

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

Volume 21 ▲ Number 2 ▲ Spring 2010

- ▲ **Standards for Nurse Expert Witnesses:  
A Recommendation**
- ▲ **Factors Influencing Use of Unlicensed  
Assistive Personnel in the Intra-Operative Environment**
- ▲ **Sharpen Your Writing Skills**
- ▲ **Low Back Pain (Part One Non-Surgical)**
- ▲ **One (L)NC**



**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  
Kara DiCecco, MSN RN LNCC  
Patricia Fedorka, PhD RNC  
Holly Hillman, MSN RN  
Lori Hinton, PhD BS RN  
Mary O'Connor, PhD RN  
Eileen Watson, EdD RN MSN ANP  
GNP LNCC  
Suzanne Langroth, BSN RN 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 2 ▲ Spring 2010

## Features

---

**\*Standards for Nurse Expert Witnesses: A Recommendation..... 3**

*Tamara C. McConnell, MSN RN PHN*

*Stephanie Vaughn, PhD RN CRRN*

The importance of expert testimony is crucial in medical malpractice cases. Whether it be in front of a jury or judge, the role of the expert witness is critical in explaining medical terminology, procedures, and standards of care. In the event of an attack on his or her credibility, the qualifications of the nurse expert witness (NEW) must be sufficient. The focus of this article is to discuss evidence-based recommendations for establishing minimum standards of expertise for those nurses who testify as expert witnesses. A comprehensive literature review of nursing and medical expert qualifications was performed for the purpose of contrasting current published guidelines. Today, specific criteria or competencies that set minimum standards of expertise for the nurse expert witness do not exist. Nursing's professional obligation to uphold and maintain its standards coupled with the recent acknowledgement by the judicial system that only nurses should opine on nursing standards of care are the significant reasons why the establishment of minimum standards of expertise for the nurse expert witness should be considered.

**\*Factors Influencing Use of Unlicensed Assistive Personnel in the Intra-Operative Environment..... 8**

*Mary Arbogast, CST RN BS CNOR*

In July 2007, the ANA has officially renamed Unlicensed Assistive Personnel (UAP) to Nursing Assistive Personnel (NAP) to accurately describe and include individuals who are licensed or formally legally recognized in some states. For the purposes of this article, the term UAP has been used to clearly define individuals who are not licensed or legally recognized.

**\*Sharpen Your Writing Skills, Part I ..... 13**

*Pat Iyer, MSN RN LNCC*

*One should not aim at being possible to understand, but at being impossible to misunderstand. - Quintilian*

This is the first part of a two part article. Part I addresses the focus of your writing, the format of your material, and the design elements of your reports. Part II covers flow, organizing, editing, proofreading, and saving your work.

## Departments

---

**Editorial .....2**

Spring is Here!

*Bonnie Rogers, DrPH COHN-S LNCC FAAN*

**Clinical Maxim .....16**

Low Back Pain (Part One Non-Surgical)

*Kara DiCecco, MSN RN LNCC*

**References and Resources.....21**

Low Back Pain/Non-Surgical Online Resources

*Kara DiCecco, MSN RN LNCC*

**Professional Practice, Trends, and Issues .....22**

One L(NC)

*Julie Dickinson, MBA BSN RN*

**Book Review .....25**

Case Studies in Nurse Anesthesia

*Kara DiCecco, MSN RN LNCC*

*\*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.*

# Spring is Here!



For many of us, we have made it through a bit of a harsh winter. In many parts of the country we had lots of snow, ice, and cold. But nature somehow manages to bring a resilience that gives us a fresh perspective on future opportunities. About a month ago, my daughter was at an event for teenage girls that focused on personal growth, leadership, and self-esteem. The organization sponsoring the event also provides educational and personal growth learning services to children in developing countries focusing on reading, writing, public speaking, presentation skills, and developing habits to nurture self-esteem. The organization's owner, also a teacher, showed a short video clip of the work being done with the children, in this case in Africa. When the program was completed, they conducted an "exit" interview with a sample of the children, asking what had been learned or gained through participation in the program. One of the boys about 10 years old, instead of saying he had learned how to write or speak better, said, "I learned I can have a future bigger than my past". I marveled at this wisdom and vision spoken by a 10 year old boy in a country without many resources. WOW, I thought! So, while we may think what we do influences others in certain or specific ways, the influence we have may be greater or more profound than we can imagine. As nurses we are very fortunate to touch and influence many lives in the course of our work, but we may not fully realize the impact we have even in small ways. And as we grow in our professional lives, we will continue to be fortunate to have these opportunities to touch and influence others in positive directions we don't yet know about.

In this issue Julie Dickinson describes her new role as an LNC and all that she has learned in just one year. As you read her article, you can feel the passion for the difference she has already made throughout her nursing work and that this will continue in this new LNC specialty area she has chosen. Tamara McConnell and Stephanie Vaughn provide an excellent discussion on the importance of standards for nurse expert witnesses. It is clear from their discussion that these types of standards can benefit the client and impact credible and clear decision-making. Mary Arbogast provides an interesting article that describes the importance of having the appropriate professionals making the appropriate decisions, and recognizing when and what kinds of delegation of tasks are needed and to whom. In a two part article, Pat Iyer gives a timely and valuable discussion on the keys to successful writing outlining several key points to help make your documents clear, organized, and concise but reflecting the content intended. Finally, Kara DiCecco provides an excellent review of low back pain (non-surgical) and its relationship to legal considerations along with helpful resources for diagnostic and treatment modalities.

In all of these articles, what we do as nurses and LNCs is evident... from standards' development, judgment about delegation, clear communication, knowledge acquisition, and professional growth. Each and everyone of these discussions can play an important role in influencing decisions and actions that impact our clients and our patients so their future can be bigger than the past.

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

# Standards for Nurse Expert Witnesses: A Recommendation

Tamara C. McConnell, MSN RN PHN  
Stephanie Vaughn, PhD RN CRRN

## KEY WORDS

Evidence-based, Standards of Care, Testimony

---

*The importance of expert testimony is crucial in medical malpractice cases. Whether it be in front of a jury or judge, the role of the expert witness is critical in explaining medical terminology, procedures, and standards of care. In the event of an attack on his or her credibility, the qualifications of the nurse expert witness (NEW) must be sufficient. The focus of this article is to discuss evidence-based recommendations for establishing minimum standards of expertise for those nurses who testify as expert witnesses. Today, specific criteria or competencies that set minimum standards of expertise for the nurse expert witness do not exist. Nursing's professional obligation to uphold and maintain its standards coupled with the recent acknowledgement by the judicial system that only nurses should opine on nursing standards of care are the important reasons to consider the establishment of minimum standards of expertise for the nurse expert witness.*

---

## Purpose

The purpose of this article is to discuss evidence-based recommendations for establishing minimum standards of expertise for those nurses who testify as expert witnesses. A comprehensive literature review of nursing and medical expert qualifications was performed for the purpose of contrasting current published guidelines. Specific criteria or competencies that outline minimum standards of expertise for the nurse expert witness have not been formally published. Nursing's professional obligation to uphold and maintain its standards coupled with the recent acknowledgement by the judicial system that only nurses should opine on standards of care (SOC) are the significant reasons why the establishment of minimum standards of expertise of the NEW should be considered.

## Background

Nursing's role in providing patient care has expanded in response to increasing patient acuity, technology, evidence-based practice, managed care, and the advancement of the profession. Because of this professional evolution, nurses are in a position of higher accountability. This accountability equates to increased liability and as a result, nurses are at higher risk for being sued. In response to increasing malpractice litigation, nurse expert witnesses are frequently consulted to provide opinions on deviations or adherence to nursing standards of care.

Recently, there has been judicial recognition that only nurses should opine and testify to nursing SOC. Historically, the courts have allowed physicians to provide such testimony. In 2004, an Illinois Supreme Court Case ruled that physicians may not testify about nursing SOC and that only nurses can offer such opinions. The court quoted a 2003 amicus brief from The American Association of Nurse Attorneys that stated:

A physician, who is not a nurse, is no more qualified to offer expert opinion testimony as to the standard of

care for nurses than a nurse would be to offer an opinion as to the physician standard of care....Certainly nurses are not permitted to offer expert testimony against a surgeon based on their observances of physicians or their familiarity with the procedures involved (p. 13).

Unfortunately, the court did not establish specific criteria or competencies required of the nurse expert (Murphy, 2004). In *Purtill v Hess* (111 Ill2d 229, 489, NE2d 867 [1986]), the court did list requirements for a physician expert which included that the expert witness "must show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians in a similar community" (p. 867). The judge still has the discretion to allow the physician to testify based on whether he or she feels that the physician is qualified. This is an area of vital significance for nurse experts and the profession as a whole to establish their own criteria for opining on standard of care issues. As stated by Butler (2004), "the nursing profession — and only the nursing profession — has the right, duty, responsibility, and expertise to determine the scope and nature of nursing practice including the standard of care for nurses. This includes those standards introduced as evidence in the legal arena" (p. 8).

## Significance for Nursing

Nurse expert witnesses are consulted to provide opinions on nursing SOC. As previously discussed, there has been judicial recognition that only nurses should opine on nursing SOC issues; however, because the court did not establish specific criteria or competencies required of nurse expert witnesses, an opportunity to establish such criteria exists.

An evaluation of specific qualifications of those testifying is vital in determining minimum standards of expertise. These standards will enhance the credibility of nurse expert witnesses and strengthen the integrity of the nursing profession.

**Table 1: Qualifications of Medical Experts According to Professional Organizations**

	<b>AMA</b> American Medical Association	<b>ACOG</b> American College of Obstetricians and Gynecologists	<b>ACR</b> American College of Radiology	<b>AAN</b> American Academy of Neurology
Current , unrestricted license to practice medicine	X	X	X	X
Board Certification	X	X	X	X
Active clinical practice and/or teaching publications	X	X	X	X
Specialty of expert appropriate within case subject	X	X	X	X
Devoting >20% of time to medical legal work	X	X	X	X

Why is this important? Any registered nurse can proclaim to be an expert in his/her specialty. Currently, attorneys evaluate a nurse’s curriculum vitae to determine whether the nurse is qualified as an expert. Judges then certify the nurse at trial. The nursing profession and specialty nursing organizations have a responsibility to define the practice, including the qualifications of nurse experts. Additionally, an opportunity exists to educate attorneys that “a nurse is nurse is a nurse” is not an accurate statement. This is especially inaccurate when considering the expertise of one nurse expert over another.

### Literature Review

In reviewing the literature about the use of nurse experts, some authors have offered their definitions of a nurse expert. Jasper (as cited in Naumanen-Tuomela, 2001) defined the expert nurse as “a nurse who has developed the capacity for pattern recognition through high level knowledge and skill, extensive experience in the specialist field, and who is identified as such by her peers” (p. 257). Though this definition is important in recognizing those with clinical expertise, it does not capture the qualification criterion of nurse expert witnesses.

More appropriately, Perry (1992) discussed her views on the qualifications of the clinical nurse specialist (CNS) as an ideal expert witness because of education, training, clinical expertise, and publications. Though she acknowledged that “any nurse has knowledge that an ordinary person does not have and thus can qualify as an expert witness” (p. 122), she asserts that the qualifications of the CNS lend more credibility to serving as an expert. Furthermore, Perry concurred with Butler (2004), Cady (2000), Croke (2006), Koniak-Griffin (1996), Murphy (2004), and Ruiz-Contreras (2005) that nurse expert witnesses must be clinically competent and active within their areas of specialty.

Knowledge of nursing SOC is a key component in a nurse expert’s repertoire. According to Iyer (2003), “the standard of care is a term used to designate what is accepted as reasonable

under the circumstances” (p. 38). It is regularly referred to as that degree of care, skill, and judgment usually exercised by an ordinary prudent nurse under the same or similar circumstances (Albee, 2007; Austin, 2006; Brent 2001; Butler, 2004; Carroll, 1996; Croke, 2006; Demarco, 1976; Dimond, 2005; Ferrell, 2007; Hampton, 2004; Klepatsky, 2006; Koniak-Griffin, 1996; Murphy, 2004; Perry, 1992, Ruiz-Contreras, 2005; Tingle, 2002). As evidenced by an historical perspective of standard of care with articles dating back more than 20 years, it is important to emphasize the importance of this knowledge base as a vital element that any nurse expert witness should possess.

Rendering opinions and testifying to SOC are the essential elements of what the nurse expert is qualified and expected to perform. Koniak-Griffin (1996) pointed out that in response to a claim of malpractice, nurses may be asked to “provide unbiased opinions on matters within their area of clinical expertise” (p. 71). Croke (2006) referenced Federal Rule of Evidence 701 and stated that the expert witness “must be qualified by reason of education, training or experience to opine about a given subject matter” (p. 4). Of note, the person who “qualifies” the nurse expert witness is a trial judge. The designation of expert is by a judge and is not based on a set of criteria. This situation is seen specifically with sexual assault nurse examiners (SANE) who are subpoenaed in criminal cases to provide testimony. This is an important distinction because SANE testimony does not usually involve nursing standard of care issues but a criminal prosecution (Frasco, 2002; Campbell, 2007).

Federal Rule of Evidence 702 dictates expert witness qualifications, but only requires that the expert be qualified by virtue of their knowledge, skill, experience, training, or education. Furthermore, it indicates that scientific testimony should be admitted into evidence if the testimony “will assist the trier of fact to understand the evidence or to determine a fact in issue (Brenner, 2007 p. 613). Other federal rules of evidence such as 703 and 706 allow a broader scope to the background on which expert opinions are based, and allow

the judge to appoint an expert to testify before the court, notwithstanding those retained by counsel.

