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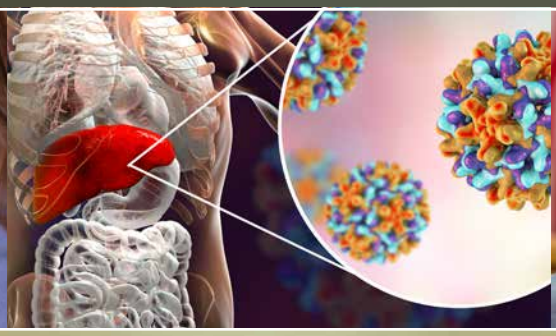
THE JOURNAL OF Legal Nurse Consulting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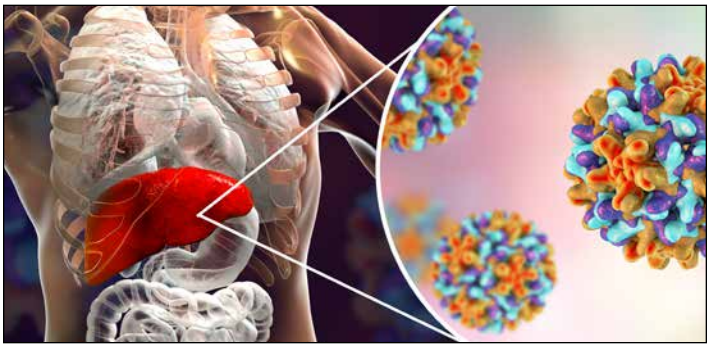

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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

PURPOSE

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

MANUSCRIPT SUBMISSION

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

MANUSCRIPT REVIEW PROCESS

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

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ARTICLE SUBMISSION

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

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

INSTRUCTIONS FOR TEXT

- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 6th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Note current retrieval date for all online references.
- Include a 100-word abstract and keywords on the first page
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

INSTRUCTIONS FOR ART, FIGURES, TABLES, LINKS

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

INSTRUCTIONS FOR PERMISSIONS

The author must accompany the submission with written release from:

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- Any recognizable person in a photograph, for unrestricted use of the image
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GENERAL INFORMATION

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

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

Kim Beladi,
BSN RN LNCC

President, AALNC

President's Update

For the AALNC, as for many other organizations, growing membership has two critical elements: finding new members and retaining current members. I want to tell you how AALNC has focused on both of these critical elements over the last several years.

We have increased marketing campaigns on LinkedIn, Facebook, Twitter, and email to attract potential new members. These efforts are beginning to bear fruit: There are 429 new members this year!

We are also devoting efforts to retaining the 1154 renewing current AALNC members. As a recent article in Board Forward, a publication from SmithBucklin, points out, "Retention is the outcome of effective engagement." Associations often put resources into new member recruitment, renewals, and education, but rarely focus enough on engagement, such as programs specifically designed to enhance intermediate and advanced practice.

This lead me to focus on participation, sharing, partaking, and involvement within our organizational structure. We know that people who are more deeply engaged in association activities are more likely to find value from their investment in membership. The more value we offer, the better the retention. Our member surveys tell us that AALNC's many webinars, online modules, volunteer opportunities, annual and local chapter fora, and books and educational material offer real value to LNCs at all stages of the novice-to-expert continuum.

My professional success started with AALNC and it continues today. So here's my challenge to current and new members: Get involved! Find your value in engagement with your professional organization. My networking, education and participation in programs has given me that value, and it's there for the asking for each of you, too.

Attend networking opportunities, read *The Journal of Legal Nurse Consulting* (free access at www.aalnc.org, or join the over 130 subscribers who get it in hard copy), join a committee, visit the Professional Development Center, write a letter, ask a question … there is so much at your fingertips.

FIND YOUR VALUE.

Sincerely,

Kim Beladi, BSN RN LNCC

Having Fun with Publishing

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

Editor, JLNC

Welcome to the September 2018 JLNC focusing on trials and trial prep. You'll find some information on helping an attorney put together a mock trial to prep for a med mal case, a piece on serving as a medical fact witness with a side of demonstrative evidence hints, a piece on how best to prep a nurse expert witness (your client's or yourself), and the ever-popular Round Table with LNCs sharing their ideas and experiences.

The puckishly-acronymed INANE, the International Academy of Nurse Editors, has an online journal that solicited submissions of outstanding articles from all its editor members, of which I am pleased to be one. The membership represents professional journals of every persuasion and purpose from countries around the world, edited by nurses. I am pleased to report that our 2017 Article of the Year, *A Comparison of Monitored Anesthesia Care and Procedural Sedation: What LNCs Need To Know* (Bedford, Dean, and Walker) will represent the JLNC, alongside works from the likes of American Journal of Nursing, Nursing Administration Quarterly, Nursing, Advances in Skin and Wound Care, Interdisciplinary Journal of Partnership Studies, Research in Gerontological Nursing, Advances in Nursing Science, Oncology Nursing Forum, Journal of PeriAnesthesia Nursing, Journal of Forensic Nursing, Journal of Infusion Nursing, Journal of Healthcare Quality, Nurse Researcher, Nursing Management, Dimensions of Critical Care Nursing, Journal of Nursing Scholarship, Archives of Psychiatric Nursing, and many more.

Though not all of us practice as nurses anymore, you'd be wrong to think nurse editors from these august publications would be humorless egghead academics. Not surprising that it's a very literate bunch, but they're funny too. As an example, one of our ongoing discussions on the list includes a bit of doggerel that begins, "That APA, that APA / I do not like that APA / I do not like it when I write / I do not like it when I cite / I do not like it in a book / I do not like it in a Nook …" in a discussion of how the APA is not the be-all, end-all of everything (with properly cited references, of course). We have also had passionate condemnation of predatory publishing, tongue-in-cheek opinions on the Oxford comma, the mind-bending concept of "self-plagiarism" (salami is involved), and what to do with student papers and the faculty that requires them to submit without the slightest guidance or hope of acceptance. The annual meeting in my hometown of Boston this year promises to be a fun time. I'm presenting on a topic near to my heart: "Your Board Wants You To Do What? Having Fun With A Practice Journal." I thought they'd give me fifteen minutes in a little room in the back, but it looks like I have an hour in the ballroom, so they must be interested. It will be different! Because we are.

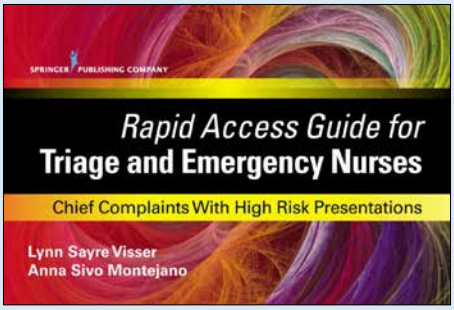
It's been a hot summer so far as I write this, in more ways than one. Certainly the fires and the droughts and the flooding from major storms related to global warming worldwide pretty much mirror the human effects we're enduring, themselves related to massive amounts of man-made hot air. I hope both the hurricane season and the mid-term elections will be calm, but it's not looking good in more ways than one. Pray cooler breezes and heads prevail in the coming months.

(picture credit : Wikipedia)

Wendie A. Howland MN RN-BC CRRN CCM CNLCP LNCC

Editor's Choice: Book Review

Wendie Howland MN RN-BC CRRN CCM CNLCP LNCC



Rapid Access Guide for Triage and Emergency Nurses: Chief complaints with high-risk presentations

Lynn Sayre Visser, MSN, RN, PHN, CEN,CPEN

Anna Sivo Montejano DNP, RN, PHN, CEN

ISBN: 9780826196279
e-book ISBN: 9780826196378
Springer Publishing Company

Legal nurse consultants would find this extensively-referenced handbook invaluable in triage in their own settings.

This is a follow-up book to the authors' previous award-winning *Fast Facts for the Triage Nurse* (2015) (with Valerie Aaren Grossman, MALS, BSN, RN). While Fast Facts includes guidance for key procedures and protocols for EDs and urgent care, the *Rapid Access Guide* leads the working triage nurse to achieving the goal of triage itself: *Identifying patients who must have immediate or rapid intervention*. Legal nurse consultants would find this extensively-referenced handbook invaluable in triage in their own settings to answer intake screen questions about initial emergency management for the retaining attorney, evaluate subsequent assessment and care, and obtain supportive references on standards and policies.

The inspiration for this pocket-sized work was the authors' collective "Book of Brains," a compilation of notes and insights from over fifty collective years of emergency care practice. Readers will be rewarded from the first pages with easy-to-read lists of terms and abbreviations, screening tools, and checklists, thoughtfully designed with plenty of white space to write or paste in any supplemental materials for customization, e.g., policies, protocols, phone numbers, and resources.

