

*The Journal of*  
**Legal Nurse  
Consulting**

Volume 21 ▲ Number 4 ▲ Fall 2010

- ▲ **Actual or Potential Fraud: A Closer Look at EMS Training**
- ▲ **To Intend or Not to Intend: That is the Question**
- ▲ **Volunteerism and Legal Considerations**
- ▲ **Repetitive Strain Injury**
- ▲ **Moral Accountability: An Ethical Duty to Oneself**
- ▲ **Membership Today: A Question of Belonging**



**AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS**

American Association of Legal  
Nurse Consultants  
401 N. Michigan Avenue  
Chicago, IL 60611-4267  
877/402-2562  
312/321-5177  
Fax: 312/673-6655  
E-mail: [info@aalnc.org](mailto:info@aalnc.org)  
Web site: [www.aalnc.org](http://www.aalnc.org)

**Editor**

Bonnie Rogers, DrPH COHN-S LNCC  
FAAN

**Board of Directors**

*President*

Karen Huff, BSN RN LNCC

*President-Elect*

Sharon K. McQuown, MSN RN LNCC

*Past President*

Suzanne Q. Langroth, BSN RN LNCC

*Secretary/Treasurer*

Marianne Hallas, RN BS MBA LNCC

*Directors at Large*

Barbara Boschert, RN BSN  
Beth Diehl-Svrjcek, RN MS CCRN NNP  
CCM LNCC  
Elisabeth Ridgely, BS RN LNCC  
Dawn Williams, RN BSN LNCC CLCP  
Elizabeth Zorn, BSN RN LNCC

*The Journal of Legal Nurse Consulting*

**Editorial Board**

Bonnie Rogers, DrPH COHN-S LNCC  
FAAN, Chair  
Kathleen Ashton, PhD APRN BC  
Judy Bulau, RN MSN  
Kara DiCecco, MSN RN LNCC  
Holly Hillman, MSN RN  
Mary O'Connor, PhD RN  
Ann Peterson, EdD MSN RN FNP-BC LNCC  
Eileen Watson, EdD RN MSN ANP  
GNP LNCC  
Beth Diehl-Svrjcek, RN MS CCRN NNP  
CCM LNCC, Board Liaison

**Staff**

*Executive Director*

Kaye Englebrecht

*Managing Editor*

Amie Shak

## *The Journal of Legal Nurse Consulting*

### **Purpose**

The purpose of The Journal is to promote legal nurse consulting within the medical-legal community; to provide both 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](mailto:JLNC@aalnc.org).

### **Manuscript Review Process**

Submissions are peer-reviewed by eminent professional LNCs with diverse professional backgrounds. Manuscript assistance can be provided upon request to the editor. Acceptance is based on the quality of the material and its importance to the audience.

---

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

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

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

Copyright ©2010 by the American Association of Legal Nurse Consultants. All rights reserved. For permission to reprint articles or charts from this journal, please send a written request noting the title of the article, the year of publication, the volume number, and the page number to Permissions, *The Journal of Legal Nurse Consulting*, 401 N. Michigan Avenue, Chicago, IL 60611-4267; [JLNC@aalnc.org](mailto:JLNC@aalnc.org).

*The Journal of Legal Nurse Consulting* (ISSN 1080-3297) is published quarterly (Winter, Spring, Summer, and Fall) by the American Association of Legal Nurse Consultants, 401 N. Michigan Avenue, Chicago, IL 60611-4267, 877/402-2562. Members of the American Association of Legal Nurse Consultants receive a subscription to *The Journal of Legal Nurse Consulting* as a benefit of membership. Subscriptions are available to non-members for \$165 per year. Back issues are \$20 for members and \$40 per copy for non-members. Orders for back issues are subject to availability and prices are subject to change without notice. Replacements because of non-receipt will not be made after a 3-month period has elapsed. Back issues more than a year old can be obtained through the *Cumulative Index to Nursing & Allied Health Literature* (CINAHL). CINAHL's customer service number is 818/409-8005. Address all subscriptions correspondence to Circulation Department, *The Journal of Legal Nurse Consulting*, 401 N. Michigan Avenue, Suite 2200, Chicago, IL 60611-4267. Include the old and new address on change requests and allow 6 weeks for the change.

The Journal of

---

# LEGAL NURSE CONSULTING

Volume 21 ▲ Number 4 ▲ Fall 2010

## Features

---

**\*Actual or Potential Fraud: A Closer Look at Emergency Medical Services (EMS) Training..... 3**

*M. Thomas Quail, MS Ed R.N. LNC EMT-B*

Fraud occurs when a contractor has knowingly presented a false claim to receive payment for goods purchased or services rendered. An estimated “23.7 billion dollars in improper Medicare and Medicaid insurance claim payments were made for the year 2007.” This article will review three investigations which resulted in actual or potential fraud involving the lack of appropriate training.

**\*To Intend or Not to Intend: That is the Question..... 10**

*Robert M. Julien, MD PhD and Kara DiCecco, MSN RN LNCC*

Few areas of legal practice balance on such a precarious edge as the allegations of rape. To traumatize the victim repeatedly as they pass through a crucible of trial proceedings and the uncertainty of judicial disposition is arguably almost sadistic in its approach. Conversely, the mental torment, alienation by society and likelihood of imprisonment for the falsely accused is just as egregious. A third, equally disturbing and frightening scenario unfolds when the guilty go free. In the following article, we explain from the medical perspective the essential elements of memory, consent, intent, and pharmacologically-altered mental capacity.

**\*Volunteerism and Legal Considerations..... 16**

*Beverly Pruitt, RN LNCC*

Unemployment is high and millions of Americans are without health insurance. Given the need for often unaffordable basic health care, more doctors, nurses, dentists, and visual specialists are needed to provide volunteer services but may be concerned about potential legal pitfalls. Good Samaritan Laws have been enacted by every state and the District of Columbia to encourage volunteer assistance. The Federal Volunteer Protection Act was passed by Congress in 1997 to limit liability. The reality is few organizations and volunteers get sued.

## Departments

**Editorial .....2**

*Bonnie Rogers, DrPH COHN-S LNCC FAAN*

**Clinical Maxim .....20**

Repetitive Strain Injury (RSI)

*Kara DiCecco, MSN RN LNCC*

**References and Resources.....26**

Repetitive Strain Injury (RSI)

*Kara DiCecco, MSN RN LNCC*

**Questions and Answers.....28**

Membership Today: A Question of Belonging

*Rhonda L. Newberry, BSN RN CCRN LNC*

**Professional Practice, Trends and Issues .....30**

Moral Accountability: An Ethical Duty to Oneself

*Eileen Watson, EdD MSN RN ANP and Holly Hillman, MSN RN*

**Book Review .....31**

A Firm Foundation: Review of Legal Nurse Consulting Principles and Practices

*Kathleen Ashton, PhD APRN BC*

*\*These articles have been selected for inclusion in the 2010 JLNC Nursing Contact Hour Program. Participants of the program will be able to earn nursing contact hours for completion of an online post-test about this article. See detailed instructions at the conclusion of the article.*

# Continuing to Grow Through Learning



Dear Colleagues,

The *Journal* has made a nice transition from the paper copy to the electronic format. Access to the online version is very user friendly and *Journal* issues can be easily printed and stored in your own personal binders if you desire to do that. This change will also provide an economic savings to the membership while continuing to provide outstanding articles for the readership.

This issue of the *Journal* is chock-full of interesting and thought provoking papers and information. Thomas Quail, who is well experienced as an Emergency Medical Technician, provides an intriguing article on practice issues in emergency medical training. Quail provides several excellent case scenarios about actual or potential health care fraud that can occur specifically with regard to training in the EMS industry, and the need for the LNC to be familiar with state laws regarding scope of practice, and training, licensure, and license renewal requirements.

Dr. Robert Julien and Kara DiCecco discuss the issue of intent as a legal standard and how both judges and juries struggle with the core question of purposeful action in a case. This is compounded when the use of substances may be involved which affects memory issues or calls into question the individual's ability to act with a deliberate will. A clear knowledge of the impact of amnestic drugs as they relate to the ability to engage in intentional activity is critical.

Beverly Pruitt describes the important role of medical voluntarism particularly in remote areas, and how volunteering can provide the opportunity for clinically qualified LNCs to maintain skills. She reports that the overall exposure for liability associated with volunteer activity is low. Ms Pruitt identifies different experiences that LNCs have with a unique perspective for handling these kinds of situations, and that LNCs can help inform and reassure others regarding legal issues of volunteering.

Dr. Eileen Watson and Holly Hillman provide an examination of ethical accountability particularly as nurses are faced today with many new and challenging dilemmas such as, staff downsizing, end-of-life issues, doing more with less, and institutional policies and conflicts. They point out that nurses must be skilled in ethical decision-making and utilize available resources to help in dealing with difficult dilemmas.

Kathleen Ashton give a solid book review on the new Legal Nurse Consulting Principles and Practices, two volume set. The review provides the reader with a synopsis of what can be found in each volume and the importance and relevance of the content. If you don't already have a copy of these important volumes, you will be sure to want to have these references handy in your office.

In the Question and Answer department, the question of why belong to the professional organization is addressed by Rhonda Newberry. Ms. Newberry discusses important benefits such as networking, employment opportunities identified, and the availability of resources. Organizations often provide educational conferences which can help supplement your career goals. The Clinical Maxim by Kara DiCecco gives a thorough discussion on Repetitive Strain Injury including terms, and standards and law. In addition, excellent References and Resources are provided for the reader who wishes to delve more into the topic.

I am confident that our readers will enjoy and learn from all of these contributions. As per the Question and Answer and why belong to the professional organization, the *Journal* is a prime example of the value you get from being a member.

Warm regards,

Bonnie Rogers  
Editor-in-Chief, *The Journal of Legal Nurse Consulting*

# Actual or Potential Fraud: A Closer Look at Emergency Medical Services (EMS) Training

M. Thomas Quail, MS Ed R.N. LNC EMT-B

## KEY WORDS

Health Care Fraud, Emergency Medical Services, Emergency Medical Technician Training, Pre Hospital, Legal Nurse Consultant

---

*Fraud occurs when a contractor has knowingly presented a false claim to receive payment for goods purchased or services rendered. Medicare and Medicaid programs are the most likely for fraudulent abuse which is expected to continue to rise as people live longer. An estimated "23.7 billion dollars in improper Medicare and Medicaid insurance claim payments were made for the year 2007" (Fraud Statistics, 2009; Riely, 2008). Fraud or fraudulent activities may be committed by anyone who is employed, licensed, or provides services to the health care industry. This article will review three investigations which resulted in actual or potential fraud involving the lack of appropriate training.*

---

## Introduction

The Federal Bureau of Investigation (FBI) Health Care Fraud unit and the Office of the Inspector General (OIG) are federal agencies that investigate individuals and organizations that abuse and defraud public and private health care systems. These agencies work in conjunction with State Attorney General Offices and local enforcement bureaus to address vulnerabilities within the health care system (FBI, 2006; U.S. General Accounting Office, 1987; U.S. Government Accountability Office (GAO), 2004; U.S. Department of Health and Human Services (DHHS), Office of Inspector General (OIG), 2006-2009; U.S. GAO, 2005; Office of Attorney General (OAG), 2009; Stock, 2009).

Government audits report an estimated "23.7 billion dollars in improper Medicare (\$10.8) and Medicaid (\$12.9) insurance claim payments..." were made for the year 2007 (Fraud Statistics, 2009, p.6; Riely, 2008). In the same year, the government reported they "... won or negotiated approximately 1.8 billion dollars in judgments and settlements ... in health care fraud cases, and proceedings," as a result of their investigations (DHHS & U.S. Department of Justice (DOJ), 2008, p. 1; DHHS/OIG, 2007, p. 3).

Medicare and Medicaid programs are the most likely for fraudulent abuse which is expected to continue to rise as people live longer (FBI, 2006); however every healthcare program is vulnerable to fraudulent activity. "The Center for Medicare and Medicaid estimates total health care expenditures by 2012 will exceed 3.3 trillion dollars" (FBI, 2006, p.8). Fraudulent payments are estimated to be 3 to 11 percent of the expenditures (FBI, 2006; U.S. General Accounting Office, 2002).

Fraud is defined under the False Claims Act as "a contractor has knowingly presented a false claim for payment to the United States. The fraud can occur wherever Federal or State monies are directly or indirectly used to purchase goods or services" (U.S. GAO, 2006, p. 1; Qui Tam, <http://www.quitamonline.com/fraud.html>).

Fraud or fraudulent activities are committed by pharmaceutical and health care suppliers, physicians, dentists, and transportation companies, essentially anyone who is employed, licensed or provides services to the health care industry (DHHS/OIG, 2007-2009; EMS Responder, 2008; FBI, 2006; Internal Revenue Service, (IRS), 2008, October; Qui Tam, 2009; Trust Solutions, 2009).

Health care suppliers commit fraud by phantom billing, duplicate claim submission, kickbacks, or by charging for equipment and supplies never ordered and/or distributed. Transportation companies such as ambulance or chair care services commit fraud by up-coding, double billing, and billing for transporting patients when another means could have been utilized. Physicians and dentists commit fraud by performing unnecessary surgeries, prescribing dangerous drugs, and performing inappropriate testing. Other fraudulent activities include the diversion of drugs and prescriptions, falsification of medical necessity forms, documenting treatment or procedures that were not performed, or lack of appropriate training (DHHS/OIG, 2007-2009; FBI, 2006; U.S. GAO, 2006; Osborne, 2008; Qui Tam, 2009; Trust Solutions, 2009).

This article will review three investigations, which resulted in actual or potential fraud involving the lack of appropriate training. These cases occurred in the Emergency Medical Services (EMS) industry in the Commonwealth of Massachusetts.

## Training Requirements

State licensing agencies define training, licensure, and license renewal requirements in their codes, statutes, and/or regulations. Licensed health care agents include, but are not limited to physicians, nurses, dentists, dental hygienists, emergency medical technicians, pharmacists, respiratory therapists, physical therapists, and radiology technicians (California v Freeman, 2007; IRS, 2008, March; Vargas, 2007; Wolf & Clark, 2009). Licensed health care providers receive some form of formalized initial training in their

field which provides the foundation of knowledge in order to achieve a license. After licensure, continuing education courses provide supplemental professional education in order to meet current standards of care. Courses may also provide the opportunity for the health care provider to learn a skill, such as cardiopulmonary resuscitation (CPR) or the proper use of the automated external defibrillator (AED).

In the EMS industry, it is necessary for the legal nurse consultant (LNC) to have a comprehensive knowledge of the state EMS system, as it can vary from state to state (National Academy of Sciences, 2007; Quail, 2005). LNCs must be familiar with Emergency Medical Technician (EMT) training, licensure requirements and renewal, and how patient treatment varies depending on the EMT's license. In Massachusetts, the Office of Emergency Medical Services (OEMS) is the state's licensing authority for both the ambulance service and the EMT, and regulates training, licensing, and retraining, and provides enforcement provisions (MA. Department of Public Health (DPH), Office of Emergency Medical Services (OEMS), 2007, August, Code of Massachusetts Regulations, 105 CMR 170.000 et. seq; Quail, 2004, 2005).

Massachusetts EMT students are initially trained by a state accredited training program. The student may be trained to provide care at the basic, intermediate, or paramedic level. All EMT students must complete EMT basic life support (BLS) training prior to enrollment into an advance life support program (ALS). Basic life support training is between 110-150 hours of didactic and practical skills; intermediate level training is an additional 260-320 hours; and paramedic level training is an additional 800-1200 hours. The initial training course guidelines adhere to the U.S. Department of Transportation (DOT) National Standard Curriculum (DOT, 2004; MA., DPH, OEMS, 2007, August, EMS Regulations).

EMT students at all levels must attend and pass a healthcare provider CPR/AED program and successfully pass the state written and practical examinations to become licensed. EMT-Paramedic students have the additional responsibility of completing an advanced cardiac life support (ACLS) program (MA., DPH, OEMS, 2007, August, EMS Regulations).

Massachusetts EMTs' license is only valid when the EMT is an employee of the ambulance service and EMTs are not allowed to practice as an EMT outside an ambulance service. In addition, the EMT's scope of practice may change from a paramedic to an intermediate depending on the ambulance license and ambulance staffing configuration (MA., DPH, OEMS, 2007, August, EMS Regulations; Quail, 2004, 2005).

Massachusetts ambulances are inspected and licensed by state EMS inspectors. Each ambulance is licensed at either the basic or advanced level and requires a minimum staff of two state licensed EMTs. The ambulance service is also required to obtain a state and federal drug control license, and equip the ambulance with specific equipment for BLS or

ALS treatment (MA., DPH, OEMS, 2007, August, EMS Regulations).

Massachusetts EMT license renewal is every two years and requires a healthcare provider CPR/AED program or ACLS training, a minimum number of continuing education hours, and a multi-day refresher course. The number of continuing education hours is based on the EMT's level of licensure (DOT, 2004; MA., DPH, OEMS, 2007, August, EMS Regulations).

