litigation and in Personal Injury Litigation. He has also been selected to be listed under personal injury law in the Super Lawyers directory every year since 2007 and has been listed as one of the Top 50 Super Lawyers in Upstate New York. He can be reached at sschwarz@faraci.com.



Elizabeth Zorn, RN, BSN, LNCC joined the Faraci Lange law firm (Rochester, NY) in 1995, providing medical expertise and research in defense of medical malpractice and other personal injury cases.

A board certified legal nurse consultant with more than 30 years' experience in the legal field, Elizabeth is an active member of the American Association of Legal Nurse Consultants (AALNC), The American Association for Justice and the Monroe County Bar Association. In April of 2013, Elizabeth was named President of the American Association of Legal Nurse Consultants and represented the AALNC at a discussion about health care at the White House in 2012.

She wrote a chapter for AALNC's LNC Principles and Practice, 2nd (2003) and 3rd (2010) editions, several modules in AALNC's LNC Online Course, several JLNC articles, and edited AALNC's "Getting Started in Legal Nurse Consulting." She has served on many national AALNC committees and presented at professional and educational programs and webinars for attorneys and nurses. She has mentored multiple LNC interns at her law firm over the past 12 years. She is also currently serving on AALNC's Scope & Standards and Revised Online LNC Course Committees. From 2010 to 2014, Beth served on the AALNC board of directors. She can be contacted at elzorn@faraci.com.

Test Your Case Screening Skills

You're an in-house LNC in a medical firm, and your secretary took these notes from phone calls and passed them along. You decide: Reject or investigate? Take a minute to jot down your thoughts, then check the answers on page 43.

Test Your Case Screening Skills

Elizabeth Zorn, RN, BSN, LNCC

Case 1: "Surgeon removed her appendix in June 2009. He bruised her bladder and severed an artery (she has operative report). She has been sick ever since the June 2009 surgery. Her PCP sent her for 3 or so CT scans- medical group did studies and found infection in body and found an abscess from a piece of the appendix that was left inside her (found about a week and a half ago). Thurs has to go for another imaging study- not sure what- they are going to put dye in her body and she had to do an enema. She is on pain pills- Dilaudid and oral antibiotics. They are talking about surgery. She has been sick for two years. She was admitted to hospital about 1.5-2 wks ago for 5 days or so. She didn't have much information for me. Says that the pain pills 'have her all over the place.' She called another law

firm but they had a conflict and referred her here."

Case 2: "Patient underwent lap gastric bypass in March 2008. By May, she was having trouble keeping any food or medications down, was trying. She had dizziness, muscle weakness, visual changes, seen and went home from the ED in mid-May 2008. Got inability to walk, short term memory loss and severe metabolic disturbances. Back in the ED late May 2008. Sat in the ED for 2 or 3 days without seeing surgeon or a neurologist. Finally a neurologist admitted her to the ICU, but no diagnosis for several days, severe thiamine deficiency that by then caused severe, permanent cognitive and functional deficits. She is in her 30s, in a nursing home, unable to walk, with severely diminished vision and short

term memory loss which appears to be permanent."

Case 3: (online firm inquiry): "I was wondering if I had a case. I went to the ER a few nights ago with pain in my belly button. After many hours of sitting in the ER room waiting, the doctor came back and said I was just fat and I had an ulcer, so I left. A few days later the pain got worse so I went to see my aftercare doctor. He said the CT scan report showed that I had an umbilical hernia that needed surgery. So the first doctor didn't want to do his job and sent me out with something that could've killed me.

Check your answers on Page 43. 🐾



Anatomy of a Medical Malpractice Demand Letter

Elizabeth K. Zorn, RN, BSN, LNCC

Keywords: medical malpractice, demand letter, settlement

Both defense and plaintiff counsel use plaintiff's demand letters to initiate settlement discussions. The recipients analyze them, and the parties either enter into settlement negotiations, attempt alternative dispute resolutions procedures like mediation, or proceed to trial. Settlement can occur at any point during an active case, sometimes before litigation but most often during discovery after key depositions.

A legal nurse consultant (LNC) with in-depth knowledge of case issues is invaluable in drafting a demand letter for a plaintiff's attorney. Drafting a demand letter is a high-level LNC skill requiring significant experience analyzing claims and excellent writing skills. On the defense side, an LNC can assist defense counsel to analyze it. This also requires advanced critical analysis of case issues and strategy.

Format and length varies with attorney preference and case issues, but generally includes a summary of the facts and plaintiff's analysis of the liability, causation, and damages claims. The letter may also include plaintiff's monetary demand. Support for the plaintiff's arguments and conclusions comes from medical records, deposition testimony, expert witness opinions, and peer-reviewed medical literature. The demand letter

should also explain medical concepts, abbreviations, and acronyms, and may include anatomy drawings.

Following is a demand letter in a medical malpractice case involving both medical and nursing negligence.

I wrote the initial draft, and the attorney made the final edits. All identifying information has been changed.

FACTS

On December 17, 2000, Mary White was a 38-year-old mother of two who lived in Small Town, New York. She had been unable to work since May 11, 1999 due to a right shoulder injury sustained at work. She had been diagnosed with a torn rotator cuff injury and reflex sympathetic dystrophy.

Mary's relevant medical history included intermittently symptomatic mitral valve prolapse (MVP), palpitations and syncope. Echocardiogram in December 1997 revealed MVP and trace mitral regurgitation. It was otherwise within normal limits. Ms. White also suffered from anxiety and depression treated intermittently by her primary care physician with Paxil and Xanax. One week prior to her admission on December 17, 2000 Mary had polyps removed from her vocal cords and was taking Zithromax and Tylenol.

On December 17, 2000 Mary developed an itchy rash on her legs and trunk. She called her primary care physician, who told her to go to the emergency room because his office hours had ended for the day. [White p. 35-37]. Mary presented to the Emergency Room at Mercy Hospital complaining of an itchy rash on her legs and trunk. She never had any complaints of difficulty breathing, shortness of breath or throat tightness and no such complaints were ever documented by any of the providers.

Upon admission to the Mercy Hospital Emergency Department the triage nurse noted: "Started Zithromax and Tylenol #3 on 12/11. On Thursday, patient had rash on arms then rash spread behind knees. Presently patient is covered with red itchy rash – not relieved by Benadryl."

Mary was evaluated by Dr. Brian Spence. Dr. Spence's documentation of his physical exam noted: "White female itching her legs. Rash on legs and

thighs. No other complaints. Rash – urticarial, consistent with drug reaction. Quiet voice. Without pharyngeal edema. Lungs clear bilaterally without wheezes. Heart regular without murmur. Neuro intact."

Dr. Spence's diagnosis was "allergic reaction." At 8:30PM, he ordered Benadryl 50mg IV, Solu-Medrol 125mg IV and Epi 1:1000 0.3 [cc] sq [subcutaneously] before taking a patient history [White p 44]. Ms. Cassady documented that she administered these medications as ordered at 8:30PM. In fact, the epinephrine, Benadryl and Solu-Medrol were administered intravenously. Mary is emphatic that she never received a subcutaneous injection of anything during this visit [White p 41-42] Defendant's own billing records document that the plaintiff was billed for "Epinephrine 0.1mg/ml ABBJCT" which equates to 1:10,000, the intravenous epinephrine dose. In addition, Ms. Cassady administered the epinephrine and other medications prior to taking a history except for Mary's name and address [White p 39-40].

Immediately following administration of the epinephrine, Mary complained of chest pain and dizziness. Nurse Cassady documented:

At 8:30PM after receiving epi 1:1000 0.3, patient became pale, complained of heart racing as if she was going to pass out. Eyes rolled back, patient disoriented. At 8:40PM patient complained of classic radiation [of pain] to left arm. Nitroglycerine 0.4mg given sublingually ...

Dr. Spence's documentation related to this event was:

Patient had increased heart rate and became very dizzy with epi. She calmed with Benadryl. She complains of some chest heaviness/pressure. Observed for some time. Nitro x 1 – systolic BP decreased to 100.

Chest pain a little better. Will observe overnight. At 1AM, awake – no complaints. Still at little itchy. At 1:15AM, Troponin increased to 1.32. Discussed with Dr. Allen. Will give Lopressor to decrease heart rate [which was running 114-120]. He will see in AM. Patient with no complaints of chest pain. + itchy legs. HR 102. Systolic BP 115 after 5mg Lopressor – reluctant to give more now. Stable all night. Repeat Troponin 1.45 – Dr. Allen aware.

Despite her complaints and condition following administration of the epinephrine, Dr. Spence intended to send Mary home. However, she refused to go home and so Dr. Spence decided to keep her overnight and observe her [White p 47; Jones p. 101].

LIABILITY

Plaintiffs contend that administering epinephrine to Mary under these circumstances was below the standard of care. Epinephrine should never be administered to a patient with an allergic reaction unless there is severe shortness of breath and throat tightness which could indicate the loss of the airway. Mary did not experience any symptoms of restricted airway. Moreover, administration of epinephrine to Mary was also contraindicated by her preexisting MVP, a condition Dr. Spence failed to uncover due to his grossly inadequate history taken before he made his diagnosis and prescribed the epinephrine. In addition, Mary was given the epinephrine intravenously rather than subcutaneously as ordered by Dr. Spence, another departure from the standard of care by the nurse at Mercy Hospital.

Plaintiffs have retained experts in Emergency Medicine, Cardiology, and Pharmacology. These experts are emphatic that it was improper for Dr. Spence to prescribe SQ

AFFIDAVIT OF LAUREN DANAHY, RN, BS, MBA, CCM, LNCC

I, Lauren Danahy, make oath and state as follows:

1. I am qualified to depose to this affidavit because I am over the age of 18 and fully competent to testify as to the matters herein. I have been actively engaged in the practice of nursing within the fifteen year period immediately prior to the incident giving rise to this claim and am a Certified Case Manager and a Legal Nurse Consultant Certified.

My qualifications are outlined in the attached curriculum vitae and made a part hereof. I am familiar with the standard of care as it pertains to the management in situations such as those that unfolded in this case.

2. I am an expert as defined by Nebraska Statute 27-702.

3. I have reviewed the following records in regards to the case regarding

- a. - Correctional Facility: Nursing Notes and Medication Administration Record (MAR) for - 6/7/11-6/8/11
- b. Nebraska State Patrol Interviews of: -, RN (6/10/11); Dr. -, MD (6/23/11); - (Deut) (6/10/11); -, LPM (6/9/11); and - Deputy (6/9/11)
- c. State of Nebraska Board of Nursing:
- d. Centers for Medicare and Medicaid Services (CMS) guideline for medication administration in 2011.

4. I note the following from the records: The County Correctional Facility medical records indicate that Ms. - was the nurse who initially saw Mr. - while out in the booking area, this was around 5:20pm on 6/7 /11. She was made aware per Mr. - and a correctional officer, that Mr. - had injected methamphetamine twice earlier that day as well as ingested two "8 balls" of methamphetamine directly prior to his arrest. He was stopped at 3:00 pm on 6/7 /11 by - Police at which time he ingested the two "8 balls" of methamphetamine so as not to have it found on his person.

Ms. - conducted M-medical intake and placed a call to Dr. -(Medical Director at the jail) and obtained a telephone order (T.O.) for 1 mg of Ativan PO BID x 2 days.

At time of incident (2011) Centers for Medicare and Medicaid Services (CMS) had a guideline for medication administration being 30 minutes before or after the scheduled time for the medication. Ms. - LPN, charted the 5:24pm dose of 1 mg of Ativan (Mr. - first dose of the medication) under the 8pm timeslot on 6/7 /11, it is not noted that this dose was given at 5:24pm on the med sheet as is usual and customary in nursing practice to document specific time that the medication was given if not given within the allotted time (30 minutes before or after scheduled dose). The standard of care is also to make a notation in the notes section as to why the variation occurred.

Mr. - 0800 dose of 1 mg Ativan was given at 10:30am on 6/8/11 by Ms. - RN when she was called out to booking due to corrections staff feeling as though -was having a seizure. This was 2.5 hours after the prescribed time. This was a breach to the standard of care as this dose would be considered two hours late. However, this LNCC notes that Mr. -had gone from 5:24pm on 6/7 /11 to 10:30am on 6/8/11 which is 16 hours and 54 minutes in between the Ativan 1mg doses. The medication had been ordered BID x 2 days, which means that Mr. -was intended by the Medical Director to have a dose of medication every twelve hours. Ms. -inaction of giving Mhis scheduled 8 a.m. dose of Ativan is clearly a breach of nursing standards of practice.