*Daubert v Merrill Dow Pharmaceuticals*, 509 US 579 (1993) was a pivotal decision in the evolution of expert testimony. Established in 1993, latitude was given to judges in allowing or excluding expert testimony. Brenner (2007) states:

In redefining admissibility, the court sought to provide sufficient discretion to trial judges while providing safeguards for juries by recognizing the value of vigorous cross-examination by the opposing side, the presentation of contrary evidence, and careful instructions to juries on the burden of proof. In other words, rather than excluding testimony entirely and frustrating the legal process, emphasis at trial would defer to legal course in persuading a jury regarding the weight and reliability (or lack thereof) of the testimony. Such cross examination is itself given wide latitude. For example, the history of a defendant may not be admissible, whereas the history of an expert witness may be exposed during cross-examination to impeach credibility (p. 613).

In other words, the questioning of an expert's history and qualifications is allowed much broader latitude than the questioning of a defendant. For example, an expert may be asked about his or her testifying experience to include the ratio of plaintiff to defense cases and the number of times the expert has been retained by a particular law firm.

A recent review of the medical literature reveals an overwhelming consensus that exists within professional medical societies. Within the literature are published guidelines by several professional organizations that outline recommendations for qualifications of individual expert witnesses.

Kesselheim and Studdert (2007) have estimated that at least 38 of the 104 member organizations within the American Medical Association's House of Delegates have established language in their codes of ethics regarding expert witness conduct. The six areas addressed are personal qualifications, case research, opinion, content, partisanship, and reimbursement (Brenner, 2007). Additionally, at least eight specialty medical societies have issued guidelines for expert witnesses to ensure minimum standards. Table 1 illustrates examples of specific medical societies and their recommendations for expert requirements.

The preservation of relevant, evidence-based and ethical testimony by medical experts relies on recommended qualifications by professional organizations. For example, the American College of Obstetricians and Gynecologists recommends that the physician expert have Board Certification, which is recognized by the American Board of Specialties or American Board of Osteopathic Association or a board of equivalent standards. This qualifies the expert by virtue of successful completion of the certification exam. Additionally, familiarity with standard of care at the time of alleged malpractice is qualified by having active clinical

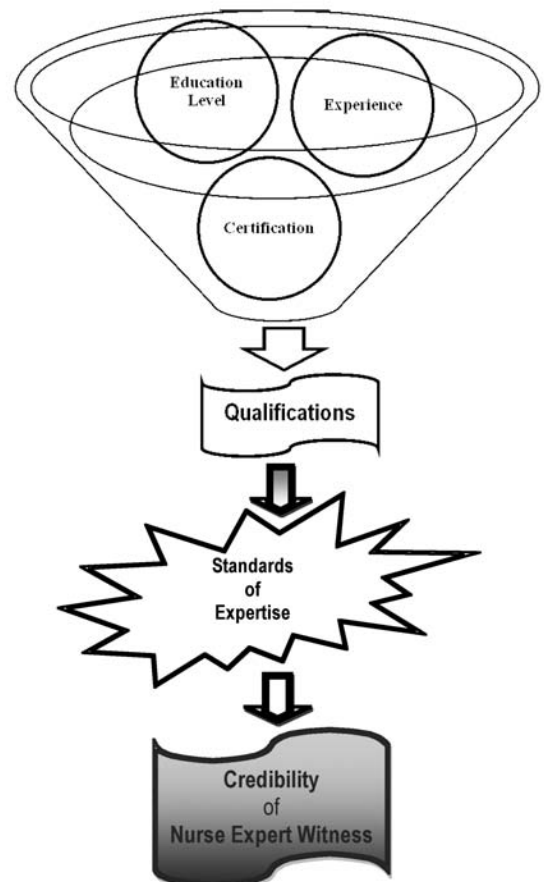
practice or teaching experience (Amon, 2007; Hampton, 2004; Hawkins, 2005; Schulte, 2008; Tenenbaum, 2005; Williams, 2006).

There are trends in restricting medical testimony to qualified experts. Despite some societal positions that an expert may not necessarily have the same clinical experience to testify, some states do not agree. The California Health and Safety Code §1799 states that experts testifying in emergency department care must demonstrate "substantial professional experience in the field during the last five years." This is being supported by the ACEP's position of having relevant experience to case subject matter within the past 3 years. The American Medical Association generally supports this by stating in its code that experts should have "recent and substantive" experience in their testifying areas and limit their testimony to their "sphere of expertise." This is evidence of a trend to promote and preserve professional integrity and credibility (Brenner, 2007; Kesselhiem & Studdert, 2007).

## Conceptual Model

The conceptual model depicted in Figure 1 illustrates the association of three elements that culminate into a nurse

**Figure 1: Conceptual Model of the Standards of Expertise for the Nurse Expert Witness.**



**Table 2: Recommended Qualifications of a Nurse Expert Witness**

1.	Current, active, unrestricted registered nursing license
2.	Baccalaureate degree
3.	Certified in specialty area (i.e. Critical Care Registered Nurse (CCRN))
4.	Active clinical practice and/or teaching
5.	Knowledge of the standard of care pertinent to the case subject

expert witness' qualifications. An evaluation of educational level, experience, and certification leads to the formation of standards of expertise. Ultimately, establishment of these standards strengthens the credibility of a NEW.

The importance of expert testimony is crucial in medical malpractice cases. Whether it be in front of a jury or a judge, the role of the expert witness is critical in explaining medical terminology, procedures, and SOC. In the event of an attack on his or her credibility by opposing counsel, the qualifications of the nurse expert must be exceptional. According to Demorest and Whitman (2004) one of the primary ways that jurors decide which expert to believe is a comparison of qualifications.

Integration of educational level, experience, and training forms the overall qualifications of the NEW (Butler, 2004; Cady, 2000; Koniak-Griffin, 1996; Perry, 1992). Specifically, it is beneficial to have specialty certification, a minimum of five years of clinical experience, a baccalaureate degree, and strong analytical and organizational skills (Koniak-Griffin, 1996). The combination of these qualifications leads to the formation of standards of expertise.

Nursing SOC have been established by nurse practice acts, professional organizations, and evidence-based publications (Cady, 2000; Carroll, 1996; Ferrell, 2007; Lott, 2001; Murphy, 2004; Perry, 1992). Establishment of standards of expertise, promotes a higher level of professionalism, and ultimately leads to increased credibility of nurse expert testimony.

## Conclusion

Based on this comprehensive literature review and experience as nurse expert witnesses, the authors recommend, as highlighted in Table 2, minimum standards of expertise for nurses testifying as expert witnesses. Nurses have legal obligations to the public, their patients, the profession, and their employers. Unethical and inaccurate testimony is contrary to these obligations, an established code of ethics, and professional standards. This testimony is one that plagues not only nursing, but other professions as well. Unfortunately, there are individuals who will cater their testimony to the

desire of counsel, despite their knowledge to the contrary, to satisfy their client. Development of standards of expertise for the NEW would indirectly protect the public by reducing the incidence of unethical testimony.

In January 2006, the American Association of Legal Nurse Consultants (AALNC) published their position statement regarding testimony by an expert witness. Currently, the requirements recognized by the AALNC for opining on nursing SOC is that the expert be a licensed, registered nurse who is competent to testify to such standards. This position is distinctly different from the necessary qualifications of medical expert witnesses (see Table 1).

Because AALNC is the professional society of nursing that promotes the practice of legal nurse consulting and expert witnessing, it is incumbent upon the organization to evaluate and create its own criteria for the NEW. AALNC can use an evidence base of scholarly literature within the nursing, medical and legal to establish, promote, and maintain these recommendations for nurse expert witnesses.

## References

- Albee, T. (2007). The legal nurse consultant as a board of nursing expert witness. *Journal of Legal Nurse Consulting* 18(1): 11-14.
- American Association of Legal Nurse Consultants (2006). *Position statement: Providing expert nurse witness testimony*. Retrieved from [www.aalnc.org/images/ExpWit.pdf](http://www.aalnc.org/images/ExpWit.pdf) testimony
- Amon, E. (2007). Expert witness testimony. *Clinics in perinatology* 34: 473-478.
- Austin, S. (2006). Ladies and gentlemen of the jury, I present the nursing documentation. *Nursing* 2006 36(1): 56-62
- Brenner, R.J. (2007). The expert witness: Understanding the rationale. *American College of Radiology* 4: 612-616.
- Brent, N. (Ed.). (2001). *Nurses and the law* (2nd ed.). Philadelphia, PN: W.B. Saunders Company.
- Butler, K.A. (2004). Interest of amici curiae brief: Submitted in support of respondent, Sullivan v. Edward hospital, Illinois Supreme Court. *Journal of Nursing Law*, 9(4), 6-14.
- Butler, K.A. (2004). Nursing: Qualifications for testifying on standard of care. *Journal of Legal Nurse Consulting*, 15(4), 6-9.
- Cady, R. (2000). So you want to be an expert witness? Things you need to know. *American Journal of Maternal Child Nursing*, 25(1), 49.
- California Health & Safety Code §1799.
- Campbell, R., Long, S.M., Townsend, S.M., Kinnison, K.E., Pulley, E.M., Adames, S.B., Wasco, S.M. (2007). Sexual assault nurse examiners' experiences providing expert witness court testimony. *Journal of Forensic Nursing* (82)1, 7-14.
- Carroll, M. (1996). Nursing malpractice and corporate negligence. How is the standard of care determined? *Journal of Nursing Law* 3:53-60.
- Cohen, F.L. (2004). The expert medical witness in legal perspective. *The Journal of Legal Medicine* 25:185-209.
- Croke, E. (2003). Nurses, negligence and malpractice. *American Journal of Nursing* 10(9): 54-63.
- Croke, E. (2006). Nursing malpractice: Determining liability elements for negligent acts. *Journal of Legal Nurse Consulting* 17(3): 3-7, 24.
- Daubert v. Merrill Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).
- Demarco, C.T. (1976). Breach of duty when you are liable for drug-related injuries. *Nursing* 76, April: 103-106.
- Demorest, L.E. & Whiteman, N.S. (2004). Voir dire of expert witnesses: tactical considerations when challenging qualifications. *Medical Malpractice Law and Strategy*, 21(4), 1, 3, 6.



- Dimond, B. (2005). Exploring the principles of good record keeping in nursing. *British Journal of Nursing* 14(8): 61-64.  
 Fed. R. Evid. 702.  
 Fed. R. Evid. 703.  
 Fed. R. Evid. 706.
- Ferrell, K.G. (2007). Documentation, part 2: The best evidence of care. *American Journal of Nursing* 107(7): 61-64.
- Frasco, L. (2002). Nurse testimony in criminal court: What is admissible? *American Journal of Nursing* 102(5): 65-66.
- Grant, P.D. (1999 Apr-May). Telling it to the judge. Examining the role of nurses as expert witnesses. *AWHONN Lifelines* (2): 43-47.
- Hampton, S. (2004). The role of the expert witness. *Journal of Wound Care*, 13(10), 435-436.
- Hawkins, T.S. (2005). Expert testimony: A perspective from the trenches. *American College of Radiology*, 2, 126-130.
- Iyer, P. (Ed.) (2003). *Legal nurse consulting principles and practice* (2nd ed.). Baton Rouge, LA: CRC Press.
- Johnson, S. Preparing to be an expert witness. *New Zealand Nursing Organization* 13(1): 19.
- Kesselheim, A.S. & Studdert, D.M. (2007). Role of professional organizations in regulating Physician expert witness testimony. *Journal of the American Medical Association* 298(24): 2907-2909.
- Klepatsky, A.D. (2006). Duty: A historical perspective. *Journal of Legal Nurse Consulting* 17(1): 15-18.
- Koniak-Griffin, D. (1996). Expanding horizons: From bedside nurse to expert witness. *Journal of Perinatal Neonatal Nursing*, 10(3), 70-82.
- Lott, J.W. & Brown, G. (2001). The nurse expert witness: *Newborn and Infant Nursing Reviews* 1(3): 181-191.
- Manley, K. (2008). *Nursing talent*. *Nursing Standard* 22(22): 18-19.
- Murphy, E.K. (2004). The expert nurse witness. *AORN*, 82(5), 853-856.
- Perry, S. E. (1992). The clinical nurse specialist as expert witness. *Clinical Nurse Specialist*, 6(2), 122-27.
- Purtill v. Hess*, 111 Ill2d, 489, NE2d. 867 (1986).
- Ruiz-Contreras, A. (2005). The nurse as an expert witness. *Topics in Emergency Medicine*, 27(1), 27-35.
- Schulte, D.J. (2008). Reeves decision changes expert witness qualifications. *Michigan Medicine: The Journal of the Michigan State Society* 107(3):7.
- Tenenbaum, M.J. (2005). Expert witness guidelines: it's our turn. *Clinical Infectious Diseases* 40: 1391-1392.
- Tingle, J. (2002). The professional standard of care in clinical negligence. *British Journal of Nursing* 11(19): 1267-1269.
- Williams, M.A., Mackin, G.A., Beresford, H.R., Gordon, J., Jacobson, P.L., McQuillen, M.P., Reimschisel, T.E., Taylor, R.M., Bernat, J.L., Rizzo, M., Snyder, M.G., Amery, M., & Brannon, Jr., W.L. (2006, Jan). American academy of neurology qualifications and guidelines for the physician expert witness. *Neurology* 66(1): 13-14.

**Tammi McConnell, BSN MSN RN PHN MICN** has served as an expert witness in critical care, emergency and medical/surgical cases for plaintiff and defense since 2002. She is co-owner of Clinical Litigation Services (CLS) that specializes in providing expert services and referrals for nursing malpractice issues. She is a Charge Nurse within an Emergency Department and Level II Trauma Center and is a member of the Emergency Nurse Association (ENA), Sigma Theta Tau (STTI) Nursing Honor Society, Association of California Nurse Leaders (ACNL), and AALNC-National and Orange County Chapter. Her contact email is [tammi.cls@gmail.com](mailto:tammi.cls@gmail.com).

