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AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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# *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.

## 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.



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# LEGAL NURSE CONSULTING
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## Features



## Departments



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# Help us Increase our Expertise by Serving AALNC's *Journal of Legal Nurse Consulting*

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This message is to ask you if you might be interested in serving the American Association of Legal Nurse Consultants in the capacity of member of the editorial board or as a manuscript reviewer for *The Journal of Legal Nurse Consulting*. We are looking to widen the areas of expertise and expand the *Journal* in both of these areas. As you know, the *Journal* serves our members and readers by providing a wide variety of topics related to legal nurse consulting and the field is growing. Thus, increasing our expertise capacity will add more value to the knowledge base of our specialty. Listed below are the qualifications and specific duties for editorial board members and reviewers. Please review this carefully and if you are interested in serving in either capacity, please let us know by contacting me at rogersb@email.unc.edu.

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*Continued on page 19*

# Evidence-Based Practice for the Legal Nurse Consultant

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**KEY WORDS**
**Evidence-based Practice, EBP, Work Product, Clinical Question, Research, Clinical Expertise, Critical Appraisal**

*Evidence-based practice (EBP) is a model that is being used across healthcare disciplines in order to consistently achieve quality outcomes in patient care. EBP guides interventions by seeking out the best available evidence; its methods provide instruction to the practitioner for evaluating the quality and suitability of evidence. The goals of EBP as well as its methods have applications for all aspects of patient care, but can also guide the practice of nurses outside of the direct patient care environment. Legal nurse consultants (LNCs), in particular, can utilize the concepts embodied in EBP to improve the work product they provide to clients. This article will discuss the process of EBP as well as its applications to the practice of the LNC.*

Evidence-based practice (EBP) is an approach to patient interventions which is being utilized across healthcare disciplines and has been embraced by nurse leaders. The goal of EBP is to optimize patient outcomes by basing patient interventions upon the best and most reliable sources of evidence available. Accordingly, DiCenso, Guyatt and Ciliska (2005) define EBP as "the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making" (p. 4). The importance of EBP methods is demonstrated by the Institute of Medicine's (IOMs) inclusion of evidence-based decision making in the 10 rules formulated in their report on recommendations for the redesign of healthcare. In this report, *Crossing the quality chasm: A new health system for the 21st century*, the IOM states (rule 5), "Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place" (Institute of Medicine, 2001, p. 4).

The quality goals of EBP are applicable to nurses in whatever setting they may practice. In the legal arena, the field of legal nurse consulting is a recognized nursing specialty with well-defined professional standards. The role of the legal nurse consultant (LNC) is described by Noonan (2003) as a cross-jurisdictional advocacy that involves acting as liaison between the different worlds of healthcare and law. Noonan states that the LNC acts as a truth-teller, defending the standard of care. In further describing the role of the LNC, Magnusson, Joos, Pike, Janes, and Beerman (2003) state that LNCs are qualified to "evaluate, analyze, and render informed opinions about the delivery of healthcare and the resulting outcomes" (p. 162). If the above noted EBP methods are applied to LNC practice, the LNC will excel in this specialized role as an advocate for truth who renders opinions. The purpose of this article is to describe EBP methods and to suggest ways in which these methods can be applied to the specialized field of legal nurse consulting.

## Evidence-Based Practice

The goal of EBP is to improve patient outcomes. However, for the LNC, the concept of patient outcomes is defined differently since the client who is being served is not a healthcare patient, but instead is a party (i.e. the client) in need of a liaison between healthcare and the law. When the LNC provides a service in this role, the influence of the resulting work product can be considered an outcome. When evidence-based methods are used to create LNC work product, the resulting influence can positively affect client satisfaction with both the LNC individually and the profession of nursing as a whole.

An evidence-based process is comprised of parts or steps to achieve a desired goal. These steps can be applied to many areas of LNC practice, including client education regarding healthcare issues, working with experts, and medical record analysis. By utilizing strong evidence, the work product rendered by the LNC will be supported and validated. Melnyk and Fineout-Overhol (2005) identify five steps in the evidence-based process as outlined in Figure 1 on page 4.

The first and most vital step to beginning an evidence-based process is to formulate an accurate *clinical question*. The purpose of this step is to concisely define what information is being sought. In asking an appropriate and well-defined clinical question, further inquiry is focused on obtaining the most relevant information, thus limiting cost and preventing wasted time and effort (Wright, Brand, Dunn, & Spindler, 2007). Nurses involved in healthcare settings form clinical research questions by asking 'who' is the patient, 'where' is the healthcare setting, 'what' is the health problem of interest, and 'when' that is, a timeframe in the course of the health problem (Macnee & McCabe, 2008). Although clinical research questions created by an LNC may not follow this exact format, these questions may serve as a guide. When forming a clinical question, the LNC must also consider any legal issue in question. For example, if a plaintiff's petition for damages includes chronic pain, the LNC should include the 'what' of chronic pain in a clinical question for research.

Once the search is focused by a precise clinical question that encompasses necessary information, the second step is to *collect the best evidence*. Types of evidence which meet EBP standards are noted by Melnyk and Fineout-Overhol (2005, p. 7) to include (a) evidence from research and expert leaders, (b) patient assessment, (c) clinical expertise and, (d) patient preferences and values. Although these concepts appear to apply only to clinical nursing, the LNC can utilize the same model with some modifications to fit LNC practice needs:

(a) Evidence from research and expert leaders: This evidence is generally gathered through a systematic review of healthcare literature via a search of peer-reviewed journals, textbooks, and publications of professional organizations.