In reviewing Dr. - interview with the - State Police, it is noted that he stated "the nurse's routine was they checked vitals, blood pressure, pulse, respirations and temperature." It is noted that in methamphetamine withdrawal, temperature is a critical item to monitor and it is noted that nowhere in the nurse's notes/ charting that one was taken. Dr. - also stated "it is his experience if a person ingests methamphetamine orally they have a couple of hours from the time they ingest it to get their stomach pumped or to be given charcoal." And finally, he stated "the maximum effect that would come after methamphetamine would be approximately two hours after swallowing." LNCC notes that two hours post-ingestion would have been 5pm. That would have been twenty minutes prior to Ms. - phone call to Dr. -when he was briefed on Mr. - ingestion of two "8 balls" of methamphetamine and Dr. - did not give an order to send Mr. -to the hospital, rather, he gave a T.O. for 1 mg of Ativan PO BID x 2 days. It is also noted that Ms. -did not chart any statement regarding her inquiry of the doctor to send Mr. - to the hospital during that window of opportunity to have his stomach pumped and to be evaluated by professionals in a hospital environment.

In reviewing the MAR, it is noted that the BP check Q shift order is written on the sheet and there are no BP readings documented.

5. In my experience, these facts and circumstances require the following standards of care. Based on my review of the above records, it is my opinion that, within a reasonable degree of nursing probability, reasonable grounds exist to initiate a medical negligence claim against Health Care, Dr. - Ms.- and Ms.1111.

6. In my opinion, given the facts, and the standards one would reasonably expect to have applied to these circumstances, I believe the medical professionals in this case acted negligently by doing the following or having failed to do the following: Health Care, failing to send Mr. - to the Emergency Room for an evaluation after being notified by the inmate and corrections officers that Mr. -had injected methamphetamine twice and ingested two "8 balls" of methamphetamine that day, within four hours and twenty minutes of Ms. - call to Dr. - on 6/7 /11. Mr. - had ingested the two 118 balls" of methamphetamine immediately prior to his arrest at 3pm on 6/7 /11, therefore, per Dr. - interview with the State Patrol, Mr. - was just outside of the "two hour window" (by 20 minutes) he reported they have after ingestion of a substance to have his stomach pumped. The nursing staff also fell below the standard of care by their inaction of giving the prescribed doses of Ativan in a timely fashion, Mr. - went for over 16 hours between the first and second dose he was given, which potentially exacerbated his withdrawal symptoms, throwing him into a crisis situation that inevitably lead to his death.

7. My opinions are based on my years of experience in similar circumstances, and have never been disqualified in any court.

8. I certify that I have not been found guilty of fraud or perjury in any jurisdiction.

9. Under penalties of perjury, I certify that I have read the foregoing and that the facts stated in it are true.

FURTHER AFFIANT SAYETH NAUGHT.

LAUREN DANAHY, RN, BS, MBA, CCM, LNCC

The foregoing instrument was acknowledged before me this ___ day of ___ 2014, by ___ , who is (personally known to me) (or who has produced) ___ (as identification). (Signature of Notary) _____

Name of Notary Typed, Printed or Stamped)



Dr. Spence's order for SQ epinephrine was contrary to the practice guidelines of these major medical associations.

epinephrine for an itchy rash in the absence of anaphylaxis, respiratory distress, laryngeal edema or other severe symptoms and that it was grossly improper for nurse Cassidy to administer the epinephrine intravenously. In addition, it was improper for these providers to administer any treatment prior to taking a patient medical history in the setting of a non-urgent condition. It was also improper to administer epinephrine unnecessarily to a patient with intermittently symptomatic MVP. Both Dr. Knapp and Dr. Allen, Mary's subsequent treating physicians also told her that she should never have been given epinephrine [White p.54].

1. Failure to take an adequate history

Mary presented to the Emergency Room with new onset acute urticaria. Her rash was assumed to be an allergic reaction to medication (Codeine with Tylenol and/or Zithromax) begun six days earlier. However, this assumption was made without a detailed history of the circumstances preceding and surrounding the recent onset of the urticaria. For example, Dr. Spence did not elicit history from Mary White that she had been on a course of Zithromax the prior month (for bronchitis) without ill effect. He also did not elicit a history of MVP [Spence p. 35]. This

failure to take an adequate history was by itself a departure from the standard of care and was also consistent with a pattern of practice established by Dr. Spence.

Dr. Spence's conduct has been investigated by the Office of Professional Medical Conduct multiple times prior to this incident. Pursuant to a Consent Agreement and Order BPMC #00-000 (attached) signed in July 1998, Dr. Spence was charged with nineteen specifications of professional misconduct, including:

- Improper record keeping and failure to perform an adequate medical history and/or physical examination
- Negligence on more than one occasion
- Gross negligence
- Gross incompetence

Dr. Spence admitted guilt to four of the nineteen specifications in full satisfaction of the charges against him, including failure to obtain an adequate history and/or physical examination. He agreed to a penalty of "censure, reprimand and monitoring for a period of three years." His care and treatment of patients was still being monitored at the time he treated Ms. White in 2000.

2. Improperly administering IV Epinephrine

Epinephrine stimulates adrenergic receptors (nerve fibers that release norepinephrine or epinephrine) in dose-related fashion. It causes vasoconstriction of peripheral blood vessels, and has been associated with constriction of coronary artery vessels due to vasospasm, especially in a subset of susceptible patients (i.e. those with coronary artery disease or underlying tendency to rhythm disturbances). It is the initial drug of choice for treating cardiac arrest; bronchoconstriction and hypotension from anaphylactic shock; and severe reactive airway disease. It is *never* appropriate to administer it for an itchy drug related rash unless there is severe bronchoconstriction due to its potential significant adverse effects, including hypertension, significant dysrhythmias and angina due to coronary artery vasospasm. Its use for the treatment of allergic reactions should only be considered when the allergic reaction is life-threatening.

At the time Dr. Spence prescribed the epinephrine for Mary she was not suffering from anaphylaxis, respiratory distress, laryngeal edema or other severe/potentially life-threatening symptoms. The providers at Mercy all documented that she had no respiratory problems whatsoever such as shortness of breath or wheezing, and that her lung sounds were normal. She was also normotensive. In spite of this, and prior to taking a medical history, Dr. Spence ordered IV Benadryl, IV Solu-Medrol and "Epi 1:1000 0.3 sq," all to be administered at the same time. Moreover, in spite of the order to give the epinephrine subcutaneously, all three of these medications were given by nurse Cassidy intravenously. [White p. 41-42]. Although Nurse Cassidy denied this in her deposition, the billing records document, "Epinephrine 0.1mg/ml ABBJCT" which is the standard intravenous dose of 1:10,000. Further corroboration of the fact that the epinephrine was given IV is provided

by the rapid onset of symptoms after the administration. The medical literature consistently reports that the onset of action of IV epinephrine is 1-2 minutes whereas the onset of action when administering subcutaneous epinephrine is 5-10 minutes. As documented in detail below, Mary's symptoms occurred almost immediately following the epinephrine.

According to the practice guidelines promulgated by the American College of Allergy, Asthma, and Immunology and the American Academy of Emergency Medicine, the appropriate treatment of urticaria (when this is the only presenting finding) caused by a presumed drug reaction is a) withdrawal of the offending medication if possible; b) antihistamine therapy; and c) glucocorticosteroid therapy if deemed necessary. Subcutaneous (SQ) epinephrine is only considered when a patient presents with an anaphylactic drug reaction or there is concern about airway compromise or possibly angioedema (diffuse swelling under the skin). Thus, Dr. Spence's order for SQ epinephrine was contrary to the practice guidelines of these major medical associations.

Moreover, Mary received an IV dose of epinephrine, not a SQ dose. As conceded by Dr. Spence at his deposition [Spence p. 36], administration of *intravenous* epinephrine for a mild allergic reaction is below the standard of care. In fact, according to our experts, it is far worse than that. It is gross misconduct.

It is well-documented in the literature that systemic administration of epinephrine, even at therapeutic doses, may lead to generalized central nervous system stimulation manifested as fear, anxiety, nervousness, excitability, psychomotor agitation, headache, tremor, and disorientation. Vasoactive and smooth muscle responses to epinephrine can result

in nausea, vomiting, diaphoresis, pallor, and respiratory distress. Cardiac arrhythmias (or arrhythmia exacerbation), including palpitations are well-described potential adverse effects of epinephrine due to beta-stimulation of the myocardium and conduction system. Thus, systemic epinephrine should only be administered in the setting of a life-threatening condition (such as asystole) for which epinephrine is an acceptable treatment.

Mary White had a history of intermittently symptomatic (palpitations) MVP. Studies show a variety of adrenergic (relating to nerve fibers that release norepinephrine or epinephrine) abnormalities associated with MVP, including an increase in urinary epinephrine/norepinephrine and beta-adrenergic sensitivity. Thus, except when treating life-threatening conditions, epinephrine and related drugs are generally contraindicated in patients with MVP because they are *extremely* sensitive to adrenaline and it may precipitate panic attacks as well as irregular heart rhythm, rapid heart beat, and chest pain.

In summary, Dr. Spence failed to take an appropriate history despite previously being reprimanded by OMPC for this very act, and improperly ordered systemic epinephrine in a patient with MVP for an itchy allergic rash not accompanied by any other signs/symptoms. Nurse Cassady failed to take a patient history prior to administering the medications that were ordered, failed to question an order for SQ epinephrine in a patient that presented only with a rash, and then administered the epinephrine intravenously instead of as ordered, the latter constituting gross negligence.

CAUSATION

After the administration of the IV epinephrine by Nurse Cassady, Mary suffered an almost immediate reaction

that led to a myocardial infarction. The morning of 12/18/00, Dr. Allen, a cardiologist, was called in for a consult. Dr. Allen noted that Mary had presented to the Emergency Room with a severe rash and pruritus but "without any shortness of breath or difficulty breathing." He further noted that administration of the epinephrine had "resulted in severe chest pain and tachycardia. Patient ruled in with positive troponin level for non-Q-wave MI." In addition to his written notations to this effect, Dr. Allen also told Mary and her husband that the epinephrine had caused her heart to speed up and spasm which caused her to suffer a myocardial infarction [White p53; Jones p. 110].

Dr. Allen further noted his plan to transfer Mary to Elmhurst Hospital and again restated his diagnosis of an "acute non-Q-wave myocardial infarction, allergic reaction, s/p polypectomy." Her discharge medications included Solu-Cortef (a steroid), Nitropaste (nitrate which dilates coronary arteries), Cardizem (diltiazem, a calcium channel blocker used to treat angina), Ecotrin (aspirin therapy), and Xanax (anti-anxiety). She had not been on any cardiac medications for several years prior to this. He noted that once her rash resolved, "she may need to have cardiac catheterization for further evaluation."

Dr. Allen's diagnosis was partially based on the troponin testing done at Mercy. Mary's troponin levels on 12/18 (1:28AM) were 1.32; (6:25AM); 1.45 and (1:19PM) 1.72. The lab report from Mercy states: "In myocardial injury, cardiac troponin becomes elevated in 3-6 hours, peaks in 12-18 hours and remains elevated for 5-9 days." This is precisely the pattern that would be expected for an MI at the time she received the IV epinephrine.

An EKG done at 10:07 PM was interpreted as "sinus tachycardia,



For another sample opinion affidavit and timeline, go to AALNC.org.

low voltage QRS, borderline EKG.” A subsequent EKG ordered by Dr. Allen was interpreted as “Normal sinus rhythm, non-specific T-wave abnormality, abnormal EKG.”

On 12/18/00, Mary was transferred to Elmhurst Hospital’s ICU via ambulance. The Physician’s Certification Statement related to medical necessity for an ambulance states: “Acute MI. Needs ICU bed and cardiac monitoring.” The morning of 12/19/00, she was transferred from the ICU to the cardiac telemetry unit. Repeat EKG on 12/19/00 revealed “inverted T-waves, ?ischemia.” T-wave inversion is a frequent sign of a recent MI. An echocardiogram was also done to evaluate cardiac and valvular function following her “non-Q wave myocardial infarction.” This revealed, “normal left ventricular chamber size with minimally hypokinetic inferior basal segment with overall normal ejection fraction. Normal aortic valve. MVP without mitral regurgitation. Trace tricuspid regurgitation.”