The authors use icons to identify "red-flag" findings and special considerations for pediatrics or geriatrics. This book sets out the priority questions, assessments, and interventions to determining patient level of urgency for the most commonly seen presentations in alphabetical order for easy reference. These include

- Trauma, neurological, cardiac, and respiratory emergencies
- Sepsis, infectious disease emergencies
- Burn emergencies
- Toxicology emergencies
- Abdominal emergencies
- OB/GYN and male reproductive emergencies
- Eye, ear, nose, and throat emergencies
- Behavioral health emergencies
- Active shooter/violence/disaster management

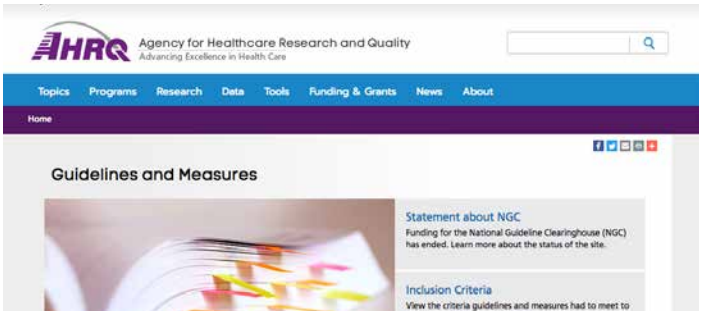
Each is formatted into three sections: Chief Complaint, Red Flag Findings, and Key Tips, e.g., core measures, worst-case scenarios, and suggestions for other chapters to check for related information. Each section, in turn, gives an easy-to-scan table with questions to ask, assessment, and interventions. A separate initial section prominently provides rapid screening checklists for time-critical immediate decisions for possible STEMI, stroke, and sepsis.

Rapid Access Guide for Triage and Emergency Nurses: Chief complaints with high-risk presentations is available from the publishers or at your favorite online bookseller.

Wendie A. Howland, MN, RN-BC, CRRN, CCM, CNLCP, LNCC is the owner of Howland Health Consulting in Massachusetts, offering legal nurse consulting and life care planning for plaintiff and defense clients nationwide. She is the Editor of the JLNC and the JNLCP and can be reached at whowland@howlandhealthconsulting.com.

NATIONAL CLEARINGHOUSE GUIDELINES WEBSITE DOWN

I wrote to the National Guideline Clearinghouse about losing the website in July. This is the response that I got; I thought others might be interested.



Dear Pam Steinacher,

Thank you for your email regarding the closing of AHRQ's NGC/guideline.gov and for noting the value of it in your work (and others' work).

The Agency knows that many individuals and organizations have built routines and processes around the presence of NGC, so we are exploring a path(s) to sustain NGC or some evolution of NGC and will continue to do so even after the site is offline.

If you aren't signed up to receive updates about NGC through AHRQ's email service, consider doing so: https://guideline.gov/subscribe. We will use this service to apprise subscribers of updates about NGC (even after July 16, 2018).

Thank you, again, and thank you for all that you do to advance evidence-based practice.

Pam Steinacher, RN LNC CHRM MSCC CNLCP
Steinacher Medical Legal Consulting, Inc.
Jerseyville, IL 62052

" 'Knock, knock.'
'Who's there?'
'HIPAA.'
'HIPAA, who?'
'I'm sorry, but I cannot disclose that.' "

"Clinicians and patients alike will laugh at this, but behind the laughter are anger and frustration. The Health Insurance Portability and Accountability Act (HIPAA), a law created to protect patients, has borne with it serious obstacles to effective care. How did this happen? What went wrong on the road to protecting privacy?"

"How HIPAA Harms Care and What to Do About It."
Donald Berwick MD MPP, JAMA 6/20/2018

"Individuals' health data are now solicited, aggregated, analyzed, shared, and sold in ways poorly understood and largely unregulated. … Because HIPAA extends only to covered entities, it does not apply to data collection by social media, wellness apps, and similar services…"

Lawrence Gostin JD, Sam Halabi JD MPhil, and Kumanan Wilson MD MSc
"Health Data and Privacy in the Digital Era." *JAMA* 6/20/18

WHAT'S WRONG WITH THIS?

Actual record, copied into at last four months of office visit notes. Send yours to jlnc@aalnc.org!

Progress Notes by _____, MD at 10/27/2016 2:00 PM (continued)

- omega-3 fatty acids-fish oil 340-1,000 mg capsule, Take 2,000 mL by mouth 2 (two) times a day., Disp: , Rfl:
- sertraline (ZOLOFT) 50 MG tablet, Take 50 mg by mouth daily., Disp: , Rfl:
- vit D3-folic acid-B2-B6-B12 2,000-800-0.32 unit-mcg-mg tablet, Take 5,000 capsules by mouth daily., Disp: , Rfl:
- amoxicillin (AMOXIL) 875 MG tablet, TAKE 1 TABLET BY MOUTH EVERY 12 HOURS FOR 14 DAYS, Disp: , Rfl: 1
- BOTOX 100 unit injection, , Disp: , Rfl:
- niacin 500 MG tablet, Take 500 mg by mouth daily. Takes 1000mg at bedtime, Disp: , Rfl:

Test Your Case Screening Skills

CASE #1

Cheryl Smith and her brother Dr. Ryan O'Brien called about their deceased father, Dr. Sam O'Brien. He had been in the Baptist Home since 2006. Apparently he had a bed sore on his coccyx that progressed to a point that was beyond imaginable - a cavity a golf ball could fit into (has a photo). The family was never told how bad it was - always downplayed. On 5/27/11 they moved him to a facility in Oklahoma where Cheryl lives. He died 6/15/11. Had a history of Parkinson's/dementia. They are going to call me back with cause of death from the death certificate. No autopsy.

CASE #2

I was wondering if i had a case that could be further pursued i went to the ER a few nights ago and i went in with pain in my belly button after many hours of sitting in the ER room waiting to be told what was wrong the doctor came back and stated to me that i was just fat and i had an ulcer. so i leave and a few days later the pain is getting worse so i go see my aftercare doctor and he see that on the original report from the cat scan it showed that i had a umbilical hernia and it needed surgery so the first doctor didn't want to do his job and sent me out with something that could've killed me

CASE #3

Cindy presented to ER 6/5/11 with abdominal pain. After CT, diagnosed with diverticulitis - discharged with Cipro and Flagyl. On 6/7/11 she went back to hospital by ambulance with severe abdominal pain - given IV antibiotics. Had to have a section of her colon removed - had an ileostomy - hopefully will be reversed in Sept. if all goes well. She feels that if she had been treated with IV antibiotics from the get go that she wouldn't have required surgery. Wonders if someone missed something when her colon perforated. ABC Health Ins. (her carrier) has sent her a request for information about the original surgery and whether she's filing a PI claim or not.

Check your answers on page 23.

Test Your Case Screening Skills

You decide: reject, or investigate?

In Pursuit of Highly Credible Communication: What Nurses Need to Know Before They Testify

Charlotte (Charli) A. Morris, M.A.

Every human decision-maker has experience being a patient. The vast majority of us take our first breaths on this planet in the hands of healthcare professionals. As a result, the expectations we all have for nurses are extremely high and deeply rooted. This reality is present in every clinical interaction nurses have with their patients. We also know how those expectations, and your influence, will be measured in medical malpractice cases. While this article will focus on the formal work of testifying witnesses, note that your communication as a fact or expert witness begins the moment you become involved in a case, and your influence be measured in every interaction you have with others including counsel, opposing counsel, judges, mediators, arbitrators and jurors, for better or worse.

As a trial consultant I am retained as a non-testifying expert to support the legal team. I have had many hundreds of opportunities over twenty-five years to use social science research to help lawyers and their clients communicate effectively and persuasively throughout the course of litigation. The principles for good communication apply to all witnesses and I also draw on decades of medical malpractice focus group research for the best advice I give to healthcare providers. It also doesn't hurt that I'm the daughter of one of the best labor and delivery nurses I have ever known. Nurses are among the most important and most interesting witnesses in many medical malpractice cases. With great support and preparation they can also be the best teachers.

WHERE DO WE BEGIN?

Understandably, most witnesses I meet come to the preparation session concerned about what they might be asked and worried about whether they will know how to answer. Beyond the basics, many also wonder if their job will be affected by how well they do in a deposition or if their personal lives will be exposed by opposing counsel. Some are preoccupied with their long-standing fear of public speaking, and others are terrified by the prospect of being burned by the heat of a skillful cross-ex-

amination. Above all, your testimony must be truthful; but telling the truth in a meaningful and powerful way involves all the complexity of interpersonal communication.