(b) Evidence from patient assessment: This assessment is indirect in the case of the LNC; the assessment is made from the health record review.

(c) Clinical expertise: The LNC is a nurse expert; this expertise is described by DiCecco (2007):

"...registered nurses (RNs)...have achieved competency in the basic principles of kinematics, physics, organic chemistry and statistical analysis in order to obtain professional licensure. The skill and expertise in reviewing and understanding medical literature is borne out of advanced education and hard-won clinical experience" (p. 3).

(d) Patient preferences and values: The concept is one of guidance and autonomy in regard to medical interventions; the clinical nurse does not violate the preferences or values of the patient in providing treatment. The LNC is guided by the requirements (preferences and values) of the client for whom the work is being produced.

The third step in the EBP process is to critically appraise the evidence that has been collected. In this step, analysis centers on assessing the validity, relevance, and applicability of the evidence gathered. In appraising the quality of evidence from research and expert leaders, DiCenso et al. (2005) advise that there is a hierarchy of strength of evidence. The authors note the following levels of evidence:

- Systematic reviews of randomized controlled trials (RCTs): RCTs involve subjects randomly assigned to the experimental or control group and are the strongest design to demonstrate a cause and effect relationship;
- Single randomized controlled trials;
- Systematic review of observational studies: An observational study involves participants who are assigned to the experimental or control group based on participant or clinician preference;
- Single observational studies;
- Physiologic studies (e.g. studies of blood pressure, heart rate, oxygen saturation, etc.);
- Unsystematic clinical observations (e.g. random observations by an individual nurse) (DiCenso et al., 2005; Melnyk & Fineout-Overhol, 2005)

The fourth step in the evidence-based process is *integrating the evidence*. This process combines the findings of the systematic review with clinical expertise and available resources, and then applies the result to interventions as appropriate to client preferences or values (Melnyk & Fineout-Overhol, 2005). In clinical healthcare settings, this step involves the formulation of clinical decisions and planning of treatment. In the legal environment, the LNC integrates evidence of a systematic literature review into a final work product. An example of a final evidence-based work product would be a medical record analysis that integrates the findings of a systematic literature review. In some instances, the literature review itself may be the final work product.

**Figure 1: Steps to evidence-based practice (DiCenso et al., 2005; Melnyk, & Fineout-Overholt, 2005)**

1. Formulate a clinical question
2. Collect the best evidence
   (a) Evidence from research and expert leaders
   - Systematic reviews of randomized trials
   - Single randomized trials
   - Systematic review of observational studies
   - Single observational studies
   - Physiologic studies
   - Unsystematic clinical observations

   (b) Evidence from patient assessment
   (c) Clinical expertise
   (d) Patient preferences and values
3. Critically appraise the evidence
4. Integrate evidence with clinical expertise resulting in decisions / change in practice
5. Evaluate the change

The fifth and final step of the evidence-based method is *evaluation* of the change that resulted from the evidence-based process. As one of the most basic components of the nursing process, evaluation is understood by nurses to be a vital part of a continuum of excellence. When evaluating evidence-based applications, the LNC should examine the process itself, that is, the utility and effectiveness of the EBP procedures, as well as the outcome of its use, such as client satisfaction. Through ongoing evaluation, the LNC will continually improve the final work product.

## Evidence-Based Methods in LNC Practice

For the purpose of adding clarity to the discussion of EBP applications for the LNC, a case scenario is presented. Although the LNC practices in a wide variety of settings and may find many ways of utilizing EBP in his or her practice, the following example of how EBP was applied in one case may prove useful as an illustration. Review and analysis of health records is described by D'Andfrea, D' Amico and Davis (2003) as the "cornerstone of the LNC practice" (p. 732). Therefore, this scenario will discuss evidence-based applications in the context of analyzing health records.

**Scenario: Use of EBP in Medical Record Analysis**

The LNC is asked to review and analyze a set of health records. Upon such review, the nurse finds that the plaintiff, Ms. Smith, is a 51-year-old female who experienced a failed left total knee arthroplasty (TKA). Due to the TKA failure, a surgical revision was required. The device had been in situ for six years at the time of revision arthroplasty. Review of the health records reveals that Ms. Smith is moderately active and is employed as a sales clerk in a busy retail store. At the time of revision arthroplasty, Ms. Smith is morbidly obese with a body mass index (BMI) of 48.1 kg/m$^2$ based on a height of 5'5" and weight 290 pounds (range: BMI > 40 kg/m$^2$ = morbid obesity [Medline Plus, 2009]). Health records indicate that Ms. Smith's average BMI was 47 kg/m$^2$ during a period of 10 years prior to revision arthroplasty. The plaintiff's petition for damages alleges that the particular medical device used in the original TKA was defective and the cause of failure.