On 12/21/00 Mary was transferred to Franklin General Hospital (FGH) for a scheduled coronary angiogram. Her discharge medications included

Ecotrin, Cardizem, Lovenox (a blood thinner), Nitropaste, and Xanax. She arrived at FGH, but due to her extreme anxiety, was unable to go through with the procedure as planned despite being given Ativan for her anxiety. She was then discharged to home that same day.

On 12/29/00, Mary saw Dr. Knapp, her primary care physician. She documented: “Had MI after epi for hives – minimal. Went to FGH but too anxious to undergo catheterization. Gets tired. On Cartia and Isosorbide. Thinks it was spasm. Happened 12/17/00.”

It is clear based on the medical documentation that the diagnosis was a non-Q-wave MI following the administration of epinephrine. This diagnosis was made based on her symptoms along with the elevated troponin and abnormal EKG. There is no other credible explanation for these findings nor is there any credible explanation for the MI other than the administration of the epinephrine.

DAMAGES

Mary White’s relevant past medical history is significant for symptomatic MVP occasionally requiring medication (Corgard) to treat an irregular heartbeat. However, her last documented episode of palpitations prior to 2000 was in 1991. She was not on any cardiac medications subsequent to this until after her ED visit to Mercy on 12/17/00. In 1997, she had one episode of self-limited mid-sternal chest pain, thought not to be cardiac in nature and for which she was not treated.

There is no question that Mary suffered an epinephrine-induced, non-Q-wave myocardial infarction on 12/17/00. She experienced chest pain/pressure and dizziness immediately following administration of the intravenous epinephrine. Her complaints were relieved somewhat with sublingual

nitroglycerin (to open the coronary arteries). She had three increasingly elevated troponin levels, enzymes very specifically related to the damage of cardiac muscle. In addition, she had an abnormal EKG consistent with a non-Q-wave MI. Echocardiogram on 12/19/00 revealed “minimally hypokinetic inferior basal segment” of the left ventricle, evidence of some damage to the inferior wall or bottom of the heart. This was a new finding when compared with the prior echocardiogram of 12/2/97. Finally, the working diagnosis of every single subsequent treating physician was an epinephrine induced coronary artery vasospasm causing a non-Q-wave myocardial infarction.

Following stabilization after the myocardial infarction, Mary was transferred to the Intensive Care Unit at Elmhurst Hospital for cardiac monitoring and treatment. She remained fearful, anxious, and upset about her condition. On 12/21/00 she was transferred to Franklin Hospital for an angiogram of her coronary arteries to rule out occlusive disease. However, her anxiety level was so high she could not go through with the procedure, despite being given Ativan. Thus, she was discharged home on several cardiac medications she had never been on before including Cardizem, Nitropaste, and Lovenox (a blood thinner to prevent coronary artery clots). She was also prescribed Ativan due to her high level of anxiety.

For several weeks after her myocardial infarction, Mary was extremely fatigued, fearful, and anxious. She was afraid to go to sleep at night and fearful when her husband went out of town [White p 73, 74]. On 1/12/01 Mary reported to Dr. Knapp that “has developed several phobias and anxiety increased. Afraid of riding in car, [being] around crowds despite Paxil. Again sleeping poorly. Tearful.” Dr. Knapp advised counseling

and started her on Buspar (buspirone), an anti-anxiety medication.

On 1/13/01 Dr. Allen admitted Mary to Mercy Hospital due to recent onset chest pressure, shortness of breath and lightheadedness. She also complained of fatigue and generally not feeling well. She had just started Buspar the prior evening. Her other medications included Imdur (isosorbide), aspirin, and Cardia XT (diltiazem). In the emergency room she was given nitroglycerin with total resolution of her chest pain. In the discharge summary, Dr. Allen documented that Mary White's past medical history was "significant for non-Q-wave MI approximately one month ago when she was admitted with allergic reaction to Zithromax and was given intravenous epinephrine with increase in her heart rate to about 130. Patient then had positive troponin levels ..."

Dr. Allen's discharge diagnoses were unstable angina, now stable; hypercholesterolemia; and anxiety disorder. She was ruled out for MI. His plan included a thallium stress test "in view of her past medical history of non-Q-wave MI and her reluctance to undergo cardiac catheterization." He increased her isosorbide dose, told her to continue the Cardia XT (diltiazem) and nitroglycerin PRN for further chest pain.

On 6/19/01, she was seen in follow-up at Cardiology Associates. Susan Fineman, RPA (Registered Physician Assistant) noted that plaintiff had been doing well until she ran out of medication when her insurance lapsed:

She has no insurance so has not been taking her isosorbide or carteolol (beta blocker used for anxiety, high blood pressure, and contraindicated in Prinzmetal's angina coronary artery spasm). She developed a slight episode of chest discomfort about a week ago that was similar but not quite as harsh

as the time she was having a heart attack. The episode passed....

Ms. Fineman gave her samples of Tiazac (diltiazem) in place of the carteolol. In addition:

I renewed her isosorbide and instructed her on taking it regularly. Since she is pain free right now and most likely exhibited symptoms of angina secondary to lack of medications, we are going to follow up with her in months with a stress test. She is instructed to see us much earlier if symptoms of angina reoccur.

On 10/31/01 Mary was admitted to Elmhurst Hospital for another episode of chest discomfort. In his admission note, Dr. Regan documented:

She has been maintained on the medications via samples from Dr. Schwarz's office for the most part over the past year or so. About a month ago ran out of her medications – apparently could not obtain samples...had done reasonably well without episodes of chest discomfort except one minor episode some weeks ago that resolved. Was riding in a car to retrieve samples of her medications from Dr. Schwarz's office when she was "seized" by severe chest discomfort as if there was an "elephant on my chest" with short-windedness, an episode of vomiting, some diaphoresis. She received sublingual nitroglycerin in Dr. Schwarz's office for residual discomfort when she arrived there. Referred to the ED for further evaluation.

Dr. Regan's assessment was "chest discomfort, short-windedness, nausea, and vomiting, certainly consistent with myocardial ischemia on the basis of coronary spasm or occlusive disease."

On 11/1/01, Dr. Schwarz conducted a cardiology evaluation. He noted her history of "micro-infarction" related to the administration of epinephrine and that she had been maintained on

Cardizem and Imdur "on presumption of some element of underlying ischemic disease, more likely vasospastic disease." He recommended that she continue on Cardizem and Imdur. He also urged Mary to reconsider undergoing an angiogram to further evaluate the underlying nature of her cardiac problem, despite her extreme fear and anxiety about undergoing this procedure. Stress echo on 11/2/01 did not reveal evidence for ischemia.

Mary returned to Dr. Schwarz's office for a post-hospital visit on 11/12/01. He noted:

She has continued to have "zings" of pain in her chest. These episodes last for several minutes and are not predictably related to exertion. Does have some dyspnea with physical activity. Has been taking her meds pretty much religiously now, so she is having these discomforts despite being back on her med. We thought that possibly her stepped up symptoms lately were because of her non-compliance as she had run out of her prescription. Is on diltiazem and Imdur.

Dr. Schwarz increased her dose of diltiazem and recommended cardiac catheterization due to her ongoing symptoms: "I warned her to let us know if she does have recurrent symptoms in which case we may need to move forward with a cath regardless as to whether she has [insurance] coverage or not for her health safety."

On 11/19/01, James Steinmetz, PA in Dr. Schwarz's office saw her urgently for recurrent "zings of pain in her chest" associated with tunnel vision. His differential diagnoses included MVP, coronary vasospastic disease vs some other syndrome. His plan included cardiac catheterization and he also recommended psychotherapy to assist Mary to deal with her anxiety.

Dr. Allen reevaluated her on 12/19/01.

Mary has continued to have at least weekly (sometimes several times a day) episodes of brief atypical chest pain or spasms.

He noted that she continued to have two different types of chest discomfort – one likely related to her GERD and the other, from her coronary arteries. She remained on diltiazem and isosorbide. Dr. Allen also started Mary on Protonix for GERD. On 2/7/02, Dr. Allen reported that she was doing well on isosorbide and diltiazem, with rare episodes of chest discomfort.

On 7/12/02, Mary was evaluated at Mercy Hospital ED after she suddenly felt flushed and lightheaded with chest pain and rapid heart rate.

Dr. Allen saw her in follow-up on 7/17/02. In his letter to Dr. Knapp he documented:

As you know, she ended up in Mercy ED with chest discomfort. She also says that she passed out while going to Mercy Hospital. The chest discomfort is described as a tightness and heaviness, like someone pushing on her chest. At times she has palpitations and heavy beating of her heart, described as pounding. Since that time her Tiazac was increased and she now only occasionally gets chest discomfort., which is not severe enough for her to take nitroglycerine.

Dr. Allen recommended an angiogram to rule out any fixed lesions requiring angioplasty. He told her that the risks of angiogram included myocardial infarction, stroke, cardiac arrhythmias and bleeding. Despite her extreme fear and anxiety, on 9/16/02, she underwent coronary angiography which revealed normal coronary arteries and a low normal ejection fraction of 50%.

On 3/14/03, she returned to

Cardiology Associates for follow-up post angiogram. Nurse Practitioner Abel and Dr. Lee documented:

From a cardiac standpoint, she has some randomly occurring mid-sternal, gripping pains that are very quick or may last a few minutes, without radiation. These are sometimes associated with shortness of breath and are relieved spontaneously. She also has some dyspnea on exertion at times and rare palpitations.

Their impression was: “S/P non-Q-wave MI, felt secondary to vasospastic coronary artery disease as catheterization in Sept 2002 showed normal coronary arteries and normal left ventricular function. We are recommending a nuclear stress test, however she does not have insurance other than Medicare. Does not want any testing at this time.”

At the next follow-up visit with Cardiology Associates on 10/20/03, Ms. Abel and Dr. Lee documented:

From a cardiac standpoint, she continues to have some randomly occurring mid-sternal spasm that can either be a short sting or lasting up to a couple minutes without radiation. This is sometimes associated with increased heart rate. This is relieved with Nitro. She has some fatigue and some depression.

In view of the continued chest pain, Ms. Abel recommended an adenosine nuclear stress test and follow-up with Dr. Lee for Cardiolite debriefing. They did not make any change in her medication regimen, which included diltiazem and isosorbide.

On 11/4/03, Dr. Jordan at Southwest Otolaryngology saw Mary for a follow-up visit:

She had been doing well with her acid reflux medication. She has been getting samples since she cannot afford all her medications. She did stop her Prevacid for several weeks. Her acid reflux symptoms got significantly worse....She did have a post-operative complication with drug reaction and was given intravenous epinephrine which caused an MI after her surgery three years ago.....She is very anxious.

On 11/13/03, she underwent an adenosine Cardiolite study as recommended. The indication for the procedure was “She continues to have randomly occurring midsternal chest discomfort, without radiation, lasting up to a couple minutes. She has no risk factors for coronary artery disease.”

During the study, Mary complained of “midsternal chest pressure and slight dizziness, which resolved quickly into recovery.” Impression was “IV adenosine Cardiolite injection, with mild clinical symptoms.”

On 11/18/03, she underwent an exercise myocardial perfusion study for diagnosis of “chest pain.” The results of this study were within normal limits.

On 12/4/03, she returned to Dr. Belanger for review of prior cardiac testing:

I reviewed test results with Mary – she is quite pleased with this result. At this point, from a cardiac perspective, no further evaluation is recommended. She is on both Cardizem and Imdur. There are no significant clinical symptoms that further suggest adjustment in medication is necessary.

She returned for follow-up with Dr. Belanger on 7/12/07 for an increase in her atypical chest pain:

She feels her symptoms have been

returning now for the past several months, especially since the weather has been hot. She has a gripping sensation in the left upper chest which can last up to a few seconds. This can happen several times during the day; however, there is no set pattern, no precipitation factors and no other associated symptoms. Was on Tiazac and Imdur in the past. She stopped the medicine a year ago.

Dr. Belanger's assessment was "atypical chest pain" with no major risk factors for coronary artery disease. Holter monitor testing revealed minimal atrial and ventricular ectopic activity.

In summary, since sustaining a myocardial infarction in December 2000, Mary has continued to have periodic episodes of chest pain, both on and off cardiac medications. This includes two episodes in 2001 and one in 2002; all were severe enough to warrant emergency room treatment. Each episode causes her not only pain but increased anxiety.