EMT instructors are charged with providing the proper training and oversight of the state approved programs they teach. They are also responsible to submit accurate training records to the state licensing agency upon completion of the training program (MA., DPH, OEMS, 2007, August, EMS Regulations). Fraud does occur in the EMS industry (California v Freeman, 2007; IRS, 2008, March; Vargas, 2007; Wolf & Clark, 2009). It is relatively easy to obtain a cardiopulmonary resuscitation (CPR) completion certification without attending the training or to sign an attendance roster at the beginning of the training program and then leave (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406; MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705). Untrained health care providers who continue to work in their respective health care field are practicing that discipline with a license obtained through fraudulent means. They pose an imminent threat to the public health and safety, which has significant implications for the patient, the individual, and the employer (California v Freeman, 2007; IRS, 2008, March; Vargas, 2007; Wolf & Clark, 2009).

When the OEMS investigates and determines the need to restrict an EMTs' practice or remove the ambulance service license, the agency has effectively taken away that livelihood. The OEMS in conjunction with their legal council develops the legal documents to achieve a license restriction or revocation. The licensee has the right to appeal the OEMS decision. This is achieved through a formal process and usually by an adjudicatory hearing with the state Division of Administrative Law Appeals (DALA) (MA., DPH, OEMS, 2007, August, EMS Regulations; Quail, 2005).

## Training Investigations

**Case #1.** In 2006, the American Medical Response (AMR) ambulance service hired AA as an EMT-Basic. Four months after hire the AMR contacted the OEMS to verify AA's continuing education and training as his name did not appear on the OEMS website as completing such training (MA DPH OEMS, 2006, November, Complaint Investigation Report # 06-1406). The OEMS reported AA was at one time an EMT, but had allowed his license to lapse. In order to renew his license, AA was required to successfully complete another accredited initial training program and the state's written and practical examinations (MA DPH OEMS, 2006, November, Complaint Investigation Report # 06-1406). AA successfully completed the accredited training program but failed to submit the appropriate paperwork and

fees in a timely manner, making him ineligible to test for the state's practical and written examinations. AA subsequently submitted false documents and information to AMR and was hired by AMR (MA DPH OEMS, 2006, November, Complaint Investigation Report # 06-1406).

Upon notification that AA was not state licensed, he was removed from EMT duty and placed on administrative leave. The OEMS issued an immediate Cease and Desist Order to AA and initiated an investigation. The investigation determined that AA had been practicing as an EMT without a current state license, and that he had falsified information and documentation to the ambulance service and the OEMS (MA DPH OEMS, 2006, November, Complaint Investigation Report # 06-1406).

Legal action was taken by the OEMS against AA. AA appealed and through a DALA hearing was barred from any current or future intent to practice as an EMT in Massachusetts. AMR was cited for licensure violations by allowing an unlicensed person to treat patients. The OEMS referred the AA case to the OAG and the DHHS/OIG, for further action (MA DPH OEMS, 2006, November, Complaint Investigation Report # 06-1406).

*Discussion Case #1.* AA was able to circumvent the AMR hiring process, even though AMR had in place extensive hiring practices and background checks. AA knowingly provided false documentation to AMR in order to be hired as an EMT. AA provided patient care as an unlicensed individual, which posed a threat to the health and safety of the public. AA committed health care fraud. Once AMR was aware AA was not licensed, the service immediately removed AA from the ambulance, and with the assistance of the OEMS conducted an audit of all his ambulance calls to ensure no patient was harmed.

In the 4 months that AA was employed by AMR he was involved in 218 ambulance calls, with 200 transports, 13 patient refusals, and 5 assists to other EMS units. It was determined that AA treatment met the minimum requirements of an EMT-Basic provider, patient care was not sub-standard, and no patient appeared to have been harmed.

AMR submitted insurance claims for payment for services provided by AA. Because AMR unknowingly submitted false insurance claims, the service did not commit actual fraud, but it was still culpable for repayment of the monies received from insurance providers.

AMR 2009 fee for ambulance service at the basic level was \$625 base rate, plus \$25 per-loaded mile (AMR, personal communication, June 15, 2009). In 2006, AMR fee was approximately \$300- \$400 base rate (CMS, 2006). At a minimum, AMR received approximately \$60,000 - \$80,000 for ambulance transports plus additional payment for mileage estimated at \$10-\$15 per-loaded mile. These amounts plus any penalties were required as repayment to the insurance industry for the 218 calls AA attended. As of 2009, an exact repayment amount has not been obtained from either AMR or the OIG (AMR, personal

communication, June 15, 2009; DHHS/OIG, personal communication, September 22, 2009).

**Case #2.** In 2007, a complaint was made by an EMT to the OEMS against AB, an accredited training institution instructor and sole proprietor. In his business AB taught initial EMT training, refresher training, CPR/AED, and continuing education courses. AB also contracted as a faculty member and primary instructor for three local graduate colleges providing initial EMT training (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406).

The complaint alleged that AB did not provide the minimum number of hours to teach the initial EMT-Basic training program, teach the required core content, and would arrive late or leave the sessions early. AB also allowed teaching assistants to provide instruction in his absence. The OEMS requires instructors to be physically present for each training session even if a special guest lecturer or teaching assistant conducts the training. AB had left classes early or arrived to class late because he had five initial training programs simultaneously being conducted at different college locations (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406).

The OEMS investigation validated the complaint and determined that training records had been falsified. The investigation revealed the CPR program was taught three months after the start of the initial training and the AED training had never been provided. CPR/AED training records indicated the course had been taught earlier, as required by the training prerequisites, and CPR/AED completion certificates were issued to untrained and unskilled individuals (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406).

AB submitted documentation to the OEMS indicating that 17 of the 19 students had completed the minimum requirements in order to take the state's practical and written examinations, even though grades submitted identified that some of these students had failed the training. AB submitted falsified training records which indicated that volunteers and teaching assistants received credit toward their EMT license renewal. As part of the investigation, volunteers and teaching assistants were interviewed and stated they were not present for the entire training sessions. Finally, AB submitted names of other EMTs, who were never present during the training, to receive credit toward their EMT license renewal (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406).

The OEMS began legal action against AB and set a date for a DALA hearing; however, AB opted instead to enter into a settlement agreement with the OEMS. AB was barred from performing any training for one year and prohibited from conducting initial EMT training programs, until he successfully completed a state approved remediation program. AB's license as a paramedic was not restricted so he was able to continue his employment at a local ambulance company (MA DPH OEMS, 2007, April, Complaint Investigation Report # 07-0406).

*Discussion Case #2.* AB submitted false information and documentation to a state agency. He also issued CPR/AED completion certificates to EMT students that were not trained. By definition, AB did not commit health care fraud because the complaint was filed prior to students becoming licensed. However, the EMT students were required to attend additional training sessions and had to demonstrate knowledge and practical skills to ensure they were competent to work on an ambulance. This burden was placed on the EMT students in order for them to fulfill the DOT training standards and to make them eligible to take the state practical and written examinations. If the complaint had not been filed, the students might have become licensed and would have been practicing without the proper didactic and practical skills knowledge required to be an EMT. The EMTs unknowingly would have posed a threat to the health and safety of the public.

**Case #3.** In 2008, a complaint was made by a police officer to the OEMS regarding the police department's (his employer) ambulance service. The complainant officer alleged that in 2006 and 2007, the police department sponsored EMT refresher and continuing education programs, but that the required number of hours to complete these programs was never met. He also reported that the primary instructor and other police officers would sign EMT attendance rosters, and then leave without attending training programs. These officers then submitted documents to the OEMS which knowingly contained false and inaccurate information in order to renew their EMT licenses (MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705).

During the investigative process, the OEMS investigators acquired sufficient evidence and testimony to conclude that there was a "culture" of falsifying records and programs, which not only involved the two years cited in the complaint, but began approximately in 2000 (MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705).

The OEMS conducted a trip record audit for years 2006 and 2007, to ensure patients received appropriate treatment by the police officers. The audit revealed that of the ambulance calls, 93 percent and 89 percent respectively, lacked either appropriate patient care or appropriate documentation to support the care provided to the patient. The investigation revealed that the police officers had based their treatment decisions on outdated treatment protocols. In addition, the two ambulances licensed by the town carried expired medications and did not have a drug control license to carry such medications (MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705; MA DPH OEMS-Trip Record Audit #08- 0705).

The OEMS investigation concluded that 24 police officers engaged in falsifying training attendance records and were not eligible for EMT license renewal for multiple years. These police officers used the title of EMT and provided patient care as unlicensed providers, which posed a threat to the health and safety of the public. In addition, the police officers knowingly submitted false documents and fees to the

state agency, stating their training records were a true and accurate reflection of their training. Furthermore, the police department ambulance service staff billed patients' insurance companies and received payment for services by unlicensed providers (MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705).

The OEMS began legal action against the ambulance service by immediately revoking its ambulance license, and against the individual police officers, by scheduling multiple DALA hearings. The OEMS referred their investigative findings to the OAG and OIG insurance fraud divisions for criminal action (MA. DPH OEMS, 2008, August, Complaint Investigation Report # 08-0705).

*Discussion Case #3.* The police department and staff knowingly committed multiple acts of fraud, larceny, and health care fraud by allowing patients to be treated by unlicensed providers and submitting insurance claims for reimbursement. In addition, police officers received supplemental money and overtime pay in order to attend training classes to be licensed as EMTs. The amount of money each officer received was approximately \$4,470 each year (Landwehr, 2008, 2009; Manganis, 2008).

The fallout from the OEMS investigation of the police department continues today. Medicare has revoked the town's right to bill for uncollected ambulance services. The police chief and several senior officers resigned or retired. Their retirement benefits are now in jeopardy if they are convicted of a felony. An audit revealed the police department received state grant money based on forged application documents. Every arrest and court conviction by the police officers are now being questioned on appeal, citing the possibility that false information may have been provided at trial (Landwehr, 2008a & b, 2009; Manganis, 2008, 2009; Salem News, 2008).

The OAG and the OEMS final determination was that 12 police officers would face no disciplinary action; however a letter of reprimand was issued to each officer and noted in their state licensing file. The remaining police officers who did receive their license under false pretenses entered into a settlement agreement with the OAG in lieu of criminal prosecution. Four additional officers were indicted by a grand jury (OAG, 2009; Landwehr, 2009; Manganis, 2009; Salem News, 2009).

The several police officers who entered into the settlement agreement were allowed to remain employed but were required to pay full restitution to their respective towns by repaying money received for salary and overtime pay to attend training. Each officer was fined an additional \$5,000, suspended without pay for 240 hours, and required to work an additional 240 hours without pay, as discipline. None of the police officers were allowed to work on paid details on the days they were suspended (OAG, 2009; Landwehr, 2009; Salem News, 2009). The amount of the settlement agreement owed by each police officer is approximately \$25,000 (Landwehr, 2009). The four officers indicted face various charges including fraud, larceny, perjury, obstruction of justice, multiple EMS violations, and filing false statements



during an investigation. A hearing date was set for May 24, 2010 (OAG, 2009; Manganis, 2010; Salem News, 2009).

The town ambulance service provides and bills for approximately 300 ambulance transports each year. Based on their 2008 base rate including mileage of \$350 per transport, the town owes the insurance companies approximately \$105,000 for each year of fraud proven, plus interest, and penalties. If the OIG can prove fraud existed from the year 2000 to when the ambulance license was revoked, the town could owe as much as \$840,000 plus interest, and penalties (Landwehr, 2008, 2009; OEMS-Audit, 2008).

## General Discussion

The OEMS investigates approximately 100-150 complaint cases each year. A significant portion of these complaints are with respect to the lack of rendering care to patients. Typically in a given year, only one investigation will involve a training program. However, since 2005 the OEMS has seen an increase each year in the number of investigations involving training programs and individual training instructors, all with valid findings. Although the number of training complaints and investigations remains small, there does seem to be a disturbing trend in the EMS industry, of using untrained and unlicensed EMTs (Garland, 2007; Lambert, 2008; Lambert & Clark, 2008; Landwehr, 2009; NBC-2.com, 2008; Sacramento Bee, 2007; Wolf & Clark, 2009).

EMTs report, "heavy workloads," "working odd hours," and "not enough time to complete the license renewal requirements," as their reason for falsifying license applications (EMS News, 2007, 2009; Garland, 2007; Sacramento Bee, 2007). State EMS agencies indicate audits are not routinely performed due to limited resources. False training documents may unknowingly be processed, unless a whistle blower comes forward, a record is obviously altered, or the fraudulent act is accidentally uncovered (Garland, 2007; Lambert, 2008; Lambert & Clark, 2008; Landwehr, 2009; NBC-2.com, 2008; Sacramento Bee, 2007; Wolf & Clark, 2009).

In Massachusetts, the OEMS may be overwhelmed during the license renewal period especially when municipalities require licensure by January 1 in order to distribute educational stipends to their employees. Approximately 26,000 Massachusetts EMTs renew their license over a two year period. This does not include new applications as initial training programs complete their training. State EMS licensing agencies should consider developing alternative license expiration dates, such as one's birthday, or provide for electronic licensing to decrease the volume of renewal applications similar to other health care licensing boards.

## Conclusion

The Illinois Appellate Court ruled that doctors are not qualified to testify against nurses in medical malpractice cases (Passen law group, 2009); however, a LNC with emergency

department or flight nurse experience, can investigate and testify against EMTs. The intent of this article is to inform LNCs on how easily actual or potential health care fraud can occur specifically with regard to training in the EMS industry. This article references other articles in the EMS industry and should assist the LNC in identifying how EMT fraud is committed. In EMS the EMT-Basic training provides the EMT the knowledge and foundation of emergency medicine in a minimum amount of time. License renewal courses and skills refresh and update the EMT to the current standard of care. Knowing how to assess and provide treatment is critical to the care EMTs rendered to the patient.

The LNC must also be aware that health care fraud may occur in any aspect of the health care industry and not just in EMS. When reviewing any complaint against a health care provider the LNC must first be familiar with that specialty and know the state licensing laws, training requirements, and license renewal requirements. The LNC should review a health care provider's training education as part of a background check to ensure he/she is properly trained and licensed.

## References

- Are you a fraud? (2008, July 8). *EMS Responder*. Retrieved from <http://www.emsresponder.com/online/printer.jsp?id=3229>
- California v Freeman, (Enforcement # 04-246, 2007) *The Sacramento Bee*. Retrieved from [http://media.sacbee.com/smedia/2007/01/25/19/freeman\\_dec.source.prod.affiliate.4.pdf](http://media.sacbee.com/smedia/2007/01/25/19/freeman_dec.source.prod.affiliate.4.pdf)
- Current medicare fraud schemes. (2009). *Trust Solutions, LLC*. Retrieved from <http://www.trustsolutionsllc.com/Bene/schemes.pdf>
- Criminal News Reports. (2009) *EMS Network News*. Retrieved from <http://www.emsnetwork.org/artman2/publish/criminal.shtml>
- Doctor unqualified to testify against nurse in medical malpractice case (2009, September 29). *Passen Law Group*. Retrieved from <http://www.passenlaw.com>
- Federal Bureau of Investigation (2006). *Financial Crimes Report to the Public*. Retrieved from <http://www.fbi.gov/publications/financial/>
- Fraud statistics (2009). *Coalition against insurance fraud*. Retrieved from <http://www.insurancefraud.org/>
- Fraud taints paramedic licensing process (2007, January 29). *The Sacramento Bee*. Retrieved from [www.sacbee.com/](http://www.sacbee.com/)
- Garland, S. (2007, October 12). Five arrested in diploma scam. *New York Sun*. Retrieved from <http://www.nysun.com/new-york/>
- Internal Revenue Service (2008, March) *Former owner of healthcare agency sentenced to 48 months in prison*. Retrieved from <http://www.irs.gov/compliance/enforcement/>
- Internal Revenue Service. (2008, October). *Health Care Fraud, Criminal Investigation*. Retrieved from [www.irs.gov/compliance/enforcement/](http://www.irs.gov/compliance/enforcement/)
- Lambert, L & Clark, K. (2008, June 6). Fake paramedic treated patients, duped employer. *9News.com*. Retrieved from <http://www.9news.com/>
- Landwehr, S. (2008, September 25). Investigation shuts down Hamilton ambulance service. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2008, December 11). State pulls Hamilton ambulance license, finds police falsified records. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2008a, December 16). 75-page report critical of Hamilton police procedures. *The Salem News*. Retrieved from <http://salemnews.com/>