**EBP Step 1: Clinical question**

After reviewing the records, the LNC initiates an analysis/summary of the findings. The LNC draws upon a nursing/medical background, training, and experience to identify pre-existing and potentially related conditions (Jones, 2008; Weishapple, 2001). When approaching this analysis from an evidence-based perspective, the LNC utilizes this clinical expertise to formulate a clinical question. As previously noted, the critical function of a clinical question is to focus the review to include only information that is relevant. Pertinent data will likely lead to more than one clinical question, but for the purposes of this example, one clinical question is identified.

When analyzing Ms. Smith's case, the LNC understands that excess body weight increases mechanical loads sustained by the knee, and thus may have an effect on TKA success. Based on this understanding, the LNC formulates a clinical question, "What is the effect of morbid obesity on TKA outcome in the ambulatory patient?" This question answers who (the morbidly obese patient), what (TKA), when (at outcome), and where (in ambulatory settings). This question will therefore be effective in guiding the collection of the best available evidence.

**EBP Step 2: Collecting the best evidence**

To briefly review, the sources of evidence that support EBP are research and expert leaders' opinions, patient assessment, clinical expertise, and patient preferences and values. The collection of research and expert leader evidence is generally accomplished via a systematic review of health literature that is guided by the clinical question. It is important to note that an evidence-based work product does not rest on one study alone, but instead is a synthesis and analysis of all available evidence related to the topic at hand. Textbooks may be included in the systematic review, but it should be noted that textbooks can take several years to reach publication, and therefore, evidence presented may not be the most recent (DiCenso et al, 2005). For the most current information, peer-reviewed publications should be the primary focus in the systematic review. Examples of sources that meet evidence-based standards include Cochrane Database of Systematic Reviews, Medline (National Library of Medicine, PubMed is the search engine for Medline journals), Cumulated Index of Nursing and Allied Health Literature (CINAHL), EMBASE (European biomedical and pharmaceutical journal database), PsychINFO (behavioral sciences and mental health publications), and the National Guidelines Clearinghouse (supported by the U.S. Agency for Healthcare Research and Quality) (Melnyk & Fineout-Overhol, 2005). Wright et al. (2007) encourage reviewers to examine both Medline and EMBASE as only a 34 percent overlap in journals exists between the databases.

Use of a systematic method for the collection process reduces bias and ensures consistency (DiCenso et al., 2005; Wright et al., 2007). Bias is defined as an unintended factor(s) that can lead to distortion or confounding of results and possibly incorrect conclusions (Macnee, C.L. & McCabe, S., 2008). The collection process is initiated with searches of the above noted sources. Searches should include a wide variety of search terms determined by the LNC to be the most likely to capture all possible information. The terms should "cast a wide net" and will likely result in a large number of "hits." After this initial search, the resulting titles and abstracts are reviewed for relevance to the clinical question. Analysis of potentially relevant full texts follows this overview. The bibliographies of relevant studies should also be reviewed for additional references (Wright et al., 2007). With consistent application of search methods, the LNC can ensure that the collection of evidence is thorough, therefore likely to identify all of the available evidence.

Clinical expertise is applied as the LNC utilizes his or her nursing/medical knowledge and experience to conduct an evaluation of a plaintiff's health record, and then initiates an appropriate search for evidence from research and expert leaders to support any clinical opinions rendered by the LNC. The preferences and values of the patient (i.e. the legal client) also guide the collection of additional evidence; this is especially true in the practice of the LNC as it is the client who will support the work financially.

**EBP Step 3: Critical appraisal of the evidence**

After gathering publications which most closely address the clinical question, the LNC must critically appraise the evidence gathered for inclusion in the final work product that will be provided to the client. In addition to the above referenced hierarchy of evidence, the Agency for Healthcare Research and Quality (AHRQ) identifies three domains that guide an evaluation of the strength of evidence (AHRQ, 2002; Melnyk & Fineout-Overhol, 2005). According to the AHRQ, the categories for analysis of evidence are quality, quantity, and consistency. *Quality* assessment encompasses evaluation of the study's design, methods, and any bias. *Quantity* deals with (a) study sample size, as well as overall sample size in the literature collected; (b) a strength of

causality assessment; and (c) the number of studies which address the clinical question. *Consistency* evaluates how studies with similar outcomes compare in design.

In the case of plaintiff Smith, the LNC critically appraised the research and expert leader publications identified in the systemic literature review performed in EBP Step 2. The LNC evaluated each relevant article according to strength of evidence standards for inclusion in the final work product. As an example of a critical appraisal, the LNC reviewed a study by Amin et al. (2006) that addressed the clinical question, "What is the effect of morbid obesity on TKA outcome in the ambulatory patient?" In this study, Amin et al. reported a Kaplan-Meier five-year survivorship of 74.2 percent in the morbidly obese group compared to a 100 percent survivorship in the non-obese control group ($p = 0.01$). The results seem to support a negative relationship between morbid obesity and TKA outcome. An analysis of the study methods was then conducted.