In addition, she was forced to undergo coronary angiography, a procedure she was terrified to undergo. However, she was counseled that it was imperative to rule out coronary artery disease/obstruction as a cause of her myocardial infarction and continued episodes of chest discomfort. In fact, angiography on 9/16/02 revealed patent (open) coronary arteries, indicating that the most likely cause of her myocardial infarction was in fact coronary artery vasospasm. Her ejection fraction at the time of this study was 50%, which while in the low normal range, is borderline and less than her ejection fraction of 60% on 12/18/00.

Mary has continued to have at least weekly (sometimes several times a day) episodes of brief atypical chest pain or spasms. She describes them as a zing or gripping sensation in her chest. There is no particular pattern to the pain.

As she testified, she has spasms on a weekly basis that vary in intensity and frequency and for which she takes PRN Nitro. Extreme heat and cold aggravates her spasms and palpitations [White p 60, 69, 70]. Her husband testified that she has chest pain three to four times a week [P White p 115].

Between 2000 and 2006, Mary remained on her prescribed cardiac medications whenever she could get samples or could afford to fill the prescriptions. Since 2006, she has discontinued her cardiac medications due to their side effects, expense, and lack of effectiveness in eliminating her episodes of chest pain.

Mary has recently been notified that due to her MI in December of 2000 her life insurance rates have been raised. A copy of that notification is attached.

DEMAND

In summary, as a result of defendants' negligence in failing to take an adequate history, prescribing epinephrine SQ, and then giving the epinephrine IV, Mary White sustained a non Q-wave myocardial infarction which caused a chronic intermittent vasospastic coronary artery syndrome, all of which has exacerbated her underlying anxiety disorder. In our view a jury could award \$250,000 for these damages, but we would be willing to recommend a settlement of \$150,000 if it can be accomplished before more money is spent in preparing for trial. Thank you.

SETTLEMENT OUTCOME

In this case, the plaintiff had a very strong argument on liability with clear evidence of both medical and nursing negligence. In addition, the ED physician had a history of action taken against him by the Office of Professional Misconduct, in part for the very same claim asserted against him in our case. Thus, it is likely that a jury would have found for the plaintiff on the

liability issue had the case gone to trial.

However, even assuming liability, the defense had good arguments that the resulting harm from the improper care did not result in significant heart damage or functional limitations. Also, her symptoms were well controlled with medications. Thus, it is possible that a jury would not have awarded much money for the plaintiff's claimed injuries.

Thus, both sides had incentive to reach a reasonable settlement and avoid the cost and risks of losing at trial. Following settlement negotiations, the case ultimately settled for \$60,000. ♡

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Demonstrative Evidence: Instruction and Ethical Persuasion

Mindy Cohen, RN, MSN, LNCC

Keywords: Demonstrative evidence, legal nurse consultant, science of persuasion, psychology

Demonstrative evidence (DE), the visual representation of facts or issues in medico-legal settings, has come a long way from poster boards. Whether in the form of computerized graphics, video content, 3D-animation, or interactive media, its powerful capacity to create intellectual and emotional impact makes today's DE a valuable asset for the legal nurse consultant. This article shares our experience with DE as a tool of instruction and ethical persuasion in legal nurse consultancy. We want to show you how to use these techniques in the pursuit of justice in your own area of influence.

There is a profound difference between good and great evidence. Good evidence is often verbal or written and targets our logic. Great evidence follows the age-old adage of, "Show, don't tell." Great evidence targets all of senses and captivates the audience. Demonstrative evidence is great evidence.

The American Bar Association defines demonstrative evidence as, "evidence addressed directly to the senses without intervention of testimony" (ABA, 2012, para. 3.05). These include photographs, simulations or models, anatomical and surgical illustrations, x-rays, and forensic animation, among others. Our brain processes such visual information 60,000 times faster than auditory information, which is understood at only a 10% rate. Demonstrative evidence relies on this and involving the senses and emotions in decision-making. Given this opportunity, legal nurse consultants (LNCs) can leverage our unique professional knowledge and creativity educating and ethically influencing the adjuster, opposing counsel, judge, and jury to help our clients prevail.

FACTORS TO CONSIDER

The most successful LNC leads the process of demonstrative evidence creation and planning, collaborating closely with attorney-clients about how best to use DE for influence or

education on the target issues. Keep in mind the key factors: case, client, budget, and vendor.

Case

Your first goal is to understand all facets of the case background and key points of the attorney-client to develop a list of critical case materials. These could include, but are not limited to: medical records, answers to interrogatories or requests for production, relevant depositions, and plaintiff and defense expert reports. Compile and index these for easy reference.

Also study the opposing side's case thoroughly. You'll have a window into the strengths and weaknesses of both sides, helping you create demonstrative evidence that builds on your case strengths, while exploiting and targeting the opposing side's weaknesses. For example, in one plaintiff's case, a physician failed to diagnose a deep venous thrombosis (DVT) and provided no treatment, resulting in the patient's death from a pulmonary embolism two months later. We used **Figure 1** in mediation to overcome one defense case weakness: the two-month gap between when symptoms first appeared and death.

Attorney-Client

It is impossible to create successful strong DE without knowing the

attorney-client's expectations and needs. Discuss goals and timeframe for the evidence frankly when you do the case material review.

It is essential to determine the attorney's strategy as it relates to the medical evidence: What critical points will the client be making, and how? For example, in a medical malpractice case, does the attorney want to show a timeline reflecting when the deviation occurred, an illustration of the injury, or both? These questions lead to the creation of valuable material, even if the attorney does not know precisely what is needed at the earliest stage.

Figure 2 depicts a timeline of care deviation that ultimately resulted in the death of the patient. The visual representation of time highlights the key fact that no care was provided over the critical two and a half hour interval during which the patient's health declined drastically.

Consider not only how your estimated time to produce DE fits with the attorney's, but how to fit the vendor's and/or expert's time into the equation. If outside vendors will produce any exhibits, then you will have to know their availability. For exhibits that require expert authentication, allow for time to obtain expert approval, perhaps repeatedly, during the process.

For example, in one case, an animation

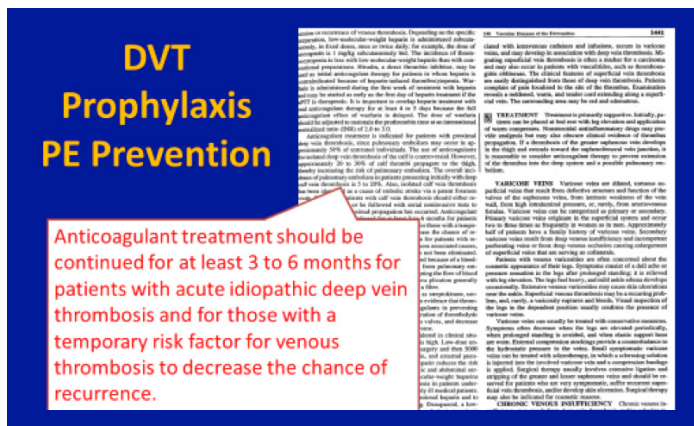


Figure 1. DVT prophylaxis and PE prevention, page from a textbook

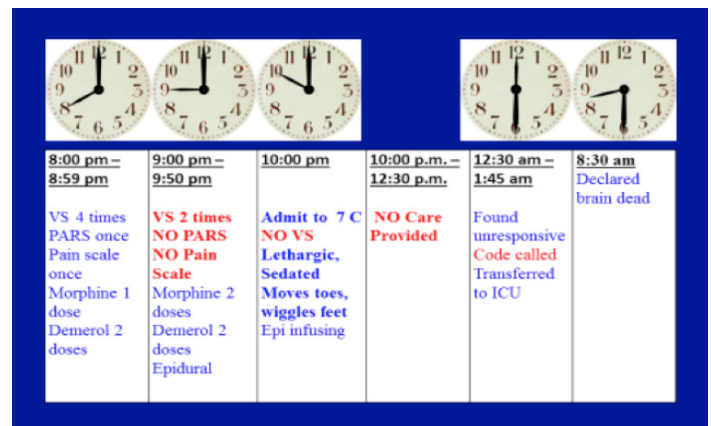


Figure 2. Timeline of care deviation

The American Bar Association defines demonstrative evidence as, "evidence addressed directly to the senses without intervention of testimony."

was used to demonstrate a vaginal infection that spread through mesh to the coccyx following hysterectomy. The LNC needed the expert's approval to confirm the location of loose stitches in the vaginal cuff, verify the mesh's placement from the vaginal cuff to the sacral promontory, and approve the finished product. All these steps took time, working around many individuals' tight schedules.

Budget

Careful attention to budget is critical to avoiding runaway costs and a disappointed client. Estimate your budget carefully, including your time as well as the vendor's and any expert's. When using an outside vendor, get pricing approved by your client before moving forward. Be sure to obtain an appropriate retainer to cover costs if your client is not

paying the vendor directly. Always keep your client informed of budget throughout the process; no one likes surprises, especially those that involve higher costs.

Once you understand the case, your client's expectations and timeline, and the budget, you can begin to identify the most straightforward path to successful DE. Clarity and communication are key for the best results.

Vendors

When the project needs are beyond what you can produce independently, a simple online search will give you a variety of vendors. Some provide all types of exhibits; others specialize (e.g., illustrations, 3D animations, interactive calendars, or computerized graphics). As with all vendors, the relationship should be based on trust and mutual

high standards from the beginning. Emphasizing one-on-one consultation helps prevent misunderstandings that would prevent a timely and budget-friendly progress.

Many attorneys hold off in preparing exhibits in hopes of a settlement. While this is understandable, it puts DE creation on a tight timetable. Without knowing a vendor's pricing, rush fees, and accessibility in advance, producing good DE on short notice will not be possible.

Always go into your vendor meetings prepared; be ready to get the most information possible and begin building a strong working relationship. Below are some questions for any vendor that can help you determine your best choice:

- + What is your specialty?
- + (If a medical illustrator) Are you certified?
- + Do you have images, or do you purchase from another source? (You may be able to go directly to the source eliminating charges for a middleman and vendor search time.)
- + How do you prepare estimates?
- + What is your turn-around time for

Time Limited Injury			
Date	Document	Description	Treatment
7/10/02	ER	Alleged fall in hole. R testicular pain, tenderness (achy). No scrotal tenderness or ? lesion. No swelling or redness.	Motrin.
7/16/02	MD	Groin pain R & L. Probably has strain of groin.	
7/30/02	MD	More testicular pain R>L and groin pain.	
8/13/02	MD	Groin pain L > R. Testicle pain 10/10. Exam normal.	
8/27/02	US	Testicles normal. Bilateral varicoceles. L > R.	
9/10/02	MD	Small varicoceles. Subjective complaints outweigh objective findings. Refer to Dr. Kelly.	No need for surgery.
10/8/02	MD	Testicular pain is 10.	Does not see Dr. Kelly.

Figure 3. Time-limited injury

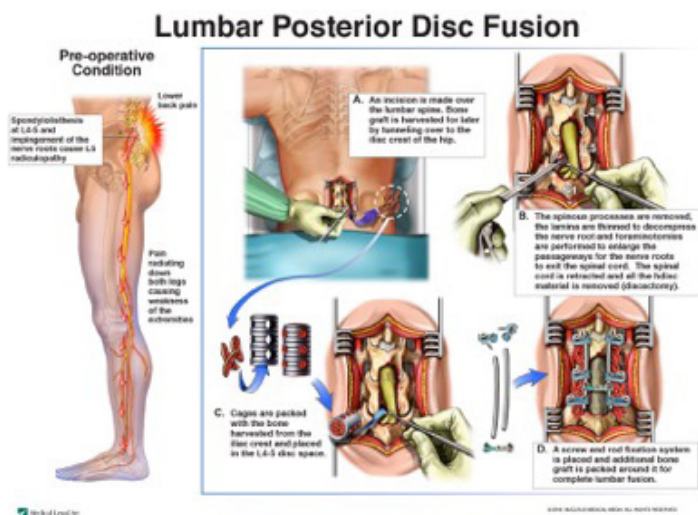


Figure 4. Generic stock photo illustration. Copyright by and reprinted with permission from Nucleus Medical Media. All rights reserved

- proofing, and for the final product?
- How many revisions are included in the price?
 - What are your policies on timing, rush fees, retainers, and payment procedures?
 - Is pricing per hour, or per project?
 - Is the exhibit licensed to us for this case only, or for repeat use?