**Stephanie Vaughn, PhD RN CRRN** has served as an expert witness and as a consultant on medical-surgical, long-term care, and rehabilitation-related cases for 15 years. She is currently an Assistant Professor at California State University at Fullerton and a part time CNS at an in-patient rehabilitation hospital. She is a member of the Association of Rehabilitation Nurses (ARN) and Sigma Theta Tau (STTI) Nursing Honor Society. Her contact email is [svaughn@fullerton.edu](mailto:svaughn@fullerton.edu).

### 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 0.5 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.

# Factors Influencing Use of Unlicensed Assistive Personnel in the Intra-Operative Environment

Mary Arbogast, CST RN BS CNOR

## KEY WORDS

Perioperative, Licensure, Delegation, Accountability

---

*In July, 2007, the ANA officially renamed Unlicensed Assistive Personnel (UAP) to Nursing Assistive Personnel (NAP) to accurately describe and include individuals who are licensed or formally legally recognized in some states. For the purposes of this article, the term UAP has been used to clearly define individuals who are not licensed or legally recognized.*

---

The American Association of periOperative Registered Nurses (AORN) National Committee on Education developed the Primer for Undergraduate Perioperative Education (2009), to help prepare perioperative nurses entering the operating room. Within the pages of the primer, unlicensed assistive personnel (UAP) are listed under the sub-heading of ancillary personnel. Also known as surgical care assistants, UAP are not required to be certified; AORN simply states they may be certified and work under the direct supervision of the perioperative registered nurse. AORN (2009) lists examples of UAP working in the operating room. The primer describes their duties and roles as such:

They assist the perioperative registered nurse in “non-nursing” duties. Their duties may include, but are not limited to: transporting patients to and from the OR, obtaining blood and blood products from the blood bank, assisting with transferring patients from the stretcher to the OR and back to the bed upon completion of the surgical procedure, assisting with limb holding during the prepping of the patient prior to the start of the surgical procedure, and the restocking of the operating room. In some institutions, nursing assistants may also be expected to clean the room (AORN, 2009, p.33).

The primer goes on to discuss what AORN calls the Perioperative Patient Experience (p. 25) which outlines the various phases of surgery: pre-operative, intra-operative, and post-operative. The intra-operative phase portion of the text describes who the “unscrubbed” team members are and who the “scrubbed” team members are. The UAP are in the category of unscrubbed personnel with no mention of them in any scrubbed role. This same information is echoed in the AORN 2008 Standards, Recommended Practices, and Guidelines (p. 258) where there is no mention of the UAP included in staffing plans during the **intra-operative** phase of surgery. The usage of the UAP is primarily during the pre-operative and post-operative stages of care where they are delegated appropriate tasks by the RN.

Delegation to UAP may be a paramount duty when one considers the many variables. Because many nurses are still trained under the primary nursing model (Kopishke,

2002), delegating is an added responsibility. The common 5 principles nurses rely upon for delegating are known as The 5 Rights of Delegation: right task, right circumstances, right person, right communication, and right evaluation (Habgood, 2000). But beyond mastering the art of utilizing the 5 Rights of Delegation, an RN must also know the state’s nurse practice act, the UAP job description, and the institution’s policy on UAP. “RN’s not only retain ultimate responsibility, accountability, and legal liability for delegation, but also for any associated problems” (Zimmerman, 2001, p.3).

Several reasons drive the use of UAP: the nursing shortage, budget cuts in healthcare due to lower Medicare reimbursements, and increase costs are just a few (TAANA, 2004). States have overlooked the RN licensure requirement to perform nursing duties and have allowed UAP to function in the RN role (Habgood, 2000). Safely delegated tasks to UAP include:

- tasks that occur frequently
- tasks which are technical in nature (complexity)
- tasks which are considered standard and unchanging (decreased need for problem solving skills)
- tasks which have predictable results (UAP ability)
- tasks which have minimal potential for risk (potential for harm) (Habgood, 2000).

*“Tasks that require perioperative nursing judgment or complex multidimensional application of the perioperative nursing process should not be delegated to UAP” (Habgood, 2000). AORN also recommends guaranteeing appropriate delegation, “state boards of nursing should promulgate clear rules on the use of UAP in OR’s and surgical suites in which nursing care is being delivered.... [And] need to pursue criminal prosecution when there is evidence that UAP are performing perioperative nursing functions” (Habgood, 2000).*

The discussion of UAP in the operating room initially began with the issues surrounding surgical technologists prior to them having a formal, nationally standardized education. Ellen Murphy, former AORN president, drew a parallel which captures and distinguishes the attitude of the non-surgical technologist UAP. She writes:

“Nor does two-week, on-the-job training provided for some assistive personnel substitute for the education

and skills that certified surgical technologists bring to the scrub role” (Murphy, 1995).

Each state’s nurse practice act dictates the legal scope of professional nursing practice. Nurse practice acts provide guidance on what can or cannot be delegated, the substance of which may be vague and left open to interpretation, especially in the perioperative arena. There is a definitive concept, though, providing guidance in every state. This concept is that one cannot delegate the nursing process: assessment, diagnosis, planning, intervention and evaluation. Also, one cannot delegate any task which requires specialized skills, expert knowledge, or professional judgment. Many nurses, though, find this very confusing because they are unfamiliar with either their state’s nurse practice act or what nursing duties cannot be delegated (Kido, 2001).

Delegation to UAP is important to understand for both the RN and the UAP. If a task is delegated that is actually considered ‘nursing’ then there could be legal recourse against the UAP and/ or the RN who delegated the duty. Hildegard Peplau, RN, EdD, FAAN, a nursing leader, made a distinction that has rarely (if ever) been brought to light. When disputing a study that declares “only 17% of the nurse’s actions require a nurse” Peplau said this:

Perioperative nurses themselves have sometimes fostered this misunderstanding by explaining our roles in terms of what we do (e.g., tasks) rather than what we are thinking before, during, and after we do them. What we do is observable; what we are thinking is not. What we do frequently are tasks, so it is understandable, but not acceptable, that perioperative nursing is assumed to consist mostly of things nurses now can “do” (Murphy, 1999).

This leaves only one conclusion: nurses cannot delegate what they “know” which is exhibited during assessment or evaluation and even in nursing judgment. Nurses may delegate tasks; however, only when the application of their nursing knowledge isn’t necessary to safely carry it out.

If a state board of nursing has opted to use guidelines instead of rules to be the format of its position, then the guidelines serve the same function as those from various organizations such as AORN or ANA. They do just that—guide. They are not law which means guidelines are open to interpretation and therefore may contribute to, instead of prevent delegating mistakes.

The type and amount of training for UAP varies within 1 week to a 4 week period. Because there is lack of standardized education, debate continues about their use. A significant point about the use of UAP made during testimony in front of NY State Assembly’s Standing Committee on Health, by then Deputy Commissioner of NY State Education Department, Johanna Duncan-Poitier:

“In the health care field, decreasing nursing staff and using UAP to provide licensed professional services is neither prudent nor cost-effective. It can seriously harm

the public. We must not confuse economic development with appropriate healthcare.” (“Testimony” 1999).

In her January 23, 2001, executive summary to the Board of Regents, Ms. Duncan-Poitier discusses the efforts of the Professional Practice Committee in curtailing illegal practice efforts. She writes:

“Unlicensed individuals and entities that practice a profession can be prosecuted by the office of the Attorney General for a felony criminal violation.... The unauthorized practice of a profession by an unlicensed person is also distinct from professional misconduct of licensed professionals who practice beyond their professions’ scope of practice.... There is, however, a growing trend involving the use of unlicensed assistive personnel to provide licensed professional services in institutional settings, such as hospitals and health care clinics. This practice has expanded as institutions are downsizing in response to pressures to reduce costs. The use of unlicensed assistive personnel to provide professional services is illegal unless specific statute permits it.” (Duncan-Poitier, personal communication, January 23, 2001).

To further echo these sentiments is the case of *Healthtrust v Cantrell* (689 So 2d 822 [Ala] 1997) (Duffy, 2000). It is a well-known case in perioperative circles where a surgical technologist holding retractors during orthopedic surgery was found negligent for the patient’s injury. The hospital was also found liable through vicarious liability. There was allegedly improper placement of the retractors within the incision of the nine-year-old patient who was receiving hip surgery. According to court documents, the case focus was that of an unlicensed assistive person in an assistant role. It is important to note that within the intraoperative setting, the person holding retractors is not always [referred to as] the ‘assistant’. In fact, depending on title, they are referred to as the ‘sponge nurse’ or the ‘second scrub’. These titles generally denote the **duty** of the person, but do not reflect the persons’ level of expertise and education. Therefore, it is not out of the question, that the jury may have identified the surgical technologist as the ‘assistant’; a role traditionally held by the registered nurse, physician assistant, certified first assistant, another surgeon, or registered nurse first assistant. It was demonstrated throughout the trial that the surgical technologist was not properly trained to hold hip retractors on a child as evidenced by him not knowing various anatomical landmarks, distance between those landmarks, and the area surrounding the sciatic nerve. There were also data which confirmed that the surgical technologist caused damage by inappropriate shifting of the retractor. The hospital had a duty to train and document that training along with competency of personnel according to AORN standards of care. This event begs the question: why would an institution put patients at risk by allowing an even lesser formally educated and experienced individual to fulfill this role?

Since policy also plays a role in the action of the UAP, it is important to note how policy is made. Every situation involves some amount of risk so the premise of risk-benefit analysis is to measure the level of risk versus the level of benefit. This can be achieved through collaboration with the legal department or risk management department. Questions each OR manager should ask when making policy.

- Will the policy prevent this incident from occurring again?
- Will the policy improve care to the targeted population?
- Will the policy create the potential for a different type of incident?
- Will the policy create potential liability by being so restrictive that the staff ignores its existence?
- Will the policy create risk because it conflicts with other policies or standards of practice within the institution or profession?
- Will the policy make sense when explained to reasonable members of the community? (Duffy, 2000).

Policies are the “rules for ensuring a consistent level of patient care” (Duffy, 2000) and are the guidelines for employees. There may also be a set of unwritten policies to which everyone must adhere. Courts have recognized these unwritten sets of rules and also have used them as evidence in court. This kind of information, Duffy writes, has impact on juries’ deliberations (2000).

According to the manual of Perioperative Services, it was The Impact of Technology that spurred the need for assistive personnel to scrub during cases (2000). For example, total joint replacements, invasive abdominal and gynecological surgeries, and open heart surgery, all may require someone to provide exposure by holding retractors or supporting a limb. Because of the fiscal responsibility necessary in the current economic ‘crisis’, it was seemingly more prudent to have UAP fill this role to save money (Voss, 2000). It must be once again noted that a standardized system of training and education is necessary, along with constant competency review. A clear, concise job description with distinct boundaries will also ensure patient safety, the safety of the UAP, and the efficient use of ancillary staff.

The little voice inside you, your conscience, and the golden rule all have been used to help describe surgical conscience. It is doing the right thing even when no one is looking (Girard, 2007). It is calling out even the most experienced of nurses if he contaminates the field, regardless of what others may think. It is always being the patient’s advocate regardless of the expense. One must know aseptic / sterile technique to be able to appreciate the rules. The enforcement of the rules is where the surgical conscience comes into play; therefore, if you do not have a complete understanding of the rules, then there is no way you can enforce them. UAP do not know what they do not know and this presents a problem when allowing UAP to scrub or even set up a sterile field. They have not been given enough information over a period of time to build a surgical conscience.

There is another type of surgical conscience within the perioperative environment known as the collective surgical conscience (Girard, 2007). This is the entire surgical team working in concert through the principle of surgical conscience on a broader spectrum. This includes giving support to every team member when pointing out breaches in technique, unsafe practices, and patient advocacy concerns. AORN has defined direct staff caregivers as such:

The direct caregivers in the OR are defined as those directly involved in providing care to patients undergoing surgical or other invasive procedures. Individuals providing direct care include perioperative registered nurses and surgical technologists/ licensed practical nurses (AORN Staffing Skill Mix, 2007, p 413-414).

UAP do not have the advantage of a prior clinical rotation as a student to be able to observe surgical conscience at work; nor do they adequately acquire the fortitude to resist temptation when having to reject some unsafe practices, such as incomplete skin prepping (Girard, 2007).

There are sources of conflict within the OR environment which may inhibit the safest and best use of UAP. These sources include but are not limited to: interpersonal conflicts of interest, communication barriers, and authoritarian management style. Each of these can contribute to unsafe UAP practices. Primarily, the single most dominant source of conflict related to the UAP and patient safety is that of ambiguous jurisdiction (Voss, 2000). This is defined as “Not knowing who should be doing what and how roles and duties overlap” (Voss, 2000). With this type of conflict, it is best to have clear concise job descriptions, a readily available copy of the state’s practice act, and open communication as to each person’s role for various functions within the perioperative environment.

The ANA published a study in May of 2000 which they believe, “provides proof that there is a link between RN staffing and quality of patient care” (Medscape, 2009). The study essentially found, according to Mary Foley, MS, RN, then president of the ANA, that “Shorter lengths of stay and fewer complications translate into lower hospital costs. Not only do patients fare better, but hospitals can actually save money by using highly skilled nurses in adequate numbers; the best care is also the most economical”(Medscape, 2009).

Accountability and responsibility are core fundamentals of perioperative nursing practice in the OR. This accountability and responsibility is what “determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care” (Berlandi, 2002). UAP clearly are responsible for their own actions when given tasks assigned to them; however, it is the RN’s duty to the patient and judgment bearing the responsibility of the case outcome. In an article discussing perioperative ethics, Berlandi discusses tasks associated with UAP (2002). The only intraoperative task suggested is the opening of sterile supplies. This would give more time to the RN to perform necessary patient assessments. Unlike perioperative nurses,

UAP do not possess the clinical knowledge and expertise to “act independently and with authority to accept accountability and responsibility” (Berlandi, 2002).