Before we can even begin to address the facts in the case or how to handle tough questions, I like to start the preparation with ten questions designed to get a witness thinking more broadly about what she brings to the table. The first things I need to know about a nurse before I can begin making my best suggestions for how he will approach giving a deposition or testifying at trial are:

- How would you describe your *previous experience* as a witness? What advice have you been given? How well do you think you did?
- What *do you understand your role* in the case to be? How *do you compare to other witnesses?* How *important* is your testimony to the overall case?
- What do you think *your strengths* as a witness will be?
- What do you think *your weaknesses* as a witness will be?
- What are your *fears* about being a witness? What *concerns* you the most?

These are not questions that most witnesses have heard from even the most thoughtful and supportive attorneys; lawyers tend to get right down to business when time is inevitably short. But we should not rush through your preparation without getting an adequate assessment of baseline, just as experienced nurses would never skip over getting a patient's vital signs.

Answers to my question about the witness' role in the case, for example, are always interesting. Witnesses who have lived within the cone of confidentiality of ongoing litigation often have no idea even who the other witnesses will be, so they don't know where they fit into the bigger picture. It can be incredibly comforting to a nervous witness when we talk about how he will contribute to, but not carry alone, our best presentation of evidence.

The next five questions get us closer to the facts of the case:

- What do you most want the jury to know *about the case?* What do you most want to *teach or explain?*
- What do you most want the jury to know *about you?* What *impression* do you want to make?
- What do you have to say *that will help* the case?
- What do you have to say *that will hurt* the case?
- What kind of *help* do you *want or need* from your attorney?

Many witnesses are surprised and delighted to be asked what they want the jury to know about them as a person, because it has never occurred to them that jurors are genuinely (and humanly) interested in witnesses beyond the testimony they give. Every nurse has a story to tell about how she became a nurse or why he was called to the medical profession; that information can and should inform even deposition questions when the jury and other decision makers in a case are not present.

After this initial conversation with a witness we will then do at least two very important things before launching into practice Q&A: perspective-taking and theme development.

PERSPECTIVE-TAKING: BE YOUR BEST NURSING SELF

First, I want witnesses to think critically about the perspective they will take when they testify. Telling a witness to

"just be yourself" is terrible advice. The self I am with my children in church is very different from the self that I am with my college roommates at a basketball game. We know that every situation brings out something different in all of us. We don't want nurse witnesses getting stuck in the perspective of Reluctant Deponent, Nervous Nelly, or Scared Stiff. We want them to feel grounded in their best nursing practices.

When the lawyer comes in hot or uses sarcasm to argue his point in the form of a question, I want a nurse witness to think about the last patient she treated (or the last patient's worried spouse, or the last patient's curious parent) before she answers. I want a nurse to think to herself, "I'm so glad you asked me that," and "That's a great question." I want a nurse to imagine that the attorney is just like that patient or family member who has been googling medical terms and researching alternative treatments.

In other words, a nurse witness can treat the attorney like he is the anxious, concerned or confused loved one who is asking questions out of ignorance or fear. When you take the proper perspective, your best nursing instincts will kick in before you answer even the most hostile question. When you imagine yourself standing at bedside, wearing your scrubs, in the familiar bustle of the hospital or clinic where you practice, your response will be calm, rational, reassuring, confident, and delivered in the words you use with ordinary people. That is your best nursing self.

THEME DEVELOPMENT: MAPPING THE TERRAIN OF YOUR TESTIMONY

While we do remind witnesses to give testimony one question at a time, depositions and cross-examinations are not, and should not be mysterious walks through the dark woods of all possible questions. Your attorney knows the territory your testimony will cover; although no one can predict exactly which questions you will be asked, we're also not flying blind.

I recommend in our prep sessions that we develop a list of topics into which virtually all substantive questions may fall. These can be broadly defined as issues and themes, but we're not writing a script. We just want to break down the entire universe of possible questions into manageable parts and make conscious decisions about how we want to address them. Then, when a witness is listening carefully to every word in every question, she will think about what she wants to communicate clearly instead of wondering whether she's doing it "right."

Below are topic areas and themes we developed with a witness during preparation for deposition. In this case, labor and delivery nurses gave carboprost (Hemabate) instead of fentanyl (Duragesic, Sublimaze, and others) to a patient whose pre-existing diaphragmatic hernia was not known to the doctors and nurses during a protracted and difficult labor and delivery. The hospital (on behalf of the nurses) had admitted the medication error as soon as it was discovered, apologized to the patient, and the baby was born without serious injury, but mother required an emergency Cesarean section and then multiple additional surgeries as a result of complications from the undetected pre-existing condition.

Willful/Wanton Conduct, Conscious Disregard for Patient Safety?

- We were not negligent, reckless, unsafe or dangerous
- Mistakes can happen on any job; this was not medical malpractice
- When nursing mistakes happen, we are trained to respond quickly and appropriately

Wrong Medication

- Vials for fentanyl and Hemabate are the same: shape, size, color, label font
- Hemabate is typically refrigerated, this vial was not
- Mother sick but that's not unusual in labor and this mom was very uncomfortable and in pain before she got what we thought was fentanyl
- Baby heartrate is what we responded to when call for emergency Cesarean section
- Patients can also have adverse reactions to the right medications and we respond

Nursing Policies, Procedures and Protocols

- Practice guidelines are not standard of care
- Not every patient gets the exact same treatment
- Not a substitute for our training, experience or the particular needs of patients
- We practice within guidelines and use our best clinical/medical judgment

Sequence / Pattern / Multiple Medical Errors

- Retrieval error and administration error are the same mistake: not noticing the label says Hemabate instead of fentanyl

What we know about how to help healthcare professionals communicate effectively as witnesses verbally and nonverbally is supported by empirical research and practice.

- *How* mistake is made: Both nurses make same type of mistake for same reasons: size, shape, color of vials and Hemabate in non-refrigerated system
- *Why* mistake is made: Genuine concern for patients; mom having trouble staying in position for monitoring baby when baby was in distress and we couldn't re-position her; wanted mom to get pain relief as fast as possible

Apology

- Have always wanted mom to know how sorry we are; we are here to tell her so ourselves
- Our primary concern after the Cesarean section was the full recovery of mom and baby
- Any conversation with the patient in the moment might have made us feel better, but not her

Injury/Causation: Hemabate

- Hemabate is a drug that causes uterus to tighten, our first concern was baby

Jurors at trial are given explicit instructions by the judge that empower them to be the ultimate judges of witness credibility.

- Patient needed a Cesarean section to deliver safely because we gave Hemabate by mistake; fortunately, baby recovered well after brief stay in NICU

Pre-Existing Condition/Outcome for Mother

- Stay in our lane; leave questions of causation to experts/doctors
- Knew about prior hiatal hernia causing pain, but didn't know about diaphragmatic hernia
- There are other doctors and nurses who continued with her care after L&D who are in a better position to answer those questions.

When we clearly identify all of the allegations being made and how nurses might respond, based on their own recollections, the medical records, and well-established nursing practices, we help nurse witnesses recognize that they are fully capable of answering appropriately and testifying truthfully on every substantive issue in the case.

GETTING DOWN TO BUSINESS: WHAT MAKES A WITNESS CREDIBLE?

After we've fully explored the ideas above in the first of several preparation sessions with a nurse then we begin to talk about the specific skills a witness will need to communicate most effectively.

Empirical research in communication and psychology teaches that it is never just what we say and it is always how we say it. Whether people find us credible or not will depend on a wide variety of factors that contribute to our trustworthiness, competence and likeability.

- When we are curious about whether a witness is *trustworthy*, we ask: Is the witness reliable? Is she consistent? Is he objective? Does he make honest concessions? How well does she listen?
- When we consider *competence*, we observe: Is the witness knowledgeable? What are his credentials? What is her experience? How well does she teach? Is he intelligent? Precise? Confident? Can she also admit there are things she does not know?
- When deciding whether we *like* a witness, we wonder: Is she empathetic? Is he defensive? Does she seem friendly, open, and warm? How is his sense of humor? Does he have a temper? Is she interesting?

Our judgments about another person's credibility come naturally and without

conscious thought. We form powerful impressions almost without thinking and most of us don't carry a checklist of questions or qualities we use to measure another person's credibility. But jurors at trial are actually given explicit legal instructions by the judge that empower them to be the ultimate judges of witness credibility.