- Landwehr, S. (2008b, December 16). Cops may face criminal charges. *The Salem News*. Retrieved from [http://www.salemnews.com/archivesearch/local\\_story\\_351002037.html](http://www.salemnews.com/archivesearch/local_story_351002037.html)
- Landwehr, S. (2008, December 17). Pension for Hamilton police chief on hold. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2009, January 14). Medicare revokes town's right to bill for ambulance runs. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2009, February 19). Hamilton police sergeant resigns. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2009, August 3). Hamilton officers must pay heavy forfeits and fines. *Gloucester Daily Times*. Retrieved from <http://www.gloucestertimes.com>
- Landwehr, S. (2009, August 4). Danvers cops also punished for role in EMT scandal. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2009, August 11). EMT training difficult to monitor. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Landwehr, S. (2009, October 6). Rest of Hamilton cops will not be disciplined. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Manganis, J. (2008, December 13). Lawyers: Town, officers could be in legal jeopardy. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Manganis, J. (2009, March 19). Will EMT probe taints cops' court testimony? DA fears report could have. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- Manganis, J. (2009, August 14). Four pled not guilty in police training scandal. *The Salem News*. Retrieved from <http://www.salemnews.com/>
- MA Department of Public Health, Office of Emergency Medical Services (2006, November). *Complaint Investigation Report # 06-1406*.
- MA Department of Public Health, Office of Emergency Medical Services (2007, April). *Complaint Investigation Report # 07-0406*.
- MA Department of Public Health, Office of Emergency Medical Services (2007, August). EMS Regulations. (105 CMR 170.000) Retrieved from [www.mass.gov/dph/oems](http://www.mass.gov/dph/oems).
- MA Department of Public Health, Office of Emergency Medical Services (2008, August). *Complaint Investigation Report # 08-0705*.
- MA Department of Public Health, Office of Emergency Medical Services (2008, December). *Hamilton Police Department Ambulance Trip Record Audit #08-0705*.
- National Academy of Sciences (2007). Emergency medical services at the crossroads. Retrieved from [http://www.nap.edu/openbook.php?record\\_id=11629](http://www.nap.edu/openbook.php?record_id=11629)
- Office of Attorney General, Martha Coakely (2009, March). *Fiscal Year 2008-Annual Report*. (Public Document NO-12). [http://www.mass.gov/Cago/docs/ourorganization/fy08\\_annual\\_report\\_final.pdf](http://www.mass.gov/Cago/docs/ourorganization/fy08_annual_report_final.pdf)
- Office of Attorney General, Martha Coakely (2009, August 13). Press Release: Former Hamilton police chief and three others arraigned in EMT training scandal. Retrieved from <http://www.mass.gov/ago/>
- Osborne, D. (2008, July 25). Investigating health care fraud. *Ezine@articles*. Retrieved from <http://ezinearticles.com/>
- Our view: Scandal extended beyond Hamilton town line (2009, August 5). *Salem News Online*. Retrieved from [http://www.salemnews.com/archivesearch/local\\_story\\_216235915.html](http://www.salemnews.com/archivesearch/local_story_216235915.html)
- Potter, S. (2009, January). Court upholds ruling that doctor was not qualified as expert witness. *Chicago Daily Law Bulletin*. Retrieved from <http://www.lawbulletin.com/>
- Quail, M.T. (2004, Spring). The basic life support ambulance trip record. *Journal of Legal Nurse Consulting*, 15 (2), 18.
- Quail, M.T., (2005, Spring). The Advanced Life Support (ALS) Trip Record. *Journal of Legal Nurse Consulting*, 16 (2), 25.
- Report chronicles alleged misuse of grant (2008, December 15). *Salem News Online*. Retrieved from [http://www.salemnews.com/archivesearch/local\\_story\\_350001643.html](http://www.salemnews.com/archivesearch/local_story_350001643.html)
- Riely, K. (2008, June 30). Medicaid, Medicare made \$23 billion in improper payments. *Cybercast News Service*. Retrieved from <http://www.cnsnews.com/>
- Stock, S. (2009, November 1). I-Team: Medicare fraud, the new cocaine cowboys. *Cbs4.com*. Retrieved from <http://cbs4.com/>
- State investigates unlicensed EMT (2008, October 16). *NBC-2.com*. Retrieved from <http://www.nbc-2.com/Global/story.asp?S=10695129>
- U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2006). *Ambulance fee schedule public use files*. (CY-2006). Retrieved from <http://www.cms.hhs.gov/AmbulanceFeeSchedule/>
- U.S. Department of Health and Human Services, Office of Inspector General. (2006, April). *Review of ambulance services provided by American Medical Response of Massachusetts, Inc.* (Publication A-01-04-00502). Retrieved from <http://oig.hhs.gov/oas/reports/region1/10400502.pdf>
- U.S. Department of Health and Human Services, Office of Inspector General (2007). *State Medicaid fraud control units*. (Annual Report FY 2007). Retrieved from [http://oig.hhs.gov/publications/docs/mfcu/mfcu\\_2007.pdf](http://oig.hhs.gov/publications/docs/mfcu/mfcu_2007.pdf)
- U.S. Department of Health and Human Services, Office of Inspector General (2008, November). *Health care fraud and abuse control program reports*. Retrieved from <http://oig.hhs.gov/publications/>
- U.S. Department of Health and Human Services, Office of Inspector General (2009, May). *Enforcement Actions: Civil monetary penalties—criminal and civil enforcement*. Retrieved from <http://oig.hhs.gov/fraud/enforcementactions>
- U.S. Department of Health and Human Services & the U.S. Department of Justice (2008, November). *Health care fraud and abuse control program*. (Annual Report for FY 2007). Retrieved from [www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2007.pdf](http://www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2007.pdf)
- U.S. Department of Transportation, National Highway Traffic Safety Administration (2004). *Emergency medical technician-basic national standard curriculum*. Retrieved from <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbsnc.pdf>
- U.S. General Accounting Office (1987, July). *Health care fraud: Characteristics, sanction and prevention*. (Publication AFMD-87-29BR). Retrieved from <http://archive.gao.gov/d28t5/133704.pdf>
- U.S. General Accounting Office (2002, May). *Vulnerable payers lose billions to fraud and abuse*. (Publication GAO/HRD-92-69). Retrieved from <http://archive.gao.gov/t2pbat6/146547.pdf>
- U.S. Government Accountability Office (2004, July). *Medicaid program integrity: state and federal efforts to prevent and detect improper payments*. (Publication GAO-04-707). Retrieved from <http://www.gao.gov/new.items/d04707.pdf>
- U.S. Government Accountability Office (2005, April). *Federal Bureau of Investigation, accountability over the HIPAA funding of health care fraud investigations is inadequate*. Retrieved from <http://www.gao.gov/new.items/d05388.pdf>
- U.S. Government Accountability Office (2006, January). *Information on false claims act litigation*. (Publication GAO-06-320R). Retrieved from <http://www.gao.gov/new.items/d06320r.pdf>
- Vargas, M. (2007 March 30). City may face fine over unlicensed EMT. *Star-Telegram*. Retrieved from <http://www.accessmylibrary.com/>
- What is the false claims act? (2009, June). *Qui Tam Online Network*. Retrieved from <http://www.quitamonline.com/>

Wolf, J & Clark, K. (2009, January 14). Fake paramedic admits he was an imposter. *9News-Colorado*. Retrieved from <http://www.9news.com/>

**M. Thomas (Tom) Quail, MS Ed, RN, NREMT**, has a background in Emergency Medicine that spans over 30 years. Quail has been an Emergency Medical Technician (EMT) for 35 years, a Registered Nurse for 27 years, and a Legal Nurse Consultant for 8 years. Since 2000 Quail is a clinical coordinator for the Commonwealth of MA, Department of Public Health (DPH). He conducted investigations for 9 years for the Office of Emergency Medical Services and currently is at the DPHs' Bureau of Environmental Health, performing health research, specifically with regard to amyotrophic lateral sclerosis (ALS) also known as Lou Gehrig's disease. Quail provides continuing education lectures for nurses and EMTs in pre-hospital emergency medicine, forensics, and toxicology. He has articles published in the field of Emergency Medicine, Forensic Science, Law Enforcement, and Toxicology. Quail is a member of the Southern New England Chapter of the AALNC and American Academy of Clinical Toxicology; associate member of the American Association of Legal Nurse Consultants and Northeastern Association of Forensic Scientists and a charter member of the National Association of Emergency Medical Technicians. Quail may be contacted at [tom.quail@state.ma.us](mailto:tom.quail@state.ma.us).

### **2010 JLNC Nursing Contact Hour Program**

This article has been selected for inclusion in the 2010 JLNC Nursing Contact Hour Program. To register (new participants): Visit [www.aalnc.org/edupro/journal/CNE/2010.cfm](http://www.aalnc.org/edupro/journal/CNE/2010.cfm) to purchase access to the 2010 JLNC Nursing Contact Hour Program.

Current participants: Login to the AALNC Web site with your member ID and password to access the 2010 JLNC Nursing Contact Hour Program online portal. Once logged in, click on the link to the online portal within the left-menu navigation options. You will then be required to complete a 5–10 question post-test about the information presented in this article. A passing score of 70% is necessary. After successfully completing the post-test, you will be able to print your certificate of completion, indicating contact nursing hours earned. AALNC is an approved provider of continuing nursing education by the Illinois Nurses Association, an accredited approver, by the American Nurses Credentialing Center's (ANCC's) Commission on Accreditation.

This activity is eligible for nursing contact hours. Nursing contact hours offered through an ANCC accredited provider are recognized by the majority of state licensing boards and nursing certification boards.

# To Intend or Not to Intend: That is the Question

Robert M. Julien, MD PhD and Kara DiCecco, MSN RN LNCC

## KEY WORDS

Sedatives, Behavior, Amnesia, and Intent

---

*Few areas of legal practice balance on such a precarious edge as the allegations of rape. To traumatize the victim repeatedly as they pass through a crucible of trial proceedings and the uncertainty of judicial disposition is arguably almost sadistic in its approach. Conversely, the mental torment, alienation by society, and likelihood of imprisonment for the falsely accused is just as egregious. A third, equally disturbing and frightening scenario unfolds when the guilty go free. If the core legal issue is one of consent, jurors are understandably confused by the lawmaker's language in defining meaningful consent. The various statutory interpretations between geographic boundaries leave even the most seasoned legal professional struggling to adequately explain the standard. It is this standard however, where medicine has an even greater responsibility in assisting the triers-of-fact to distribute justice. In the following article, we explain from the medical perspective the essential elements of memory, consent, intent, and pharmacologically-altered mental capacity.*

---

Central nervous system (CNS) depressants represent one of the largest categories of drugs involved in alleged criminal activities ranging from driving under the influence (DUI) to date-rape cases to homicides. More specifically, the ability of sedative drugs and alcohol to blunt memory and “executive functioning” leads to the vital question of whether or not they may reduce one’s ability to act intentionally, with intent, or with “conscious awareness.” For example, an alleged victim of a date rape believes (because of the amnesic quality of these drugs) that he/she was unconscious or an unwilling participant which could lead to allegations of rape. In reality, the alleged victim might indeed have been awake and consenting, even while amnesic. This necessitates discussion of the psychopharmacology of memory, specific intent, and mental capacity when under the influence of these drugs and/or alcohol.

In a career span of 30 years, an anesthesiologist will render around 30-40,000 patients incapable of forming memory during surgical or diagnostic procedures. Additionally, an anesthesiologist or psychopharmacologist should be familiar with the mechanisms of memory formation and consolidation (the embedding of these memories) and delineate how sedative-hypnotic drugs affect memory processes. If testifying in court, this medical expert will be called upon to explain how the inability to form memory correlates with brain dysfunction, inducing a temporary state of drug-induced dementia.

## Memory Formation

The fundamental starting point for this analysis is to ask three questions: a) what is memory? b) what is dementia? and, c) how are the two related? Current views of the process of memory formation hold that memory is actually a protein, transcribed from our DNA located within glutamate-releasing neurons within the brain (Alberini, 2007; Gold, 2007; Lu, Kimberly & Lu, 2007; and Costa-Mattioli, Sossin,

Klann & Sonenberg, 2009). At this writing, the *cofactors* that regulate the production of memory proteins from DNA are as yet undetermined. Regardless, when we “learn” something, a protein is formed from the DNA via the RNA, and that protein is released into the cytoplasm of the neuron which eventually embeds itself within the dendrite of the neuron. This embedding of the protein within the wall of a dendrite is called “consolidation.” However, some substances can affect the consolidation process. For example, factors associated with high blood alcohol concentrations in an individual prevent this consolidation of encoded stimuli and thereby create the mechanism for absence of memory (Hartzler & Fromme, 2003, Lee, Roh & Kim, 2009).

Unfortunately, even under normal functioning, these proteins may only last 12 months and may be the major reason why old memories “fade” over time. Therefore, memories must continually be reformed and it is now felt that a major purpose of dreaming is to “re-live” memories and form new memory proteins.

## A Question of Competency

In organic dementia (e.g., Alzheimer’s disease), the patient is unable to form new proteins from DNA and is thus unable to form short-term memories. For example, you visit a relative diagnosed with Alzheimer’s (dementia), leave briefly, and return to find he or she has no memory of your earlier visit. The old memories remain intact however, because the protein formation for older memories was already in place before the onset of the Alzheimer’s.

This leads to the logical question, how “competent” then is a patient who cannot form new memories (e.g., a “demented” person)? While the answer to this question is dependent on the statutory interpretations in local jurisdictions, it can be reasonably argued that a demented person is not responsible for his or her actions and cannot form the necessary specific “intent” required by law. For example, let’s say you have a

parent with Alzheimer's disease living with you and while you are gone briefly, the parent signs a contract for an expensive roof remodel you do not need. The legality of the binding contract can be readily challenged. Here, the issue is because one is demented (owing to the inability to form new memory proteins), that person is incompetent, lacking in "executive functioning," and is incapable of providing a legally-binding state of intentional behaviors and actions.

Now the same argument holds true when one is demented not because of an organic cause, but from ingestion of a sedative drug to the point where memory protein formation is blocked and one is in a state of drug-induced "blackout" or dementia (Hartzler & Fromme, 2003; White, Signer, Kraus & Swartzwelder, 2004; and Perry, Argo, Barnett, Liesveld, Liskow, Hernan, et. Al, 2006). Sedative drugs include ethyl alcohol, benzodiazepines, barbiturates, inhalants, gamma-hydroxy-butyrate (GHB), and various "date rape" drugs. Of these, alcohol is by far the most common intoxicant used to the point of inducing the loss of ability to form memory proteins ("blackout"). Ingesting alcohol-containing beverages to a blood alcohol content (BAC) of about 0.25-0.30 grams% (grams% is the number of grams of ethanol that are contained in 100 milliliters of blood) provide enough alcohol within brain neurons to suppress the formation of memory proteins from the intoxicated person's DNA and RNA. In this situation, using self-reported amnesia as the only indicator of brain dysfunction, one is mentally compromised, executive (cortical) functioning is lost, and behaviors are not "intentional" but reflexive (expressed emotionally at a brain-stem level) or from prior experience. Table 1 summarizes effects of dementing drugs.

Review the following situations as they relate to legal consent and intention:

- A person sustains a gunshot wound while intoxicated and comes to the operating room for emergency surgery. The victim had no memory of being shot due to intoxication. Surgery must be performed but the person is intoxicated and therefore incapable of signing a legal consent. Medical personnel sign an emergency consent indicating the person is incompetent but surgery is emergently needed and cannot be delayed until the patient is sober. In this situation, medical personnel recognize that the patient cannot comprehend the consent form, will not remember signing any form, and could not process necessary information (risks, benefits, and other required disclosures) to make an informed decision to proceed or not to proceed with surgery. The patient cannot "intend."
- A person is accidentally pre-medicated before getting to the operating room for elective surgery. The surgery is cancelled because a legal consent cannot be obtained.
- A person ingests an Ambien before going to bed. The person awakens, drives a car and crashes; all performed in an Ambien-induced blackout. The warning on the Ambien's package insert recognizes sleep-related driving as an Ambien induced activity. In this state, did

the person "intend" to drive the car? Was the person operating with intact executive functioning?

- A patient is administered Versed (midazolam) for a colonoscopy. The patient is so wide awake afterwards that he or she is allowed to drive home. The person arrives home, but has no memory of leaving the hospital, driving, or getting home. Again the question is whether or not the patient was capable of intent while in the amnesic state.

## Awareness of Actions

The next logical inquiry of the person's capacity is, if one is amnesic, can a person be awake and yet be in a state of blackout? Wouldn't amnesia for events imply that one was either unconscious, anesthetized, or at the very least incapable of being behaviorally cognizant? If one is amnesic, wouldn't everyone around know from the person's behavior that they were essentially demented? Not necessarily. The majority of date rape cases have this in common: the victim (plaintiff) states that she cannot remember the sex act and was therefore unconscious, unwilling, and did not consent because of physical helplessness or incapacity while the accused partner (defendant) states that she (the alleged victim) was awake, consented, and indeed was very physically active. Who is right?

Lee, Roh, and Kim (2009) define alcoholic blackout as the following, "An alcoholic blackout is amnesia for events of any part of a drinking episode without loss of consciousness. It is characterized by memory impairment during intoxication in the relative absence of other skill deficits. It is not to be confused with 'passing out.'" (pp. 2785).

The following scenario based on personal experience illustrates the reality of the amnesic effect. Several years ago, when Versed (midazolam) first became available clinically, I was scheduled to administer anesthesia to a 35-year-old female scheduled for an elective hysterectomy. Versed is a benzodiazepine of short half-life and available for use by injection. It is marketed as a sedative/amnesic drug. Although I was never sure why, this patient insisted on being awake for the procedure. I administered two milligrams of Versed as a premedication for sedation and anxiolysis while I placed an epidural catheter. She was awake for the procedure. I dosed the epidural and we proceeded to the operating room. She remained wide awake, chose all the music for the 2 1/2 hour procedure, and chatted continuously. She was wide awake in the recovery room and later on the unit. At 11 p.m. that night, I received a call from the unit nurse that this patient was very upset because I promised her she would be awake, and yet I had put her to sleep. I went to the hospital at midnight to explain to the patient that I had honored her request and that she had been wide awake during the procedure but was unable to form memory proteins because the Versed had blocked their formation. To this day, I'm not sure she ever accepted my explanation or forgave me for taking away any memory of the procedure. Memory is a process totally separate from behavior or state of alertness.