The purpose of the Amin et al. study was consistent with the clinical question. The nonprobability convenience sample was 41 morbidly obese TKA subjects selected from the clinical unit of the authors (assumed to be ambulatory-based on the use of postoperative rehabilitation protocols), representative of the target population of morbidly obese patients. The sample was matched with a control group of 41 non-obese TKA subjects; use of a matched sample reduces bias by ensuring that important characteristics are the same in the control and experimental groups (Macnee, C.L. & McCabe, 2008). The sample size of 41 was sufficient as the authors determined this rate to be comparable to literature reports of the relative frequency of morbid obesity populations. The follow-up time was 38.5 months (range 6 to 66 months) and no patients were lost to follow up (therefore reducing attrition bias [Wright et al., 2007]).Thus, critical appraisal of the details of this study indicated to the LNC that AHRQ *quality* and *quantity* standards were met by the study design, cohort size, bias reduction through matched sampling, and follow-up time. Although randomization was not possible in the study, this limitation was addressed through sample matching. Based on this analysis and critical appraisal, the LNC included Amin et al. (2006) in the final summary of literature (EBP Step 4).

**EBP Step 4: Integration of evidence to affect practice**

After the systematic literature review is conducted, the LNC integrates the information gathered from assessment of the health records with the findings of the literature review to determine the impact on practice given and if practice needs to be altered. Based on this synthesis of information, analysis of the record is supported by peer-reviewed scientific literature.

By comparing this evidence-based method to that of simply offering analysis and opinion based solely on the clinical expertise of the LNC, it becomes apparent that utilizing the full range of available evidence is most likely to result in the desired outcome of client satisfaction. The LNC has presented an accurate representation of the current knowledge as contained in the healthcare literature and applied it to the need of the client. This process makes healthcare information accessible to the client, so LNC work product demonstrates the value of the profession of nursing to act as liaison to the legal client. Outcomes of work product produced in this manner exhibit the important role of the LNC as liaison, advocating truth and bridging the technical worlds of health information and legal services.

**EBP Step 5: Evaluation**

For the LNC, evaluation is performed with each application of EBP to LNC work product. Rather than a conclusion, evaluation of EBP application is an on-going activity which examines process and outcomes. Evaluation can be undertaken in the form of questions. The broad questions that should be examined include:

- What defines a good outcome for the client?
- Was the clinical evidence consistent with the standard of care?
- Are there ways to improve the collection of evidence?
- Are there methods which can be used to better summarize and present the findings?
- Was there client satisfaction with the outcome?

Questions of evaluation will direct the LNC in the future utilization and expansion of evidence-based methods.

## Conclusion

Client preference will ultimately dictate the allocation of resources which make the practice of the LNC possible. With consistent and effective applications of EBP methods by the LNC, clients will be educated in the advantages of utilizing nurse experts to assess and advise in legal matters which involve the delivery of healthcare. Thus, a need for the LNC is created and enlarged, and willingness of the client to allocate resources increases. By identifying the highest quality evidence related to clients' individual cases and then making such valuable information accessible, positive outcomes for both client and LNC will be realized.

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# Case Management Consent: A Requirement

*Jeanine H. Hinkle, RN BSN MBA*

**KEY WORDS**
**Case Management, Informed Consent, Authorization, Empowerment**

*The following article explores informed consent related to case management services. Clients often feel vulnerable during times of illness and informed consent can help to empower them to make their own decisions regarding their healthcare. Case managers should obtain informed consent from their clients before beginning case management services and ensure that clients understand this is a voluntary decision that impacts the healthcare plan. Case managers must discuss all elements of informed consent to provide the client with an understanding of the continuous process of case management.*

"Good morning Mr. Smith, my name is Jeanine Hinkle. I am a nurse case manager assigned to your case by your insurance company. I am here to help you; do you have a few minutes? I should explain case management and the services we provide you." This step is easy to skip and might be especially difficult when you have a chatty client eager to discuss his disease process. As a nurse, you want to hear all about the clinical history and complete a clinical assessment and evaluation to help Mr. Smith reach the stated goals. However, the initial conversation with a client must include education about case management services followed by obtaining informed consent. Providing this information will help to increase client compliance (Lakatos, 2009; Tseng et al., 2010; Ziegler et al., 2009). This article explores obligations case managers have to obtain informed consent from the client for case management services.

Informed consent is the process by which a fully informed client can participate in choices about his healthcare (Edwards, 1998). The Case Management Society of America (CMSA) Standards of Practice for Case Management (2010) state that the client should consent to case management services prior to service initiation. Is this as simple as the client signing the form on the dotted line? A report from the Institute of Medicine (2003) states that traditional informed consent often does not appropriately inform and empower the participant, because the information in the consent document increasingly serves institutional rather than participant needs. Muller and Flahery (2002) remind us that this simple act does not relieve case managers of the professional obligations to the client. The goal of informed consent is that of a legal and moral issue - it provides the client and his support system with empowerment to make personal decisions regarding healthcare. The Bioethics Project at the University of Washington identifiy generally accepted elements required for a fully informed consent (Edwards, 1998):

- Nature of the decision or procedure
- Reasonable alternatives to the intervention that is proposed
- Risks and benefits related to each alternative
- Assessment of patient understanding
- Acceptance of the intervention by the client.

Case managers must explain the services they can provide using language that the client can understand, and in ways that permit the client to make a voluntary choice (CMSA, 2010). If needed, an interpreter should be used to reduce communication barriers for individuals that have language, hearing, or visual challenges. The client's understanding should be continually assessed. This verbal explanation should include the case management process and the potential advantages and/or disadvantages of receiving case management services as well as any costs that may be incurred. Alternatives to the proposed case management services should also be explained (CMSA, 2010). How the health information is obtained, utilized, and protected is also important. The client should be told of his/her right to refuse case management services and the right to terminate services anytime. The case manager has an obligation to maintain a client's right to privacy, which takes precedence over the request to start case management services. The need to start case management does not justify intrusion into the client's life (American Nurse Association, 2005).