DEMONSTRATIVE EVIDENCE IN DIFFERENT VENUES

Where and to whom will this evidence be presented? As when you use any persuasive material, knowing and targeting your audience is crucial. Each venue and audience brings unique implications to the delicate matters at hand; DE is rarely “one size fits all.” Without special care in customizing DE, it will not reach its potential.

Demonstrative evidence has two principal uses: mediation and arbitration or trial. Here, one can see how considering the venue and audience dictates the creation of useful DE.

Mediation

With the recent push for settlement,

mediation has become the grounds for education that demonstrates a strong case. You should create targeted DE to help your attorney address the mediator directly, even though representatives from both sides are present.

Mediation occurs in a smaller venue without a jury present and thus has different qualifications for submitted evidence. DE’s purpose is educating to influence settlement. In this environment (as opposed to in court), specificity is often not as crucial; the material can be less sophisticated and more general. For instance, you might be able to produce a cost-effective chart for mediation, where a trial might require a more elaborate (and likely more costly) exhibit.

Figure 3 shows a chart used in mediation and arbitration to summarize facts in a defense case. The claimed injury was time-limited and the plaintiff received no treatment or follow-up. This chart was an easy and cost-effective way to represent critical facts.

Because attorneys often refer to reports during mediation, supplemental diagrams and images provide further explanation and a more convincing

picture. Use stock photographs to explain concepts visually and in more detail than words can capture. Because you are explaining a general concept, the image does not require the same level of exactness as it would in trial.

For example, **Figure 4** is a stock photo showing a male with L5-S1 fusion to explain the procedure of a female plaintiff had on L4-5 in mediation. Despite the differences, there was no barrier in understanding the procedure as it occurred on the female plaintiff.

Figure 5 illustrates the report statement, “In order to prevent post-operative blood clots, mechanical compression stockings were placed on her legs while she was in bed to promote circulation.” In this case, the image demonstrates what the stockings look like and what it might be like to wear them.

When searching for general illustrations to use in mediation be sure to review the image’s copyright and usage rules. Check carefully to see whether permission or fees are required. Some websites, such as www.sciencesource.com, may allow free use of images for some purposes, while Lexus Nexus Med



Figure 5. Reprinted with permission of Maverick Photo Agency LTD

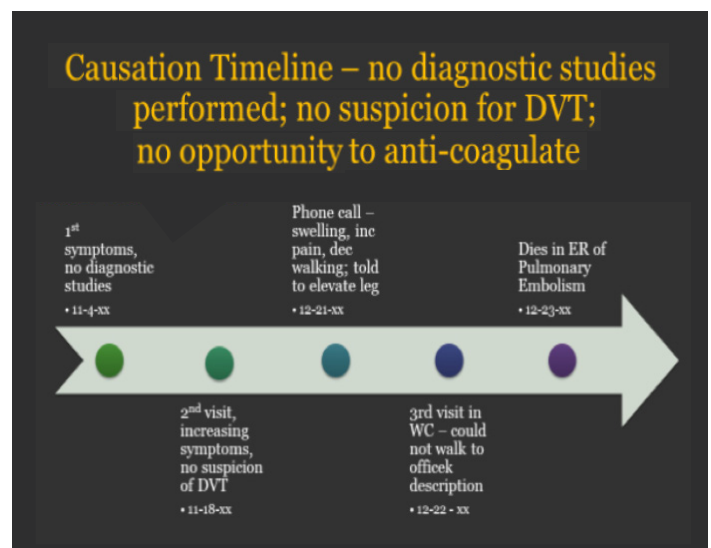


Figure 6. Alternative for use where Figure 1, a textbook page, might not be acceptable.

Mal Navigator, Medical Dictionaries, Shutterstock, and others allow use of their images with a paid subscription.

Arbitration and Trial

Arbitration and trial venues have strict rules controlling DE introduction and use. Both require adherence to local, state and federal guidelines. In some localities and states, certain materials are not permissible. The images below highlight an instance where DE that was appropriate for mediation was not presentable in trial based on one state's guidelines and laws.

For example, compare **Figure 6** to Figure 1. You might develop something similar if state regulations did not permit the use of textbook pages as evidence.

Confer with your client to understand these rules before you start work. The Federal Rules of Civil Procedure (FRCP) require sharing expert DE at the time an expert's report is filed with the court (FRCP 26, a, 2, B, iii), or 30 days before trial (FRCP 26, a, 3). Admissibility varies among federal and state jurisdictions.

Generally, however, the first hurdle a demonstrative exhibit must overcome in terms of admissibility is its purpose. Settled law states if a judge determines DE is being introduced for the purpose of clarifying and illustrating a witness's testimony, then it is admissible (*People vs. Kynette*, 1940). Visual and tactile exhibits are often judged as more

probative (affording proof or evidence) than prejudicial, as courts are primarily concerned with DE's potential to be used in a misleading or confusing way for the jury. Federal Rules of Evidence Rule 403 addresses the requirement that probative value outweighs prejudicial value (FRE 403). This reduces the potential for a judge to hear reversible error from an appellate review of the case. However, DE effectiveness ultimately depends not on whether it is admitted, but on a witness's testimony on its foundation.

Our legal system classifies demonstrative exhibits as either summary or pedagogical. Understand this important distinction when preparing DE.

In litigation, voluminous records are often too unwieldy to introduce in a way the jury can readily interpret and understand. Under FRE 1006, demonstrative exhibits can be introduced for the purpose of summarizing or substituting for such records admitted as evidence. There is an added benefit: courts may allow juries to take summary demonstrative exhibits into the jury room during their deliberations (Truss 2012). Pedagogical exhibits are not allowed into the jury room under FRE 611a, because their use is to be instructive for the jury, and should not be confused with evidence that a jury may be allowed to examine (Federal Evidence Review, 2013).

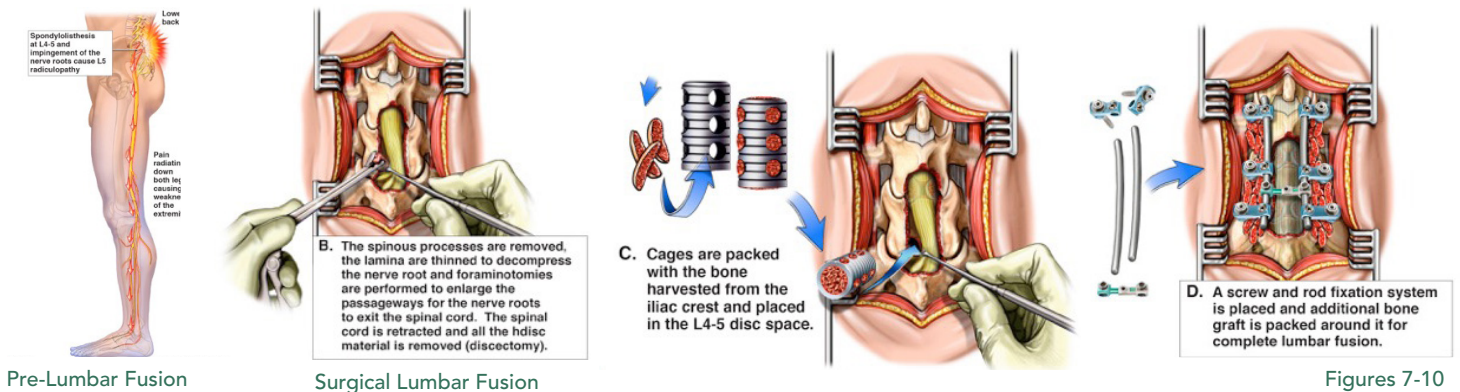
Opposing counsel may want undermine

DE credibility. You can anticipate this and preempt such attempts during preparation and pre-discovery consultation with the attorney-client. Accuracy is always valuable. At trial, "demonstrative exhibits must constitute an accurate and reasonable reproduction of the objects or matters involved in the actual case" (*Advanced Trial Handbook*). No information can be included that isn't already found in expert reports, or previously disclosed to opposing counsel. All exhibits must be accurate and authenticated. Be careful to include only facts in demonstrative exhibits, not opinion.

USING RESEARCH AND CREATIVITY TO DEVELOP EFFECTIVE DE

The most effective exhibits are simple, interesting, and accurate. The effective LNC understands it's important to simplify complex medical issues to reach the target audience both intellectually and emotionally. It can be equally critical to have an informing and motivating effect on opposing counsel before trial if the opportunity for settlement presents itself.

DE requires research and genuine creativity. Once your assignment is clear and you have selected the most pertinent case materials, you are ready to begin developing your exhibit. It is perfectly acceptable to research good examples to suggest possibilities. Below are some questions you should



ask yourself (or your vendor) in the planning phase:

- Is this something I am going to do alone, or do I need an outside vendor?
- If using a vendor, what expertise do I need?
- How much do I need to do to make an effective presentation to the vendor?
- What key words should I put into an internet search engine for researching ideas about presentation method, illustrations, etc.?
- What are some alternative ways in which each key issue might be presented?

Creativity requires thinking outside of the box; it is invention and improvisation. But remember that in this context your creativity has imposed limits: the rules of evidence. Do not be afraid, however, to stretch your imagination within ethical boundaries to influence an opposing attorney or jury.

The following scenarios are real-world examples of using your creativity to

enhance and solve problems in the creation of demonstrative evidence.

- A settlement brochure often includes “A Day in the Life” video and more. It is an overview of the entire case starting with pre-injury level of function, moving to the liability, and ending with damages. It can include images of medical records, deposition video and transcripts, interviews with client and family members, footage of care being provided, summaries of the vocational/lost wages effect, the life care plan, and the functional and emotional effects of the injuries on the client. This is one of the most holistic and powerful pieces of demonstrative evidence you can provide.
- A client wanted a “A Day in the Life” video, in which the injured plaintiff’s family members spoke about the accident, his injuries, and how they affected his life. We priced several vendors, but found all were beyond the client’s budget. How could we accomplish this video on a lower budget? In what non-legal settings had I seen video interviews of people

telling their stories? I thought of the videographer who filmed my son’s Bar Mitzvah—she could film while the attorney conducted the interview, and she could edit to the client’s specifications. We solved a common budget problem by utilizing a vendor with a more general skill set. For more information on “A Day in the Life” videos refer to page 31-33.

- I worked a case that required explanation of two surgeries at the same time, corpectomy for a burst fracture and fusion for a lumbar disc herniation. Both required removal of part of the spinal column and use of a bone graft and metal for the fusion. The goal was to differentiate the presentation of each surgery to keep the audience engaged.

After researching the treatment procedures, I found stock animations online. I spoke with a medical illustrator and learned I could use a stock image and tweak the written commentary, though I could not change the image itself. Ultimately, I found an animation online for corpectomy, and I turned one stock image into five to depict the



Figure 11

sequential storyline of the fusion. **Figures 7-10** reveal how I modified the stock image in Figure 4 (L5-S1 fusion) in a relatively inexpensive and easy way to illustrate a procedure specifically for a unique case. (All copyright by and reprinted with permission from Nucleus Medical Media. All rights reserved.)

- Consider using comparisons and analogies. These can allow a jury to see a picture before and after a series of events; comparisons can

communicate a sense of cause and effect. Both **Figures 11 and 12** were used in cases where a specific event had a causal relationship to the patient. **Figure 11** highlights the patient's pain after a fall, showing no increase compared to pre-injury. **Figure 12** shows the increase in personal care needed after a motor vehicle accident using a bar chart.

- Interactive calendars can demonstrate the course of a patient's care, pain, and suffering. They put

critical elements into an easy-to-understand time line. The interaction enables the LNC to show different views of the timeline, all while maintaining the same story. For example, the next two illustrations show two views of one calendar. **Figure 13** shows the key code for twelve different treatments and/or events with unique markers, and all days in which blood and blood gases were drawn. **Figure 14** is a view of the same interactive calendar with a call-out box for case information as it pertains to one of the unique markers. Reprinted with permission of Trial Technologies, Inc.