Recall, an elderly patient with Alzheimer’s disease is awake, can dress, go to meals, and so on, but is totally incapable of forming memory; the definition of dementia.

### Specific Intent

Another equally important legal consideration is intent. The testifying medical expert is often asked to comment on the effects of alcohol or a related sedative (benzodiazepines, barbiturates, etc.) on one’s ability to act “intentionally” to resist, assault, flee, drive, etc. Regarding the ability to act “intentionally” in a drug-induced demented state, there are variations on the legal manifestation of intent, all of which can be affected by the mental aberrations produced by alcohol or sedative-hypnotic intoxication. Intent refers to a determination to perform a particular act or to act in a particular manner for a specific reason (The Free On-Line Dictionary, West’s Encyclopedia of American Law).

- Inability to form memory is also associated with inability to form conscious intent as legally defined: Intent implies aimful and goal-directed behavior; purposeful behaviors, or acting with purpose. It involves planning

**Table 1. Summary of the Effects of Dementing Drugs**

Can induce a “blackout” or “drug-induced antegrade amnesia”
Can cause a drug-induced “organic brain syndrome” that resembles the memory loss seen in the dementias such as Alzheimer’s Disease
Can cause a loss of short-term memory formation for the duration of drug action (or blood alcohol persisting above about 0.25 grams%)
Can impair the “frontal lobe” which is the seat of executive functioning. Decreased or obstructed executive functioning leads to impaired thought, insight, intelligence, and judgment.

and desire. It involves a determination or resolve to do a certain thing. Intent is the planning and desire to perform an act. Without intact executive functioning, one is incapable of meeting this definition (West’s Encyclopedia of American Law).

## Maximize Your Membership Benefits!

As a member of AALNC, you can increase your legal and medical knowledge, expand your network of contacts, and stay up-to-date on the hottest topics affecting LNCs today!

### Membership in AALNC includes:

- **The Journal of Legal Nurse Consulting** – AALNC’s official journal is published quarterly. Members are also able to access past issues online through the JLNC Archives (within the Members Only section).
- **Professional Liability Insurance** – AALNC officially sponsors Professional Liability Insurance offered through Nurses Service Organization. The insurance offered through NSO has many exclusive benefits and features that enhance your protection as a practicing LNC and offers discounts not available elsewhere!
- **Attorney Awareness** – AALNC has initiated a dedicated marketing campaign to attorneys from all practice specialties. As a member of AALNC, you know that the

professional organization for LNCs is working to raise awareness of the specialized skills an LNC brings to each case.

- **LNCLocator** – When attorneys need an LNC, they turn to AALNC’s public online LNC search engine, the LNCLocator. This tool allows attorneys to quickly and easily search for an LNC by geographic area, nursing specialty, or LNC practice area. Being listed in the LNCLocator is a free membership benefit.
- **VerdictSearch** – AALNC members are entitled to receive 30% off any VerdictSearch print publication, including newsletters, books, binders, and indexes, as well as 30% off the annual subscription price of the VerdictSearch Online Database.



For more information about AALNC membership and its countless member benefits, please visit [www.aalnc.org/membership/](http://www.aalnc.org/membership/).

- It is clear that intent cannot be formed when one is in a demented state of brain functioning, be that based on an organic basis (e.g., Alzheimer’s disease) or effectively drug/alcohol induced. While a person may have acted recklessly, unlawfully, and with apparent intent, such actions did not result from intentional and directed actions or thoughts.

*Author’s note: It is important to note that intent as defined here refers to the plaintiff’s intent. The state of mind of the defendant with regard to intended action (mens rea) is subject to specific legal definition concerning the criminal act and not discussed here.*

## The Alcohol Factor

Alcohol is readily available, permissible at the legal age and often enjoys social acceptance in college, at parties, during celebrations, on dates, and at a myriad of other functions. Unfortunately, alcohol’s pervasive use is anything but benign. Alcohol use is also implicated in the majority of date rape claims.

At a BAC of about 0.25 grams% and higher, formation of memory protein stops, behavior is uninhibited by the alcohol, and a state of anterograde amnesia follows and persists until the BAC, as a result of metabolism, falls below a critical level. In general, blackout occurs at BAC levels ranging from about 0.25-0.30 grams%. Alcohol “blackouts” are generally determined by self-report and by estimation of the blood alcohol concentration at the time of an act (Table 2).

Considering these potentially causative factors above, a woman who was out drinking heavily one evening may awaken the next morning to discover she has had sexual intercourse, becomes angry due to the fact she has no memory of the event, and assumes she must have therefore been “unconscious” and incapable of consent. Even though she cannot recall the event, at the time of the incident she may have appeared to be a very willing partner, even consenting

by words and actions. The latter is wholly supported by the sexual partner who recalls that the woman *was* willing and contributing. Several hours later she visits the emergency room where a rape case workup is performed. Because the alcohol has been continually metabolizing during this several hour delay, the BAC is negative and since no other drugs were consumed a drug screen is likewise negative.

To determine the degree of impairment to address the legal question of ability to consent, the medical expert must go by the patient’s report of the drinking history during the period in question and estimate through calculation a reasonable BAC at the time of the incident. Alternatively, if an amount of alcohol was identified on screening, retrograde extrapolation can be performed by adding an estimated amount of ethanol metabolized from the time of the event until the time the blood sample was drawn (Widmark calculation, see Garriott, 2008). This is often calculated at a fall rate of 0.015 grams% per hour. The important pharmacological point in this matter is whether or not one is capable of “acting,” “performing,” “responding,” “participating,” or “consenting” (by words or actions) in sexual activity during the period when memory is not formed (i.e., during a “blackout”). Here, the answer is most definitely yes. Similar to “conscious sedation” in medical procedures, the patient does not remember the performance of uncomfortable medical procedures (such as a colonoscopy under Versed sedation) but the person is alert, functioning, conversing, and responding to the procedure even though he/she has no memory of the actual event. Indeed, the patient can even appear to be fully awake. Medical providers who have administered sedation have witnessed this occurrence numerous times but the layperson has no similar knowledge or understanding. This situation requires careful presentation to judges and juries. Table 3 provides a list of some amnestic (date rape) drugs.

**Table 2. Estimation of alcohol ingestion to achieve BAC of 0.25 grams % (“blackout threshold”) for women and men**

Women	Men
100 lbs: 6 drink equivalents	120 lbs: 8 drink equivalents
120 lbs: 7 drink equivalents	140 lbs: 9 drink equivalents
140 lbs: 8 drink equivalents	160 lbs: 10 drink equivalents
160 lbs: 9 drink equivalents	180 lbs: 11 drink equivalents
180 lbs: 10 drink equivalents	200 lbs: 12 drink equivalents
200 lbs: 11 drink equivalents	220 lbs: 14 drink equivalents
	240 lbs: 16 drink equivalents

*Reprinted with permission from Julien, R.M. (2008) “A Primer of Drug Action”(11<sup>th</sup> ed.) pg. 102*

In this table, a “drink-equivalent equals one ounce of 40% “hard” alcohol (expressed as “proof” at a concentration of 2:1 - 80 proof = 40% alcohol), three ounces of 12% wine, or one 12-ounce (3.2%) beer. Virtually all beers today have higher alcohol concentrations; from 4.9-6.0%, higher if fortified. Additionally, few bars actually pour a 1-ounce “shot” or serve a 3-ounce pour of wine; it is generally greater. With this in mind, just two Long Island Iced Teas (with a recipe that includes 5 distinct liquors) can render a 120 pound female amnestic if ingested over a short period of time.

*In the table above, subtract one drink equivalent for each hour that has elapsed since the start of drinking.*

**Table 3. Common “Date Rape” Drugs (not an all-inclusive listing)**

<p><b>Alcohol (Ethyl Alcohol, Ethanol).</b> Stand alone, alcohol is the most common date-rape drug. Synergistic effect when added with other drugs.</p>
<p><b>Detection:</b> Concentration/Proof varies by distillation method.</p>
<p><b>All the benzodiazepines. Xanax (Alprazolam)</b> is commonly encountered in these cases.</p>
<p><b>Detection:</b> Pill may be crushed to add to drink or food.</p>
<p><b>Rohypnol (Flunitrazepam).</b> Not legally available in the United States.</p>
<p><b>Detection:</b> Pill form that looks like aspirin. Detection highly unlikely as drug is odorless, tasteless, and colorless. Does not alter appearance of drink when added.</p>
<p><b>Gamma hydroxybutyrate (GHB)</b> and its precursor Gamma Butyrolactone (GBL). Easily manufactured from industrial chemicals by street vendors which makes the exact concentration of the drug unknown.</p>
<p><b>Detection:</b> Associated with a salty or soapy taste, this effect may be masked in flavored drinks or salty drinks. Orange juice is commonly used to mask the taste.</p>
<p><b>Phencyclidine (PCP).</b> A psychoactive drug that causes dissociative effects. Ability to create relative immunity to painful stimuli and manifestations of psychotic behavior. PCP is Schedule II drug in the United States.</p>
<p><b>Detection:</b> Comes in oral form, powder or liquid, may be smoke or inhaled. In pure liquid form it is yellow, but street manufacturing techniques may alter the color range tan to brown and change the consistency to range from a powder to a gummy paste.</p>
<p><b>Ketamine (Ketalar).</b> Ketamine is a derivative of PCP, a drug dispensed in liquid form and either ingested or injected. Sometimes used in anesthesia and commonly used in veterinary clinics.</p>
<p><b>Detection:</b> May be dried to a powder for smoking or inhaling.</p>
<p><b>Scopolamine (from Belladonna or datura stramonium).</b> Small white pill.</p>
<p><b>Detection:</b> Unlikely as drug is odorless, tasteless, and colorless. May be slipped into drinks or crushed and sprinkled onto food.</p>

*The terminology “date-rape” drug is used here for its familiarity in the media. Many names refer to these substances, such as “club” drugs or the recently proposed “sexual assault” drugs. It is also important to consider that any of these drugs may be in combination with other drugs to create a synergistic effect and enhancing their toxicity. The exact onset, peak effect and duration depend on numerous factors. For example, an empty stomach may affect the onset. These factors, along with route taken, must be taken into consideration for all drug evaluations. Helpful resource may be found at <http://www.aafp.org/afp/w004/0601/p2619.html>*

## The Memory-Behavior Disconnect

Right or wrong- if the legal question were one of behavioral activity independent of executive functioning, jury deliberations would likely be brief. For example, in all cases of date rape drug use, one loses the ability to form memory (e.g., is amnesic), yet can be awake and fully participating and positively engaging in the sexual activity. Since the legal issue (depending on statutory language and jurisdiction) may center on the defendant’s ability to have “reasonably known” the *degree* of the (now) plaintiff’s impairment in judgment *despite* the seemingly cooperative behavioral activity, the straightforward finding is not obvious. Unfortunately, victims and police often do not understand this; it is presumed that the victim was incapacitated and unable to participate to the degree the accused should have reasonably known he or she was incapable of giving meaningful consent. Without careful presentation to the Court, the defendant may be convicted without evidence to the contrary. The following case illustrates the point.

A young female was drinking with friends at a bar. She claimed she had no memory of leaving the bar, meeting a male, and having sex in a pickup truck. She claimed she was administered a date-rape drug, *passed out* [emphasis added], was taken from the bar, and raped. Charges were filed and trial was scheduled. Shortly before trial, a video-tape of the parking lot behind the bar was located. It showed her leaving the bar of her own accord, laughing and skipping across the parking lot, standing on the running board of the pickup, getting into the truck, removing her blouse, and the truck leaving. She testified she had no memory of leaving the bar or any events thereafter. By the defendant’s testimony, they had consensual sex. The case was dismissed.

Often times, in allegations of rape, evidence is unfortunately not preserved to either support the victim’s story or exonerate the falsely accused. In the above example, memory loss was dissociated from behavioral activity and this was clearly obvious on surveillance tape. Inability to form memory proteins implies a state of amnesia or drug-induced dementia with loss of executive cortical functioning and this state is differentiated from the discredited behavioral ability witnessed on the tape.

Intent as a legal standard is elusive and defies a common understanding. In deliberations, both judges and juries struggle to dissect the thought processes of the parties where the core question of purposeful action is at issue. However, their duty to deliver justice is exponentially challenged when those cases involve the complexity of issues that arise with the use of substances which call into question the individual’s ability to act with a deliberate will. Not surprisingly this area of law is subject to constant scrutiny, evolving case law, political activism, and triumphs and tragedies of justice for both plaintiffs and defendants. In order to adequately prepare the attorney-client’s case for trial, a solid understanding of the effects and manifestations of date rape drug use is essential.



A working knowledge of the impact of the effects of amnesic drugs as they relate to the ability to engage in intentional activity is also needed. To do less fails ethical representation.

## Textbook Resources for Learning More

- Baselt, R.: "Disposition of Toxic Drugs and Chemicals in Man" (8<sup>th</sup> edition, 2008).  
Garriott, J.C., editor: "Medical-Legal Aspects of Alcohol", (5<sup>th</sup> edition, 2008).  
Julien, R.M. "A Primer of Drug Action", (11th ed., 2008).

## References

- Alberini, C.M. (2008). The role of protein synthesis during the labile phases of memory: Revisiting the skepticism. *Neurobiology of Learning and Memory* 89(3), 234-246.
- Costa-Mattoli, M., Sossin, W.S., Klann, E., and Sonenberg, N. (2009). Translational control of long-lasting synaptic plasticity and memory. *Neuron* 61(1), 10-26.
- Gold, P.E. (2008). Protein synthesis inhibition and memory: Formation vs. amnesia. *Neurobiology of Learning and Memory* 89(3), 201-211.
- Hartzler, B., and Fromme, K. (2003). Fragmentary and en bloc blackouts: Similarity and distinction among episodes of alcohol-induced memory loss. *Journal of Studies on Alcoholism*, 64(4), 547-550.
- Lee, H., Roh, S., and Kim, D.J. (2009). Alcohol-induced blackout. *International Journal of Environmental Research and Public Health*, 6, (2783-2792).
- Lu, Y., Christian, K., and Lu, B. (2008). BDNF: A key regulator for protein synthesis-dependent LTP and long-term memory? *Neurobiology of Learning and Memory* 89(3), 312-323.
- Perry, P.J., Argo, T.R., Barnett, M.J., Liesveld, J.L., Liskow, B., Hernan, J., et al. (2006). The association of alcohol-induced blackouts and grayouts to blood alcohol concentrations. *Journal of Forensic Sciences*, 51(4), 896-899.
- White, A.M., Signer, M.L., Kraus, C.L., and Swartzwelder, H.S. (2004). Experimental aspects of alcohol-induced blackouts among college students. *American Journal of Drug & Alcohol Abuse*, 30(1), 205-224.

**Dr. Robert Julien** received his Ph.D. in Pharmacology from the University of Washington and his Medical Degree from the University of California at Irvine. Previously an Associate Professor of Pharmacology and Anesthesiology at the Oregon Health Sciences University, Dr. Julien practiced anesthesiology in Portland, Oregon until 2006. An acclaimed teacher and author, Dr. Julien recently published the 12th edition of his psychopharmacology textbook, *A Primer of Drug Action* (Worth Publishers, 2011). Now with 36 years of continuous publication, *A Primer of Drug Action* is regarded as the definitive textbook of psychopharmacology, covering both psychotherapeutic agents as well as substances of abuse.

**Kara L. DiCecco MSN RN LNCC** is an Assistant Professor at Wilmington University in Wilmington, Delaware where she teaches in both the nursing and LNC programs. She has 15 years experience both in-house and as an independent LNC. She has authored numerous articles including co-publishing in *Trial* magazine. She is a past editor for the *Journal of Legal Nurse Consulting* and a Distinguished Service Award recipient for AALNC. She can be reached at [kdicecco5@comcast.net](mailto:kdicecco5@comcast.net).

## 2010 JLNC Nursing Contact Hour Program

This article has been selected for inclusion in the 2010 JLNC Nursing Contact Hour Program. To register (new participants): Visit [www.aalnc.org/edupro/journal/CNE/2010.cfm](http://www.aalnc.org/edupro/journal/CNE/2010.cfm) to purchase access to the 2010 JLNC Nursing Contact Hour Program.

Current participants: Login to the AALNC Web site with your member ID and password to access the 2010 JLNC Nursing Contact Hour Program online portal. Once logged in, click on the link to the online portal within the left-menu navigation options. You will then be required to complete a 5-10 question post-test about the information presented in this article. A passing score of 70% is necessary. After successfully completing the post-test, you will be able to print your certificate of completion, indicating contact nursing hours earned. AALNC is an approved provider of continuing nursing education by the Illinois Nurses Association, an accredited approver, by the American Nurses Credentialing Center's (ANCC's) Commission on Accreditation.