In New York, for example, jurors may be instructed (in part):

> You are to consider only the evidence in the case. But in your consideration of the evidence, *you are not limited to the statements of the witnesses*. You are permitted to draw, from facts which you find have been proved, such *reasonable inferences as seem justified in the light of your experience*. You, as jurors, are the sole judges of the credibility of the witnesses. You may be *guided by the character* of the testimony given, or by evidence to the contrary of the testimony given.
>
> You should carefully scrutinize all the evidence, and all of the evidence *which tends to show whether one side's presentation is worthy of belief.*
>
> *(emphasis added)*
>
> *PJI 1:7-1:8 (2017)*

In North Carolina, jurors will similarly be told (in part):

> *You are the sole judges of the credibility of each witness.*
>
> *You must decide for yourselves whether to believe the testimony of any witness. You may believe all, or any part, are none of that testimony. In determining whether to believe any witness you should use the same tests of truthfulness which you applied your everyday lives. These tests may include: the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testified; the manner and appearance of the witness; any interest, bias, or partiality the witness may have; the apparent understanding and fairness of the witness; whether the testimony of a witness is sensible and reasonable; and whether the testimony of the witness is consistent with other believable evidence in the case.*
>
> *N.C.P.I – Civil 101.15 (2017)*

These instructions reflect what research demonstrates about the components of credibility. They tell jurors to consider factors well beyond the content of a witness' testimony; they go even farther and require jurors to weigh the many extralegal factors that can and do influence how their decisions will be made. For you as a

witness, that means that you will need to think carefully about not just what you say, but how you say it.

INCONSISTENCY CAN BE A CREDIBILITY-KILLER

The greatest threat to your credibility as a witness is inconsistency, which can take many forms and which is not limited to the facts you deliver. A witness' testimony can be inconsistent in one or more of the following ways:

- over time (when you documented your care of a patient in the medical record compared to when you give your deposition);
- across speakers (what you say compared to what another witness says);
- under varying circumstances (deposition testimony or trial, direct examination or cross); and
- within your own delivery (when you say, "I care deeply about my patients" in a loud, strong voice punctuated with downward inflection and a verbal exclamation point)

My goal is to bring a witness' own awareness and consciousness about these aspects of credibility to the forefront. Because while our only duty is to tell the truth, our real opportunity as a witness is to tell it in the most credible, and therefore most persuasive, way.

WHAT WE SAY AND HOW WE SAY IT: GIVING EFFECTIVE TESTIMONY STARTS WITH STRONG LISTENING SKILLS

There are two primary ways we communicate: through language (verbal) and para-linguistics (nonverbal). Within nonverbal communication there are countless way to convey or betray the meaning of our words: body language, gestures, facial expressions, micro-expressions, tone of voice, vocal pitch, rate of speech, and more.

It takes nurses years to learn and acquire the vocabulary of their work and that of other healthcare professions. This jargon serves as shorthand for communicating quickly and effectively on the job. But you probably also know how to turn it off; when speaking to your patients and their loved ones you use the language of your household or, more importantly, their own.

We know that words matter. The words you choose can be a firm command, a gentle encouragement, or a calm reassurance. We are usually at our best when we are choosing our words well, even in the ordinary course of our work day. At the very least, we are also aware in the moment when we have chosen badly so then we can find more words to offer an apology or to clarify.

In my preparation with nurses for deposition or trial, we are also focused on words. It starts not with speaking, but with listening. When we are being questioned by an attorney, whether opposing counsel or our own, our best bet is to listen closely for every word. In print, it looks like this: *We. Listen. To. Every. Single. Word. Of. Every. Single. Question.*

There are good reasons for this. When we listen to every single word we will give ourselves a chance to know whether we understand the question at all. And, if not, we'll seek clarification before we start to answer or ask the attorney to rephrase it. I tell witnesses that rephrase the question rather than inviting the attorney to repeat the same bad question verbatim.

We will also find out whether we are actually being asked a question. For example, some lawyers disguise comments, opinions and speeches with rising inflection. It's when your voice goes up at the end of a sentence? Sometimes our eyebrows go up too? And we tend to leave more space at the end of the sentence? We look expectantly at the person we are talking to?

All of the sentences above are only statements, but if you read them aloud using the punctuation as your cue, they sound like questions. A careful, listening witness will recognize whether a lawyer is truly asking, or merely looking for agreement with an idea that could be very much at odds with the facts or our best testimony about the facts.

For the nurses involved in the case described above, what they said and how they said it made a critical difference in how they were perceived by opposing counsel (who takes the deposition to size up the witnesses), opposing counsel's client (a mother upset about a Cesarean section delivery and the complications she endured after her child's birth) and, ultimately, the judge or a jury.

Jurors at trial are given explicit instructions by the judge that empower them to be the ultimate judges of witness credibility. Your testimony can have a meaningful effect on the outcome.

CONCLUSION

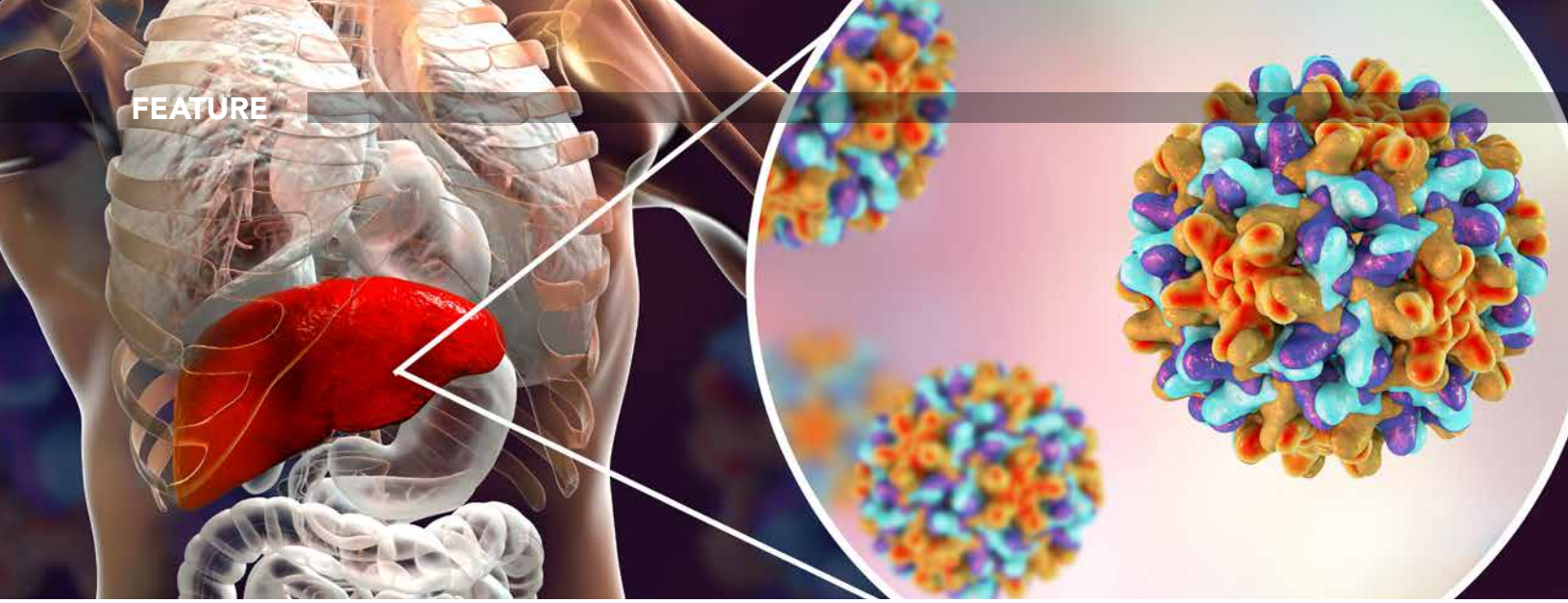
What we know about how to help healthcare professionals communicate effectively as witnesses verbally and nonverbally is supported by empirical research and practice.

Critically, we don't have, or need, much time to make the right impression on our audience. Social science research on impression formation supports our trial consulting practice of testing witness credibility in focus groups using "thin slice" stimulus, such as video deposition clips. Research by Titcomb and Brodsky at the University of Alabama, for example, has shown that human judgments of deceptiveness, psychopathology, personality, relationship stability, and intentions have all been shown to be accurate even when subjects make those judgments based on as little as 30 seconds to 5 minutes of exposure. While we cannot yet prove whether those judgments translate into ultimate decision-making outcomes such as jury verdicts, the research is powerful because it is proof that we never get a second chance to make the first impression. For more reading on their research and its practical application for expert witness credibility, see http://www.thejuryexpert.com/2012/09/thin-slices-of-testimony/.

SUMMARY

Whether you are retained as a nurse expert or fact witness you deserve great preparation that takes into account the elements of verbal and nonverbal communication which make you the most effective advocate for your care and treatment of patients. Ultimately, the decision-makers in a case will do the deciding, but your testimony can have a meaningful effect on the outcome and on your experience being a witness.

Charlotte (Charli) A. Morris, M.A. has been assisting lawyers with all aspects of case development and trial preparation since 1993. She has a Master's in Litigation Science from the University of Kansas where she was one of the first to complete an advanced degree designed for trial consulting. When she is not traveling the country to prepare witnesses, conduct focus group research, or teach persuasive communication skills, she can be found in the carpool lane waiting for her three children who swim as much as she works. She can be contacted at charli@trial-prep.com.