Demonstration of meeting the informed consent standard is through evidence that informed consent was given (CMSA, 2010). To be compliant with this standard and cover all topics required, an initial telephone interview assessment script and checklist is helpful. The figure on the next page provides an example of a first call checklist which can be modified based on the service provider's needs and requirements. It is important that the case manager initial and date each assessment point to comply with the CMSA Standards of Practice. Additional written documentation of the first client contact should be well documented and in the client's case management file.

Upon confirmation of verbal consent for case management services, the case manager can send an introductory packet of information which should include a brochure about the organization the case manager represents; an introductory letter explaining case management services including the completed case management assessment checklist; a medical information

**Figure**

| First Call Checklist | All items must be completed with the client, dated, and initialed by Case Manager | |
|---|---|---|
| **Item to be completed** | **Date** | **CM's Initials** |
| Introduce yourself, give your credentials, and describe what company you are representing. | | |
| Explain how the client's name was obtained for potential case management services. | | |
| Explain case management services including HIPAA mandated confidentiality of health information. | | |
| Explain the case management process. | | |
| Explain advantages/disadvantages of enrollment into the service. | | |
| Explain the right to refuse case management services and the right to withdraw from the service at anytime. | | |
| Obtain verbal consent for case management services. | | |
| Explain that a packet of information will be sent, and describe the contents including a request for signature confirming consent of case management services. | | |

release form for the client's signature; and a consent form for written (signature) consent for case management services.

For ease of client compliance to obtain valid consent for case management services, include a stamped preaddressed envelope for the client to return the signed authorization. Although case management services can be started and continued once the verbal agreement is obtained, written consent is recommended. The case manager needs to actively pursue written consent and should document this process (URAC, 2009).

If a client has not reached the age of majority, a parent or legal guardian must provide the verbal and written consent. A legally appointed decision-maker can make the consent decision if the client proves incapable of providing informed consent. The client's attorney, in fact, has the same right to information refusal as the client (Muller & Flarey, 2004).

When a client refuses case management services, the case manager should document this and the reason for refusal, if available, and notify the insurance company or the represented third party payer company. Understanding the reasons for refusal can help to modify the assessment strategy thereby increasing the use of case management services. For those providing case management services, a quality assurance review and analysis might prove beneficial and provide insight for improved case management policies and procedures. This could further validate the success of new, outcomes-based processes for obtaining such consent, and could be valuable marketing information to highlight.

Informed consent provides the client, and the support systems, the power to make educated healthcare decisions and increase compliance (Lakatos, 2009; Tseng et al., 2010; Ziegler et al., 2009). As nurse case managers, we strive to help the clients achieve healthcare goals. Further studies are needed to explore which methods of client education achieve the best outcomes and client satisfaction. Method variations to examine should include telephonic, in-person, webcams, online information, recorded clips, translators, or other forms of communication.

## Conclusion

Informed consent is an important aspect within both the CMSA Standards of Practice and URAC Case Management Standards. To be compliant with these standards, case managers have an obligation to obtain informed consent from clients prior to beginning case management services. It is important to ensure the client understands that this is a voluntary process and how this impacts the healthcare plan. Informed consent discussions give the client empowerment to make his/her own health care decisions.

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**Jeanine Hinkle** worked in the case management industry for 10 years. She worked in a variety of roles including as a Case Manager (CM), Quality Manager and CM Product Director. Within these roles, she successfully helped develop the Case Management Departments Policies and Procedures and led her company to be one of the first CM companies to obtain URAC CM accreditation. She also consulted with other organizations to help them develop policies and procedures for their internal CM departments and to obtain URAC CM accreditation. Hinkle recently moved abroad and has used this time to complete the AALNC training course.

## 2010 *JLNC* Nursing Contact Hour Program

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# Sharpen Your Writing Skills, Part II

*Pat Iyer, MSN RN LNCC*

**KEY WORDS**
**Communication, Target Audience, Format Consistency**

*Developing strong writing skills will increase the communication level needed to convey important information. The legal nurse consultant (LNC) will find that well-written reports will increase the value of the work product and ultimately reduce the workload by having a polished, accurante, and credible report.*

Part I of this article covered focus, format, and design elements of legal nurse consulting reports. This section covers flow, organizing, editing, proofreading and saving your reports. Following these concepts improves the usefulness of reports and enhances the career of the legal nurse consultant (LNC).