This activity is eligible for nursing contact hours. Nursing contact hours offered through an ANCC accredited provider are recognized by the majority of state licensing boards and nursing certification boards.

# Volunteerism and Legal Considerations

Beverly Pruitt, RN LNCC

## KEY WORDS

Medical, Volunteerism, Legalities, and Considerations

---

*Unemployment is high and millions of Americans are without health insurance. Given the need for often unaffordable basic health care, more doctors, nurses, dentists, and visual specialists are needed to provide volunteer services but may be concerned about potential legal pitfalls. Good Samaritan Laws have been enacted by every state and the District of Columbia to encourage volunteer assistance. The Federal Volunteer Protection Act was passed by Congress in 1997 to limit liability. The reality is few organizations and volunteers get sued. Volunteers are to work according to the guidelines of the assisted organizations and are legally responsible for their own conduct based on the standard of care. Georgia offers free clinics and Tennessee has passed laws allowing out of state health care providers to cross state lines and offer free services. Getting involved in lobbying for laws and volunteers is an opportunity particularly suited to LNCs.*

---

## Introduction

It is early morning in the fall. Hundreds of people have spent the cold night in their cars, waiting the chance to see a physician, dentist, or optometrist. More arrive at 4 a.m. to receive a number from soldiers assuring their place in line who are also there to maintain order. Medical volunteers quietly arrive in the early morning darkness to provide care to those who either have no health insurance or cannot afford the services their health policies do not cover. By 6 a.m. a long line has formed. The tents are filled with waiting volunteers as patients enter in numerical order. Portable lights cast just enough illumination so triage forms covering medical histories, consents, and vital signs can be completed.

Does this sound like a scene from a third world country? Sadly, it is not. This is a free medical event provided by Remote Area Medical (RAM) in the fall of 2008 in Unicoi County, Tennessee (Tricities, 2008).

## The Need for Free Medical Care

According to estimates of the Centers for Disease Control and Prevention, in 2006 there were over 43 million Americans were without health insurance (2009). In October 2009, the number of unemployed people nationally was 15.7 million or 10.2 percent, the highest rate since April 1983 (United States Department of Labor, 2009). While unemployment figures vary by state, in April 2010, Michigan had the highest state level of unemployment at 14.1 percent (United States Department of Labor, 2010). The need for health care is underscored by the growing numbers of those now potentially unable to afford payment for their visual, dental, and medical needs.

Nurses have often been seen as immune to the economic impact of job loss (Miller, 2008). Now, however, registered nurses seem to be facing layoffs in numerous settings due to having higher income and benefit packages than other medical personnel; lower paid licensed practical nurses, technicians, or aides are being hired instead. The recent

downturn in the economy that has caused even nurses to lose jobs has increased the number of all unemployed who are without health care. Those fortunate enough to have jobs that provide health insurance benefits may not receive coverage for dental and visual care. Some employees who have health care coverage may now have higher deductibles for even basic services and find that medical bills take a larger portion of their income.

Many of the Baby Boomer generation are also legitimately concerned. Failure to factor in health care costs before retirement can be devastating and Medicare coverage is unavailable until age 65 (Weston, 2010). As a large segment of the population ages, the specter of standing in long lines after taking a number and waiting hours to receive care is as close to reality as the next diagnosis, accident, or crisis that casts one into the ranks of the uninsurable.

## The Need for Medical Volunteers

Given the current need for often unaffordable basic health care, more doctors, nurses, dentists, and visual specialists are needed to volunteer and provide services in order to fill this gap. Many health care personnel have seen the need in their clinical practice. Their patients may include those who cannot afford blood pressure medications or follow-up care, or others who cannot purchase basic dental care for caries prevention.

Those drawn to the health care professions also may be drawn to volunteering. Some health care workers volunteer their skills through community organizations or state and federal agencies while others find opportunities via faith-based organizations. Many health care personnel are aware of potential legal pitfalls of offering free health care; however, basic knowledge and understanding of the legal issues may alleviate concerns of this type.

## Legal Issues Related to Volunteering

One law enacted to encourage volunteer assistance by removing the threat of liability is the Good Samaritan Law.

Every state and the District of Columbia, has enacted some version of this law. Good Samaritan doctrines contain four key elements: (1) the care rendered was performed as the result of an emergency, (2) the emergency was not caused by the person invoking the defense, (3) the emergency care was not given grossly, negligently or recklessly, and (4) aid was given with permission whenever possible (WikiAnswers, 2010). As such, these laws apply in emergency situations (Martin, 2009).

In non-emergency situations, “charitable immunity” is a legal concept that protects charitable organizations from liability in a manner similar to “governmental immunity” (Texas State Board of Pharmacy, 2009, p. 3). For this coverage to be effective, volunteers must decline compensation, defined as anything “other than reimbursement or allowance for expenses actually incurred” (Texas State Board of Pharmacy, 2009, p. 1). As a result, it may be better for licensed health care professionals to be affiliated with a specific volunteer organization because federal and state statutes protect volunteers working for a nonprofit or government entity (Texas State Board of Pharmacy, 2009).

No matter how well intended nonprofit organizations or volunteers are, their actions may inadvertently cause harm to others. Due to a few highly publicized tort actions against

volunteers, organizations were being faced with increasing insurance premiums and decreasing coverage (Martin, 2009). Alarmed by the prospect of losing volunteer services, Congress and many states have passed legislation designed to shield volunteers and their organizations from liability (Martin, 2009).

Because of the patchwork response of the states in limiting liability, Congress in 1997 passed the Federal Volunteer Protection Act. The Act provides that “no volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization. However, immunity is not absolute; if the harm is caused by ‘willful or criminal misconduct, gross negligence, reckless misconduct or a conscious flagrant indifference to the rights or safety of the individual harmed by the volunteer’ a claim may be pursued” (Martin, 2009).

Although nonprofit organizations do not generally compensate volunteers, the volunteers do render services under the direction and control of that organization under the theory of *respondeat superior* (Martin, 2009). This doctrine holds “an employer or principle liable for the employee’s or agent’s wrongful acts committed within the scope of employment or agency” (Barner, 2006, p. 619). The reality



## RNs & Rehabilitation Professionals

# Looking to expand your career?

The Capital University Law School  
**Life Care Planner Program**  
is now available *Online!*

**Expand your career in just 11 credit hours** with this intensive post-baccalaureate certificate program with a unique legal emphasis. (Includes monthly online modules and one onsite module.)

- Be your own boss, explore new career options and earn additional income in this exciting new environment
- Unique online format allows professionals to maintain their busy schedules
- Also available: LCP Advanced Practice Certificate
- Start dates in May and November

Capital University  
1903  
**Law School**

**For More Information Call: 614-236-6885 or E-mail: LCP@law.capital.edu**

is that few nonprofit organizations and volunteers get sued (Martin, 2009).

Insurance claims filed against nonprofit organizations are below average and claims against volunteers are rare (Martin, 2009). Organizations such as the Christian Medical and Dental Association and Physicians Without Borders, as well as other faith-based organizations, have no record of a suit brought against them or their volunteers (Boe, 2009).

Volunteers must work conscientiously and diligently according to the guidelines and protocols set forth by the organizations being assisted (Martin, 2009). In the course of volunteering, individuals are legally responsible for their own conduct. This responsibility is described as the standard of care and is defined in Black's Law Dictionary as providing the degree of care a reasonably prudent person would exercise in a similar circumstance (Barner, 2006). To determine liability risk, appropriate liability insurance policies must be reviewed and clarified by those seeking to volunteer.

## Volunteering in Action

Laws protecting volunteers vary from state to state. In addition to the Good Samaritan statutes, some states have passed statutes that help protect health care volunteers. Georgia and Tennessee offer two examples. There are approximately 100 free clinics operating in Georgia serving the over 1.7 million uninsured (Georgia Free Clinic Network, 2009). In 2005, the Georgia General Assembly passed the Volunteers in Medicine Act (House Bill 166). This statute provides sovereign immunity to providers who volunteer in free clinics and participate in the Georgia Volunteers in Health Care Program. Approximately half of these clinics participate in this program, which requires significant oversight and regulation, including an extensive application and background check for all volunteer applicants (D. Looper, personal communication, February 25, 2009).

In 1995, Tennessee amended their Annotated Code, Title 63, Chapter 6, to enact the Volunteer Health Care Services Act (Michie's Legal Resources, 2009). This legislation has allowed licensed health care providers from multiple disciplines to cross state lines into Tennessee and offer their services free. Tennessee is the only state that allows such an opportunity for volunteers. A Knoxville-based group known as Remote Area Medical (RAM) has put this statute to good use to provide free medical, dental, and visual care for some of the poorest residents of the Appalachian Mountain Region. A federal mandate allowing health care volunteers to cross state lines could be beneficial in the event of a national disaster. It should be less difficult for health care volunteers to give care in neighboring states than it is to travel around the globe to do the same (S. Brock/RAM, personal communication, February 25, 2009). This kind of legal support can help practitioners feel safer volunteering their skills to the public. Nurses, especially legal nurse consultants (LNCs), could help by getting involved in lobbying for volunteer protection laws in their states.

## Conclusion: The Time is Right

Although health care debate has raged across the United States and the Patient Protection and Affordable Care Act was signed into law on March 30, 2010, it will take some time to determine how these changes will impact the U.S. health care delivery system.

In an April 2010 RAM expedition to Los Angeles, California, 6,619 patients were served ("Free Mobile" 2010). There were 3,302 vision and 4,430 dental visits among the services provided ("Free Mobile" 2010).

In the Unicoi Tennessee experience with RAM, this author encountered an elderly patient with hypertension and two bypass surgeries. Her recent concern was lack of money to buy blood pressure pills. Another participant was interviewed whose hospital bills alone exceeded \$300,000 after treatment for lung cancer. She came for dental care because chemotherapy had taken its toll on her teeth and all were removed. Another client stood in line for hours, waiting for the eye exam and glasses she could otherwise no longer afford. Her spouse had a stroke and bypass surgery three years previous, and his condition required her to quit work to care for him even though she carried health insurance for them both. She was sad but thankful saying, "I can handle being without anything else. At least I've got him. He's always been my best friend."

If ever there was a time for volunteerism in nursing and other health-related fields, it is now. The overall exposure for liability associated with volunteer activity is low (Martin, 2009). Due to the current economic conditions, tremendous needs exist as close as the inner city and our own backyard. Volunteering can provide the opportunity for clinically qualified LNCs to maintain skills without having to make a commitment to a full-time job. LNCs have a unique perspective about health care needs in their community and know many of the legal ramifications involved.

Those in need of free health care resources can be informed of what is available. LNCs can help inform and reassure others regarding legal issues of volunteering. Getting involved in lobbying for protective laws for health care organizations and volunteers is an opportunity that seems particularly suited to LNCs.

Mark Twain once said, "People don't care how much you know until they know how much you care." Ask yourself, do you really care? If so, the opportunities to make a difference as a health care volunteer are abundant.

## References

- The Associated Press, Fox-Atlanta, (2009). *GA Jobless Rate Climbs to 9.3%*. Retrieved March 20, 2009 from [http://www.myfoxatlanta.com/dpp/news/GA\\_Jobless\\_Rate\\_Climbs](http://www.myfoxatlanta.com/dpp/news/GA_Jobless_Rate_Climbs)
- Centers for Disease Control and Prevention (2009). *Uninsured Americans: Newly Released Health Insurance Statistics* (On-line). Available: <http://www.cdc.gov/Features/Uninsured>
- Barner, B. A. (2006). *Black's Law Dictionary*, (3<sup>rd</sup> Pocket ed.). St. Paul, MN: West Publishing Co.

- Boe, R. (2009). Global Ministries. *Malpractice issues for health care volunteer* (On-line). Available: <http://new.gbgm-umc.org/> [Search *Malpractice issues for health care volunteers and link to 1.*]
- Free mobile health clinic returns (2010). *Los Angeles Times*. Available: <http://www.latimes.com/news/health/la-free-clinic/>
- Georgia Department of Labor. (2009). Available: <http://www.dol.state.ga.us/>
- Georgia Free Clinic Network (2009). *Uniting for a healthy Georgia. Facts*. Available: <http://www.gfcn.org/facts.php>
- Georgia General Assembly (2005). *Volunteers in medicine act*. Available: [http://www.legis.state.ga.us/legis/2005\\_06/fulltext/hb166.htm](http://www.legis.state.ga.us/legis/2005_06/fulltext/hb166.htm)
- Martin, R., (2009). Volunteer liability. The overall exposure for liability associated with volunteer activity is low but taking some practical precautions helps reduce the risk. *ADVANCE for Nurses*. Retrieved February 2, 2009 from <http://nursing.advancweb.com/Editorial/Content/editorial.aspx?CC=9447>
- Medi-Smart (2009). Nursing education resources. Nursing legal issues. Good samaritan statute. Available: <http://www.medi-smart.com/gslaw.htm>
- Michie's Legal Resources (2009). Tennessee Code. Title 63 Professions of the Healing Arts. Chapter 6-Medicine and Surgery. Part 7-Volunteer Health Care Services. Retrieved May 5, 2009 from <http://www.michie.com/tennessee/lpext.dll?f=templates&fn=tools-contents.htm&cp=tncode>
- Miller, J. A. (2008, December 7). MONITORING ATLANTA'S HEALTH: THE HEALTH CARE INDUSTRY: No vaccination for recession. *The Atlanta Journal Constitution*. Atlanta, GA. Retrieved February 5, 2009, from [www.ajc.com/services/content/printedition/2008/12/07/healthsect.html](http://www.ajc.com/services/content/printedition/2008/12/07/healthsect.html)
- Tricities.com (2008). R. A. M. Clinic helps more than 600 residents in need of healthcare in Unicoi County/Tricities Available: [http://www2.tricities.com/tri/news/local/medical/article/ram\\_clinic\\_helps\\_more\\_than\\_600\\_residents\\_in\\_need\\_of\\_healthcare\\_in\\_unicoi\\_co/14203/](http://www2.tricities.com/tri/news/local/medical/article/ram_clinic_helps_more_than_600_residents_in_need_of_healthcare_in_unicoi_co/14203/)
- Texas State Board of Pharmacy (2009). Texas disaster volunteer registry. Frequently asked questions. Available: [http://www.tsbp.state.tx.us/disaster\\_volunteer.htm](http://www.tsbp.state.tx.us/disaster_volunteer.htm)
- U. S. Department of Labor (2009). Available: <http://www.bls.gov/news.release/pdf/empst.pdf>
- U. S. Department of Labor. Bureau of Labor Statistics (2010). Available: <http://www.bls.gov/web/laus/laustrk.htm>
- Weston, L. P. (2010). 7 Pitfalls retiring baby boomers must avoid. Available: <http://articles.moneycentral.msn.com/RetirementandWills/PlayingCatchUp/7pitfallsRetiringBabyBoomersMustAvoid.aspx>
- WikiAnswers. (2010). How many states have the Good Samaritan Law? Available: [http://wiki.answers.com/Q/How\\_many\\_states\\_have\\_the\\_Good\\_Samaritan\\_law](http://wiki.answers.com/Q/How_many_states_have_the_Good_Samaritan_law)

## 2010 JLNC Nursing Contact Hour Program

This article has been selected for inclusion in the 2010 JLNC Nursing Contact Hour Program. To register (new participants): Visit [www.aalnc.org/edupro/journal/CNE/2010.cfm](http://www.aalnc.org/edupro/journal/CNE/2010.cfm) to purchase access to the 2010 JLNC Nursing Contact Hour Program.

Current participants: Login to the AALNC Web site with your member ID and password to access the 2010 JLNC Nursing Contact Hour Program online portal. Once logged in, click on the link to the online portal within the left-menu navigation options. You will then be required to complete a 5–10 question post-test about the information presented in this article. A passing score of 70% is necessary. After successfully completing the post-test, you will be able to print your certificate of completion, indicating contact nursing hours earned. AALNC is an approved provider of continuing nursing education by the Illinois Nurses Association, an accredited approver, by the American Nurses Credentialing Center's (ANCC's) Commission on Accreditation.

This activity is eligible for nursing contact hours. Nursing contact hours offered through an ANCC accredited provider are recognized by the majority of state licensing boards and nursing certification boards.

**Beverly Pruitt, RN LNCC** has more than 26 years of experience as a registered nurse. She co-founded Medical Review & Research Associates, Inc. with her husband in 1997. Beverly was the President of the Atlanta Chapter of the AALNC in 2001 and served on the board for five years. She co-presented "Introduction to Legal Nurse Consulting" at the national conference in Atlanta, GA in 2006. She has experiences in med-surg, the OR, urology and oncology. Currently, she serves as a pre and post op nurse in a free-standing surgery center. Her consulting practice includes attorneys and medical examiners in the Southeast. She volunteers with Remote Area Medical ([www.ramusa.org](http://www.ramusa.org)) and can be reached at [No1MRRA@gmail.com](mailto:No1MRRA@gmail.com).