Medical Record Fact Witness and The Use of Medical Illustration in LNC Reports:

When a picture IS worth a thousand words

Mila Carlson, PhD, MSHSA, R.N., CNLCP, CMSP and Joanne Walker, BSEd, R.N.

Keywords: Medical record fact witness, Medical Illustration, LNC reports with pictures, Summary, Evidence, Witness, Plaintiff, Defense

While many legal nurse consultants (LNCs) are familiar with the term and requirements of a fact witness, they may not be as familiar with the role and requirements of serving as a medical record fact witness. This role and using medical illustration in reports, and for jury education are explored in this article.

WITNESS VS. MEDICAL RECORD FACT WITNESS

A witness is usually a person with firsthand knowledge of an event, who witnessed an action or event, or was a participant in an event. The witness presents the details under oath. The facts are limited only to that person's knowledge of the matter in question.

Serving as a medical record fact witness is an entirely different role. This relies on experience, training, and education as a nurse, but not in a particular clinical nursing specialty. Unlike when serving as a standards-of-care expert, being licensed and clinically active is not required.

The main role of the medical record fact witness is to organize and present the information in the record. These matters are usually complicated medical cases involving multiple surgeries, medical specialties, treatments, and permanent disabilities. Organizing the details of injury and medical care found in voluminous records requires an experienced nurse who can identify the salient points. Many medical terms and surgeries need to be clarified in language (and sometimes illustrations) a lay person can understand. The role is to educate not only the jury but also the attorney. Verify that this is the role your attorney-client needs you to fill.

Understand what facts the attorney wants documented. The theory of the case may

mean the attorney wants all providers, surgeries, procedures, and treatments listed. Or pain ratings including medications and frequency may be the focus of the report. Once the assignment is clear, present the first one or two pages of the report to the attorney for review. This preview can identify any additional information needed. Revision is easier at this stage than after you have reviewed several thousand pages and completed the report. The format itself is not usually the attorney's main concern if the report is complete and easy to follow.

Further explanation may warrant a research section. This is an excellent opportunity to present medical illustrations, pictures, video snapshots, and pictures of the patient's injuries, scars, and treatments. If research is not your forte or you have time limitations, consider subcontracting an LNC proficient in this area to help.

The attorney may also request a section that explains potential complications arising from life-altering injuries or medical procedures. For example, a nephrectomy performed on a young adult with hypertension, with a longer life expectancy in which the remaining kidney may fail, followed by dialysis or transplant. This possibility should be considered as part of future medical treatment.

The client's perspective on the injuries or resulting disabilities can be powerful. A day-in-the-life video may be one way to provide this. Another is creating the story from the client's deposition, using the deponents' exact words.

Unlike an LNC who has offered expert opinion testimony, as a medical record fact witness you have no opinions. The information presented is based on facts from the records, depositions, and research, unlike the testimony of standards-of-care experts. When asked, "Ms. Nurse, in your opinion, … ?" your only answer is, "I have no opinion. The medical record states… ." Always remember your role. You are not there to opine, despite attempts to have you speak to the contrary.

The attorney will decide the timing of your testimony. Testimony early in the trial educates the jury about complicated medical information in laymen's terms, so the jury understands the injuries, surgeries, complications, and potential life-long implications before other experts speak. Summarizing the medical information and multiple medical facts introduced in evidence may be best at the end of the trial.

DEMONSTRATIVE EVIDENCE OR DEMONSTRATIVE AIDS?

Be prepared for that initial call from the attorney or paralegal. Know what you can include. Interestingly, the Federal Rules of Evidence lack a clear definition of *demonstrative evidence* or *demonstrative aids,* despite often using the terms. One reference states that courts call demonstrative evidence any means used to display or explain other testimonial, documentary, real proof, or a judicially noticed fact (Brain & Broderick, 1992).

Demonstrative evidence is any visual aid or object used to help the witnesses to demonstrate oral testimony (Imwinkelried, 2008), such as models, charts, photographs, videos, or diagrams (Brain & Broderick, ibid). Descriptive evidence can be depicted visually in an illustrative exhibit (Lane & Lane, 2016) that can be pre-made, prepared by counsel, or created by a witness during testimony (Brain & Broderick, ibid).

Demonstrative aids, sometimes called visual aids or illustrative aids, are tangible pieces of information. They help the witness demonstrate oral testimony better, to provide jurors with a better understanding of facts (Quinn, 1999).

The medical record fact witness may be asked to prepare an illustrated report. However, using visual aids can make any LNC report stand out. Websites have free medical illustrations, or the LNC can make a chart or graph. Photos of the client's injuries, surgical scars, or prosthetic limbs are useful to help jurors to put themselves in the client's place when considering the effects of an injury on quality of life and future needs.

Case study 1

The client was a 24-year-old male who sustained multiple gunshot wounds. The attorney requested the LNC's report to illustrate his many surgeries for the jury, i.e., the damage to his colon necessitating resection and colostomy.

The LNC showed the effects of colostomy surgery with a photo of a colostomy with the bag (Figure 1.), a medical illustration from ADAM (Figure 2.), and a screenshot from a YouTube video (Figure 3.).

Fig. 1. Colostomy with bag, YouTube video screenshot

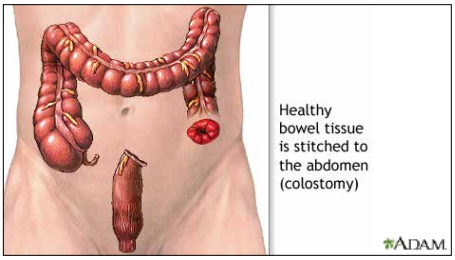


Fig. 2. ADAM illustration of colostomy formation, MedlinePlus, Medical Encyclopedia

Fig. 3. Colostomy surgery showing stoma being stitched to skin, YouTube video screenshot

The report contained the full colostomy care discharge instructions. The report also included the client's deposition testimony about his perceptions of himself and how he dealt with his colostomy, e.g., He didn't socialize with friends for a year while he had the colostomy bag because *"I felt like everyone could smell it and see it under my clothes, like it was visible."*

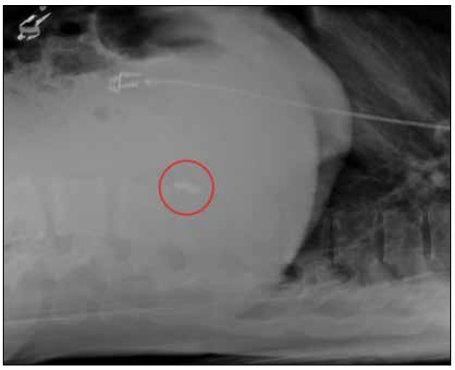


Fig. 4. X-ray of bullet near spine, Cimino-Fiallos N (2017), *Gunshot Wounds: A Targeted Approach.*

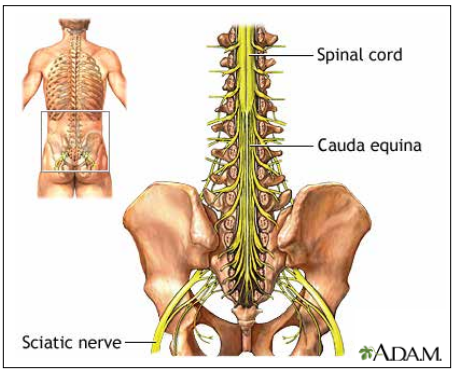


Fig. 5. ADAM illustration of spine showing cauda equina, MedlinePlus, Medical Encyclopedia

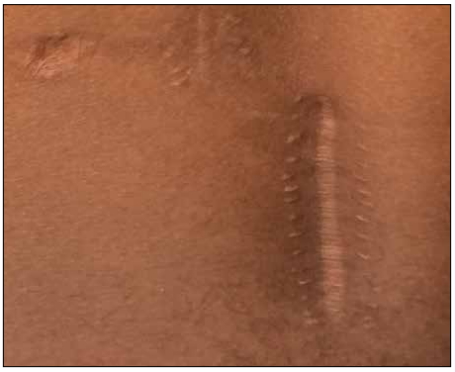


Fig. 6. Photo of spinal incision where bullet was removed, altered for client anonymity

Another bullet lodged near his spine. The report included a photo of a bullet in this position referring to a peer-reviewed article (Figure 4.), an illustration and explanation of the client's bullet's spinal location (cauda equina, Figure 5.) with a photo of the client's surgery scar, altered for anonymity (Figure 6.), and the client's deposition answers about how he felt when he was told he might be paralyzed, i.e. *"I was depressed because first, I almost died then someone told me I might be paralyzed."*

Case study 2

The client was a 55-year-old female who alleged daily headaches following 2 failed blood patches for a dural puncture during an epidural anesthetic. The attorney requested a visual representation of how very frequent headaches affected her life. The LNC designed this pie chart comparing the average duration in days of tension, menses, and migraine headaches in the general population to the plaintiff's daily headaches over a one-year period (Figure 7).