“Common-law duty requires everyone to behave reasonably so as not to injure others, regardless of whether they are professionals. This duty does not require a professional-patient relationship” (Murphy, 2002). How that plays out in the OR environment is when the same room is turned-over or re-used from patient to patient. The room must be prepared as if each patient were the first patient of the day. Meticulous attention to details such as disinfection of the room, removal of the prior patient specimens and paperwork, and removing any medications from countertops, enhances patient safety and helps prevent never-events. In a case involving a nurse anesthetist, where the nurse anesthetist erroneously used the wrong medication which was left on the anesthesia provider’s cart, the courts found on appeal [Rodriguez ex rel Rodriguez v Health ONE (24 P3d 9 [Colo App 2000])] that “perioperative practitioners in the OR may have a duty, not only to the patient they are treating, but also to all the subsequent patients in that OR who might be injured by their actions, even though they no longer are present and a subsequent practitioner acts negligently” (Murphy, 2002). Because of this responsibility and duty intra-operatively, UAP would be subjected to this common-law duty. This could be a liability due to the limited training and education which they receive.

In 2007, Norcal Mutual Insurance Company published a continuing education article entitled Supervision of UAP and Licensed Allied Health Professionals (2007). Their research outlined liability risks through claims associated with utilization of UAP and vicarious liability of the physician for the UAP. One of the most telling claims was ‘Assisting and abetting the practice of medicine without a license’ (Supervision of UAP, 2007). This is when UAP follow the direction of the physician assuming that they are somehow legally ‘covered’ by the physician, often called the captain of the ship doctrine. This is a common misconception among healthcare workers of all types and can be a problem for both the physician and the UAP. The physician could be criminally charged and prosecuted for the aiding and abetting the unlicensed practice of medicine (Supervision of UAP, 2007). Conversely, the UAP could be in violation of law and may have negligence allegations cited against them.

In 1997, when Karlene Kerfoot PhD, RN, CNAA, FAAN, published her article about role redesign and the blurring of the lines between the roles of healthcare providers, she raised serious questions with reference to the UAP reiterating that there is still the looming question if nursing has crossed the line when delegating (Kerfoot, 1997). She also points out that more study is needed if we are to finally put to rest the questions of negative public opinion, cost-effectiveness versus quality, and positive outcomes. It is true, as Kerfoot demonstrated that there is no national standard for UAP competency and there are varying competency levels which need to be addressed. But the biggest question Kerfoot raised was that of public awareness of the role of the

UAP and its lack of standardization. She doesn’t advocate more regulation, but she does urge for more collection of data before we fundamentally change the rules on how we deliver care. Kerfoot questions, “How low can you go without jeopardizing care?” (Kerfoot).

## References

- AORN (2008) *Perioperative Standards, Recommended Practices, and Guidelines*; p. 258
- AORN National Committee on Education (2009). *Primer for Undergraduate Perioperative Education: Didactic and Clinical Activities for the Perioperative Setting*. Available: <http://www.aorn.org/Education/EducationResources/PrimerForPerioperativeEducation/>
- “AORN statement on staffing skill mix,” in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2007) 413-414.
- Black, B., (2008). *The Role of Unlicensed Assistive Personnel [UAP] in Health Care Delivery*. *Medi-Legal Resource News*, 5, 1-2.
- Berlandi, J.L. (2002). *Ethics in Perioperative Practice- Accountability and Responsibility*. *AORN Journal*, 75, 1094-1099.
- Duffy, W.J. (2000). *Legal Considerations*. In C. Frye, C. Spry (Eds.), *Perioperative Services Administration, Resource Management, and Patient Care* (sec.1-3). Gaithersburg, Maryland: Aspen Publishers, Inc.

## Increase Your Earning Potential!

### University of Florida's Online and Self Paced Programs for Nurses



- Life Care Planning
- Forensic Nursing
- Health Care Risk Management
- Geriatric Care Management

<http://health.dce.ufl.edu>

**UF** UNIVERSITY of FLORIDA

- Duncan-Poitier, J. (2001, January 23). Re: Unauthorized Practice of the Professions. [To inform the Regents of our illegal practice efforts]. Retrieved from [http://www.op.nysed.gov/reports/unauthorized\\_practice.pdf](http://www.op.nysed.gov/reports/unauthorized_practice.pdf)
- Girard, N.J. (2007). *Surgical conscience: still pertinent*. AORN Journal, 86, 13-14
- Habgood, C. M. (2000). *Ensuring proper delegation to unlicensed assistive personnel*. AORN Journal, 71, 1058-1060.
- Kerfoot, K., (December 30, 1997). "Role Redesign: What Has It Accomplished?" Online Journal of Issues in Nursing. Vol. 2, No. 4, Manuscript 3. Available: [www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableOfContents/vol21997/No4Dec97/RoleRedesign.aspx](http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableOfContents/vol21997/No4Dec97/RoleRedesign.aspx)
- Kido, V.J. (2001, November). *The UAP Dilemma*. Nursing Management, 27-29.
- Kopishke, L.R. (2002). *Unlicensed Assistive Personnel: A Dilemma for Nurses*. The Journal of Legal Nurse Consulting, 13, 3-7.
- Medscape Medical News. (2009). *ANA Study Provides Proof of Link Between RN Staffing and Quality Patient Care*. New York: MedscapeWire: <http://www.medscape.com/viewarticle/411858>
- Murphy, E.K. (1995). *Unsubstantiated assumptions about unlicensed assistive personnel obscure the challenge of delivering quality patient care*. AORN Journal, 62, 8- 10.
- Murphy, E.K. (1999). *RN liability exposure for delegated acts*. AORN Journal, 69, 277-279.
- Murphy, E.K. (2002). *The importance of properly preparing the OR*. AORN Journal, 76, 1056-1058.
- New York Stated Education Department, Office of the Professions. (1999) *Testimony on Unlicensed Assistive Personnel and Illegal Practice*. Retrieved from <http://bit.ly/849Zwr>
- "Supervision of Unlicensed Assistive Personnel & Licensed Allied Health Professionals," in Claims Rx clinical & risk management perspectives (Norcal Mutual Insurance Company, 2007, September). 1-7.
- "Unlicensed Assistive Personnel (UAP) TAANA Recommendations," in the American Association of Nurse Attorneys Recommendations Regarding Unlicensed Assistive Personnel. (2004). [http://associationdatabase.com/aws/TAANA/pt/sd/news\\_article/3454/blank/blank>true](http://associationdatabase.com/aws/TAANA/pt/sd/news_article/3454/blank/blank>true)
- Voss, S.J. (2000). Legal Considerations. In C. Frye, C. Spry (Eds.), *Perioperative Services Administration, Resource Management, and Patient Care (sec.2-2)*. Gaithersburg, Maryland: Aspen Publishers, Inc.
- Zimmerman, P.G. (2001). *Delegating to unlicensed assistive personnel* [Online]. Available: <http://nsweb.nursingspectrum.com/ce/ce124.htm>

## 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 0.5 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.

**Mary S. Arbogast, CST RN BS CNOR** independent legal nurse consultant, is a graduate of The Reading Hospital School of Surgical Technology, The Reading Hospital School of Nursing, and the University of St. Francis, Joliet, Illinois. She is currently pursuing a master's degree in healthcare administration from the University of St. Francis. A member of AST, AORN, AALNC, and PCAALNC, Arbogast continues to stay clinically active working 24 hours a week in a level II trauma center operating room. She is the founder of Arbogast Medical-Legal Consulting, LLC, [www.arbogastconsult.com](http://www.arbogastconsult.com), specializing in surgical cases. She can be reached at [mary@arbogastconsult.com](mailto:mary@arbogastconsult.com).

# Sharpen Your Writing Skills, Part I

Patricia Iyer, MSN RN LNCC

## KEY WORDS

Communication, Target Audience, Format Consistency

---

*“One should not aim at being possible to understand, but at being impossible to misunderstand.” – Quintilian*

*This is the first part of a two-part article. Part I addresses the focus of your writing, the format of your material, and the design elements of your reports. Part II covers flow, organizing, editing, proofreading, and saving your work.*

---

The increasing reliance on e-mailing, text messaging, and brief news articles has conditioned us to want to think and read in concise chunks. Poorly written reports, long and involved sentences, and disorganized information will frustrate the reader and negatively affect how you are perceived as a legal nurse consultant (LNC). An e-mail survey of 528 Canadian employees showed that 85 percent of the respondents complained that weak workplace communication wasted time. Seventy percent cited lost productivity and 63 percent noted they had missed key information contained in the documents they received (Leest, 2006).

Developing strong writing skills will increase your success as a LNC. Attorneys are trained to focus on the words and how ideas are conveyed. I have seen many expert witnesses and LNCs fail in this field because of poor writing skills. Typos on resumes and poorly written reports will torpedo an LNC's career before it gets off the ground. You must recognize the power of writing skills to attract and keep clients.

Language skills learned in childhood can be refined as we mature. Some of us grew up with a “language patrol”. In my home, the language patrol pointed out misuse of words. Sometimes, the correction was done tactfully, as in “Ahem, I think the word you want is..” At other times, there was a certain amount of glee expressed when the incorrect word was used. The net effect was to encourage all of us to use the right words. Webster's Dictionary joined us at many a meal. The language patrol was also on duty when my sons were growing up. They both have excellent language and writing skills.

It is not too late to gain writing and language skills if this is not a strong area. Writing skills are improved by reading well-written books, reviewing grammar rules, and getting feedback from mentors whose writing skills are superb. In part one of this article, the focus, format, and design elements of reports are described

*You will be tempted to believe that because a connection between ideas is perfectly clear to you as a writer, it is also perfectly clear to the reader. It isn't.*

*– Lucile Vaughn Payne, The Lively Art of Writing, 1965*

## Focus

1. Identify your audience before you begin writing. The focus of your writing, the words you use, and the way you organize your material should be dictated by the needs

of your audience. The LNC typically prepares reports for attorneys. Claims adjusters, mediators, defendants, plaintiffs, and judges may also read the LNC's reports.

2. Keep your audience firmly in mind as you write. Try to understand the reader's needs, concerns, and knowledge of your topic.
3. Recognize the demands on the reader. Limit the length of your report as needed. It is difficult to provide any page length guidelines for reports. The length will be affected by the complexity and amount of information to be summarized, and the customary practices for preparing different types of reports. For example, in my experience, it is rare to see an expert witness report exceed five pages. Expert reports that are 20 or more pages are often written by inexperienced experts. They typically focus on every minute deviation, whether or not it made any difference in the case.
4. Understand who the attorney represents. Much difficulty can be avoided by verifying this information. LNCs and experts who misunderstand this essential point may write a report that is not on point for the client the attorney represents. I have seen it happen.
5. Know if the report is work product or if it is discoverable. Generally any report written by an expert is discoverable. Reports written by consulting LNCs are usually not discoverable. LNCs should be aware of who might read the report in addition to the primary audience. Sensitive or critical information might travel beyond the intended readers.
6. Avoid using a style of writing appropriate for clinical documentation. This is not a style to be used in a formal report. Nurses new to legal nurse consulting report-writing commonly make the error of writing in nursing language with incomplete sentences, medical slang, and abbreviations and terminology that are not defined. This may annoy and confuse non-medical readers. Write in whole sentences. Spell out abbreviations the first time they are used and put the abbreviation in parentheses after the term. Thereafter, the abbreviation should generally be used. Provide a brief explanation of a medical term that you think is likely to be unfamiliar to the reader. For example, the attorney is more likely to understand the term “diabetes” than “hypoxic ischemic encephalopathy.” Experienced attorneys need fewer

explanations of medical terms, but in my opinion, it is better to err on the side of offering too many rather than too few explanations.

7. Identify the purpose of the document you need to prepare. Is it to summarize information? Is it to persuade? Is it to make recommendations? Is it to analyze medical details? An LNC's report might contain all of these components.
8. Develop an outline of what needs to be covered in the report. This will help to ensure that you will not miss important points as well as help you decide the best format for the information. An outline will introduce order to the material.
9. Focus on the most important information to share. Do not include extraneous and irrelevant information.

## Format

10. Select a conventional font, such as Times New Roman or Georgia. Avoid fancy fonts that are difficult to read. Your letterhead is the place to use some of the nonstandard fonts, as long as they are readable.
11. Select size 12 as the most readable font for a document. As an option, headers may be placed in size 14 font.
12. Consider creating a table of contents for any report longer than 10 pages. The table of contents should include major and minor headers and any appendices and attachments.
13. Use the appendix of a legal nurse consulting report, depending on the focus, to include definitions of medical terms, lengthy tables, photographs, references, glossaries, medical abbreviations, or summaries of applicable literature. Avoid making the appendix a dumping ground for unrelated information.
14. Allow adequate white space within the document. Set margins of at least one inch in all directions. Skip a line between paragraphs.
15. Use justification to create a document that is easier to read than one that is fully justified. (Justification refers to both margins being straight.)
16. Use the automatic page numbering feature to number each page. Nothing identifies an amateur typist more clearly than manually typed in headers or numbers at the top of the page.
17. Make sure the first page of a letter does not have a page number at the top of the page. In Microsoft Word in the page format section, select "different first page" to eliminate the automatic page numbering on the first page.
18. Use bold on the headers to make them easy to spot.
19. Add lists, figures, tables, or other graphics to break up long stretches of text. These elements improve readability of the document.
20. Use endnotes or footnotes if appropriate for the material. Learn how to do this with features of the word processor you are using. It gets tiresome to manually change superscript numbers and it is easy to miss one. Trust me on this one—I have had to do it. Footnotes can be used for explanations of medical terms, for citations

of literature, or for comments. A comment might be included if the medical records state a certain thing happened, but there is no evidence of that occurring. The footnote becomes an aside.