## Repetitive Strain Injury (RSI)

Kara DiCecco, MSN RN LNCC

---

*Repetitive Strain Injury (RSI) encompasses a constellation of disorders that are prevalent throughout the home-based business as much as in the white and blue collar industries. Its manifestations range from the “last call” of mild symptoms to the end range of irreversible damage. The epidemic of RSI has found a public forum among the pages of PC World, Time, Smithsonian, and Forbes (Furger, 1993; Horowitz, 1994; Wolkomir, 1994; Reeves, 2005). It has been researched in the Oxford Journals as well as The Lancet (Pritchard, Pugh, Wright & Brownlee, 1999; van Tulder, Malmivaara & Koes, 2007). Its notoriety is active among student groups at Carnegie Mellon, MIT, Harvard, and Cornell. RSI targets children as well as adults. It has found a place among both the recreational and work milieux. This issue’s Clinical Maxim examines RSI and its far reaching implications.*

---

**Repetitive Strain Injuries:** The exact pathophysiology of the individual injury will be unique to the repetitive force applied but it is the repetitive force that creates a prolonged wear and tear leading to microscopic tears and/or damage to the affected body part.

**Pseudonyms** include Musculoskeletal Disorders (MSDs), Cumulative Trauma Disorder (CTD), Occupational Overuse Syndrome (OOS), Repetitive Motion Injuries (RMI), Repetitive Stress/Strain Injury (RSI), Multiple Strain Injuries (MSI), Upper Limb Disorder (ULD), Repetitive Strain Syndrome (RSS), Regional Musculoskeletal Disorder (RMD).

**Tendinitis** is the inflammation of the tendon usually at the tendon insertion into the bone. Common sites of inflammation are the shoulder, biceps, and elbow. Alternate causation: direct trauma, thermal injury, antibiotic use (levofloxacin and ciprofloxacin), smoking, rheumatoid arthritis, obesity, and diabetes (Driver, 2010).

**Tenosynovitis** is inflammation of the inner lining of the tendon sheath that houses the tendons. Common sites of tenosynovitis are the hand, wrist, and forearm.

**Bursitis** is inflammation of the bursa sac. Bursae are found over areas of friction where these small sacs provide cushion and lubrication. Common sites of bursitis are the knee, hip, and elbow. Traumatic bursitis is associated with repetitive strain injury. Alternate causation: Gout, infectious disease, rheumatic condition (Bursitis, 2008).

**Rotator cuff syndrome** is inflammation of muscles and tendons in the shoulder. Tears in the rotator cuff may also occur, distinctive symptoms differentiate between chronic and acute tear. It is associated with occupations with repetitive overhead reaching (painters, basketball players, baseball pitchers, swimmers, tennis players). Immobilizing the shoulder due to pain for 24-48 hours may lead to frozen shoulder (adhesive capsulitis) and prolonged immobility. Alternate causation: Forceful fall on shoulder, sudden, forceful resistance to shoulder (as in outstretched arm breaking fall), and heaving lifting (McNamara, 2008).

**Thoracic outlet syndrome** is compression of the nerves or blood vessels that run between the base of the neck and the armpit. It is associated with forward posture, muscle weakness or tightness causing the scalene muscles to be pinched. Alternate causation: Extra rib, fractured collarbone, excessive neck musculature (as in weight lifters), and posture anomalies (Danamy & Bellis, 2000).

**Carpal Tunnel Syndrome** is pressure on the median nerve passing through the wrist. There is sensation disturbance in the thumb, index, middle, and half of the ring finger. (See Figure 1). Alternate causation: Rheumatoid arthritis, hormonal disorders (menopause, thyroid disorders, diabetes), fluid retention from pregnancy, deposits of amyloid [abnormal protein] (Carpal Tunnel Syndrome, 2009).

**Guyon’s Canal Syndrome** is pressure on the ulnar nerve passing through the wrist. When accompanied with carpal tunnel syndrome, it is known as double-crush syndrome. Disturbance of sensation in the “pinkie” and lateral half of the ring finger (Pascarelli & Quilter, 1994) can occur.

**Ganglion cyst** is a sac of fluid that forms around a joint or tendon, usually on the wrist or fingers. It is caused by a herniation of the synovial fluid and may be painless but cosmetically unpleasant. If source of irritation is arrested it may disappear without intervention (Pascarelli & Quilter, 1994).

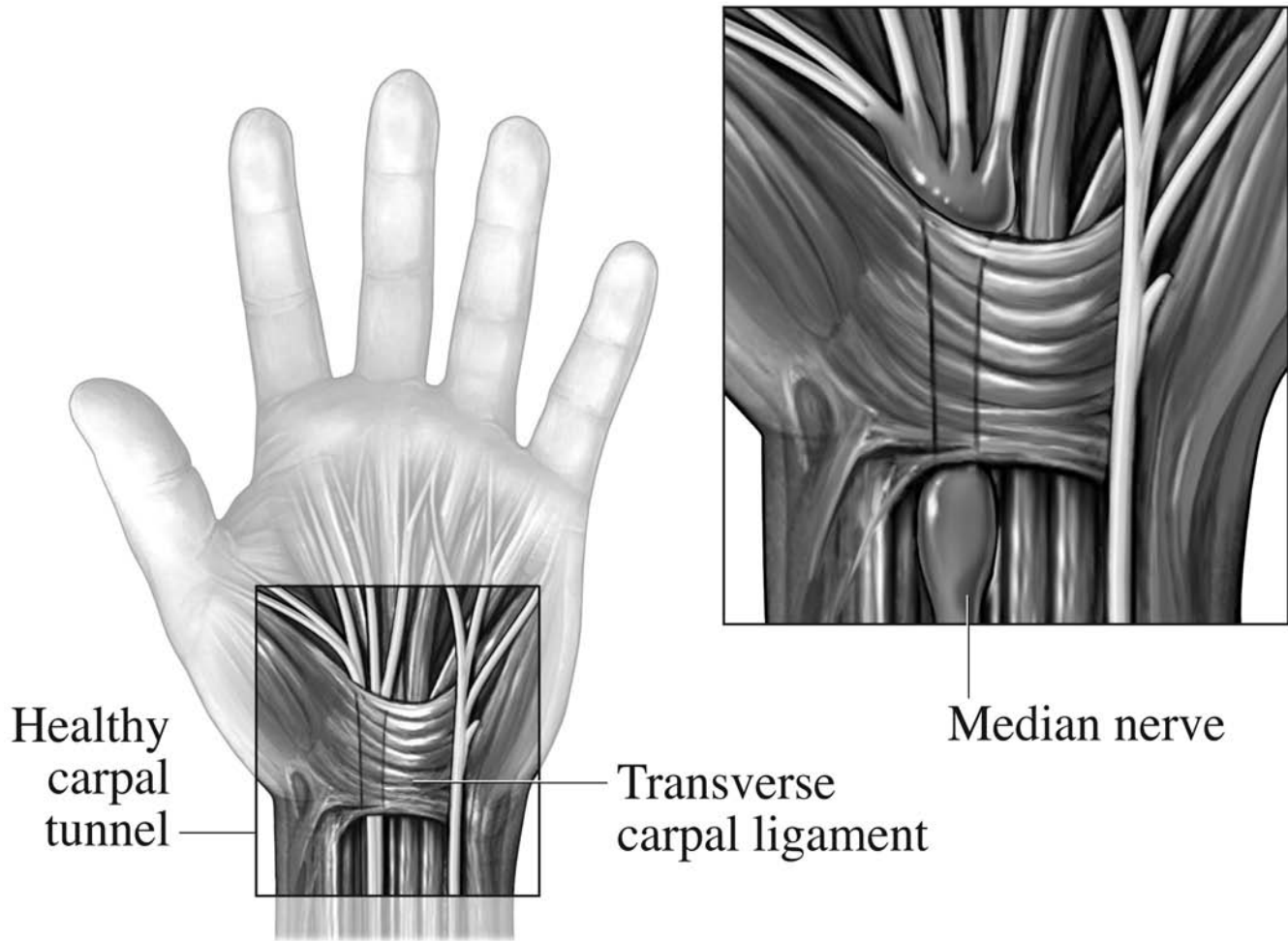
**De Quervain’s tenosynovitis** is an inflammation of the tendons in the wrist (at the side and the base of the thumb). Alternate causation: Pregnancy, breastfeeding, rheumatoid arthritis (De Quervain’s Tendonitis, 2007).

**Cubital Tunnel Syndrome** is ulnar nerve entrapment at the elbow. Nerve distribution causing symptoms in “pinkie” finger and lateral half of ring finger can occur.

**Radial Tunnel Syndrome** causes pressure to the radial nerve and usually causes pain at both sides of the forearm or at the outside of the elbow with supination and twisting reproduce pain (Pascarelli & Quilter, 1994).

**Tarsal Tunnel Syndrome** is entrapment of the tibial nerve at the foot and ankle.

Figure 1: Carpal Tunnel Healthy and Inflamed



Medical Legal Art

© 2010. MEDICAL LEGAL ART. ALL RIGHTS RESERVED. 1.800.338.9964

**Epicondylitis** is inflammation of an area where bone and tendon join. Tennis elbow is an example of lateral epicondylitis. Golfer's elbow is an example of medial epicondylitis.

**Dupuytren's contracture** is a thickening of deep tissue in the palm of the hand and into the fingers. Nodules on the fascia cause a contracture of the finger. It is associated with vibrating tools and may be associated with similar thickening in fascia of foot, known as plantar fasciitis. Alternate causation: Alcoholism, chronic disease, seizure disorders [epilepsy], heredity (Dupuytren's Contracture, 2007).

**Trigger finger inflammation** of the tendon sheaths of fingers or thumb accompanied by swelling of the tendon. Alternate causation: Diabetes mellitus, rheumatoid arthritis, gout, or may be idiopathic (Arthritis and Trigger Finger, 2010).

**Raynaud's Phenomenon** is a condition where the blood supply to extremities, such as the fingers, is interrupted, causing cold, pale fingers as well as pain sensitivity, numbness, and tingling. A bluish tinge then redness may follow the pale discoloration. It is associated with occupations using

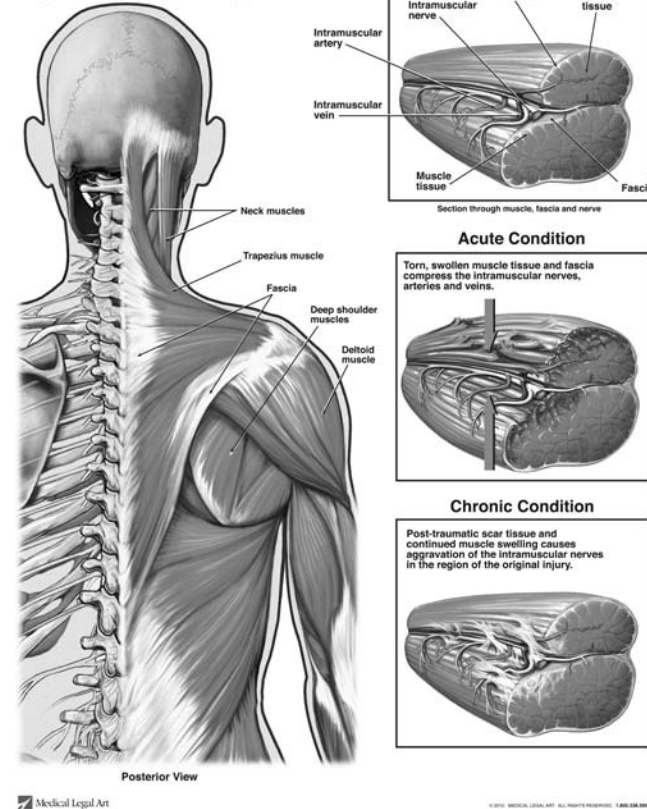
vibrating hand tools. Alternate causation: Any factor causing vasoconstriction of the blood vessels such as smoking, medications (beta-blockers, clonidine, ergotamines, estrogens, chemotherapy), rheumatoid arthritis, lupus, thoracic outlet syndrome, chemical exposure (vinyl chloride), thyroid gland disorder, carpal tunnel syndrome, scleroderma, Sjogren's Syndrome, disease of the arteries [atherosclerosis, Buerger's, primary pulmonary hypertension] (Raynaud's Disease, 2009).

**Focal Dystonia (Writer's Cramp)** is muscle spasms in the affected part of the body. Writer's cramp occurs from overuse of the hands and arms (Peddie & Rosenberg, 1998).

**Asthenopia (Eye Strain)** a.k.a. Computer Vision Syndrome (CVS) causes symptoms of fatigue, red eyes, dry eyes, neck and back pain, headache, blurring vision, eye pain, double vision, light sensitivity, and squinting. Alternate causation: Diabetes, rheumatoid arthritis, and migraines. Sjogren's Syndrome may be partially contributory to symptom constellation. Presbyopia should be ruled out as cause of eye strain (Bedinghaus, 2007).

**Figure 2: Myofascial Sprain/Strain**

Myofascial injuries commonly occur in cases of whiplash and sudden trauma. Muscle sprain or strain is the usual cause of acute (immediate) and chronic (long-term) pain associated with these injuries.



(TENS), braces/splints, nonsteroidal anti-inflammatory drugs (NSAIDS), cortisone injections (usually no more than 3 in 12 months), physical therapy, ultrasound therapy, stretching exercise, chiropractic therapy, osteopathy, and topical or oral analgesics. Complementary therapies include acupuncture, Vitamin B6 therapy, specific massage techniques, Tai Chi, yoga, muscle balancing, Kinesiology, Taubman Techniques, John Sarno's mind/body approach, and the Alexander Technique/Feldenkrais Method (Harvard RSI Action, n.d.). In severe injury refractory to conservative measures, surgical decompression or repair may be indicated.

From an ergonomic standpoint, correct hand positioning while typing on a computer key board (See Figure 3), correct height and distance for your computer equipment, and good posture in an ergonomically designed chair are key preventative measures. See additional resources for ergonomic design in References and Resources.

## Diagnostics

History and physical is needed to put the injury in context, determine degree of limitation, and identify areas of alternate causation.

Magnetic Resonance Imaging (MRI) is used to visualize tears, ruptures, or inflammation.

X-ray is done to determine arthritic changes. Arthrography is done to inject dye into joint structures for better visualization.

Electromyography (EMG) is done to determine nerve damage.

Potentially fluid aspiration (tap) of inflamed joints is performed to determine if underlying infectious process.

## Some presenting symptoms of RSI include (this list is not all-inclusive):

- Stiffness or pain in neck, shoulders, or back (See Figure 2.)
- Muscles spasms, known as neural tension
- Tiredness, numbness, tingling or pain in arms, wrists, hands, or fingers
- Clumsiness or loss of strength and coordination in hands
- Pain that is more pronounced at night and wakes you up at night
- Feeling a need to massage hands, wrists, and arms
- Burning or deep aching sensation in the affected limb
- Crepitus, limited range of motion secondary to pain
- Redness, warmth, and swelling of the affected area
- Cramping
- Sharp pain
- Eye strain/Vision Loss

## Treatment

Conservative measures include rest, thermal therapies, contrast baths, transcutaneous electrical stimulation

## Standards and Law

<http://www.osha.gov/workers.html> (enter ergonomics in search box, then choose regulations from top toolbar)

Department of Labor, OSHA guidelines for ergonomic consideration in shipyards, poultry processing plants, retail grocery stores, and nursing homes.

### American with Disabilities Act

U.S. Code Title 42, Chapter 46, §12101

Reasonable accommodations §12112(b)(5)(A)

<http://ansi.org/>

The American National Standards Institute website. Searchable database (enter ergonomics) of occupational specific standards.

<http://www.hfes.org/Publications/ProductDetail.aspx?ProductID=69>

Human Factors and Ergonomics Society published standards for ANSI/HFES 100-20007. Human Factors Engineering of Computer Workstations. Downloadable table of contents freely accessible on website.



Figure 3: Ergonomic Handpositions at Keyboard (Carpal Tunnel)

### Incorrect position



Medical Legal Art

### Correct position



© 2010 MEDICAL LEGAL ART. ALL RIGHTS RESERVED. 1.800.338.9954

[http://www.iso.org/iso/about/about/iso\\_members/iso\\_technical\\_committee.html?commid=53348](http://www.iso.org/iso/about/about/iso_members/iso_technical_committee.html?commid=53348)

International Organization for Standardization is the global community for workplace standards.

See also state specific workers' compensation, labor, and employment laws.

### Case Law

*Toyota Motor Mfg., KY., Inc. v. Williams* (00-1089) 534 U.S. 184 (2002) 224 F.3d 840, reversed and remanded. Justice O'Connor's decision that the Court of Appeals award of partial summary judgment to the petitioner on the manual task issue was improper.

<http://www.law.cornell.edu/supct/html/00-1089.ZO.html>

*Liveringhouse v. Worker's Compensation Appeal Board (ADECCO)*, No. 1639 C.D. 2008.

Pennsylvania worker's compensation case ruling on appeal finding carpal tunnel is compensable as cumulative trauma or repetitive stress injury.

[http://www.pacourts.us/OpPosting/Cwealth/out/1639CD08\\_3-19-09.pdf](http://www.pacourts.us/OpPosting/Cwealth/out/1639CD08_3-19-09.pdf)

*Lee Franklin Grace v. Kehe Food Distributors, Inc.*, No. E2005-0064-WC-R3-CV

Supreme Court of Tennessee Special Workers' Compensation Appeals Panel ruling affirming trial court's award of compensation benefits based on cumulative trauma to left knee. Appealed on basis of failure of employee to give employer timely notice of work-related injury. Illustrates the inherent difficulty of relating repetitive stress injuries in the occupational setting.