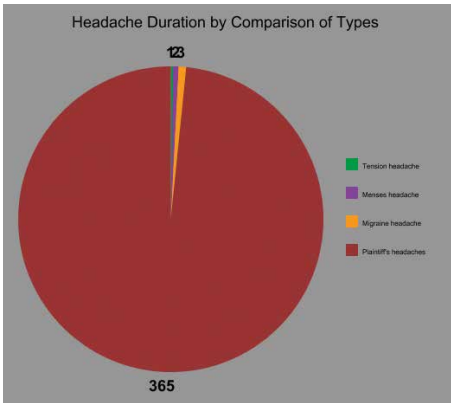


Fig 7. Graph of headaches over 1 year period, prepared by author

Key: tension headaches may last 1 day; menses headaches may last 2 days; migraine headaches may last 3 days; the plaintiff has headaches ***every day****.*

Case study 3

The client was the family of a 50-year-old male decedent who alleged negligence in treatment of an aortic root aneurysm documented in his medical records as increasing in size. He died at home when the aneurysm ruptured.

The LNC's report included an explanation with medical illustrations and surgical recommendations.

Aortic Root Aneurysms

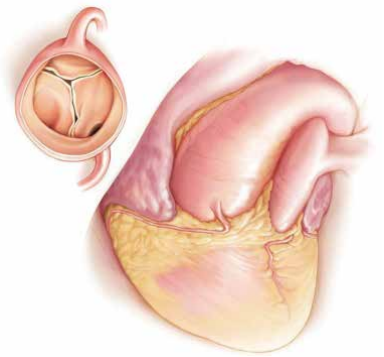


Fig. 8. Illustration of aortic root aneurysm from aortarepair.com website, Mount Sinai Health System

As the word implies, the aortic root is the first portion of the thoracic aorta that joins the outflow from the left ventricle (main heart pump) and to the remaining segments of the aorta. The aortic root is the first two to three centimeters of the aorta comprising of the aortic valve, annulus, aortic sinuses, and opening to the coronary arteries. Aortic root aneurysms are associated with acute aortic dissections. In general, elective repair is considered when the risk of rupture is greater than the risk of surgery. The consensus is to operate when the aortic root has reached 5.5 cm in good surgical candidates.

Unlike an LNC who has offered expert opinion testimony, as a medical record fact witness you have no opinions.

Using good visual aids enhances the attorney's understanding and makes the LNC's work product stand out.

Valve-Sparing Root Replacement

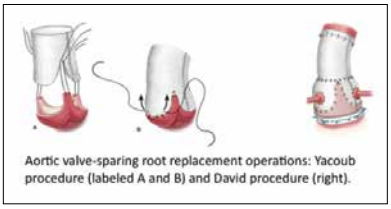


Fig. 9. Illustration of aortic valve-sparing root replacement showing grafts in Yacoub and David procedures from aortarepair.com website, Mount Sinai Health System

As described above the aortic valve is re-implanted into the prosthetic tube graft and carefully sutured to re-establish a functioning aortic valve. Occasionally, the aortic valve needs additional repair during the operation to achieve adequate closure of the valve leaflets..."

These example case studies are by no means comprehensive but provide some ideas of how the use of visual aids enhances the attorney's understanding of the medical facts. This makes the LNC's work product stand out and can give an edge to a marketing strategy.

SUMMARY

An LNC may serve as perform as an expert medical record fact witness in different types of cases. An illustrated report of medical record facts as part of the LNC's work product can educate the attorney and triers of fact, or demonstrate that one picture is indeed worth a thousand words. Medical illustration, video snapshots, and the client's own photos of injuries are valuable assets to support your attorney-client's case.

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Mila Carlson is the Founder and President of Mila Carlson & Associates, P.C., Nurse Consulting/Nurse Life Care Planning. Mila's background is in medical/surgical nursing, enterprise patient scheduling, and healthcare administration. She is a member of the American Association of Legal Nurse Consultants (AALNC), the American Association of Nurse Life Care Planners (AANLCP), and National Alliance of Medicare Set-Aside Professionals (NAMSAP).

With more than 40 years of healthcare experience, Mila assists defense and plaintiff attorneys with medical-related cases, such as medical malpractice, personal injury, criminal or family law. Life Care Planning options include preparing life care plans/ medical cost projections, critiquing opposing counsel plans, and providing expert witness testimony on these plans. She may be reached at milacarlson@milacarlson.com.

Joanne Walker BSEd, RN has been a nurse for more than 40 years and specializes in the Perioperative area. Since establishing her LNC business, Clarity Medical Legal Consulting, in 2007 she has also developed an interest and expertise in research. Joanne has testified in deposition and at trial as an expert witness. She can be contacted at jwalkLNC@yahoo.com or by phone (661-526-3467/443-616-4954).

Medical Malpractice Case Evaluation Through Mock Trials

John Savoth Esq.

Keywords: Medical Malpractice, Litigation, Mock Trial, Trial Preparation

Using a mock trial to evaluate a medical malpractice case must be properly planned to realize its benefits. Lack of proper planning can lead to pitfalls. A well-executed mock trial can meet many goals, including full case evaluation, early trial preparation, guidance for settlement, and receiving information to use during litigation.

INTRODUCTION

Handling a medical malpractice case is fraught with many elements not present in other litigation. Professionals often take actions against them personally because they may have to report the action to a state board; this can, in their minds, affect their reputations and thus their ability to practice. The medical issues alone are often complex and not easily distilled into an explanation a jury can understand. Attorneys representing a plaintiff in a medical malpractice action must understand that they will never know the medicine involved in the case better than the defendant; even so, the attorney must study and understand the medical records on which the ultimate outcome often turns. Conducting a mock trial is a prudent way for a lawyer to prepare. This article will discuss the benefits of a mock trial and suggest methods for conducting one.

WHAT IS A MOCK TRIAL?

A mock trial is an exercise which enables attorneys to give a case a "test

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run" before a jury. The cost can be considerable, depending on whether one uses an outside consultant or keeps the process entirely in house. It also depends on how detailed the attorney wants it to be. The attorney can simply give opening and closing arguments and present key evidence, or escalate all the way up to presenting live or video witnesses, depending on the budget and goals of the exercise.

A mock trial is *not* a focus group, which is more expensive, usually involves professionals with a psychology background, and focuses primarily on specific issues or the demographic makeup of the jurisdiction.

GOALS OF THE MOCK TRIAL

Case Evaluation: The complexities of a medical malpractice case means the lawyer must "get into the weeds" early to analyze the interplay of law and the applicable medical standard of care precisely. This process must include review reviewing and analyzing any retained medical or nursing expert. Living with a case for several years can distort attitudes and views; the attorney who takes ownership of the arguments and contentions can often lose objectivity and sight of the big picture.

Presenting the case to a mock trial jury before trial will expose faults in reasoning and provide an unbiased evaluation of the case's merits. Finally, most lawyers do not know or understand a jury's reaction to a case presentation until the foreman announces the verdict-- and then it's too late to fix it.

Trial Preparation: Conducting a mock trial forces attorneys to prepare their cases far before the actual trial. This allows the retained expert the luxury of analyzing the evidence, often the medical records, in advance. This allows the lawyer time to have a broad-based discussion of the expert's initial opinion to properly refine it before the opposing side sees it.

Settlement Aspects: As the case moves towards trial, the results obtained from the mock trial can be a settlement tool. Attorneys often take the detailed comments rendered by the mock jury along with the damages it determines and discloses them to the opponent. Of course, this means the jury's conclusions must be edited to ensure no aspect of the attorney's theory and argument is revealed to the opposing side. When opponents receive such information, they can be forced to potentially re-evaluate their position on the case. This often leads to a more serious attempt at resolution.

WHAT INFORMATION DO YOU OBTAIN THROUGH MOCK TRIAL?

Primarily, the attorney obtains an unbiased case evaluation. If witnesses testify either live or by video, what does the jury think of the witness's credibility and likeability? Does the jury understand the case theory? Does the theme resonate with them? Do lay people fully understand explanations for the medical procedures at the crux of the cause of action? The attorney will also have a better sense of whether a jury will accept the arguments' tone and content.

HOW TO CONDUCT A MOCK TRIAL

Several important steps must be taken to ensure that the results of the mock trial provide an unvarnished view of the case. First, an unbiased panel must be selected from a voir dire similar to the jurisdiction. To ensure the panel is committed to the process, each member must must be paid enough to make it worth their while, typically $75-$100 per day depending on location.

The closer the structure of the trial or presentation mirrors an actual trial, the more reliable the results will be. It is beneficial to use live witnesses; however, the problem arises because you only have the witnesses available for your side of the case. The best scenario is to videotape depositions of both sides' principal witnesses and show the edited videos to the panel. Unless depositions have been taken for trial, they must be edited due to time constraints if too much irrelevant testimony is placed before the panel.