21. Look for words that you use repetitively during a report, and consider taking advantage of the search and replace function. For example, if the report calls for the use of the name of a hospital, such as Valley Regional Medical Center, type V\* every time you identify the hospital. The final proofreading process will include a search and replace function to replace each use of V\*. This is a useful tool for a report that requires repetitive use of a patient's name. "Mr. Rodriquez" would be typed as Mr. R\*, and then replaced at the end of the process with Mr. Rodriquez.
22. Leave one space after any mark of punctuation that ends a sentence. The old style of creating two spaces after the end of a sentence is a carryover from the use of typewriters. If you find you have slipped into this habit, do a search and replace for the two spaces after a period. Replace with one space.
23. Use the highlighter to mark information you want to go back to before finalizing the report. For example, you may want to check a date or a fact.

## Design elements

24. Use design elements, such as contrast, alignment, repetition, proximity, and consistency to capture the attention of your reader. Careful use of design will make the difference between whether people you want to reach will pay attention to or ignore your material.
25. Make a page appear visually interesting by using contrast. Add contrast through line thickness, colors, shapes, sizes, and space.
26. Avoid using more than one or two fonts in a report. Adding additional fonts can be distracting to the reader.
27. Use light shading in the top row of a table set up as a chronology which is an effective design element. Shading draws attention to the key elements, such as date, time, source of information, and chart entry.
28. Consider associations with certain colors. Red is associated with pain, blue with depression, green with nausea, yellow with happiness, and so on. These colors can be effectively used in exhibits and timelines.
29. Consider the contrast in colors. Primary colors are easily differentiated; pastel colors are harder to distinguish, particularly at a distance. This point is important when constructing exhibits for a report.
30. Note how alignment unifies and organizes a page. Nothing should be arbitrarily placed on the page. Every item should have a visual connection with something else on the page.
31. Add a sophisticated appearance through the selective use of right alignment for title pages of reports. Right alignment forces the reader to slow down and find the beginning of the next line. It is useful for small amounts



of text, but creates difficulties in reading large amounts of text.

32. Use repetition to unify a report. Repeated elements may be typefaces, page numbers, rules, borders, graphics, colors, headlines, or subheads.
33. Use proximity to group related items so that they appear as one cohesive group rather than a bunch of unrelated bits. Be conscious of where your eyes are drawn and avoid confusing the reader. There should be a logical progression through the document.
34. Insert photographs to add interest to the document. Scan and add photographs of the plaintiff to illustrate injuries. Use photographs to educate the attorney about a particular aspect of medicine. Royalty free photographs may be downloaded from the internet, or purchased individually or in collections. Be aware of the copyrighted nature of photographs that are found during internet searches.
35. Keep items in proper proportion. For example, do not place a header in size 20 font next to text that is in size 12 font. Maintain balance.
36. Keep elements in a logical path. Use lines, dots, photos and images to direct the eyes where you want them to go. Some photographs have a natural direction. For example, the person in the photograph may be leaning so her head is in the upper left corner of the photograph. This photograph would be placed to the right of the text, so that her head was leaning towards the block of text.
37. Use consistency to improve readability; the less work the reader's eyes have to do, the more energy can be put into thinking about the messages. Be consistent with margins, paragraph indents, spaces between columns, and around photographs. Be consistent in how dates are denoted throughout the report. Either spell out all dates with the full name of the month, day of the week and year (January 6, 2010), or use purely numbers to denote dates (1/6/10).

Part I of this article provides an overview of some of the principles of constructing reports for attorneys.

## Reference

Leest, M. (2006). Good writing is good business. *New Jersey Law Journal*, 184(12), 1059

**Patricia Iyer, MSN RN LNCCC** has written, edited, or coauthored over 125 books, chapters, articles, case studies, and online courses. She is a past president of AALNC. She may be reached at [patmedleague@gmail.com](mailto:patmedleague@gmail.com).

## 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 0.25 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.

## Low Back Pain (Part One Non-Surgical)

Kara DiCecco, MSN RN LNCC  
Renee Champion, RN, BS

---

*Back pain may range from simple strain and sprain to emergent surgical intervention. The etiology may be benign and self-limited or it may be chronic and disabling. The exact cause of the pain may be grossly obvious or stealthily elusive. Over 85 percent of patients who seek medical care from their primary physician have low back pain that cannot be reliably accounted for by a specific disease process or spinal anomaly (Chou, Qaseem, Snow, Casey, Cross, Shekelle and Owens, 2007). Whatever the cause, undeniably low back pain exacts a heavy economic toll through missed days from work and mounting insurance claims. Back pain is not restricted to any age, gender, or ethnic demographic. Because of its prevalence in worker's compensation and personal injury litigation, familiarity with the nomenclature, multiple causes, and presentations of low back pain is needed. In Part One, The Clinical Maxim will look at non-surgical low back pain.*

---

### Pathophysiology

Back pain may be due to muscle irritability or inflammation of intra-abdominal structures. It may be caused by poor muscle tone from incorrect posture or weakened abdominal muscles from the added weight of pregnancy. Common presentations of low back pain include restricted range of motion (hypomobility), spasms (physiologic splinting), and stiffness. Those affected may describe the pain as deep, burning, gnawing, aching, sharp, or tearing. The pattern of pain may be constant, intermittent, or self-limited depending on its cause.

### Possible Etiologies

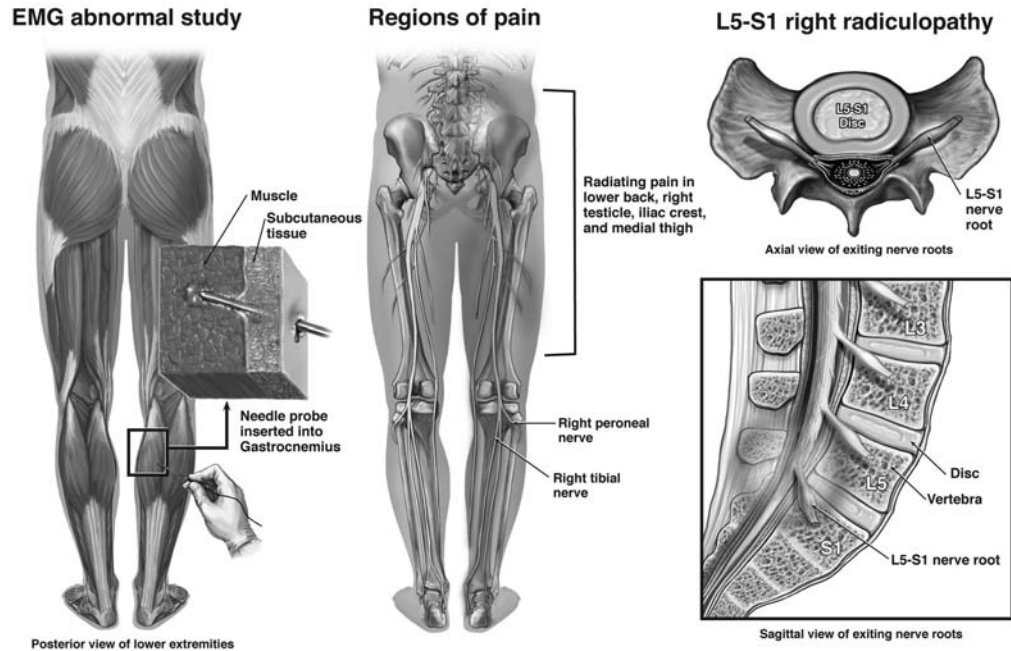
- Trauma
- Degenerative change
- Obesity
- Smoking
- Congenital deformity (scoliosis)
- Fracture (wedge compression fracture, stable or unstable burst fracture)
- Osteoporosis
- Stenosis

### Terminology

- Spondylosis-Ankylosis (fixation) of the articular processes in the vertebra (Lukens et al., 2005).
- Spondylolysis-Defect (stress/fatigue fracture) of pars interarticularis. On a normal oblique lumbar radiograph, the posterior spinal elements of one side form a "Scotty dog" appearance. The erosion of the pars interarticularis shows across the neck of the Scotty dog (appearance of "fractured neck" on the dog.) This is not an acute injury (Schwartz & Reisdorff, 2000).
- Spondylolisthesis-The spinal vertebra above slips forward on top of the vertebra directly below. The more severe the forward slippage (misalignment) the more severe the grading. Degree of slippage is generally graded I-IV. For

example, Grade I represents 25 percent of the superior vertebra slipping forward on the inferior vertebra where Grade IV represents 100 percent of the superior vertebra slipping "off" the inferior vertebra. Occurs most commonly at the level of L5-S1. The examiner may palpate a noticeable "step-off" in the affected area of the spine (Gann, 2001).

- Piriformis Syndrome-Sciatic nerve may be trapped as it passes the sciatic notch under or through the muscle (Gann, 2001).
- Facet Impingement Syndrome (Lumbago)-Joint capsule is impinged between articular surfaces leading to inflammation, spasm, and pain (Gann, 2001).
- Degenerative Disc Disease (DDD), Degenerative Joint Disease (DJD), Osteoarthritis (OA)- These terms refer to a condition of segmental degenerative disease. Spurs may be present which can lead to reduced mobility and joint space narrowing. The common sites are at the L4-L5, S1 levels (Gann, 2001).
- Spinal Stenosis-Narrowing of the spinal and/or intervertebral canal may be degenerative or congenital.
- Mechanical Low Back Pain (Postural Syndrome)-Due to deformation of soft tissue from prolonged static forces. Common in sedentary persons, especially younger than 30,
- Lumbar Sprain-Common cause forced flexion with contra lateral side bending/rotation. Common site at iliolumbar ligament.
- Ankylosing Spondylitis-Chronic and inflammatory rheumatic disease leading to spinal fusion.
- Coccygodynia-Painful condition of the coccyx usually as a result of a direct fall on the buttocks.
- Radiculopathy-In the context of low back pain, a radiating pain that travels down the lower extremity/ extremities. Its pattern typically corresponds and terminates within a specified dermatomal distribution (area supplied by nerve root).



**Figure 1: Radiculopathy**

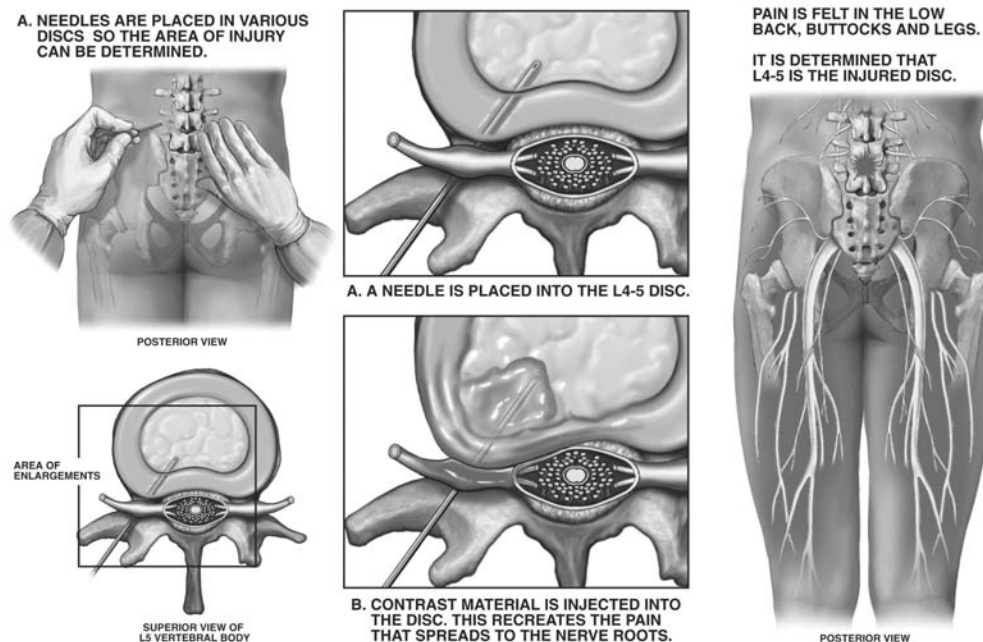
© 2010 Medical Legal Art. All rights reserved. (800) 338-5954

## Diagnostic Criteria/Testing

- Determining or confirming the cause of low back pain may warrant limiting or expanding individual testing based on specific clinical presentation.
- Electromyography (EMG)/Nerve Conduction Study (NCS) is used to determine slowing of the nerve conduction and/or contraction of the nerve root (see Figure 1).
- Computed Tomography (CT Scan) can provide a more detailed look at the lumbar spine than can conventional X-ray. CT is particularly helpful for showing problems with bones, such as arthritis or some types of spinal stenosis. Using progressive slices, the views can then be reformatted into a 3D view of the structure.
- Myelogram is done to evaluate for disk pathology and degenerative changes of the spine. A needle is introduced into the spinal canal under fluoroscopic guidance and iodinated contrast is injected into the thecal sac (contains the nerve roots). Radiographs are then obtained. It is routine to follow the myelogram with a post-myelography CT scan.
- Discogram/Discography “pressurizes” the disc by injecting dye into the center. If the patient experiences a reproduction of the normal pain (concordant) then the disc is determined to be the source of pain (see Figure 2).
- Bone Scan is used to determine presence of infection, tumor, or occult fractures but cannot distinguish between these. A radioactive tracer is injected which can reveal problem areas on the skeletal structure itself.
- Magnetic Resonance Imaging (MRI) is used for visualizing soft tissues, such as the spinal cord, disks, and nerves, as well as the bones. MRI will show tumors and disk disease.
- X-rays are taken to show if the vertebrae are lined up normally or misaligned (subluxation) or to detect spur formation (osteophytes), decreased disc space (loss of height/desiccation), and/or intervertebral foramen narrowing.
- Dexa Scan (Dual Energy X-ray Absorptiometry) is used to determine the degree of osteopenia/osteoporosis.
- Somatosensory Evoked Potentials (SSEP) is used to assess the speed of electrical conduction across the spinal cord. (Also used in the intra-operative period to evaluate spinal cord function, usually in cervical and thoracic areas).
- Straight Leg Raise (SLR) is tested in the affected leg in radiating back pain. The examiner places one hand under the ankle and one on the knee. The leg is raised by the examiner, keeping it straight, to the patient’s tolerance. If pain is reproduced in the back or leg, the degrees at which this occurred is noted (for example, 45 degrees) and the test considered positive.