<http://www.docstoc.com/docs/34882027/LEE-FRANKLIN-GRACE-v-KEHE-FOOD-DISTRIBUTORS-INC>

### Articles and Publications

1996 article in *The Tech* (MIT's online newspaper) by contributing editor Thomas R. Karlo regarding endemic repetitive strain injuries at MIT available at <http://tech.mit.edu/V116/N24/rsi.24n.html>

Musculoskeletal Disorders and Workplace Factors: A Critical Review of Epidemiologic Evidence for Work-Related Musculoskeletal Disorders of the Neck, Upper Extremity, and Low Back available at <http://www.cdc.gov/niosh/docs/97-141/>

Worker Health Chart 2004. Contains descriptive epidemiology research on worker morbidity and mortality in the United States available at <http://www.cdc.gov/niosh/docs/2004-146/>

Paddock, C. (2009). Computer injuries rising in U.S., especially involving young children. *Medical News Today*. Available at <http://www.medicalnewstoday.com/articles/153383.php>

van Tulder, M., Malmivaara, A. & Koes, B. (2007). Repetitive Strain Injury, *The Lancet*, 369(9575), pp. 1815 – 1822. doi:10.1016/S0140-6736(07)60820-4

Abstract regarding the definition, symptomatology, diagnostic limitations, and treatment options of RSI. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)60820-4/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)60820-4/abstract)

Pritchard, M. H., Pugh, N., Wright, I. & Brownlee, M. (1999). A vascular basis for repetitive strain injury. *British Society for Rheumatology*, 38, pp. 636-639.

Full text available at <http://rheumatology.oxfordjournals.org/content/38/7/636.full.pdf>

Yi-chao, Z. (2004). Treatment of repetitive strain injury with acupuncture combined with behavior medicine therapy, *Journal of Acupuncture and Tuina Science*, 2(4), pp.44-47  
Abstract available at <http://www.springerlink.com/content/u414x73256w63643/>

## Legal Considerations

- Potential for failure of employee to timely report occupational injury due to cumulative effect and delayed onset in severity of symptoms
- Risk of subsequent and compensatory injuries as worker attempts to compensate for affected extremity by using other extremity to perform repetitive tasks
- Misdiagnosis and alternate causation issues (such as degenerative changes, underlying pathologic process) as symptoms may present confounding or atypical pattern
- Some high risk occupations are computer work, assembly line, manual labor, dentistry, musicians, athletes, cashiers, baggers, and migrant farm workers.
- Damages dependent on degree of impairment
- Potential for psychological claim based on chronic impairment
- Potential for economic claim as the result of limited employability or loss of job

## Potential Experts

- Internal medicine or family practice as treating primary physician and source of referral
- Orthopedic Surgeon (Sports Medicine)
- Neurosurgeon
- Neurologist
- Rheumatologist
- Psychiatrist
- Physical therapist and/or muscle physiologist
- Pain Management Specialist (may include Acupuncturist)

- Psychologist/Psychiatrist
- Ergonomist
- Occupational Health Specialist
- Vocational Rehabilitation Specialist

## References

- Arthritis and Trigger Finger (2010). Retrieved October 9, 2010 from <http://www.webmd.com/osteoarthritis/guide/trigger-finger>
- Bedinghaus, T. (2007). Computer vision syndrome. Retrieved October 9, 2010 from [http://vision.about.com/od/sportsvision/a/Computer\\_Vision.htm](http://vision.about.com/od/sportsvision/a/Computer_Vision.htm)
- Bursitis (2007). Retrieved October 9, 2010 from <http://www.medicinenet.com/bursitis/article.htm>
- Carpal Tunnel Syndrome (2009). Retrieved October 9, 2010 from <http://www.mayoclinic.com/health/carpal-tunnel-syndrome/DS00326/DSECTION=causes>
- Damany, S. & Bellis, J. (2000). It's not carpal tunnel syndrome: RSI theory and therapy for computer professionals, Philadelphia, PA: Simax
- De Quervain's Tendonitis (2007). Retrieved October 9, 2010 from <http://orthoinfo.aaos.org/topic.cfm?topic=a00007#Causes>
- Driver, C. (2010). Tendinitis. eMedicineHealth. Retrieved October 9, 2010 from [http://www.emedicinehealth.com/tendinitis/article\\_em.htm](http://www.emedicinehealth.com/tendinitis/article_em.htm)
- Dupuytren's Contracture (2007). Retrieved October 9, 2010 from [http://www.medicinenet.com/dupuytren\\_contracture/](http://www.medicinenet.com/dupuytren_contracture/)
- Furger, R. (1993). Danger at your fingertips. *PC World*, May, p. 118.
- Haraldson, S. J. & Blasko, B. (2005) Repetitive motion injuries. eMedicineHealth. Retrieved October 9, 2010 from [http://www.emedicinehealth.com/repetitive\\_motion\\_injuries/article\\_em.htm](http://www.emedicinehealth.com/repetitive_motion_injuries/article_em.htm)
- Harvard RSI Action (n.d.). Retrieved October 9, 2010 from <http://www.rsi.deas.harvard.edu/printable.html>
- Horowitz, J. (1994). How you can avoid repetitive strain injury. Retrieved October 9, 2010 from <http://www.time.com/time/magazine/article/0,9171,981664,00.html>
- McNamara, R. (2008). Rotator cuff injury. eMedicineHealth. Retrieved October 9, 2010 from [http://www.emedicinehealth.com/rotator\\_cuff\\_injury/page12\\_em.htm](http://www.emedicinehealth.com/rotator_cuff_injury/page12_em.htm)
- Pascarelli, E. & Quilter, D. (1994). Repetitive strain injury: A computer user's guide, New York, NY: John Wiley & Sons.
- Peddie, S. & Rosenberg, C. H. (1998). The repetitive strain injury book. Lincolnwood, IL: Lowell House
- Raynaud's Disease (2009). Retrieved October 9, 2010 from <http://www.mayoclinic.com/health/raynauds-disease/DS00433/DSECTION=causes>
- Reeves, S. (2005) Avoiding repetitive strain injury, *Forbes*. Retrieved October 9, 2010 from [http://www.forbes.com/2005/08/18/career-work-rsi-cx\\_sr\\_0818bizbasics.html](http://www.forbes.com/2005/08/18/career-work-rsi-cx_sr_0818bizbasics.html)
- Wolkomir, R. (1994). When the work you do ends up costing you and arm and a leg. *Smithsonian*, 25(3), pp. 90-98.

**Kara L. DiCocco MSN RN LNCC** is an Assistant Professor at Wilmington University in Wilmington, Delaware where she teaches in both the nursing and LNC programs. She has 15 years experience both in-house and as an independent LNC. She has authored numerous articles including co-publishing in *Trial* magazine. She is a past editor for the *Journal of Legal Nurse Consulting* and a Distinguished Service Award recipient for AALNC. She can be reached at [kdicecco5@comcast.net](mailto:kdicecco5@comcast.net).



is pleased to support

AALNC

AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

*Since 1984, ReMed has provided rehabilitation and long term supported living for people with acquired brain injury. ReMed provides residential, outpatient and community and home-based programs in the Philadelphia and Pittsburgh areas.*

*ReMed has specialty programs to address the needs of individuals with neurobehavioral issues, dual diagnosis (brain injury and substance abuse) and chronic pain.*

For more information please visit our web site at [www.remed.com](http://www.remed.com) or call us at 1-800-84ReMed/484-595-9300.

*Supporting Even  
the Longest Journey®*

## Repetitive Strain Injury (RSI)

Kara DiCecco, MSN RN LNCC

---

*Here you will find related information and resources to the topic of Repetitive Strain Injury (RSI). This list is not exhaustive and this is not an endorsement of any commercial sites. As with any online resource, the reader must independently confirm its authority and credibility.*

---

### Glossary of Terms Common to RSI

#### RSI Terminology and Definitions

<http://ehs.virginia.edu/ehs/ehs.ergo/ergo.definitions.html>

Excellent glossary from the University of Virginia.

#### Typing Injury FAQ

<http://www.tifaq.org/articles/repetitive-strain-injury-glossary.html>

Information regarding ergonomic design standards, ergonomic training, and adaptive devices. Glossary credited to Kevin Byrne, MD - CorpMed, LLC; for use of glossary terms from Ergo Health training software, <http://www.corpmed.com>.

#### University Based Advocacy Groups for RSI

<http://www.rsi.deas.harvard.edu/index.html>

Harvard RSI Action is a student website. Promoted as “providing education and support for people with repetitive strain injury.”

<http://ehs.virginia.edu/ehs/ehs.ergo/ergo.msi.html>

Here you will find excellent information on the prevention of RSI and the adaptive/ergonomic design considerations to be implemented for worker safety.

<http://web.mit.edu/atic/www/rsi/index.html>

Massachusetts Institute of Technology (MIT) in Boston brings forth a multitude of accessibility resources to prevent RSI and increase student, faculty, and public awareness.

<http://www.ohsu.edu/croetweb/links.cfm?subtopicID=95>

From the Center for Occupational Research and Environmental Toxicology at Oregon Health & Science University: resources for head to toe RSI. Includes an extensive list of occupational settings and safety concerns at <http://www.ohsu.edu/croetweb/index.cfm>

<http://ergo.human.cornell.edu/default.htm>

Cornell University Ergonomics Web (CU Ergo) website is the work product of the students and faculty at Cornell Human Factors and Ergonomic Research Group (CHFERG) under the direction of Professor Alan Hedge in the Department of Design and Environmental Analysis at Cornell University. The cleverly named “Ergotecture” is the focus of this phenomenally extensive resource.

<http://eeshop.unl.edu/rsi.html>

RSI pages From the Department of Electrical Engineering at the University of Nebraska, Electrical Engineering Shop. The opening page is the Computer Related Repetitive Strain Injury webpage. Provides tutorial on the origin and dynamics of upper limb RSI. Offers practical suggestions and an extensive reading list.

### Ergonomic Design

<http://www.ergonomic-resources.com/>

Listing of ergonomic postures and links to various products, including a free white noise generator to eliminate noise distractions at <http://www.speechprivacysystems.com/white-noise/>

<http://www.ergonomictimes.com/>

Commercial website providing extensive list of adaptive design tools and equipment for the workplace.

[http://www.easydse.com/risk\\_assessment.htm](http://www.easydse.com/risk_assessment.htm)

Commercial site offering free workstation analysis via interactive feedback. Homepage of the Easy Display Screen Equipment (easyDSE).

### Employer Sponsored Initiatives

<http://www.safety.duke.edu/Ergonomics/>

Occupational & Environmental Safety Office at Duke University defines ergonomics as “the science of matching workers to jobs to produce users.” The goal is to make the job easier, safer, and more efficient.

<http://www.ehs.uci.edu/programs/safety/ergo.html>

The University of California, Irvine (UC Irvine) Ergonomics Program promotes its mission to prevent pain and suffering as well as costs to the University associated with RSI.

<http://www.cmu.edu/rsi/WhatIsRSI.htm>

This web address takes you to the Carnegie Mellon RSI website. As an institution, Carnegie Mellon has a dedicated task force for RSI identification and prevention. Site contains employee brochures, patient education materials, and reference links.

<http://www.soundergonomics.com/pdf/WRMSDweb.pdf>

Although a 2003 publication, this pdf provides industry standards to prevent work-related musculoskeletal disorders in the field of Sonography (ultrasound).

---

<http://www.safety.appstate.edu/ergonomics>

Appalachian State University, Health and Safety. Sound and practical advice for setting up computer workstation under resources. Includes link to brief, interactive tutorial from <http://www.healthycomputing.com/office/setup/flash-all.html>

[http://www.umdnj.edu/eohssweb/publications/ergo\\_self\\_assessment.pdf](http://www.umdnj.edu/eohssweb/publications/ergo_self_assessment.pdf)

A handy self-analysis guide for evaluating the computer workstation from the University of Medicine and Dentistry of New Jersey.

[http://www.umdnj.edu/eohssweb/publications/computer\\_ergo\\_guide.pdf](http://www.umdnj.edu/eohssweb/publications/computer_ergo_guide.pdf)

<http://www.oerc.org/>

Office Ergonomics Research Committee homepage is found at this web address. Site is promoted as the cumulative effort of US companies to better understand the relation of musculoskeletal disorders (MSDs) and office technology. Apple, Dell, Microsoft, and Remedy Interactive are among the membership.

## Governmental Resources

[http://www.osha.gov/pls/oshaweb/owasrch.search\\_form?p\\_doc\\_type=STANDARDS&p\\_toc\\_level=1&p\\_keyvalue=1910](http://www.osha.gov/pls/oshaweb/owasrch.search_form?p_doc_type=STANDARDS&p_toc_level=1&p_keyvalue=1910)

From the United States Department of Labor, searchable database of the Occupational Health and Safety Administration (OSHA) for the regulations and standards, hearings, and procedures related to occupational safety.

<http://www.cdc.gov/niosh/topics/ergonomics/>

A branch of the Center for Disease Control and Prevention, The National Institute for Occupational Safety and Health is an essential site for research on the topic of RSI. Offers access to epidemiological studies, and government publications of this office. Here you can search NIOSHTIC-2, a searchable bibliographic database of occupational safety and health publications, documents, grant reports, and journal articles supported in whole or in part by NIOSH.

<http://www.rsi-therapy.com/statistics.htm>

Commercial website containing statistical data from governmental resources. \*Note site does not link back to host.

## Support

[http://webspaces.webring.com/people/kl/la\\_rsi/index.html](http://webspaces.webring.com/people/kl/la_rsi/index.html)  
RSI LA is a support group from the Los Angeles, California area which is very active in promoting awareness of RSI. Mainly focuses on California legislation but some good generic resources.

<http://www.rsi-relief.com/>

Website created by Randy Rasa, provides numerous resources and educational links for RSI. Adheres to the HONCode.

<http://www.rsiaction.org/>

Boston based support group for those with RSI. A program of Massachusetts Coalition for Occupational Safety and Health (MassCOSH).

<http://www.amara.com/aboutme/rsi.html>

Individual effort of Amara Graps (RSI diagnosed) which provides extensive listing of web resources for RSI.

<http://www.certifiedpst.com/arms/>

Website for Association for Repetitive Motion Syndromes (ARMS). Mainly focuses on upper limb RSI and associated injuries.

## Adaptive Strategies

<http://www.workrave.org/>

This free download is to institute preventative measures for avoiding RSI. Animated program opens a box at regular intervals to remind you of taking a break, switching tasks, exercises, etc. Very clever!

<http://www.cyberciti.biz/tips/repetitive-strain-injury-prevention-software.html>

Article explaining the WorkRave download authored by Vivek Gite.

<http://www.bilbo.com>

Commercial website for Bilbo Innovations, Inc. provides alternate input devices such as easily adaptable foot pedal controls for keyboard functions. Two especially helpful areas <http://www.bilbo.com/altinput.html> <http://www.bilbo.com/bilbo.html#applications>

<http://www.pcshorthand.com/>

Information regarding "shorthand" ability word processing programs in Windows XP, Windows Vista, etc. Takes abbreviations typed such as "asap" and automatically transcribes it to read the full text "as soon as possible."

<http://www.nuance.com/for-individuals/by-product/dragon-for-pc/index.htm>

From Nuance information for voice recognition software, in particular one of the first on the scene of voice recognition, "Dragon Speak."

[http://www-01.ibm.com/software/pervasive/embedded\\_viovoice/](http://www-01.ibm.com/software/pervasive/embedded_viovoice/)

Commercial website for alternate voice recognition software from IBM.

## Expert Resource

<http://www.usernomics.com/>

A division of Interface Analysis Associates, expert resource for Human Factor Analysis and Ergonomic Design. (*See author's biography on p. 24.*)

# Membership Today: A Question of Belonging

*Rhonda L. Newberry, BSN RN CCRN LNC*

**Q:** In these economic times why do I need to belong to a professional organization? Is it necessary to belong at both the national and local level?

**A:** Because of today's economic times, it is even more important to belong to a professional organization that will enhance and compliment your chosen work.

Everywhere we look, we are confronted with the economic realities of today. People are losing their homes, jobs, and benefits. Tort reform has impacted the legal arena in the cases that are economically feasible to pursue and the judgment awarded. So why would we think that it would not affect our decisions in having membership in a professional organization? Do we really need to belong to professional organizations and if so, is it necessary to belong at both the national and local level?

Networking is one of the key elements for the legal nurse consultant. It is the term most often used in professional organizations. It is not simply talking to people at a cocktail party but it provides for an exchange of ideas and information among individuals that share common interests. We have many networking opportunities including family, work, school, church, and neighborhood. But these networks often do not address the needs of the "professional" you, nor the needs and concerns of your profession. The professional network group may, and often does, lead to contacts and opportunities that you possibly wouldn't previously know about. For example, if you talk to a friend about a professional issue or concern, he or she will discuss the issue and may offer one or two possible solutions. This is a bilateral conversation and the solutions are limited to the person with whom you discussed the issue. Then perhaps, you have the same conversation with five colleagues and the number of possible solution rises to 10. The number of interactions increases exponentially as individuals are added, giving more possibilities and potential solutions by aiding in technical knowledge. This example represents what can happen with networking opportunities.