The attorneys who will try the case must participate and provide the openings and closings. Stand-ins, even if from the attorney's firm, will not be effective because one wants the jury to assess the merits of the presentation style of the attorney trying the case.

Some practitioners think that if a plaintiff lawyer is presenting the mock trial, they should get a defense lawyer to play the other side, because they believe a plaintiff lawyer will not have the mindset or experience on how to defend a medical malpractice case. However, others think that they must use an attorney from their firm who knows the file well, because the visiting defense lawyer will not know the subtleties and nuances of the case.

It is vital to understand that the mock trial tries to accurately present the evidence, theory and argument. The goal is

Presenting the case to a mock trial jury before trial will expose faults in reasoning and provide an unbiased evaluation of the case's merits.

The closer the structure of the trial or presentation mirrors an actual trial, the more reliable the results will be.

not to "win" the mock trial. The attorney must distill the facts to the essential elements so the jury will understand their position and arguments without being distracted by irrelevant information. Finally, it is advisable to conduct the mock trial at a neutral location to ensure the jury is not aware of which side is conducting the trial.

Some attorneys choose a more limited presentation to home in on specific aspects. These can include the jury's consideration of specific case issues, particular claims and/or defenses, or the extent of damages only.

ROLE OF THE LEGAL NURSE CONSULTANT (LNC)

An LNC should be retained to review all the evidence obtained through discovery to provide professional insight to the attorney on potential medical issues. An LNC can also be an expert witness before the mock jury, particularly in describing whether nursing care was within the acceptable standard of care. Whether retained as a consultant or expert witness, the LNC is a vital resource to help determine the viability of various arguments the attorney intends to posit.

POTENTIAL PITFALLS OF A MOCK TRIAL

The attorney must understand the information or results obtained from a mock trial. Inconsistent or incorrect results will often lead to an inaccurate analysis of the case's strengths and weaknesses. One must not attempt to win the mock trial by presenting the evidence in a biased manner. One must expose the mock jury to all positive and negative aspects in order to obtain a realistic assessment of its overall value.

The cost of a mock trial can be considerable (often over $10,000), so it is only recommended for cases with a potential value that will justify the expense.

SUMMARY

A mock trial is an effective tool for any attorney handling a medical malpractice case. It requires early preparation and analysis to gain a better understanding of potential pitfalls in case theory and argument that will be presented to a jury. Its usefulness is determined by the level of work and detail put into the process. Since cost is a factor, mock trials are generally reserved for significant medical malpractice cases. The rewards offered are very beneficial and can lead to a just result.

John E. Savoth, Esquire is the Deputy Court Administrator for the Special Courts of the 38th Judicial District in Montgomery County, Pennsylvania. He is also an adjunct professor at Delaware Law School, Widener University, teaching Evidence, Trial Advocacy, Public Speaking and serving as director of the school's interscholastic trial team. Prior to his current position with the courts, John was a trial lawyer for 30 years, most recently being Of Counsel to the Philadelphia based firm of Saltz, Mongeluzzi, Barrett & Bendesky. He served as Chancellor of the Philadelphia Bar Association in 2012. He can be contacted at jesavoth@widener.edu.

Check Your Answers

Test Your Case Screening Skills Page 8

Case #1:
Referred out to firm specializing in long term care litigation.

*Potential recovery (even assuming negligence) not sufficient to offset the cost of litigation

*Pressure ulcer may not have been preventable – would have to look at records

*Would have to look at impact of pressure ulcer (pain & suffering; loss of function)

*Death may not have been related to ulcer – may be problematic that autopsy not done

*Significant underlying medical/cognitive issues – limited life expectancy

Case #2:
Reject

*Different care and treatment would not have changed the outcome

*Lesson: lack of empathy and poor/inappropriate communication with patients makes it much more likely they will seek legal counsel in the event of a poor/unexpected outcome.

Case #3:
Reject

*Probably no malpractice (prescribing oral antibiotics vs IV initially)

*Insufficient damages

Tales from the Court: Experienced LNCs at Trial and Deposition

Minda Lee Lockeretz, BSN, RN, CRN

Keywords: LNC at trial, LNC at deposition, LNC experiences, LNC stories, nurse expert witness, in-house legal nurse, legal nurse experiences, courtroom experiences

A Round Table collection of candid "courtroom war-stories" from experienced LNCs to convey expertise, helpful tidbits, pitfall avoidance strategies, humor, and the importance of staying cool under fire.

Trial and deposition experience for the legal nurse consultant (LNC) varies. Whether working as expert witnesses or in-house, nurse consultants know preparing for court takes time, research, commitment to the record, linguistic and auditory strategy, insight, and, apparently, a side of gumption. In this candid Round Table discussion, we invited LNCs with deposition and trial experience to share helpful tidbits, pitfall-avoidance strategies, humor, and the importance of staying cool under fire. Volunteers came from the 2018 AALNC Annual Forum in Clearwater, Florida, by colleague referral, and from the LNC-Exchange list.

JLNC: What hadn't occurred to you until you experienced it on trial or at a deposition?

JD: I had no idea how many things the attorneys must consider about each question asked by opposing counsel. Is the question leading? Is the content within the scope of the expert's disclosure? What did the expert opine at

the deposition on that topic? Does the question call for speculation? And more!

Anonymous (Anon.): The concept of active listening! Listen carefully to each question, take a breath before answering (to give time for any objections), and answer what was asked. Don't elaborate unless you're prepared to be quizzed on every extra word of your reply.

Anon.: One time, I was questioned about something the client allegedly said that didn't sound familiar. I started searching my documents when the OC said, "Never mind; it's okay." It turned out the client had never been asked about the issue! When in doubt, always ask the opposing counsel to show you the document in question.

JM: I didn't know that objections have no discernible effect during a deposition. Court rules permit objections to be noted, but the deposition continues, and the questions must be answered. If the attorney uses portions of the deposition during the trial, objections then come into play. If no objections were made during the deposition, they might not be allowed during the trial.

KP: I had no idea how long it would take to prepare for deposition and trial. You must be able to answer and recite case facts and details cold, which means hours of preparation: re-reading deposition transcripts, anticipating, and preparing answers to questions that will likely be asked.

JLNC: If you were to cast a Lifetime TV miniseries about your legal nurse courtroom experience, what characteristics would the actor have to express to define the role of expert witness?

Anon: Calm, pleasant, put together, knowledgeable but non-threatening, with a dry sense of humor.

Anon.: Personable but strong; friendly but not a pushover; capable but not cocky.

LB: Wear a poker face. While it's important to be passionate, the jury reads everything.

JLNC: What routines help you when you prep the day of the trial or deposition?

Anon.: Get a good night's sleep! I double check that all my materials are thoughtfully organized for deposition. For the trial, I review the facts, reports, and know my deposition cold.

JM: I practice my spiel alone and out loud with a timer, then again in front of a peer or layperson (e.g., friend or family member, keeping confidentiality). Hearing myself speak helps me realize when I might be confusing or convey an unintended tone. The timer helps me stay mindful of how long before people (the judge or jury) tune out.

KP: Most crucial routine to me is to put all other casework away! For a day or two before the deposition, I focus my attention on that one case. I don't want to get confused about case details.

JLNC: As an expert witness, how do you maintain composure with hostile OC? Have you ever been pushed past your limits?

Anon.: I keep smiling and repeating that I'm trying to work with them. If it gets too bad, I'll ask on the record to please stop yelling or bullying me.

Anon.: I show no emotion or reaction. It irritates the OC just like it irritates a self-important surgeon.

Anon.: I once swore in Italian out of frustration. Not my proudest moment, but on the deposition transcript it just reads "unintelligible."

Anon.: I remind myself what my mom always taught me; never allow ignorance to get me upset. I also remember that my role as a summary provider gives the client a voice. I don't want to be discredited.

KP: I have not been pushed past my limits outwardly, but inside my head, I've been screaming! I had an attorney throw himself around in his chair, cranking his head backward and hitting the chair while rolling his eyes. It was annoying, but I maintained my composure.

JLNC: Was there a time when you had difficulty keeping your cool?

Anon.: I was 45 minutes late to a deposition due to heavy construction and incorrect address. I was quite flustered when I arrived. The opposing counsel sniped at me from the beginning and conducted the entire deposition using the "would you agree" tactic, only allowing me to answer yes or no. If I replied anything else, he repeated the question stating he would continue repeating it until I cooperated. I was so rattled that when I was driving away, I didn't notice yellow tape and traffic cones isolating fresh asphalt. I hit some equipment, it got stuck on my bumper, and three workers had to chase me as I drove away. Not one of my better days!