## Select Treatment Options

- Radiofrequency Neurotomy: A radiofrequency cannula is inserted under X-ray guidance into a specific region of the medial branch nerves. The nerves are lesioned (altered) to block pain impulses from the select nerves. Therapeutic responses average 3 to 12 months.
- Epidural Steroid Injections (ESI): A step-wise series of steroid and/or anesthetics (under fluoroscopic and CT



**Figure 2: Herniated Disc - L4-5 Discogram**

© 2010 Medical Legal Art. All rights reserved. (800) 338-5954

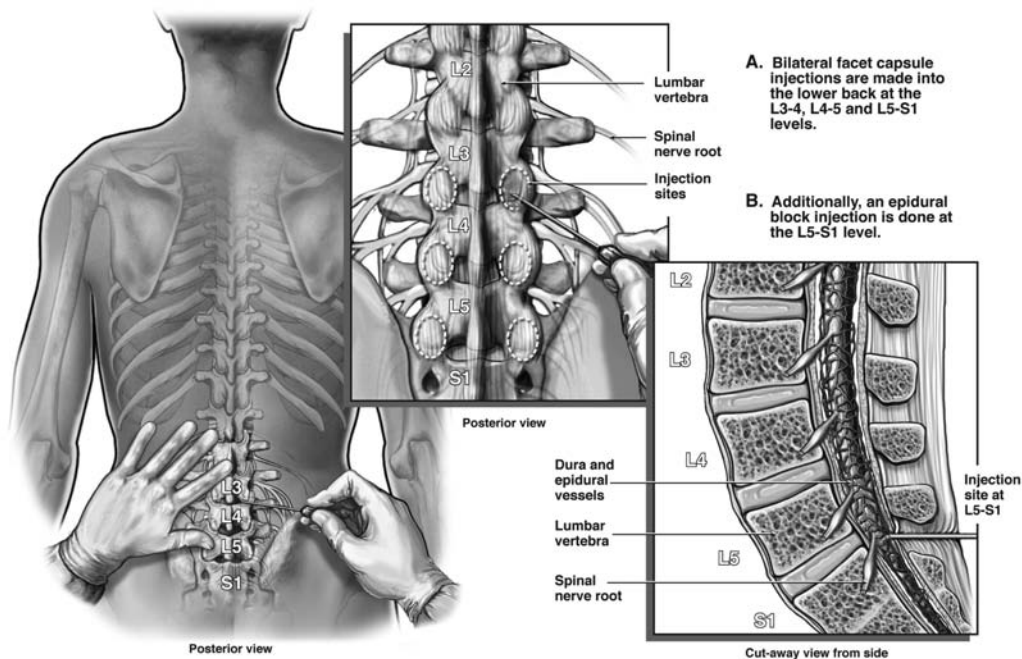
guidance) to target a specified nerve root. Typically for a diagnostic block, lidocaine and bupivacaine (Marcaine) are injected. For a therapeutic block a combination of steroid (Celestone, Kenalog or Depo-medrol) and bupivacaine are used. A similar but more focused procedure is used for Selective Nerve Root Blocks (SRNB) (Wagner & Yao, 2009) (see Figure 3).

- IDET/Intradiscal Electro-Thermal Therapy: A catheter is inserted into the disc and heated to 194 degrees Fahrenheit. Heat is used to destroy the nerve endings and shrink loose ligaments to “reseat” the disc.

## Legal Considerations

- Spina Bifida Occulta is the incomplete fusion of the neural arch (generally in the low back). Because of the vertical lucency seen on X-ray, misdiagnosis of a vertical fracture through the ventral body may be made (Schwartz & Riesdorff, 2000).
- Low back pain that escapes evidentiary proof through generally accepted scientific methods (testing) makes establishing the reliability of the diagnosis and the credibility of the client a core issue in litigation.
- Chronic steroid use and/or osteoporosis may be an alternate cause of stress fractures.
- Normal variations in the thoracolumbar spine may be mistakenly viewed as pathologic conditions (Schwartz & Riesdorff, 2000).
- Consistent use of a rating scale, for example 1-10 scale (10 being the most severe) provides a measurable record of response to treatment modalities.

- Non-surgical back pain treatment may include acupuncture, chiropractic treatment, physical therapy, treatment modalities (such as, Transcutaneous Electrical Nerve Stimulation (TENS) Unit, massage, traction, spinal manipulation and/or hydrotherapy), anti-inflammatories, muscle relaxants, analgesics, and/or rest.
- A complete physical exam and diagnostic work-up is needed to identify all co-morbid or confounding conditions (metastatic cancer, spinal abscess/infection, multiple myeloma, kidney problems, aortic abdominal aneurysm [AAA], or alcoholism).
- A return to work clearance may entail a Functional Capacity Exam (FCE) to determine work limitations in lifting, bending, stooping, reaching overhead, kneeling, crawling, and pushing/pulling.
- Work Hardening Programs are prescribed physical therapy programs averaging six-weeks in duration to allow the client to build strength and endurance. In the program actual job duties are reproduced to replicate the demands on muscle, gait, and balance functioning.
- Positive Hoover’s test and the presence of “Waddell’s Signs” may indicate “malingering” or nonorganic findings. These terms are mistakenly sometimes used as interchangeable.
- Controversy still exists regarding the true interpretation and implications of the presence of Waddell’s signs upon examination. The reappraisal of Waddell’s signs (1998) was offered to clarify the true intent of the author’s observations and conclusions since the original article is often misinterpreted. The following are article citations to both the original and reappraisal of non-organic signs, respectively.



**Figure 3: Lumbar Facet and Epidural Block Injections**

© 2010 Medical Legal Art. All rights reserved. (800) 338-5954

Waddell, G., McCullough, J.A., Kummel, E. & Venner, R.M. (1980). Non-organic physical signs in low-back pain. *Spine*, 5(20), pp. 117-125.

Main, C.J. & Waddell, G. (1998). Behavioral responses to examination: A reappraisal of the interpretation of “nonorganic signs”. *Spine*, 23(21), pp. 2367-2371.

A commonly used tool for self-reporting (by the patient) regarding the impact of low back pain on their activities of daily living (ADLs) is the Oswestry Disability Index.

### A Look at Case Law and Resources

An informal search of online case law was conducted using the GOOGLE search engine and keywords (in quotes) “disability,” “low back pain,” “pain rating,” “diagnostics,” “glossary,” and “case law” in alternating string searches. A review of the information retrieved provided both formal and informal sources. A sampling of the preliminary results (though not all-inclusive) via internet retrieval is provided here.

### Articles

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. *Ann. Intern. Med.* 2007, 147-478-491. <http://www.annals.org/content/147/7/478.full>

Evaluation and Treatment of Low Back Pain: An Evidence-Based Approach to Clinical Care. *Muscle Nerve*, 2003, 27, 265-284.

Nonpharmacologic Therapies for Acute and Chronic Low Back Pain: A Review of the Evidence for an American Pain Society/American College of Physicians Clinical Practice Guideline. *Ann Intern Med*, 2007, 147, 492-504.

Discography in practice: A clinical and historical view. *Curr Rev Musculoskelet Med*, (2008), 1, 69-83. (Originally published online Nov. 13, 2207). <http://www.springerlink.com/content/57320ux14762211/>

Rating and Interpretation of the Oswestry Disability Index Fairbank JCT & Pynsent, PB (2000). *The Oswestry Disability Index*. *Spine*, 25(22):2940-2953.

Davidson M & Keating J (2001). A comparison of five low back disability questionnaires: reliability and responsiveness. *Physical Therapy* (2002) 82, pp.8-24. Available at <http://www.tac.vic.gov.au/upload/Oswestry.pdf>

### Case Law

*Allen v. Tomkins/Dearborn*, 2000 WL 973294 (Del. Super.) Industrial Accident Board ruling on total disability from low back pain in the absence of objective testing.

*Hinson v. Johnson*, 2009 WL 418304 (Del. Super.) Injury from auto accident to low back. Jury established causation but no damages secondary to pre-existing injuries.

*Crowhorn v. Boyle*, 793 A.2d 422 Delaware Superior Court case. Excellent example of the failure of defendant expert’s testimony to qualify under Daubert in

back injury case. Available at <http://www.lexisone.com/lx1/caselawsitemap/State-Courts-Delaware-100001-2002.html>

Hough v. State Farm Insurance Company, (E.D. Mi. 2007) (No. 06-10764). Ruling on Motion in Limine for testimony on discography. Available at <http://www.websupp.org/data/EDMI/2:06-cv-10764-81-EDMI.pdf>

Parties redacted. Medical Contested Hearing No. 09119 M6-09-17565-01.

Texas state law on worker's compensation coverage and compensability of discography. Available at <http://www.tdi.state.tx.us/medcases/medcchconcrnt09/09119M6r.pdf>

## Glossary

From the American Journal of Neuroradiology.  
[http://www.asnr.org/spine\\_nomenclature/glossary.shtml](http://www.asnr.org/spine_nomenclature/glossary.shtml)

## Potential Experts

- Internal medicine or family practice as treating primary physician
- Orthopedic Surgeon
- Neurosurgeon
- Physiatrist
- Physical therapist and/or muscle physiologist
- Pain Management Specialist
- Chiropractor
- Psychologist/Psychiatrist
- If named defendant is an Orthopedic Nurse Practitioner or Orthopedic Physician Assistant, counsel may choose to identify an expert witness with similar expertise.

## Damages

- Depending on individual presentation and severity, economic damage due to loss of potential career/educational advancement and/or chronic disability due to inability to work.
- Sequelae of chronic pain condition, impact on psychological and psychosocial factors (such as depression, anxiety, social withdrawal).

## References

- Chou, R., Qaseem, A., Snow, V., Casey, D., Cross, T., Shekelle, P. & Owens, D. K. (2007).  
Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann. Intern. Med.* 2007, 147-478-491.
- Gann, N. (2001). *Orthopaedics at a glance: A handbook of disorders, tests, and rehabilitation strategies.* Thorofare, N.J.: Slack, Inc.
- Lukens, R. et al. (Eds.) (2005). *Stedman's medical dictionary for the health professions and nursing (5th ed.)*. Philadelphia: Lippincott, Williams & Wilkins.
- Schwartz, D. T. & Reisdorff, E. J. (Eds.) (2000). *Emergency radiology.* New York: McGraw Hill Companies.
- Wagner, A.L. & Yao, Z. (2009) Paraspinal injections: Facet joint and nerve root blocks.  
*Emedicine.* Retrieved February 1, 2010 from <http://emedicine.medscape.com/article/345382>

**Kara L. DiCecco, MSN RN LNCC** is LNC/Chief Paralegal for the Law Offices of Doroshow, Pasquale, Krawitz & Bhaya in Wilmington, Delaware. She is an Adjunct Professor with the Legal Education Institute at Widener School of Law, teaching courses in Legal Nurse Consulting, Healthcare Law and Ethics, Medical/Legal Research, and Internet Legal Research. She received her master's of science in leadership with a legal nursing focus from Wilmington University, where she also teaches as Adjunct Faculty in the nursing program and fusion courses in legal nurse consulting. She continues to work in clinical practice in urgent care and is a volunteer instructor for the American Heart Association in BCLS/ACLS/PALS/ACLS-ExP. She can be reached at [kdicecco5@comcast.net](mailto:kdicecco5@comcast.net).

**Renee Campion, RN BS** began her career with Liberal Arts and culminated with a BS in Education from Millersville University in Pennsylvania. Campion then entered into the medical field as a medical receptionist. In 1977, she graduated with honors from an associate degree nursing program in 1979. Campion has worked in Med/Surg, ICU, CCU, and as an office nurse. She changed careers becoming a pharmaceutical sales representative for nine years. Her career led her into insurance case management. In January 2009, Campion began an LNC course. Her goal is to work for a plaintiff Med/Mal law firm, eventually owning her own LNC business.

*The topic matter offered in "The Clinical Maxim" is not meant to provide medical or legal advice, only to acquaint the reader with an overview of clinical conditions and/or diseases as well as their clinical/legal implications. As with any medical-legal matter, the reader is admonished to consult the services of a medical and/or legal professional, respectively. The reader is also reminded to critically analyze and evaluate the sources offered here and confirm their reliability independently.*

## Low Back Pain/Non-Surgical Online Resources

Kara DiCecco, MSN RN LNCC

---

*Editor's note: If you would like to learn more about low back pain and the considerations of representation in back pain cases, below you will find a list of online resources. This list is not exhaustive nor an endorsement of any commercial sites. As with any online resource, the reader must independently confirm its authority and credibility.*

---

### Low Back Pain/ Non-Surgical

<http://www.fpnotebook.com/Ortho/Exam/LwBckExm.htm>

#### Physical Examination

Excellent resource for the assessment and evaluation of the client with low back pain. This site also contains other physical assessments. The website, Family Practice Notebook is courtesy of Scott Moses, M.D.

<http://video.aol.ca/video-detail/low-back-exam/1548797179/?icid=VIDURVEDU02>

#### Streaming Video

From AOL, streaming video for low back examination.

<http://www.spine-health.com/conditions/back-pain/lumbar-discogram-technique-diagnosis-back-pain>

#### Diagnostic Lumbar Discogram

This website offers a comprehensive explanation of the lumbar discogram, a technique used to determine the origin of the client's back pain.

<http://www.spine-health.com/video/facet-joint-injections-back-pain-relief-video-0>

#### Facet Joint Injections

This Web site is sponsored by Spine Health. Link to information "About Us" did not provide information regarding the website host other than the name but it does offer a helpful animated tutorial on facet joint injections.

<http://www.spineinstituteny.com/treatments/epidural.html#overview>

#### Caudal and Transforaminal Epidural Injections

Web site of the Spine Institute of New York (Beth Israel Medical Center). Scroll down the page to view forensic animation of caudal and transforaminal epidural injections.