- Sometimes still images and words are not sufficient to explain the various points of a complicated case. If you face this issue, seek vendors who can create animation or 3D imagery. Many use computer-assisted design and 3D printing to create DE. These can be images based on radiologic studies or models of a broken bone that the juror can see and feel. For example, to show damages from a severe eye injury, one expert used a facial model in court to remove, clean, and then replace an artificial eye (Allen v. Seacoast Products, Inc., 1980). Its strong effect on the jury



Figure 12

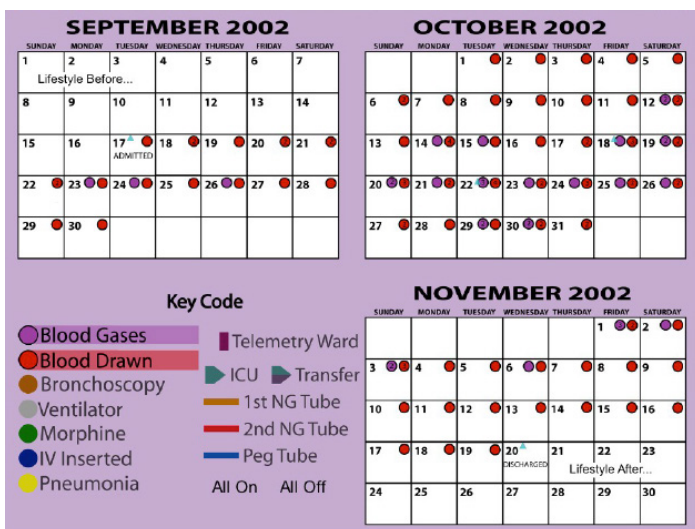


Figure 13

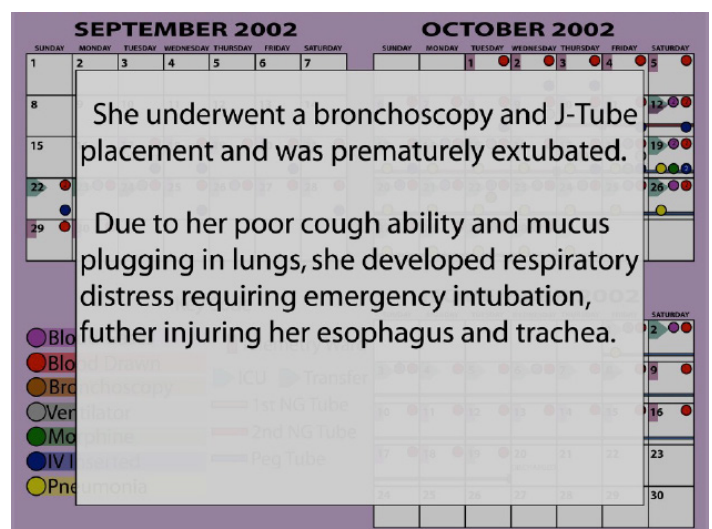


Figure 14

makes these kinds of DE worthy of your evaluation. If you do use these, ensure your DE:

1. Is anatomically based on documented operative reports and radiologic data
2. Accurately depicts the theory of liability, causation and/or damages explained in the expert report
3. Doesn't create unfair prejudice
4. Is authenticated by medical experts

CONCLUSION

Attorneys want effective ways to influence fact-finders and gain support for their points of view. Demonstrative evidence is a significant tool of instruction and ethical persuasion. Using charts and illustrations, computerized graphics, video, 3D products, animation, or interactive media creatively is a powerful way for you to provide intellectual and emotional impact for your clients. To enjoy the most success, be comfortable with a wide range of DE formats and consider how to persuade people with different learning styles: auditory learners who are more receptive to influence through what they hear, visual learners who prioritize what they see, and kinesthetic learners who are hands-on. Remember: a strategy that uses DE to identify and clarify central issues effectively and persuasively is often successful. 🐼

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It's important to simplify complex medical issues to reach the target audience both intellectually and emotionally. It can be equally critical to have an informing and motivating effect on opposing counsel before trial if the opportunity for settlement presents itself.

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Day-in-the-Life: Video as Evidence

Kelly Deutsch

Keywords: Legal video, day-in-the-life, personal injury, damages, sentinel events

Subjects who are permanently or catastrophically injured need to have the harm they have suffered told effectively and convincingly. How a story is presented to a jury or mediator is critical for damages assessment and awards. In most cases, mere words to describe the loss do not compare to watching a person try to adapt to a new life full of physical limitations and challenges. If seeing is believing and a picture is worth a thousand words, a day-in-the-video is worth its weight in gold.

When it comes to all personal injury matters, the subject's lawyer must first prove opposing parties liable and present the client's damages. Liability

is sometimes more obvious, but attempting to communicate and assess the value of the subject's injuries is not. This is especially true if jurors have had no exposure to a catastrophically-injured person. Trying to explain a quadriplegic's day is nearly impossible. Demonstrations of injuries in court are permissible, and so are demonstrations of activity of daily living: day-in-the-life videos.

Day-in-the-life-videos are typically presented to demonstrate injuries (permanent and/ or catastrophic), and their effect on the subject's daily living activities. Carefully videotaped footage of these activities, (e.g., rising, feeding, bathing, toileting, and physical, speech,

and occupational therapy) can vividly demonstrate dependency, limitations, and frustrations better than words. Whether the subject is managing life independently, has a caretaker, or lives in a care facility, a day-in-the-life-video can effectively communicate what the struggle with completely ordinary daily tasks is like with a permanent personal injury.

BETTER THAN WORDS

Video circumvents the impracticality of having jurors witness the subject's injuries and challenges firsthand, especially if the subject is homebound or cannot not perform certain tasks for demonstration, e.g., bathing or

toileting. It is a powerful tool for personal injury cases, and the courts wholeheartedly agree.

In *Grimes v. Employers Mutual Liability Insurance Company of Wisconsin* (1977) the court found the day-in-the-life video submitted by the subject exemplified “better than words” the effect the injury had on the subject’s life in terms of pain and suffering and loss of enjoyment of life.

Similarly, in *Arnold v. Burlington Northern Railroad* (1988) the court noted that although the video offered to illustrate and supplement the subject as cumulative testimony, “the day-in-the-life film communicated to the jury effectively, and perhaps better than words could do, what subject’s life...was like.” [emphasis added].

Also, in *Bannister v. Town of Noble* (1987), the court surmised that “a jury will better remember, and thus give greater weight to evidence presented in a film as opposed to more conventionally elicited testimony.”

TRIAL ADMISSIBILITY GUIDELINES

Courts have established that day-in-the-life videos must conform to the same rules as other forms of demonstrative evidence. Their admissibility is subject to broad, although not absolute, judicial discretion. The submitting party must provide appropriate legal foundation for its admission into evidence, showing that the videotape is an accurate portrayal of the events depicted, (*Cisarik v. Palos Community Hospital*, 1991). Someone who has personal knowledge of the videotape’s contents and must be available for in-court cross-examination to lay foundation: typically the subject, a caregiver, nurse practitioner, or the person most knowledgeable from the video production company.

Most courts will admit videos provided



that (1) their probative value outweighs any prejudice to the defendant (*Arnold v. Burlington Northern Railroad*, 1988) and (2) there are no demonstrated improprieties in the video’s content or production techniques (*Ocasio v. Amtrak*, 1997).

In order to be representational, day-in-the-life-videos must have a foundation of accuracy and fairness (*Foster v. Crawford Shipping Company*, 1974). For instance, the scenes depicted in the video may be unpleasant, but its prejudicial impact cannot substantially outweigh the video’s probative value. If the video does not present probative value it may not be admitted into evidence.

Counsel must also show that the daily activities were typical for the subject, so that the video would not be unduly prejudicial (*Cisarik v. Palos Community Hospital*, 1991) Nor should the day-in-the-life-video contain inter alia, artistic highlighting that emphasizes some scenes more than others, obvious exaggerations, self-serving behavior by the subject/subject(s), scenes that serve mainly to create sympathy, or those that contain other unduly inflammatory material.

DOCUMENTING SUBJECT’S DAILY ACTIVITIES

Because a day-in-the life video must follow the Rules of Evidence, it must be filmed and edited in a precise way. It is best to commission an experienced

legal video production company that understands the common admissibility requirements and has a track record of having work admitted at trial.

If the subject is in a nursing or rehabilitation facility, the attorney must receive permission to film there. The videographer must be very careful not to film other patients at the facility. Should someone be inadvertently videotaped, that person’s face must be blurred during the postproduction editing process. This also applies to nudity during changing, toileting, or shower; those must be blurred as well out of respect for the subject and members of the jury.

The videographer should approach the taping as an unbiased third-party solely to document the subject’s typical day. It is helpful for the videographer to know what sequence of events to expect, but should never direct or dictate the subject’s actions or ask the subject to do anything out of the ordinary.

The most critical time of the day is usually when the patient receives morning care. The videographer should arrive before the typical rising time and begin recording before any care begins. During filming colloquy should be kept to an absolute minimum, with the videographer recording the ambient sound.

Most day-in-the-life videos can be videotaped in four hours. However, if a subject is in a rehabilitation facility,



physical, occupational and other therapies may be scheduled throughout the day. The video should be edited to a reasonable timeframe. A good goal is about 12 minutes in order to keep jurors' attention.

Editing can be vexing, because it must strike a delicate balance of what should and should not be in the final cut. For instance, a jury does not need the entire process of digital rectal stimulation for a bowel movement when thirty to sixty seconds will make the point.

The video will be played while the person best suited to authenticate it is on the stand. That person, usually someone who was present during the filming, may be asked to narrate the actions seen on screen (Cisarik, 1991).

FOR PERMANENT INJURY CASES

One misconception is that day-in-the-life videos are for catastrophic injury only. Though the average juror has not been exposed to the daily activities associated with quadriplegia or a quadrilateral amputation, nearly any permanent injury can be documented and presented for a lasting impression. This is all about assessing how the subject has been harmed so the jury can award the proper damages. If seeing is believing, and a picture is worth a

thousand words, then a day-in-the-life video is worth its weight in gold.

Although there is no absolute measure for how a day-in-the-life video affects the bottom line, I personally have been involved in cases where the jury has awarded significant sums after watching the day-in-the-life video.

- A case involving a 13-year-old boy who was paralyzed from the chest down after being shot by Los Angeles Police Department was awarded \$24 million. (Rubin, 2016)
- A teenage subject was rendered paraplegic after being involved in a car accident with a defective seat belt was awarded \$12.5 million (Hirsch J, 2014)
- A medical malpractice matter involving a 27-year old who went into septic shock at a hospital and had all 4 limbs amputated as a result, was awarded \$13.3 million during arbitration after the video was played (conaldoylalelaw.com, 2015)

Although these cases may not be typical, they demonstrate the effectiveness of presenting video as evidence of harm caused.

SUMMARY

Day-in-the-life videos can be effective, and should be admissible at trial as

demonstrative evidence as long as they do not contain inter alia, artistic highlighting, obvious exaggerations, self-serving behavior, scenes which serve little purpose other than to create sympathy, or other unduly inflammatory material.

To view a day-in-the-life exemplar video, visit: <https://vimeo.com/124573273>.

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Demonstrative Evidence: Specialty Timelines

Alicia Luke, RN, LNCC

Keywords: LNC work product, timelines, specialty timelines, chronology

Specialty timelines can take many forms depending on the demands of the case, the needs of the client, and the audience that will review them. We present different timelines throughout three phases of a case evolution, from helping decipher to helping persuade. In initial case analysis, a specialty timeline will help the LNC see complex data to find patterns and anomalies. Later, specialty timelines help explain complex data and findings to an audience who may not have the technical knowledge, and can often be instructive or persuasive.

You're looking at an immense medical record. The plaintiff has numerous wounds documented by three different facilities over two years. Some facilities call a wound X, others call it Y. There are multiple treatments, and additional injuries have occurred midway through. How do you break down all of this data and present it to your client? Specialty timelines. From deciphering complex data to demonstrating patterns of refusals to a non-medical audience, the correct specialty timeline will help you communicate your findings quickly and effectively.

LEGAL NURSE CONSULTANT WORK PRODUCT

One of the main questions the legal nurse consultant (LNC) should ask when developing any medical-legal work product should be: "What is the most effective and efficient method to communicate critical information?" Reports should be clear and concise to "tell the story." What are the advantages of one format over another? How does the LNC decide on which to use?

The most important factors to consider are the purpose of the report and the intended audience. Will the report help educate, persuade? Does it take into account the complexity of the information and the affect it may have on the end-user?