## Flow

1. Limit paragraphs to a single topic or major idea. Ensure the opening sentence of the paragraph accurately reflects the content of that paragraph.
2. Avoid writing long paragraphs. The reader will tire before getting to the end of the paragraph. A long paragraph can often be broken into at least two pieces.
3. Vary the length of sentences and paragraphs. This will add visual interest to the document.
4. Avoid writing long sentences. These are called "run on," as you run on and on with the thought. The reader often gets lost by the time the long sentence is over and either misses the point, or has to re-read the sentence to make sense of it.
5. Use alliteration to create flow. Alliteration is defined as the repetition of the same sounds or of the same kinds of sounds at the beginning of words or in stressed syllables. A commonly used example of alliteration is "Peter Piper picked a peck of pickled peppers." A clinical example could be the use of a header: *North Nurses Need New Negotiation Skills*
6. Provide transitions between paragraphs so that there is a bridge or a logical flow to the next new idea. Transitions help the reader understand the connection between the paragraphs.
7. Use transitions to connect (and, or), create a sequence (first, second, next), compare or contrast (similarly, instead), exemplify or summarize (for example, in short), or echo thoughts from prior sentences by repeating words or phrases (Oettle, 2007).
8. Avoid referring to a patient as "he" or "she" the first time the patient is mentioned in a new paragraph. Instead, identify the person by name. For example, instead of starting a paragraph with, "He was immediately seen by the triage nurse," write, "Mr. Warren was immediately seen by the triage nurse."
9. Do not overuse proper names at the beginning of a sentence: *Mr. Viglione was the victim of a motor vehicle crash. Mr. Viglione was brought to the emergency department by the Always Ready First Aid Squad.* The second Mr. Viglione should be "he." Repetition of his name interrupts the flow. *Mr. Viglione was the victim of a motor vehicle crash. He was brought to the emergency department by the Always Ready First Aid Squad.*
10. Use parallel construction. It sets up an expectation of what will follow. For example, start each item in a list with the same form of a verb.
    *The emergency department nurse performed these procedures:*
    *Inspecting the skin for injuries*
    *Obtaining blood for testing*
    *Arranging for a CT scan*
11. Do not begin a sentence with the proper name that ended the previous sentence.
    *The medication belonged to Mr. Jones. Mr. Jones was admitted to the hospital with gastrointestinal bleeding.* A revision of these two sentences is: *The medication belonged to Mr. Jones, who was admitted to the hospital with gastrointestinal bleeding.*
12. Write short sentences. Say what you have to say, and no more. Do not use several words when one will do.

| **Instead of:** | **Use:** |
|---|---|
| *in the event that* | *if* |
| *on or about* | *on* |
| *prior to* | *before* |
| *subsequent to* | *after* |
| *for the reason that* | *because (Dubose, 1997)* |

13. Avoid adverbs used for effect, which add nothing to the sentence's meaning. This list includes: actually, basically, essentially, and generally. These words can be used meaningfully, but often are not (Dubose, 1997).
14. Avoid intensifiers, such as whatsoever, utterly, clearly, really, obviously, absolutely, completely, and never, when making attempts to persuade. These words merely give voice to your indignation. If you find yourself using these

words, ask whether your facts can persuade without the purported boost (Dubose, 1997).

15. Be consistent in the use of a comma before a conjunction that separates a list of nouns. It is correct to either include or omit the comma but there needs to be consistency throughout the document for each and every sentence.

    *The nurse gathered the dressings, tape, and saline before entering the room. She placed the items, chart, and water on the table.*

    *The nurse gathered the dressings, tape and saline before entering the room. She placed the items, chart and water on the table.*

16. Use an active voice that is direct and assertive.
    Active: *Jane assisted the patient out of bed.*
    Passive: *The patient was assisted out of bed by Jane.*

## Organizing

17. Create predictability. One way to achieve this is through the application of the advice often applied to making a presentation: Tell them what you are going to tell them, tell them, and complete by telling them what you told them.



18. Provide an organization for your report that is logical. Writing in haste may result in a disorganized report that will be difficult to follow.
19. Avoid use of all caps in headers. Caps are difficult to read. Some word processing spellcheckers cannot detect spelling errors in all caps words.
20. Use headers to introduce new subjects and to create a logical flow of information. Follow a consistent style for identifying first and second-level headers. For example, capitalize the major words in a first-level header. A header under a first-level header is a second-level header. Capitalize the first word only of the second-level header. Example:
    *First-level header: Medical and Social History*
    *Second-level header: Medical history*
21. Consider using an outline format of A, B, C and 1, 2, 3 for identifying the headers. Pick a system and use it consistently.
22. Place at least two points under every header. It is incorrect to have only one section under a point in an outline. For example, A. should have 1. and 2., not just 1.
23. Do not skip a line under a header that is used above a paragraph. The header will be clearly tied to the paragraph below it without the intervening blank space.
24. Take control of a paragraph in the first sentence. State your points in your own words. Quotations may add weight to your opinions, but their use as the first sentence in a paragraph may have the opposite effect.
25. Get to the point. Avoid providing repetitive information.
26. Start with the most important points. Place minor information in the middle of documents, paragraphs, and sentences.
27. List items in descending order of importance, and address the most important points first.
28. Discuss items in the same order in which you introduced them. The order sets up an expectation in the reader's mind as to what will be discussed first, second, and so on.
29. Use single-sentence paragraphs to emphasize important ideas. They will stand out.
30. Provide normal values for laboratory tests in parentheses after stating an abnormal value.
31. Do not ramble. The presentation of factually correct, easy-to-follow information is often more important than other aspects of the report.
32. Be consistent in the use of terms. For example, use either physician or doctor, but not both in the same document.
33. Summarize the major points at the end.
34. Consider presenting an executive summary at the beginning of the document. This would be appropriate for a long work product document. Read through the document and pick out the major points. Capture the important details but do not create a word-for-word reiteration of the report.