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

#### Diagnostic Injections

Institute for Low Back and Neck Care (see patient resources: Injections)

[www.acr.org/SecondaryMainMenuCategories/.../LowBackPainDoc7.aspx](http://www.acr.org/SecondaryMainMenuCategories/.../LowBackPainDoc7.aspx)

#### Imaging

Very conservative consensus in PDF format on the necessity of imaging in acute low back pain.

American College of Radiology (ACR) Appropriateness Criteria: Last reviewed 2008.

<http://www.indianradiologist.com/cme13.htm>

#### Imaging

According to the Web site, Indian Radiologist.com is a group of Radiologists across India, with the main aim of creating a forum for Indian Radiologists and to contribute to Radiology education on the Internet. Excellent imaging studies and straightforward explanations of disc disease.

<http://www.webmd.com/back-pain/glossary>

#### Glossary

Glossary of terminology related to back pain from Wed MD, Back Pain Center.

[http://journals.lww.com/spinejournal/Abstract/1986/03000/A\\_Controlled,\\_Prospective\\_Study\\_to\\_Evaluate\\_the.3.aspx](http://journals.lww.com/spinejournal/Abstract/1986/03000/A_Controlled,_Prospective_Study_to_Evaluate_the.3.aspx)

#### Articles

A Controlled, Prospective Study to Evaluate the Effectiveness of a Back School in the Relief of Chronic Low Back Pain

[http://www.painandthelaw.org/mayday/jlme\\_31.1.php](http://www.painandthelaw.org/mayday/jlme_31.1.php)

Series of articles on chronic pain from the Journal of Law, Medicine & Ethics.

<http://www.medicinenet.com/discogram/article.htm>

Article on discography explaining the anatomy and procedure from Medicine.net.

<http://www.spine-health.com/index.html>

Series of informative articles on back pain from Spine Health website.

[http://guideline.gov/summary/summary.aspx?doc\\_id=13479&nbr=006888&string=low+AND+back+AND+pain](http://guideline.gov/summary/summary.aspx?doc_id=13479&nbr=006888&string=low+AND+back+AND+pain)

#### Treatment Guidelines

Institute for Clinical Systems Improvement: Adult Low Back Pain

[http://guideline.gov/summary/summary.aspx?doc\\_id=11515&nbr=005968&string=low+AND+back+AND+pain](http://guideline.gov/summary/summary.aspx?doc_id=11515&nbr=005968&string=low+AND+back+AND+pain)

*Continued on page 24*

## One L(NC)

Julie Dickinson, MBA BSN RN

---

*Named after Scott Turow's infamous "One L," a chronicle of his first year at Harvard Law School, this is a look back on my first year as an on-the-job LNC.*

---

As I approach the conclusion of my first year as an in-house legal nurse consultant (LNC), I find myself reflecting back on this past year. I had expected the transition from hospital setting to "Corporate America" to be arduous, but it was actually quite smooth. My biggest challenge was learning how to use the postage machine!

"Why was this drastic change so natural and effortless?" Perhaps it was due to my experience as a traveling nurse: adapting quickly to new environments is a necessity as a traveler. And while this certainly helped, it seemed to be something more. . . Something ingrained. . .

In further contemplation, my attention turned back to the basics. What are the fundamental skills of clinical nursing? What did I learn as a student of Nursing 101?

- Prioritization
- Organization
- Attention to detail

Check. Check. Check.

- Utilization of one's resources
- Active learning
- Calmness in fast-paced environments
- Critical thinking

Check. Check. Check. Check.

- Follow-up
- People skills
- Ethical considerations
- Clinical knowledge

Check. Check. Check. Check. The list goes on and on.

Aha! Perhaps this is why my transitional year has gone without a hitch. The skills embedded during my clinical years can be applied to my work as an LNC. I already had the tools in place to be successful; I simply carried them into a different setting.

### Prioritization

Assessing a patient assignment and prioritizing care for those patients is analogous to assessing my case workload and prioritizing the work. This activity is performed multiple times throughout the day in both the clinical and legal settings. Which case has an upcoming deposition? Which case has a court-ordered deadline impending? Which case is scheduled for trial next month? These questions help me to plan my work and schedule my day. For example, if I receive

supplemental medical records on a case with an upcoming deposition, updating the medical chronology becomes a priority, as this information is necessary for preparation.

### Organization

Organization is key to being successful in nursing, regardless of one's specialty or practice area. Just like juggling different patients with different diagnoses scheduled for different procedures during a clinical shift, I juggle different cases (patients) with different complaints (diagnoses), and different legal strategies (procedures) throughout my day. In the span of eight hours, my cases can range from root canal therapy to an amniotic fluid embolism to a motor vehicle accident to compartment syndrome. Organization is absolutely critical. Every person organizes differently, and it is important to find what works best. My personal choice is a running to-do list, used in conjunction with Outlook calendar. Each case name is followed by a list of tasks, when and by whom they were assigned to me, and the date I completed them. After just 11 months, my list is 52 pages long! But it works for me. I cannot possibly remember everything I have done and when, on every case, so this, my "peripheral brain," keeps me organized.

### Attention to Detail

Being detail-oriented is obviously important in clinical nursing. Noticing subtle changes in a patient is part of our role. The same is true for LNCs. For example, in a case alleging a failure to diagnose pancreatitis in a timely fashion, it is important to look not only at the amylase and lipase levels but also the trend. While the patient's amylase and lipase levels were mildly elevated during hospitalization at the defendant hospital, the classic spike in values did not occur until the patient was eight days into her stay at the subsequent rehabilitation facility.

### Awareness and Utilization of Resources

Mentors/resources are very important to all nurses but particularly to a new nurse or to an experienced nurse starting a new specialty. LNC work is no different. Make yourself aware of resources available to you and use them when needed. They are invaluable. Ask questions. Use experience to learn. My clinical background was telemetry, emergency nursing, and administration. So when my first obstetrical client case



arrived, I was out of my element. When an attorney asked me an obstetrical question, I answered: "I do not know, but I will find out." I then utilized online, professional, and AALNC resources to obtain the requested information. The attorneys appreciate my honesty and my willingness to learn.

## Active Learning

Active learning has been the foundation of my transitional year. While I completed an LNC course, I find I learn best from doing, from being hands-on. So from writing chronologies to locating expert witnesses to learning how to use the postage machine, on-the-job learning has been vital to my success. In addition to these examples, I was fortunate to have the opportunity to attend a dental malpractice trial with a partner at my firm. It was an incredible learning experience. It allowed me to see how my behind-the-scene work assisted the attorney at the trial. I learned first-hand how attorneys process information and then present that material to a jury. Every situation has opportunities for learning. Take advantage of them.

## Calmness in Fast-Paced Environments

As upcoming events and deadlines approach, things can get quite hectic. Fast-paced environments are nothing new to nurses. So when the firm's first trial since my employment arrival was looming, I was ready: last minute preparations, last minute changes, phone calls at 9:30 pm, and pressing deadlines. The chaos was familiar; it was simply in a different environment. Staying calm in these situations allows for clearer and more creative thinking. For example, in one dental case heading to trial, the dentist defendant mentioned during a break in jury selection that the jury would be unable to see the depth of the tooth's periodontal pocket as he measured the periapical radiograph with a ruler while on the stand. Trial was to begin in three days. Our team brainstormed, which led to the idea of overlaying a ruler on the x-ray and having a photo lab enlarge the image, which was projected on a screen during trial. The jury was able to see for themselves how deep the pocket was from viewing this image. We won the trial!

## Critical Thinking

Just as a clinical nurse examines his/her patient from all perspectives (physical/spiritual/mental/emotional), I too critically think about my cases. While I am used to thinking in black and white, the legal profession thinks in shades of gray. It is an ongoing challenge to learn how to think like this. When drafting a mediation position statement, I consider the different angles from which I can tackle what is in the records. When meeting with a client, I think about how plaintiff's counsel is approaching the defendant and the medical record. How can the facts be used to counter the plaintiff's approach? For example, when working on a case involving triage in an emergency department, one automatically thinks of the triage nurse, but not always. In one case the patient arrived

by ambulance which meant, at this particular facility the patient may have been triaged and assigned an acuity level by the charge nurse. Think outside the box. The most obvious answer is not always the correct one.

## Follow-Up

Just as clinical nurses perform a task (administer pain medication) and then follow up on the effectiveness or response to that intervention (did the pain decrease?), I do the same thing now. When reviewing medical records, one of my tasks is to identify providers from whom records are missing. My intervention is to send a letter to plaintiff's counsel requesting either the missing records or an executed authorization to obtain these records. Follow up: Did I receive the requested records or the authorizations? Intervention: Send the authorizations to the healthcare providers. Follow-up: Did I receive all the records requested?

## People Skills

I thought when I left my last clinical position as a nursing administrative supervisor that the experience of dealing with unpleasant phone calls from upset customers and staff had come to an end. Alas, I was mistaken. While the volume of calls has certainly reduced dramatically, they are still a part of my new job. For example, after I requested medical records from one dentist's office, the office manager called me, irate. She had already copied these records multiple times. Why couldn't I get them from other counsel? Fortunately, the same people skills used in clinical situations helped me to successfully handle this phone call and obtain the needed medical records.

## Ethical Considerations

Nurses learn basic ethical principles related to the care and treatment of patients. Nurses are taught to do no harm, do good, be fair to all persons, and respect autonomy including maintaining patient confidentiality and privacy. These same ethical principles are applicable in the legal arena. How do I, as an LNC, do no harm? I keep my clinical skills up-to-date and maintain my professional nursing license. I take accountability for my actions by admitting and learning from my errors. I remember that my conduct reflects upon our profession as a whole and therefore act with integrity and honor. How do I, as an LNC, be fair to all persons? When working on a case, I maintain objectivity. I do not discriminate or let my personal beliefs interfere with my review. Lastly, whether I am in the office or in the hospital, I help to inform clients of their choices and protect the privacy and confidentiality of their information.

## Clinical Knowledge

Of course, using the nursing knowledge gleaned from the clinical experience is the very core of legal nurse consulting. Clinical education, experience, and knowledge are the very foundation of our ability to consult in the legal arena. It

is what makes us so valuable. Whether we are screening cases for merit, writing chronologies, discussing cases with attorneys, or writing mediation position statements, our clinical knowledge is being employed.

## Conclusion

In so many ways, my years as a clinical nurse have prepared me for success as an LNC. The skills embedded during my time “in the trenches” has allowed me to smoothly transition into the legal nursing specialty. This past year has been full of invaluable lessons, both about legal nurse consulting and about me. I look forward to learning what lessons and challenges are in store for my second year as an LNC. But I have no doubt I will be prepared.

**Julie Dickinson, MBA BSN RN** began working as a Legal Nurse Consultant at Fontaine, Alissi & Knapp P.C. in Hartford, Connecticut in 2008 after a decade of clinical nursing. Dickinson assists in the defense of medical and dental malpractice and personal injury claims. After earning an MBA from Yale University in 2007, Dickinson joined the AALNC. Dickinson was a member of the Southern New England Chapter of AALNC from 2007 to 2009, where she also served on their Board of Directors as Director-at-Large and Secretary. In 2010, Dickinson co-founded the Connecticut Chapter of AALNC and is serving as the inaugural president.

---

## References and Resources

*Continued from page 21*

### Treatment Guidelines

The American College of Physicians and the American Pain Society

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

### Pain Management

Impressive web resource from the collaborative effort of St. Louis University and the American Society of Law, Medicine & Ethics

<http://www.medscape.com/resource/painmgmt>

### Pain Management

From the Medscape database, article on Advanced Approaches in Chronic Pain Management.

**Kara L. DiCecco, MSN RN LNCC** is LNC/Chief Paralegal for the Law Offices of Doroshow, Pasquale, Krawitz & Bhaya in Wilmington, Delaware. She is an Adjunct Professor with the Legal Education Institute at Widener School of Law, teaching courses in Legal Nurse Consulting, Healthcare Law and Ethics, Medical/Legal Research, and Internet Legal Research. She received her master's of science in leadership with a legal nursing focus from Wilmington University, where she also teaches as Adjunct Faculty in the nursing program and fusion courses in legal nurse consulting. She continues to work in clinical practice in urgent care and is a volunteer instructor for the American Heart Association in BCLS/ACLS/PALS/ACLS-ExP. She can be reached at [kdicecco5@comcast.net](mailto:kdicecco5@comcast.net).

# Case Studies in Nurse Anesthesia

By Sass Elisha, EdD CRNA

Copyright 2011; 666 pages, paperback

Publisher: Jones and Bartlett, Sudbury, MA

ISBN: 9780763763879; cost \$63.95

Reviewed by Kara DiCecco, MSN RN LNCC

I am increasingly aware each day of the parallel lines of healthcare (read as medicine and nursing) and the law. My metaphoric self is convinced they were twins separated at birth... each choosing different paths but with a mirror approach to those in their care. What I envision even after many years of separation, put together in the same space, the similarities would be strikingly apparent. Each profession relying heavily on analytical analysis; the 'devil is in the details' as the saying goes. Each practitioner looking for conclusive proof only to have it elude them at every turn due to uncontrollable variables. Each trying to establish an honest connection in their relationship with those seeking their advice in order to provide the best possible outcome. Likewise, clinical case studies are just variations on a theme; the fact pattern seeks to achieve the same objective in information exchange. Even the adversarial exchange between the two professions is a hallmark of sibling behavior at times.