Some organizations require national membership to belong to the local membership group or chapter. The national membership organization is responsible for the global needs of the organization, adherence to bylaws, and maintaining the integrity of the organization. It does not usually address the needs of a regional or local group unless it impacts the majority of the whole group. The local chapters are responsible for the members in its locale and the problems, concerns, or needs incurred in its area.

Most professional organizations are formally organized and recognized within that industry. They publish newsletters or journals which are meant to keep its readers current on issues and developments of interest to the reader in the specialty area, and provide information about the leaders in the organization. This will enable you to contact them with questions or concerns and they can also be a resource about future employment or collaboration.

Often there is a mechanism in place for sharing employment opportunities within the professional organization. Employers often view membership and participation in professional organizations as a commitment to the specialty field and encourage their employee's membership and participation.

There are also organizational sponsored conferences, programs, and other educational opportunities, often with marginal fees. Because of the economic times, many organizations have partnered with other professional organizations enabling its members to collaborate about projects, research, or common issues. This further increases the networking possibilities. In addition, grants or other funding arrangements are sometimes offered to members for special projects or education.

No matter what your expertise, there is a professional organization that will enhance your career goals. Membership dues and/or fees may be tax deductible. The cost of belonging to a carefully selected professional organization is outweighed by the many benefits such as, educational opportunities and professional advancement and development. Take advantage of the many benefits offered in the professional organization you choose. This is the best utilization of your education and professional development dollar.

**Rhonda L. Newberry, BSN RN CCRN LNC,** Paralegal has been a member of AALNC since 2005 and practicing as an independent LNC, since 2002. She serves as president-elect/secretary for the St. Louis chapter. Newberry remains clinically active as well as an expert witness for critical care and cardiology. She can be reached at [Newberry01@att.net](mailto:Newberry01@att.net).



# FINR

*Providing the Full Continuum of Care  
for individuals with neurologic dysfunction.*



Skilled Medical Rehabilitation Center  
@ FLORIDA INSTITUTE FOR NEUROLOGIC REHABILITATION, INC.



## Sub-Acute

Coma Stimulation  
Ventilator Weaning  
Wound Care



FLORIDA INSTITUTE FOR  
NEUROLOGIC REHABILITATION, INC.

## Post-Acute

Intensive Rehab  
Pediatric Rehab  
Neurobehavioral  
CARF Accredited  
JCAHO Accredited



FLORIDA  
INTEGRATED  
NEUROLOGIC  
GROUP



## Assisted Living

Supported Living  
Supervision & Safety  
CARF Accredited

800-697-5390

finr.net

## Moral Accountability: An Ethical Duty to Oneself

Eileen Watson, EdD MSN RN ANP and Holly Hillman, MSN RN

Due to an ever-changing healthcare environment, nurses are facing a plethora of ethical dilemmas that increase their risk of legal liability. Issues such as fiscal constraints, hospital downsizing, inappropriate staff/patient ratios, end-of-life care issues, technology, competency, and medical futility challenge nurses' relationship between colleagues, patients, institution, and society. These challenges present "...ethical issues and stresses in intra-professional and inter-professional relationships not envisioned in years past" (Hook & White, 2009, P. 4). To help decrease legal liability risk when dealing with ethical conflicts, nurses need to possess ethical decision-making skills for delivery of quality, competent, and safe patient care (American Nurses Association (ANA), 2001; American Association of Colleges of Nursing (AACN), 1999, 2008; Fry & Johnstone, 2002; Guido, 2010; International Council of Nurses (ICN), 2006). Questions challenging the profession of nursing ask what ethical decision-making skills do nurses need to possess to successfully deal with ethical conflicts.

A review of current nursing literature identified three areas of ethical duties for nurses: personal, professional, and societal (ANA, 2001; Fry, Veatch, & Taylor, 2011; Guido, 2010; Hook & White, 2009). There is a plethora of nursing literature discussing a nurse's duties owed to the profession and society. A more recent ethical thread found in the literature was that nurses first owed a "duty to oneself" = moral accountability. De Casterie, Grypdonck, Vuylsteke-Wauters, & Janssen (1997) studied 2,624 nursing students ethical behavior for five different nursing dilemmas. Guided by Kohlberg's theory of moral development, results of the study indicated that most nursing students are at the conventional level of moral development that is, "students are guided by professional rules, norms and duties, and have not yet succeeded in making personal ethical decisions on the basis of their own principles and acting according to such decisions" (p. 12). Ulrich et al. (2007) examined ethical climate, stress, and job satisfaction among 1,215 nurses and social workers in four regions in the United States. Results found that moral distress was the main reason nurses gave for either leaving the nursing profession or leaving their job position.

The 1986 the Ethical Code for Nurses with Interpretive Statements discussed "duty to oneself" as an interpretive statement. In its' 2001 revision, the ANA restated the "duty to oneself" as "Provision 5: The nurse owes the same duties to self as to others, including the responsibility to preserve

integrity and safety, to maintain competence, and to continue personal and professional growth" (ANA, 2001, p. 18).

Similarly in 2008, the AACN developed the Essential for Baccalaureate Education document stating the student must learn to "...Reflect on one's own beliefs and values as they relate to professional practice" (AACN, 2008, p. 5). Guido (2010) summarized this duty by stating:

"Understanding one's ethics and values is the first step in understanding the ethics and values of others and in assuring the delivery of appropriate nursing care" (p. 4).

In today's healthcare practice environments, nurses face many challenges that are fraught with difficult decisions. Foundational skills in ethical decision-making form the basis for the application of moral accountability making it essential that safe and competent patient care be rendered. Moral accountability or "duty to oneself" requires that nurses examine their own attitudes, beliefs, and values in order to more effectively work through ethical dilemmas using a cogent and logical process that respects the needs of the patient. In the end, this will preserve the rights of the patient, reduce legal liability risk, and foster the duties to the profession and to society.

### References

- American Nurses Association (2001). Code of ethics with interpretive statements. Washington, DC: Author American Association of Colleges of Nursing (AACN) (1997). Peaceful death: recommended competencies and curricular guidelines for end-of-life nursing care. Downloaded August 6, 2010 from: <http://www.aacn.nche.edu/publications/deathfin.htm>
- American Association of Colleges of Nursing (AACN) (2008). Essentials of baccalaureate education for professional practice. Downloaded Sept. 5, 2010 from: <http://www.aacn.nche.edu/education/pdf/bacessentails08.pdf>
- De Casterie, B., Grypdonck, M., Vuylsteke-Wauters, M., & Janssen, P. (1997). Nursing students' responses to ethical dilemmas in nursing practice. *Nursing Ethics*, 4(1): 12-28.
- Fowler, M. ed. (2008). Guide to the code of ethics for nurses: Interpretation and application. American Nurses Association, Silver Springs, MD.
- Fry, S. & Johnstone, M. (2002). Ethics in nursing practice: A guide to ethical decision-making (2nd ed.). Massachusetts: Blackwell Science.
- Fry, S., Veatch, R., & Taylor, C. (2011). Case studies in nursing ethics (4th ed.). Massachusetts: Jones & Bartlett Learning
- Guido, G. (2010). Legal & ethical issues in nursing (5th ed.). New Jersey: Pearson.

*Continued on page 32*



# A Firm Foundation: Review of Legal Nurse Consulting Principles and Practices

Reviewed by Kathleen C. Ashton, PhD APRN BC

---

*Legal Nurse Consulting Principles and Legal Nurse Consulting Practices, 3rd ed., Volumes 1 & 2, respectively: Peterson, A. and Kopishke, L, editors. AALNC: 2010, CRC Press.*

---

Ann Peterson and Lynda Kopishke, editors, have worked with two different teams of associate editors to put together a highly readable and informative two volume set of texts delineating the principles and practices of legal nurse consulting (LNC). Useful for the practicing consultant, the set also lends itself well to the academician as a core for curriculum development in this area. This review will address both volumes.

## Legal Nurse Consulting Principles

The Principles volume contains 23 chapters that lay the foundation for the specialty of legal nurse consulting. Chapter one sets the stage with definitions and sources of law. It provides the elements of negligence and details the process of a lawsuit with important legal terms carefully defined. A thorough appendix for nursing organizations supplements the information on Standards of Care and sources.

LNCs have served as consultants to attorneys and other individuals since the 1970s. Chapter 2 traces the history of the professional organization for LNCs, the American Association of Legal Nurse Consultants (AALNC) from its 1989 beginning in San Diego to the present. The Journal began publication in 1995 and the certification exam soon followed. Some real benefits in this chapter are the appendices and the information on how exam questions are developed.

The ensuing chapters discuss the elements of triage or analysis, standards, discovery and disclosure, and informed consent. In any field communication is pivotally important and the field of LNC is no exception. The authors devote an entire chapter to this area and include such specific information as communicating with clients in the medical malpractice arena, some barriers encountered, and the LNC serving such roles as facilitator, educator, and researcher. The chapter contains good advice on legal writing, not just the basics, and actually provides information on doing literature searches.

Chapters 12 and 13 discuss medical record analysis and report preparation. Indexes of the medical chart are described, making it quite easy for the novice who is setting patterns in place. Report preparation includes information on

format and types of reports; however, one missing element is what to avoid. Sometimes what is not said is as important as things included. This is an especially important issue when writing defense reports.

The authors describe the trial process and preparing for trial in Chapter 14 with a step-by-step journey through the process that helps to ease some of the apprehension experienced by those new to trials and trial testimony. Seasoned consultants will also find this information helpful. In the next chapter, locating and working with expert witnesses are addressed with a good review of the qualities and qualifications sought. For those locating witnesses and those serving as witnesses much interesting information is presented.

Legal nurse consultants are increasingly becoming involved with defense medical evaluations and Chapter 19 focuses on communicating with the physician in these situations. In subsequent chapters case examples to assist the LNC involved with pharmaceutical and medical device product liability litigation, the complex area of evaluating toxic tort cases, and retirement income security and its connection to HMOs is discussed under ERISA and HMO litigation.

This volume concludes with a chapter on forensics where the authors delve into criminal law and explore the role of the LNC. This comprehensive text delivers on its promise to provide the foundation for the principles of legal nurse consulting.

## Legal Nurse Consulting Practices

The second volume, *Legal Nurse Consulting Practices*, is an excellent depiction of the legal nurse consulting specialty aimed at those seeking an introduction to the field as well as those more familiar with the role. Basic rules and how to get started as a LNC are introduced while providing an informative review for the more seasoned professional. Some very good sample testimony amplifies the material discussed. In Chapter 2 the authors do an excellent job of explaining the differences between the fact witness and the expert witness, an area that can be confusing.

An individual who is just starting out as a LNC will find Chapter 3 extremely useful. Here the nuts and bolts of LNC practice are explored, from setting up an office to collections. The more seasoned professional will also find tips to improve practice.

*Continued on page 32*

## Moral Accountability: An Ethical Duty to Oneself

*Continued from page 30*

- Hook, K. & White, G. (2009). Code of ethics for nurses with interpretive statements, 2001:Independent study module. Downloaded August 28, 2010 from: <http://www.nursingworld.org/mods/mod580/cccdeabs.htm>
- International Council of Nurses. (2006). The ICN code of ethics for nurses. Geneva, Switzerland: Imprimerie Fornara.
- Rankin, W. (2000). Ethics of care and the empowerment of nurses. *Journal of Pediatric Nursing*, 15(30): 193-4.
- Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Journal of Social Science & Medicine*. 65: 1708-1719

**Dr. Eileen Watson** is an Associate Professor of Nursing at California State University Long Beach, California where she teaches the course Legal Issues in Health Care. She has been an independent legal nurse consultant since 1989, specializing in plaintiff and defense medical malpractice, and personal injury litigation. She also serves as an expert witness for the California Board of Registered Nursing. She is an adult and geriatric nurse practitioner as well as a civil litigation paralegal. She is a national speaker and author in the areas of informed consent, elder abuse, and advance directives. She can be reached at [emwatson@csulb.edu](mailto:emwatson@csulb.edu).

---

## A Firm Foundation: Review of Legal Nurse Consulting Principles and Practices

*Continued from page 31*

For someone who is deciding where he or she might best fit into this specialty area of nursing, Chapters 4 through 8 could almost read as a menu from which one might decide where his/her interests lie. Areas such as case management, the insurance industry, criminal cases, practice within a law firm, and health care risk management are honestly appraised as areas in which LNCs have found their niche and built successful careers.

In the next several chapters, the authors describe several practice areas for the LNC. The authors have taken a dry and detailed area, health claim analysis, and made it interesting and inviting. Administrative health law, Medicare set-asides arrangements, and fraud are discussed in a concise and readable manner. Life care planning is an expanding area of LNC practice and Chapter 13 provides a comprehensive look at this important area. The traditional specialties within nursing practice that LNCs represent are reviewed in Chapters 14 through 18.

Attorneys are increasingly using technology in the courtroom and will turn to LNCs who, with their nursing knowledge and technical skill, can offer invaluable assistance in this process. The ins and outs of using cutting edge technology are described in Chapter 19 along with important suggestions on preparedness and troubleshooting that the LNC would do well to heed.

Chapters 20 and 21 delve into the areas of occupational health and worker's compensation claims that form an important area of practice for LNCs. The section on employment law contains useful information for all LNCs regardless of the specialty area.

This volume concludes with two detailed chapters addressing other specialties in nursing, surgical and anesthesia case evaluation, and residential and community-based care. The important issues in these two areas are addressed and resources are provided.

The editors, associate editors, and authors of the third edition have done a superb job of advancing the profession of legal nurse consulting through the dissemination of the principles and practices of this expanding field. Their work serves as the definitive resource for individuals seeking information and expertise in this important area.

**Kathleen C. Ashton, PhD, APRN, BC**, is a Professor of Nursing in the Jefferson School of Nursing at Thomas Jefferson University in Philadelphia and a Professor Emerita in the Department of Nursing at Rutgers University in Camden, New Jersey. Her research interest is in the area of women and heart disease. She has conducted numerous funded research studies over the past twenty years and has published the results of her work in leading nursing journals. Her clinical expertise is in adult health/critical care nursing and she holds an Advanced Practice license. As a legal nurse consultant, she serves as an expert witness reviewing legal cases for plaintiff and defense firms for over fourteen years. Currently, she serves as a reviewer for three nursing journals and as a board member for several community and professional groups.



# Don't Play Games With Your Career.

## Get Professional Liability Insurance through NSO.

**You've insured your car and home, but have you protected your most valuable asset – your Nursing license?**

One of the primary benefits of having your own individual professional liability policy is that you and your best interests will be protected above all others if you are named in a malpractice lawsuit.

With individual coverage through Nurses Service Organization (NSO), you get professional liability protection of up to \$1,000,000 each claim and up to \$6,000,000 aggregate for the policy term – PLUS protection for your license and legal defense for disciplinary actions, up to the applicable limits of liability, at no additional cost to you.

**So make the right move...apply now to protect your career and future.**

**[www.nso.com/aalnc](http://www.nso.com/aalnc)**

*Quick, Easy & Secure On-Line Application!*

AALNC  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

  
nurses service organization™

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA-affiliated underwriting company, and is offered through the Healthcare Providers Service Organization Purchasing Group. Coverages, rates and limits may differ or may not be available in all states. All products and services are subject to change without notice. This material is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the products and services offered. Only the policy can provide the actual terms, coverages, amounts, conditions and exclusions. CNA is a registered trademark of CNA Financial Corporation.

Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc.; in CA (License #0795465), MN and OK, AIS Affinity Insurance Agency, Inc.; and in NY, AIS Affinity Insurance Agency.

© 2010 Affinity Insurance Services, Inc.

AALNC2010



**AALNC**  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS



## Legal Nurse Consulting Educational and Networking Forum 2011

April 1–2, 2011

Pier 5 Hotel | Baltimore, Maryland

*Are you or a fellow nurse colleague interested in becoming a  
legal nurse consultant?*

The American Association of Legal Nurse Consultants is pleased to offer the...

### **Legal Nurse Consulting Online Course**

**Whether brand new or experienced in the industry, there has never been a better opportunity to expand your career and brighten your future as a legal nurse consultant!**

Developed from the recommended curriculum for legal nurse consulting, all eight modules have been created by the professional society for legal nurse consultants, AALNC. Each module of the Legal Nurse Consulting Online Course offers the combined knowledge and expertise of LNCs at the forefront of the profession, as well as the knowledge of the renowned course editors, Pat Iyer, MSN RN LNCC, Betty Joos, MEd BSN RN and Madeline Good, MSN RN LNCC.

Each module of the Legal Nurse Consulting Online Course has been approved for nursing contact hours by the Illinois Nurses Association. Visit [www.aalnc.org](http://www.aalnc.org) today for detailed information on all eight modules, as well as the many other educational products that AALNC offers for legal nurse consultants.

**Questions? Email [info@aalnc.org](mailto:info@aalnc.org) or call 877/402-2562.**

**AALNC**  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