THE PURPOSE OF THE SPECIALTY TIMELINE

Initial case analysis

Consider client expectations, case budget, any time constraints, and information complexity. The goal of initial review is investigation, determining the basic facts and needs of a case to start the conversation with the client. Ideally, work product you draft should be somewhat demonstrative, but still technical, with a goal of helping

the client determine if the case moves forward. The work product should briefly summarize the high points of the case, extent of any alleged injuries, and adherences to and deviations from standard of care. Use of a specialty timeline during the investigative phase of a review can be a concise and efficient way to outline and analyze the fundamental facts.

Table 1 demonstrates a timeline of nutrition and interventions for an 89-year-old male resident in long term care (LTC). Allegations included the facility's failure to assess for and treat malnutrition and dehydration properly, leading to his death. This format lays out basic factual information. This can be useful in helping you formulate the basis for an opinion.

At times the preliminary case investigation yields more questions than answers. A specialty timeline might be needed before any attempt at analysis when medical records are extensive or disorganized, complex or multiple injuries are alleged, or the time span is long. It is typically necessary to make several quick passes through the medical record, aggregating information into a table to develop a clearer picture of the plaintiff's status at any given period in time, simply to help get facts organized.

Table 2 is part of a specialty wound timeline in the case of a middle-aged nursing home resident who developed multiple areas of skin breakdown over two years. The complaint alleged the defendant facility failed to prevent development and worsening of pressure ulcers, resulting in bilateral above the knee amputations (AKAs). The LNC soon determined she could not keep the wounds straight and was getting bogged down with conflicting terminology in the records. Multiple hospitalizations and re-admissions during the time the alleged injuries occurred further complicated the analysis. Evaluation would have been impossible without the

timeline of wounds.

After initial review, guide the client with recommendations for further case development. Consider:

- Should the case move forward, based on the discovery of strong evidence?
- Should the client push towards early resolution, given little supportive evidence?
- Is further investigation needed to help properly value the case, mitigate damages, etc.?

ONGOING CASE DEVELOPMENT

Ensure that your work product matches the client's expectations and goals. Keep case budget and time constraints as priorities. Remember that during analysis, the report audience may expand to include experts, claim adjusters, and mediators or arbitrators. Consider what exhibits might be most helpful. Work product that is persuasive, demonstrative, but still technical can be extremely useful.

A specialty timeline is an excellent way to organize and present analysis, call attention to deviations/adherences to standard of care, and highlight case strengths and weaknesses. They can become the framework for the litigation.

Our attorney client in the malnutrition case asked for two timelines, one showing the many nutritional interventions, and one demonstrating when the resident refused care. We extracted this information from **Table 1** to create two very persuasive timelines (**Table 3**).

In the case of the nursing home resident who eventually required bilateral above the knee amputations, we immediately saw the need to develop individual timelines for all of the primary wounds. **Table 4** shows the first page of the timeline for one, the right heel wound. This made it easier to follow

DATE	BATES	CHART NOTES	INTERVENTIONS/POC MODIFICATION
03/30/07	Doe 0222-0224	Referred for caretaker's report of significant weight loss and choking with PO intake. "Dietary intake fair" •MBS – dysphagia consistent with diagnosis of myasthenia gravis. Characterized by pattern of weakness that significantly increases across eating and drinking times.	
04/03/08 – Admission to Defendant Nursing Home			
04/03/08	Doe 0079; 0463	Admitted with history/diagnosis of recurrent aspiration pneumonia	• Diet pureed with nectar thickened liquids • HS snacks ordered and offered as ordered through DOD
04/03/08	Doe 0705	Weight 167#. IBW 160#. 104% of IBW. Able to drink independently. Dining ability assisted. Has difficulty swallowing.	• Evaluation by CDM ordered • Temporary care plan initiated for chewing and swallowing difficulties
04/07/08	Doe 0706	Skin intact. Visceral protein status is WNL. Good/fair intake.	• Re-evaluation by RD planned weekly • Speech therapy ordered
04/07/08 – 04/18/08	Doe 0671	Speech therapy provided for moderately severe to severe oral & pharyngeal stage dysphagia.	
04/09/08	Doe 0018	72 hour post admission conference with family. Discussed history of feeding difficulties and possibility of feeding tube.	Care plan updated with interventions: • Diet consistency as ordered • Meal preferences on file • Monitor weekly weights & labs PRN • Educate family on possibility of feeding tube • RD/MD notified PRN
04/19/08	Doe 0671; 0693	Educated family on aspiration pneumonia and that resident would continue to exhibit pneumonia and it would eventually take its toll and resident would not recover. Informed them resident would not be getting adequate nutrition resulting in increased weakness and skin breakdown.	• ST met with family, NSO, dietary, social services regarding resident continued difficulties with choking behavior.
05/01/08	Doe 0717	Weight 163.0#	
05/06/08	Doe 0532	Refusing to participate in all Restorative services	
05/10/08	Doe 0532	Discharged from Restorative services due to refusals	• Recommended RD visit
05/21/08	Doe 0709	Family does not want TF. Anticipate further decline in weight and overall nutritional status.	• RD visit with resident/family
06/01/08	Doe 0372	Refused breakfast & lunch	
06/04/08	Doe 0287		• MD faxed regarding resident eating and drinking poorly
06/05/08	Doe 0116; 0123		• Adaptive equipment implemented for water intake during meals – long spout ribbed cup

Table 1

John Doe v. Defendant Nursing Home
 Timeline of Wounds

WOUND ¹	Coccyx	Coccyx #1	Coccyx #2	Coccyx #3	R buttock	L buttock	R heel	R inner heel	R lateral foot	R foot lateral (distal)	R foot lateral (prox)	R lateral leg AKA#1	R lateral leg AKA#2	L heel	L inner heel	L lateral foot	L lower leg (top)
DATE																	
10/19/08 – Admission to Defendant Nursing Home																	
10/19/08	Stage II													Stage IV			
12/03/08 – 12/05/08 Admission to Hospital A (no records)																	
12/05/08	Stage II				Stage II	Stage II								Stage IV			
01/02/09	Healed																
01/16/09					Healed	Healed								Eschar			
02/20/09	Stage II																
03/10/09	Split in 2 →	Stage II (R)	Stage II (L)														
03/17/09		Healed															
03/20/09 – 03/27/09 Admission to Hospital A (no records)																	
03/27/09	See #1, #2, #3	Stage II	Stage II	Stage II										Eschar			
03/30/09 – 04/01/09 Admission to Hospital B (no records)																	
04/01/09		Stage II	Stage II	Stage II				Eschar						Eschar	Eschar	Eschar	Eschar
04/07/09			Healed	Healed										Stage IV			
04/14/09		Healed												Wounds merged	Eschar		
04/20/09 – 04/22/09 Admission to Hospital B (minimal records)																	
04/21/09		Stage II	Stage II					Eschar	Stage IV	Eschar	Eschar	Eschar					Left above knee amputation
04/22/09		Stage II	Stage II					Eschar	Stage IV	Eschar	Eschar	Eschar	Stage III	Stage III			
06/02/09	Stage II	← Merged															
06/23/09	Stage II							Healed	Stage IV	Eschar	Eschar	Eschar	Stage III	Stage III			

¹ Areas in yellow highlight indicate the first notation of a wound.

Table 2

Weight & Nutrition

Weight and Nutritional Interventions

Defendant caregivers implemented interventions to assist John Doe in maintaining adequate intake and a healthy weight despite his medical conditions and refusal of care.

- 04/03: Assessed risk on admission, specialized diet ordered
- 04/03: Meal preferences obtained
- 04/03: HS snacks ordered and offered through discharge
- 04/04: Evaluation by Certified Dietary Manager
- 04/04: Weekly weights, I&O monitoring
- 04/04: Interim care plan implementation
- 04/04: Evaluation by Registered Dietician
- 04/07: **Speech Therapy** ordered for dysphagia management
- 04/09: 72 hour post-admission conference with family
- 04/15: Care plan initiation
- 04/15: Educate family on possibility of feeding tube needed
- 04/19: ST educational meeting with family, NSO, dietary, SS
- 05/19: MD order requested for **swallow study**
- 05/21: Registered dietician follow-up
- 05/29: Restorative services for walking to dining room 2x/day
- 06/02: Monitored nutritional labs
- 06/04: MD communication regarding poor intake
- 06/05: **Adaptive equipment** implemented for fluid intake
- 06/05: Registered Dietician follow-up
- 06/30: **IV fluids provided**
- 07/01: Certified Dietary Manager follow-up
- 07/08: Care conference with family due to weight loss
- 07/12: Care plan re-evaluated and updated
- 07/12: Dietary consistency changed
- 07/12: **Hydration passes** implemented
- 07/12: Added to Restorative Dining program for all meals
- 07/12: **Health Shakes** twice daily
- 07/16: Registered Dietician follow-up
- 07/22: Implemented Procrit monthly for anemia
- 07/28: MD faxed with status update
- 08/06: Care conference with family re weight loss
- 08/06: Option of feeding tube, Hospice discussed
- 08/11: Lactulose decreased to daily
- 08/16: MD faxed with status update
- 08/19: Care plan updated
- 08/19: Full feedings by staff
- 08/19: Implemented an **appetite stimulant**
- 08/19: Certified Dietary Manager follow-up
- 08/22: Registered Dietician follow-up
- 08/28: Appetite stimulant dose increase implemented
- 09/01: IV fluids provided
- 09/01: Care plan reviewed and updated
- 09/01: IV fluids provided
- 09/01: Care plan reviewed and updated

Table 3


John Doe v. Defendant Nursing home							Date: 01/04/16
Timeline of Individual Wounds							Update: 00/00/00
WOUND	DATE	PRESENT ON ADMIT?	STASIS VS. PRESSURE	STAGE	SIZE	TREATMENT	COMMENTS
08/10/09 – 08/14/09 Admission to Hospital B							
Right heel	08/14/09		Stasis	U	5.2 x 3.0 x 0cm	Accuzyme to eschar, cover with NS damp gauze.	
08/14/09 Admission to Nursing Home							
	08/21/09	Y	Stasis	U	5.2 x 3.0 x 0cm	Accuzyme continued.	Wound care consult ordered.
	08/30/09	Y			2.4 x 2.1 x 0cm		Variations noted in wound measurements.
	09/02/09	Y	Stasis	IV	5.0 x 3.2 x 0cm	Aquacel Ag, cover with Allevyn adhesive dressing daily.	+ foul odor noted in wound clinic. Started on Keflex x 10 days.
	09/06/09	Y			5.2 x 2.7 x 0cm	Ongoing.	
		Y			5.4 x 3.0 x 0cm	L-arginine started.	Wound culture + for MRSA and VRE. Admit for PICC, IV Primaxin
09/06/09 – 09/10/09 Admission to BH							
	09/10/09	Y	Stasis	IV	5.2 x 2.3 x 0cm		IV Primaxin q 8h x 3 more weeks.
	09/17/09	Y			3.0 x 3.5 x 0cm		Variations noted in wound measurements.
	09/24/09	Y		IV	4.0 x 3.0 x 0cm	Wet to dry dressing, Dakin's solution	Wound clinic visit. Wound with eschar and mildly foul smelling, "consider amputation".
	09/30/09	Y	Stasis		3.8 x 2.0 x 0cm		
	10/02/09	Y			5.0 x 8.0cm	Wound debridement per Dr. Corbin.	Culture obtained. Wound VAC started.
	10/09/09	Y		IV	5.2 x 8 x 1.0cm	Change wound VAC q 72hrs	
	10/15/09	Y			5.0 x 7.2 x 1.0cm	Continued.	Wound clinic visit. Tube feedings initiated.

Table 4

flow, timeliness, and appropriateness of measures taken by the defendant nursing home staff.

DEMONSTRATIVE EVIDENCE

Figure 1 is an excellent example of how a visual presentation of case facts can be persuasive. Using information in Tables 1 and 3, we worked with a graphic artist to sum up the story of a resident who refused care and lost weight despite multiple attempts at interventions by the facility.

Figure 2 shows a highly demonstrative and very low-tech timeline put together in a case of an evolving deep tissue injury present on admission to the nursing home. This showed that the wound was present at admission to the defendant facility, and demonstrated how facility interventions helped heal it quickly.

SUMMARY

Specialty timelines can sketch the road map to the defense's position, offer a solution, paint a picture, solve a puzzle, or persuade. Use your specific area of expertise to connect the dots to create two separate comprehensive timelines. The first should be more technical, with high-level information for an audience educated on the subject. The second reworks this information into an easily digestible, cause-and-effect demonstration for a naive audience.