## Editing

35. Edit the report after setting it aside for a day. Editing refers to a review of the entire document for clarity, content, focus, organization, and grammar. The purpose of editing is to prune your report. Many writers shortchange this part of a project, not realizing how much improvement can be made in a draft.
36. Consider finding a mentor to assist with report writing and editing, if this is not a strong point for you. Learn to value criticisms and develop the ability to separate your writing from your intellect and ego. Some people interpret a criticism of their writing as an attack on their intelligence, will not listen, and will keep repeating the same mistakes. Learn from the mentor's changes of your report.

## Proofreading

37. Avoid rushing through editing and proofreading the report. It is tempting to rush a project out the door but errors will inevitably show up.
38. Consider the effect of misspellings, typos, incorrect punctuation, and a disorganized report. They are viewed as carelessness and reflect haste and lack of effort. Create the most effective report you can. Your reputation depends on it.
39. Proofread by printing out the document and reading it line by line. Use a red pen to make it easier to spot the changes when you revise the report on the computer.
40. Read the text out loud. Read what is on the page, not what you expect to see. Listening to your sentences will help you identify errors or awkwardly phrased sentences.
41. Proofread ideally after a day has passed to allow you to read the document with a fresh eye.
42. Look for the types of errors you typically make. Double check for these. Common errors not picked up by the spell checker are "form" versus "from," "tot he" instead of "to the," and "trail" versus "trial." If you know you tend to make common errors of this nature, insert the word into the autocorrect feature, and add an asterisk after the word. For example, replace sue with use*. The asterisk will catch your eye as you proofread and prompt you to verify you've used the correct word.
43. Look for one of a pair that is missing, such as the second quotation mark or parenthesis.
44. Proofread for typos, consistency, and logical arrangement of information.
45. Ask another person with good proofreading skills to read your work. This individual will often find errors your eye has skipped over.
46. Try to avoid interruptions. If you are interrupted when inputting changes into the computer, place highlighting on the section of the report where you stopped. The highlighting will make it easier to resume in the correct spot.
47. Examine all aspects of the document, including headers and footers, and the name and address of the person to whom a letter is addressed. "…The average person is more interested in his or her own name than all the other names on the earth put together. Remember that name and call it easily, and you have paid a subtle and very effective compliment. But forget it or misspell it and you have placed yourself at a sharp disadvantage." (Carnegie, 1981). My last name has been spelled Iyre, Ilyer, Iyers, Ayre, and Tyer. The spelling I am least fond of is "Lyer."

## Saving

48. Save your work often. Power failures can ruin hours of work.
49. Back up your computer on a regular basis. Don't learn this lesson the hard way. Too many professionals have seen their work disappear in a hard drive crash.

Part II of this article provides an overview of some of the principles of constructing reports for attorneys the LNC will find beneficial in his or her practice.

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# Low Back Pain (Part II, Surgical)

*Kara L. DiCecco, MSN RN LNCC*

*Cleaving the back pain algorithm is the line between surgical and non-surgical presentation. Not infrequently, patients with low back pain fail to improve despite multiple trials of conservative therapy and cross the chasm into the realm of surgical candidate. It is at this end point that the treating physician may recommend a surgical referral. Conversely, a range of patients are advised to undergo invasive correction from the onset of symptoms based on clinical correlation with diagnostic results that reveal a fragmented and/or herniated disc. Still others require emergent surgical intervention to relieve any uncompromising pressure to the spinal cord in an effort to restore functioning or at the very least arrest progressive damage. The decision to undergo back surgery has given us hallmark case law (see below) contingent on the appropriateness of informed consent and opened the door to litigation of unfavorable outcomes. Despite this, the individual recovery in low back surgery is as much dependent on the individual's ability to experience full recovery as it is the surgeon's skill. Even surgeries that are performed with textbook precision may result in poor to no resolution of the patient's pre-surgical pain for reasons unknown. The focus of Part II is on select considerations of the surgically qualified back pain owing to a herniated disc. While beyond the scope of this maxim, thorough exploration of the patient's signs and symptoms, (such as range of motion, specific examination based on symptoms and serial evaluation of therapeutic intervention, as well as appropriate imaging studies and blood work) should be performed to rule out contributing or confounding diagnoses.*

## Pathophysiology of the "Herniated Disc"

Between the bony structures of the spinal column are the intervetebral discs (spinal shock-absorbers). The center of the disc, which is called the nucleus, is soft, springy (gel-like substance). The outermost ring, which is called the annulus (Latin for ring), is responsible for providing structure and strength to the disc (a tire-like structure). The annulus consists of a complex series of interwoven layers of fibrous tissue that hold the nucleus in place. The nuclear tissue located in the center of the disc can be placed under so much pressure that it can cause the annulus to rupture. The pressure needed to do this can range from a forcible sneeze to significant trauma. When the disc has herniated or ruptured, it may create pressure against one or more of the spinal nerves which can cause pain, weakness or numbness (Dawson, n.d.).

## Alternate Causation & Surgical Emergencies in Back Pain

- Spinal cord compression secondary to compression fracture or space-occupying lesion
- Spinal infection or abscess
- Vascular or hematologic damage
- Severe disc herniation and spinal stenosis (Arce, Sass & Abul-Khoudoud, 2001).