It is not surprising then, that I found the textbook *Case Studies in Nurse Anesthesia* by Sass Elisha, EdD, CRNA, to be an exceptional resource. The author has gathered national experts in the field of nurse anesthesiology to share an intensive, systematic approach to presenting 53 widely-used surgical procedures from the nurse anesthetist's perspective. The categories examined include the specialized procedures found in otolaryngology, general surgery, endocrine surgery, trauma surgery, thoracic surgery, organ procurement, vascular surgery, cardiac surgery, neurosurgery, ophthalmic surgery, gynecologic and obstetric surgery, urologic surgery, plastic and reconstructive surgery, orthopedic surgery, and pediatric surgery. The author extends the analysis to include two procedures (in chapters 54 and 55) requiring similar expertise in anesthesia but not associated with the operating suite: electroconvulsive therapy, and pediatric dental surgery. The amount of material covered alone is impressive but it is the 'critical thinking skills' approach the author takes that makes this text so invaluable.

I cannot state it more succinctly than it is presented in the forward by John J. Nagelhout, PhD, CRNA, FAAN: "Each case and patient scenario is discussed from the preoperative, intraoperative, and postoperative perspective. Pathophysiology, pharmacology, surgical intervention, anesthesia case management, and postoperative considerations are thoroughly discussed and evaluated. Key point, suggested readings, and review questions are presented..."

Undeniably, one of the more uncertain areas of skill development for new LNCs is screening cases for merit in areas outside of their clinical comfort zone. Often the process of looking at medical records generates more questions than it answers. But the reality is, in the plaintiff's firm, all costs for expert opinion are advanced by the firm and only recoverable if there is a successful settlement. Conversely, in the defense firm, justifying the invoice for expert opinion is subject to the approval of the client and may be denied. Maintaining a realistic approach to litigation expense is necessary to the survival of firms on both sides of the bar. While it can be argued that acceptable nursing and medical care should be universal and obvious, this observation betrays the realities of the subtleties and nuances intrinsic to the specialized practice, such as anesthesia. There is a place and need for the specialized resource and the preliminary screening of medical-legal records.

While this book would likely not survive a layman's interpretation, it will find an audience with the practicing LNC/registered nurse. The effects of anesthetic medications, the signs of complications, the anticipated equipment needs, and the significance of pre-surgical lab results unique to each one of the 55 scenarios and surgical procedures are discussed in detail. The tables of predisposing factors and co-morbidities will quickly be recognized by the LNC as risk factors and considerations for alternate causation. Each scenario presents a case synopsis, preoperative evaluation and demographic data, list of medications, diagnostic data, and height/weight/vital signs of the hypothetical patient. The reader is then walked through the key areas of the specific pathophysiology, surgical procedure, and anesthetic management and considerations. This is followed by exploration of details impacting the preoperative, intraoperative, and postoperative periods.

The student nurse anesthetist, as well as the seasoned CRNA, will recognize the value of the information. Because of the depth of coverage and quality of contributors, this text could easily find a home in the academic setting for the LNC curriculum as well. While the book has yet to be written to encompass the universal standards of care for the practice of medicine or nursing, this book certainly speaks to the wisdom and experience of those practicing in this specialty. As with many essential resources for the practicing LNC, the origins of the exceptional guide find their roots in the academic setting.

See p. 20 for author biography.

# KELYNCO

*Life Changing, Life Care Planning*

Kelynco offers the only course that incorporates the nursing process into Life Care Planning!  
Learn how to assess, diagnose, and prescribe a strategy of care.

Learn from the founder who is putting it all together- Nurse Care Planners!

Learn to Love Nursing Again! Learn to Love Care Planning Again!

Earn \$150-\$175 Per Hour.

Set Your Own Schedule.

***Get paid what you are worth -become a Certified Nurse Care Planner***

***today.*** Whether you are in business for yourself or working for a company, Nurse Care Planning offers you the opportunity to enter the ranks of the highest paid nurses in the country. Enroll now in the courses that will change your life while you continue to do what you love.

The course is totally online—totally convenient. Kelynco offers additional live webinars to assist you in your education. This is the only course where you can work in a group setting and learn the foundation of Nurse Care Planning. Step-by-step instruction to develop care plans for the plaintiff or defense. Kelynco is expanding Nurse Care Planning in 2010! Nurses write care plans for a day or for a lifetime. Learn to formulate care plans for Seniors, Personal Services, Worker's Compensation or Insurance. Kelynco teaches business set-up and shares marketing strategies for success.

Get started today!

Register Now!!

[www.kelynco.com](http://www.kelynco.com)

***Completely Comprehensive! Completely Nursing!***



NLCP Courses approved for 102 contact hours from ANCC

Kelynco's Additional Courses

Medicare Set-Aside—Special \$300.00

Care Management

Personal Nurse Advocate

Join the Network of Nurse Care Planners and let us do the marketing for you!

Executive Forum— Join us in our chapter meeting to learn, educate, share, and network with some of the best nurses in the industry. May 1-2, 2010. Forum of Nurse Care Planners are responsible for education content. Join us!

# *The Journal of Legal Nurse Consulting*

## Topics Sought for Feature Articles

### **Damages/Life Care Planning**

Calculating Damages for Pain and Suffering  
Functional Capacity Assessment  
Functional Testing: Approaches, Injury Management  
Integration

### **Ethics**

Mental Retardation and (Forced) Contraception  
HIV Litigation: Medical-Legal Issues, Treatment  
Frozen Embryos/Stem Cells  
Sperm and Egg Banks: Issues in Liability  
Wrongful Birth  
Drug Testing: Workplace, Athletes, Medical-Legal/Ethical  
Issues

### **Law**

Qui Tam and Whistle-Blower Litigation  
Expert Panels in Complex Medical-Legal Scientific Litigation  
Biomaterials  
Conflict of Interest

### **Criminal Law**

Correctional Nursing  
Death Investigation  
Prescription Medications in Death Investigations  
Sexual Assault Forensic Examination  
Driving Hazards/Doctor's Liability: Diabetics,  
Seizure, Alzheimer's  
Insanity Defense  
Shaken Baby Syndrome

### **Employment Law**

Worker's Compensation Issues: Fraud, Representing  
Undocumented Workers, Types of Injuries,  
Malingering, Assessing Disability, AMA Guidelines,  
Occupational Asthma

### **Medical Malpractice**

Medication Co-prescriptions: Responsibility in Adverse  
Reactions, Abuse  
Medical-Legal Issues in Telemedicine/Teleradiology  
Failure to Diagnose Breast Cancer: Liability, False-Negative  
Mammograms  
Dental Litigation: Temporomandibular Disorders  
Missed Diagnosis of MI  
Use of EKG and Cardiac Enzymes  
Delayed Diagnosis/Treatment of Stroke, CVA: Heparin/TPA  
Emergency Room Law

# AALNC

AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

### Paramedic Litigation

Legal Considerations in Pre-hospital Care  
Anesthesia Complications/Standards  
Plastic Surgery: Complications, Liability, Plastic Surgeon vs.  
Cosmetic Dermatologist  
Avascular Necrosis: Complications, Liability, Malpractice,  
Legal Outcomes  
Pap Smears: Malpractice in Gynecology  
Imaging Liability: Radiologists  
Alternative Therapy and Malpractice: "Accepted Practice" vs.  
"Reasonable Care"  
Cruise Ship Medical Guidelines  
Red Cross Issues and Liability

### **Obstetrical Malpractice**

Nucleated Red Blood Cells: Timing of Brain Injury at Birth  
Medical-Legal Aspects of Placental Pathology/ Examination  
Vaginal Birth after Caesarean Birth: Standards  
Contraception, Morning-After Pill  
Infertility Practices  
In-Utero Drug Exposure

### **Personal Injury**

Carpal tunnel Litigation  
Repetitive Stress Injuries

### **Psychiatric Issues**

Malingering: What to Look For  
Lack of Supervision and Liability: Suicide

### **Toxic Tort**

Carbon Dioxide Poisoning  
Mercury poisoning  
Lead Poisoning

### **Miscellaneous**

School Disability Litigation, IEPs  
School Nurse Standards  
Autopsy Findings/Terminology  
Pharmacy Responsibilities for Patient Education, Informed  
Consent  
Legalization of Marijuana  
Athletic Injuries: Medical-Legal and Malpractice Standards in  
Treatment  
Evaluation of Hearing Loss  
Ambulatory Care/Outpatient Care Settings  
Latex Gloves/Sensitivities  
Fraud: Medical Bill Review

# 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.

The logo for the American Association of Legal Nurse Consultants (AALNC). It features the letters 'AALNC' in a serif font. A horizontal line with a slight curve passes behind the letters, starting under the 'A' and ending under the 'C'.

AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

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

## Submission Guidelines

*The Journal of Legal Nurse Consulting (JLNC)*, a refereed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). The journal's purposes are to promote legal nurse consulting within the medical-legal community; to provide both the novice and the experienced legal nurse consultant (LNC) with a high-quality professional publication; and to teach and inform the LNC about clinical practice, current national legal issues, and professional development. The journal accepts original articles, case studies, letters, and research studies. Query letters are welcomed but not required. A manuscript must be original and never before published, and it should be submitted for review with the understanding that it is not being submitted simultaneously to any other journal. Once submitted, articles are subject to peer review (publication is not guaranteed).

### Manuscript format

Manuscripts should not exceed 3,000 words in length, and should be accompanied by an abstract of no more than 150 words. All manuscripts should be double spaced. The title page should include the title of the manuscript and the authors' names, credentials, work affiliations and addresses, daytime phone numbers, fax numbers, and e-mail addresses. One author should be designated as the corresponding author. The title page, the tables and figures, and the reference list should each appear on a separate page. Pages, beginning with the title page, should be numbered consecutively.

### Manuscript submission

Manuscripts should be sent to the JLNC Managing Editor via e-mail at [JLNC@aalnc.org](mailto:JLNC@aalnc.org), as a Microsoft Word attachment. (If not possible, an electronic copy on CD can be mailed to the JLNC Managing Editor; address above.) Use a minimum of formatting: do not use unusual fonts or a variety of type, and do not insert headers or footers except for page numbers. Create a separate file for tables and figures—do not insert them into the text file. Clearly label your e-mail (or CD) with the submission title, word processing program name and version, and name of the corresponding author.

### Style and reference guidelines

*JLNC* follows the manuscript style and reference guidelines of the *Publication Manual of the American Psychological Association* (6th ed.). Legal citations must adhere to the guidelines published in *The Bluebook: A Uniform System of Citation* (15th ed.), Cambridge, MA: The Harvard Law Review Association.

### Reprint permission for copyrighted material

When using figures or tables from another source, the author must obtain written permission from the original publisher and include that as part of the manuscript submission materials. The author is responsible for obtaining permission for the use of photographs of identifiable persons.

### Figures and tables

Figures include line drawings, diagrams, graphs, and photos. Tables show data in an orderly display of columns and rows to facilitate comparison. Each figure or table should be labeled sequentially (e.g., Figure 1, Figure 2 or Table 1, Table 2) and should correspond to its mention in the text. All photographs must be black-and-white electronic files.

### Manuscript review process

Manuscript submissions are peer reviewed by professional LNCs with diverse professional backgrounds. First-time authors are encouraged to submit manuscripts. Manuscript assistance can be provided upon request to the editor.

Acceptance will be based on the importance of the material for the audience and the quality of the material. Final decisions about publication will be made by the editor.

### Copyright

Upon acceptance of the manuscript, the author will assign copyright to *JLNC*. Permission for reprints or reproduction must be obtained from AALNC.

### Manuscript checklist

Please use the checklist below to be sure that your submission follows *JLNC* guidelines.

- The manuscript is being submitted exclusively to the *JLNC* and has not been published previously.
- Guidelines in the *Publication Manual of the American Psychological Association* (6th ed.) and *The Bluebook: A Uniform System of Citation* (15th ed.) (for legal citations) have been followed.
- All references cited in the text are included in and agree with the reference list. References in the reference list appear in alphabetical order and include all the elements described in *Publication Manual of the American Psychological Association* (6th ed.).
- Permission for including or reproducing previously published information (e.g., tables and figures) is enclosed.
- Numbers and percentages have been checked against one another and the text for accuracy.
- Tables and figures reflect the information in the text.
- The manuscript does not exceed 3,000 words in length, is double spaced and includes an abstract of no more than 150 words.
- The title page includes the title of the manuscript and the authors' names, credentials, work affiliations, addresses, daytime phone numbers, fax numbers, and e-mail addresses.
- Graphics are black-and-white electronic files.
- One author is designated as the corresponding author.

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**

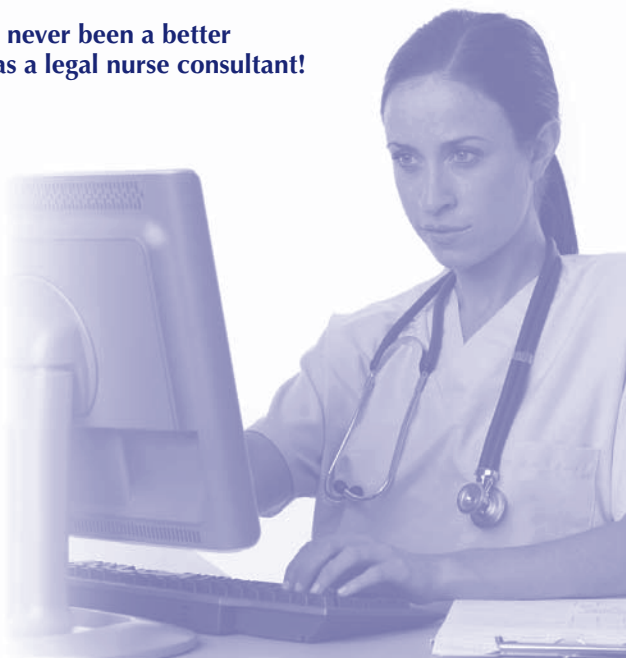
**Whether brand new or experienced in the industry, there has never been a better opportunity to expand your career and brighten your future as a legal nurse consultant!**

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



**Address Service Requested**

**AALNC**  
AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS  
401 N. Michigan Ave., Suite 2200  
Chicago, IL 60611-4267

PRESORTED  
STANDARD  
U.S. POSTAGE  
**PAID**  
Chicago, IL  
Permit No. 4184