Anon.: During a deposition, the opposing counsel was aggressive and condescending. My hiring attorney was shocked by the OC's behavior. Even the court reporter marveled and stated it was the most contentious deposition she'd ever attended. Throughout it all, I stayed calm and composed. The opposing counsel was so busy trying to intimidate me, he committed a rookie mistake and blew his case!

I once swore in Italian out of frustration. Not my proudest moment, but on the deposition transcript it just reads "unintelligible."

KP: An attorney attempted to discredit me because I couldn't recite the latest clinical briefs on a stroke medication. My expertise is as a nurse, not a physician, but his line of questioning made me appear as though I wasn't educated and unprepared to take care of stroke patients. It was very frustrating.

Not every attorney is skilled at deposition and trial preparation. Be ready to ask the questions you need to feel confident that you can give your best to the client.

JLNC: In what ways have your techniques for prepping changed since you began your on-the-record career?

Anon.: I no longer write opinions or anything in email other than to set up conference times. I'm careful about posting anything online and am wary of public speaking. I also make sure to maintain the entire file and download it to a thumb drive for OC to have at the end of the deposition. (Ed. note: Only with your attorney-client's permission)

KP: My prep time before testimony has increased. I also Google the attorney who will be deposing me. I want the full visual to help prepare mentally for the moment when I walk into the room.

Anon.: I'm very methodical now. I keep a spreadsheet that is just the salient facts, with the source, date, time, and the findings. If there is something related that either disputes or confirms the findings, I'll note that as well. I don't put any of my opinions there, but it reminds me of my "talking points" when I'm at a deposition. I make sure my attorney-client knows what he needs to ask me on cross-examination.

VP: After an experience lacking pre-trial preparation with retaining counsel, I changed my hiring contract to reflect how and when I want to be prepped by the attorney. I also make sure to have lots of extra time rather than assuming the trip will take the "normal" amount of time to arrive. I also know where everyone sits in the courtroom and have loads more courtroom experience, so I don't look so "green." The good news is that everyone starts somewhere and even a less than ideal situation can be a successful one.

JLNC: Have you ever had a legal strategy fail?

Anon.: Trial exhibits I'd prepared with the attorney were not able to be used due to a recent California ruling. Use of the exact professional guideline wording when preparing exhibits is now hearsay in CA; our exhibits were excluded (People vs. Sanchez (2016) 63 Cal.4th 665). (Note: Professional guidelines may be used if they have been interpreted and then re-worded for the understanding of the court.)

JM: I made a timeline graph (not a chronology) to illustrate causation, and it ended up just being confusing and gave no weight to the case.

Anon.: No, but I did forget one of the defendant's names and what she had done. OC had a field day with it.

JLNC: What is the most unusual thing you've seen occur in trial or at deposition and how was it handled?

Anon: Opposing counsel contacted my employer about disqualifying me as a witness. They didn't go through the appropriate channel (the judge or the attorney for whom I was testifying). My employer chatted with me, found nothing disqualifying me to testify against the other party and blessed my participation. My retaining counsel made sure to speak out about the improper procedure after I shared the experience. I was not disqualified, the OC did not depose or cross-examine me, and the Plaintiff won the case.

Anon.: At my very first deposition, my retaining counsel (RC) would kick me under the table any time there was a trick question. Then, my RC and the opposing counsel got into a shouting match; the OC threatened to compel me to fly to their state to finish the deposition. They all stood yelling at each other while the court reporter pleaded for them to speak one at a time; it turns out it was her first deposition too.

Anon: At one deposition, the opposing attorney explored my Facebook page in depth. He focused on my father's death and said, "Nurse, don't you think your level of grief makes you unable to form an accurate opinion of this case?" I asked him if his father was still alive; he replied yes. I said: "With all due respect, someday you will understand that grief is a terrible struggle, but it doesn't render one senseless. I hope that doesn't happen to you for a very long time."

JM: An attorney conducting a deposition wore too many hats. He was the attorney, representing himself (so he was also a party); the officer of the court/notary to administer the oath (which he failed to do); audio recorder and clerk. Our team did not object when he failed to administer the oath, because we knew it would make the deposition inadmissible. Once he filed the affidavit with the court stating the deposition was performed and that the deponent was "duly sworn," we were able to rebut and oppose successfully. He

was not permitted a second deposition of the witness.

JLNC: As a plaintiff/defense in-house LNC, what makes you feel the most successful in your office?

KJ: I manage a high caseload of lawsuits involving many specialties, so my ability to prioritize and find appropriate experts is essential. Working well with attorneys and meeting deadlines makes me feel good. It's fulfilling at the end of the day knowing I've contributed to another successful legal outcome for our client and our firm.

JD: Being valued as a member of the legal team. Having the attorney comment how helpful my medical chronologies were when he prepared for opposing expert depositions while soliciting and utilizing my feedback, suggestions, and ideas.

JLNC: What advice would you give a nurse considering expert work or leaving the hospital for a full-time in-house career?

LB: Shadow a legal nurse consultant for a day to see whether you like it. It is a different kind of work; lots of paperwork with very little socialization. You may miss the interaction with people and patients.

KJ: Before you leave the hospital, serve on quality assurance and peer review committees. That experience will tell you and potential employers that you can analyze cases. Tailor your resume to the position (as opposed to using your nursing resume), customize your cover letter, and think like an employer. Employers want candidates with the right mix of experience, skills, and attitude. They don't care that you're "looking for a challenging position with a progressive organization."

Anon.: Don't expect the same fees advertisements say can be made. Read every word of a contract with an attorney and get a reasonable retainer upfront. Consider subcontracting if "pounding the pavement" and marketing is not for you. Keep active clinically as that will make you more valuable to attorneys. Take a breath and pause before every answer, and finally, be proud of being an LNC and don't let others try to make you into a "just a paralegal…"

Anon.: Decide what you truly want to do. If you love your clinical work, consider doing expert work, rather than going in-house. In-house is not an "escape" from a job you dislike. If you're considering LNC work because you hate nursing, do yourself and the rest of us a favor…and find another field! LNCs should LOVE nursing!

JLNC: What is the best piece of legal nursing advice that you've received and practice today as part of your career?

Anon.: Do a good job, and your clients will advertise for you.

JD: Ask questions. The more you know, the more invaluable you can become – whether it's enhancing your work product because you grasp the legal concepts or whether it's understanding and thus anticipating your attorney's needs.

Anon.: To use the words, "My normal practice is…" or words to that effect.

JLNC: Any final thoughts about your experience you'd like to share?

Anon.: Not every attorney is skilled at deposition and trial preparation. Be ready to ask the questions you need to feel confident that you can give your best to the client.

JM: I've learned to avoid compound questions, whether drafting them or answering them. Compound questions can be confusing and may elicit an answer you don't intend, and you'll have fallen into the attorney's "gotcha" trap. For example, "Do you agree that it is standard procedure and best practice to perform an EKG on a patient with

It's fulfilling at the end of the day knowing I've contributed to another successful legal outcome for our client and our firm.

an irregular heartbeat?" Although the answer to this question may be "yes," what's considered best practice isn't always the standard procedure, and vice versa. As the witness or deponent, don't accidentally lock yourself into one answer for two questions. As someone helping prepare the queries, it's best practice not to ask compound questions, and any attorney worth their salt will object and ask you to rephrase if the deponent/witness does not ask for clarification first.

Anon.: Dress in a way that makes you feel powerful, even if you're shaking inside. Get your nails done, wear the high heels, rock your accessories. It seems superficial, but it works for me.

Anon.: If you have success- pay it forward by mentoring a new expert.

Regretfully, due to the number of submissions, we couldn't include every contribution. The amount of experience surveyed for this roundtable was vast and quite humbling. We'd be happy to hear more. Send to the editor at jlnc@aalnc.org.

Thanks to the following for sharing their experience with our readers:

Julie Dickinson, RN; julie.dickinson@aya.yale.edu

Katy Jones, MSN, RN; info@lnctips.com

Jenny McCord, BSN, RN; alaskalegalnurse@gmail.com

Kimberly M. Pearson, MHA, MBA, RN, CCHP; correctionalhealth@icloud.com

Victoria Powell, RN, CCM, LNCC, CNLCP®, CLCP, MSCC, CEASII; Victoria@vp-medical.com

with Lorie A. Brown, RN, MN, JD www.lncbizschool.com

and Anonymous (4)

Minda Lee (Mindy) Lockeretz RN, BSN, CRN is a long-time critical care and interventional radiology (IR) nurse. She is available as a testifying expert in her specialty field of radiology nursing. She may be contacted at LockeretzRN@gmail.com.

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XXV.1, March 2019 — Perioperative Care

XXV.2, June 2019 — Issues in the ED

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XXV.3, December 2019 — Nursing Practice and New Nurse Author Supplement

XXVI.1, March 2020 — Implantable Devices

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