When you develop specialty timelines, consider audience, budget, and time. Also consider needs for more in-depth analysis, a deep dive into issues, and more demonstrative or persuasive evidentiary charts. Finally, the real value of a specialty timeline is that it forces you to focus on facts, resulting in a better-developed argument, a stronger position, and a more compelling presentation. 🎯

Defendant caregivers implemented interventions to assist John Doe in maintaining adequate intake and a healthy weight despite his medical conditions and refusal of care.

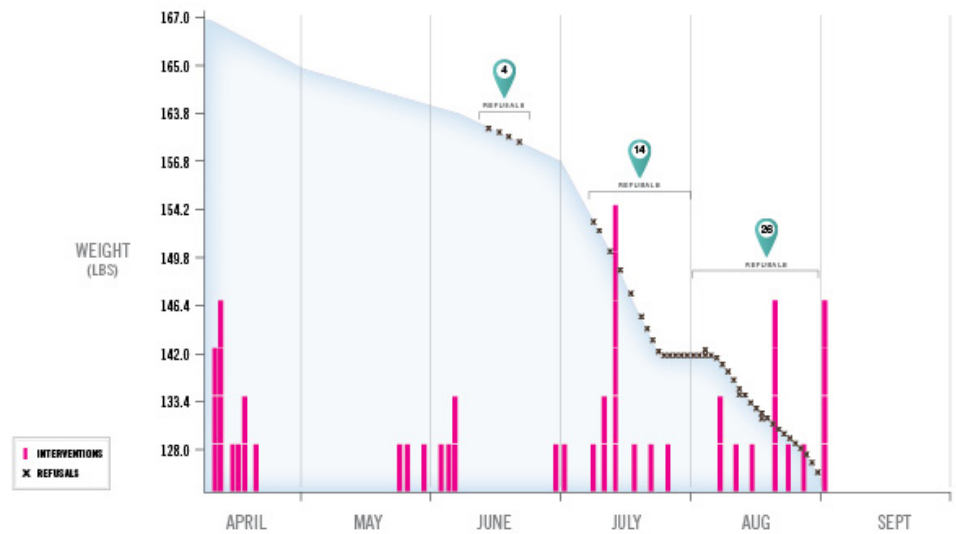


Figure 1



03/28
8 hour cardiac bypass surgery

Figure 2



Alicia Luke is President and CEO of ALN Consulting. ALN Consulting's team of medical-legal professionals provides attorneys, insurers and healthcare

organizations with everything they need for successful case outcomes. Collaboration, strategy and problem solving are at the core of Alicia Luke's passion for medical-legal consulting.

Alicia's nursing career spans two decades with experience in hospital acute care management, home health agency administration, law firm insurance defense, and regulatory compliance auditing. Alicia achieved the Legal Nurse Consultant Certified (LNCC) credential in 2009, and is recognized as a specialist in her field. She can be contacted alicia@alnconsulting.net



Medical Definitions: Terms, Abbreviations, Acronyms and Symbols

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Keywords: Definitions, terminology, root, prefix, suffix, symbols

This article briefly outlines the derivation of medical terms, how to decipher them, refers the reader to specialty area web sites that may provide glossaries, discusses symbols commonly found in medical records, and provides links for further detail.

Reviewing medical records can seem daunting when you're faced with unfamiliar medical terms. Most medical terms are drawn from other languages, particularly Latin and Greek. Medical terminology is much less mysterious if you recognize their basic components:

- prefix, the adverb or preposition at the beginning
- root, the basic meaning
- suffix, the noun, adjective, or adverb at the end

Roots can stand alone and not all words will have three components. To interpret and define a word, it helps to start with the suffix, followed by the root, and then the prefix. (Figure 1.)

Figure 1: Word components

Root words can stem from Latin or Greek, with or without prefixes

or suffixes from the same language. For example:

- autobiography comes from the Greek auto, self, bio, life, and graph, write
- appendicitis comes from the Latin appendere, appendage, and the Greek itis, inflammation
- venous is from the Latin veno, vein
- ptosis is from the Greek ptotic, falling

If you can't quickly recognize and decipher a term, you can often locate the definition by searching the internet for "medical definitions." For less common terms, you can access a specialty medical practice website (Table 1). Links to Professional Nursing Organizations can be found at <http://www.nsna.org/CareerCenter/Associations.aspx> and <http://www.nursefriendly.com/nursing/directory/national.nursing.specialty.associations>

ABBREVIATIONS, ACRONYMS AND SYMBOLS

Abbreviations and acronyms are commonly used in medical records and easily found on the internet. However, since they are subject to interpretation, context is important. When possible request a copy of a facility's list of Approved and Do not use lists.

You can find a listing of common medical symbols and abbreviations in use at one state facility at <http://www.dcf.state.fl.us/facilities/fsh/FSHOPS/151-27.pdf>. An internet search for images for "Approved symbols for nursing" will return multiple lists of symbols and common abbreviations. The Joint Commission's list of forbidden symbols can also be found at http://www.csaq.org/pdf/bulletin/issue_3/dailey.pdf

Professional Organizations	Websites
American Society of Anesthesiologists	http:// asahq.org http://.anesthesiazone.com/anesthesia-glossary.aspx
American College of Cardiology	http://www.acc.org http://heartdisease.about.com/library/blaaglossary.htm
American Dental Association	http://www.ada.org/en/ http://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter
American Academy of Dermatology	https://www.aad.org/ https://www.aad.org/dermatology-a-to-z/diseases-and-treatments/dermatology-a-z-results?Alphabet=A http://www.stchristophershospital.com/childinfo/content/derm/glossary.htm
American Academy of Otolaryngology	http://www.entnet.org/ http://ent.about.com/od/glossary/ http://www.stanfordchildrens.org/en/topic/default?id=glossary---ear-nose-and-throat-90-P02036
American Academy of Emergency Medicine	http://www.aaem.org http://www.emory.edu/EEMS/MedicalTerms.html
Endocrine Society	http://www.endocrine.org/
American Association of Clinical Endocrinologists	https://aace.com/ http://www.endocrineweb.com/endocrinology/endocrinology-definitions http://www.emedicinehealth.com/anatomy_of_the_endocrine_system/glossary_em.htm
American College of Gastroenterology	http://www.acg.gi.org http://keywen.com/en/GLOSSARY_OF_GASTROENTEROLOGY
American Academy of Otolaryngology	http://www.entnet.org/ http://umm.edu/programs/ent/health/glossary

Professional Organizations	Websites
American Society of Hematology	http://www.hematology.org/ http://www.bloodbook.com/glossary.html
American Society of Histocompatibility and Immunogenetics	http://www.ashi-hla.org http://dana.org/Publications/ReportDetails.aspx?id=44170
Infectious Disease Society of America	http://www.idsociety.org/Index.aspx http://www.hopkinsmedicine.org/healthlibrary/conditions/adult/infectious_diseases/glossary_-_infectious_diseases_85,P00627/
IVs, dosing, and weights/measures questions	http://www.dosagehelp.com/iv_terms.html http://www.infusioncare.com/resources/glossary/
American College of Physicians	https://www.acponline.org/ http://www.medicalglossary.org/specialties_medical_internal_medicine_definitions.html
American Board of Internal Medicine	https://www.abim.org/
American Society for Clinical Laboratory Science	http://www.ascls.org/ http://www.ascls.org/labtesting/labcbc.asp https://labtestsonline.org/map/gindex/ http://www.medicaltranscriptionwordhelp.com/lab-terms-words-for-medical-transcriptionists
American Academy of Neurology	http://www.aan.com http://www.ucl.ac.uk/ion/library/lib-info/glossary http://www.ninds.nih.gov/disorders/disorder_index.htm
National Association of Nutrition Professionals	http://nanp.org/ http://nutrition.about.com/od/nutrition101/a/abbreviations.htm http://nutritiondata.self.com/help/glossary http://www.emedicinehealth.com/nutrition_and_diet/glossary_em.htm
American Congress of Obstetricians and Gynecologists	http://www.acog.net http://www.propofs.com/flashcards/story.php?title=medical-terminology--obstetrics-gynecology
American Occupational Therapy Association	http://www.aota.org/ http://www.completerehabolutions.com/glossary/ http://www.alternatives4children.org/glossary/occupational-therapy-glossary.pdf http://www.totalcommunicationaustin.com/pdfs/occupational.pdf
American Society of Clinical Oncology	http://www.asco.org http://www.cancercenter.com/glossary/ http://www.cancerindex.org/medterm/medtm15.htm
American Academy of Ophthalmology	http://www.aao.org http://eyeglossary.net/ http://www.doctor-hill.com/patients/glossary.htm
American Association of Orthodontists	https://www.aaoinfo.org/ http://www.smilesbydrromine.com/ortho-terms
American Academy of Orthopaedic Surgeons	http://www.aaos.org http://www.bmc.org/Documents/bmc-orthopaedic_glossary.pdf
American Academy of Pediatrics	http://www.aap.org http://pediatrics.about.com/od/pediatricsglossary/
American College of Clinical Pharmacology	http://www.accp1.org/ http://www.theagapecenter.com/Organizations/Specialties/Pharmacy.htm http://www.medword.com/abbrevs-pharm.html http://www.bumc.bu.edu/busm-pm/academics/resources/glossary/
American Physical Therapy Association	http://www.apta.org/ http://physicaltherapy.about.com/od/abbreviationsandterms/a/PTabletabbreviations.htm http://physicaltherapy.about.com/od/abbreviationsandterms/a/PTabletabbreviations.htm
American Society of Plastic Surgeons	http://www.plasticsurgery.org http://www.plasticsurgery.org/articles-and-videos/patient-and-consumer-information/plastic-surgery-glossary.html

Professional Organizations	Websites
American Podiatric Medical Association	http://www.apma.org http://www.footlaw.com/glossary.html
Association of Pulmonary and Critical Care Medicine	http://www.apccmpd.org/ http://www.aarc http://www.theagapecenter.com/Organizations/Specialties/Pulmonary.htm http://www.emedicinehealth.com/pulmonary_embolism/glossary_em.htm
American Psychiatric Association	http://psychiatry.org/ http://www.scribd.com/doc/125684565/Glossary-of-Psychiatric-Terminology#scribd
American Psychological Association	http://www.apa.org/ http://psychology.about.com/od/glossaryfromatoz/
American College of Radiology	http://www.acr.org http://www.aradj.com/radiology-terms http://www.radiologystudents.com/radiology-dictionary/anatomical-terminology
American College of Rheumatology	http://www.rheumatology.org http://www.rheumatology.org/Learning-Center/Glossary
American College of Surgeons	https://www.facs.org/advocacy/participate/acspa http://www.acfas.org http://surgery.about.com/od/glossaryofsurgicalterms/
American College of Toxicology	http://www.actox.org/ http://www.toxnet.nlm.nih.gov http://sis.nlm.nih.gov/enviro/toxweblinks.html http://sis.nlm.nih.gov/enviro/iupacglossary/frontmatter.html
American Urological Association	http://www.auanet.org/ http://northdallasurology.com/urology-treatment-and-terms-glossary
Society for Vascular Medicine	http://www.vascularmed.org/ https://www.bcm.edu/healthcare/care-centers/vascular-surgery/patient-information/glossary

SCREENING SKILLS - ANSWERS



Continued from page 14.

Here's what one med-mal plaintiff firm decided. How did you do?

Case 1: Rejected, because bruising/bleeding, and infection are known risks of surgery; appendiceal stump syndrome is not a result of improper surgical technique; the exact nature of her problem is still not identified, so it would be problematic to establish how the problem could have been prevented; and she is not being ignored by her providers – she has had a work-up.

Case 2: Investigated and litigated because damages very significant and expert reviews on liability and causation/damages were favorable. Outcome was seven figure settlement prior to trial. Multiple defendants worked out apportionments of liability among themselves.

Case 3: Rejected because different care and treatment would not have changed the outcome. The lesson for providers is that a perceived lack of empathy and poor or inappropriate communication with patients makes it more likely they will seek legal counsel in the event of a poor or unexpected outcome.

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Looking Ahead...

XXVII.3, September 2016 — Infection

XXVII.4, December 2016 — Forensics in LNC

XXVIII.1, March 2017 — Independent LNC Practice

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