## Clinical Correlation Defined

Whatever the etiology, back pain that is unrelenting may warrant surgical evaluation. Surgical intervention is often recommended when the patient presents with the finding of a symptomatic herniated disc. This is best visualized on Magnetic Resonance Imaging (MRI) of the lumbar spine. In the interpretation of these results, it is not uncommon to find the statement "clinical correlation recommended." This is because not every finding of a herniation on MRI indicates a symptomatic patient. What follows is a rudimentary explanation of what the physical exam for suspected herniation entails and how to review your client's medical record for this correlation. This examination should likewise entail the client's history.

## Physical Examination & Diagnostic Evaluation of Herniated Disc in the Low Back

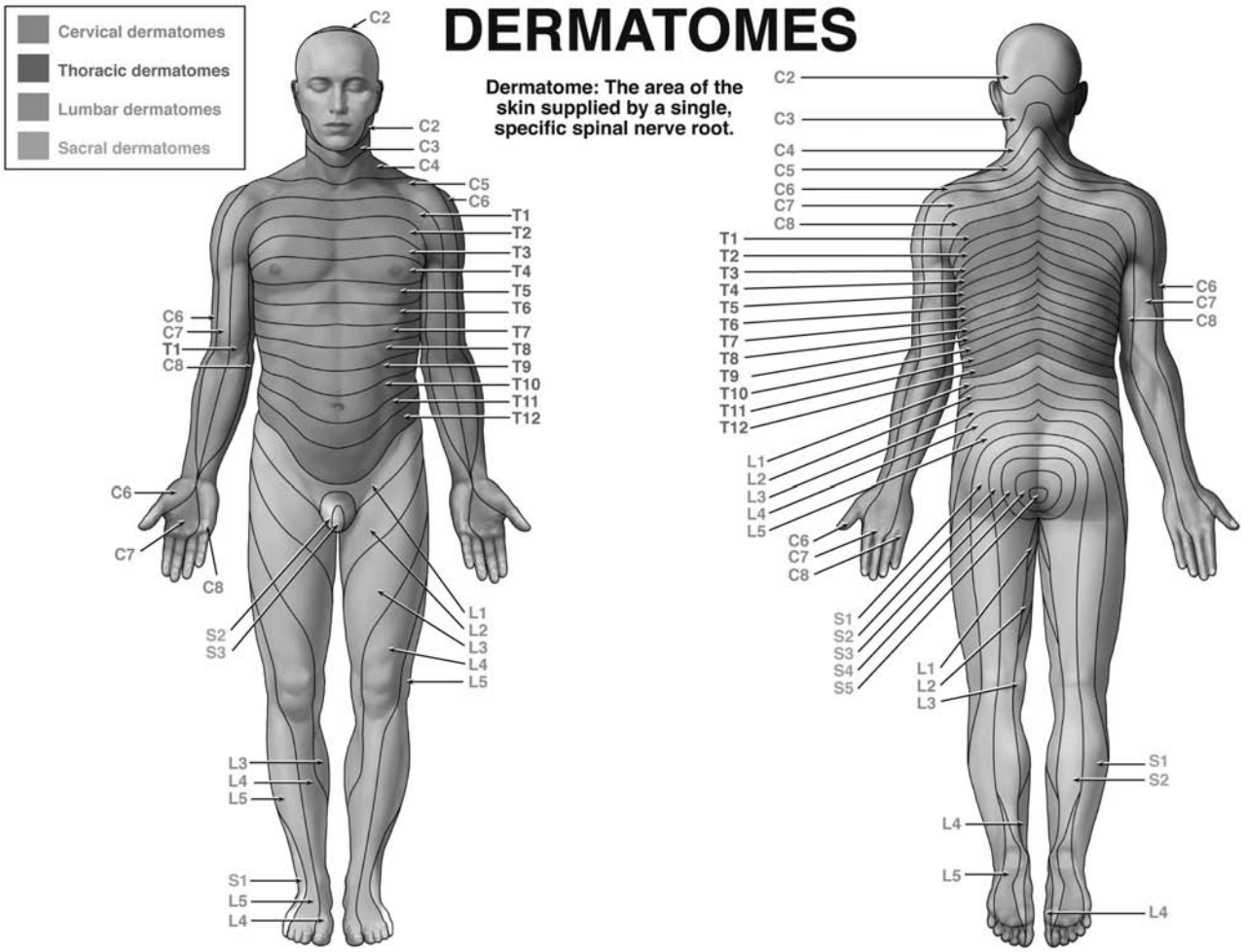
Determining or confirming the cause of low back pain may warrant limiting or expanding individual testing based on specific clinical presentation. The true decision of the need for surgical intervention rests with your client and their treating surgeon. Additionally, patients may present with atypical signs and symptoms.

## Electromyography (EMG)/Nerve Conduction Velocity (NCV)

An electromyogram is a diagnostic test involving the placement of small needles into the muscles to assess the electrical activity of muscle and nerve function.

- An EMG showing abnormal electrical muscle activity may indicate nerve degeneration (neuropathy) from nerve root compression or disc herniation or other conditions. EMG is used to diagnose problems with the muscle; NCV is able to determine problems with the nerve. Weeks after injury, abnormal, spontaneous electrical discharges may appear in muscles at rest and when tested the following indicate abnormalities:

**Figure 1.1: Dermatomes**

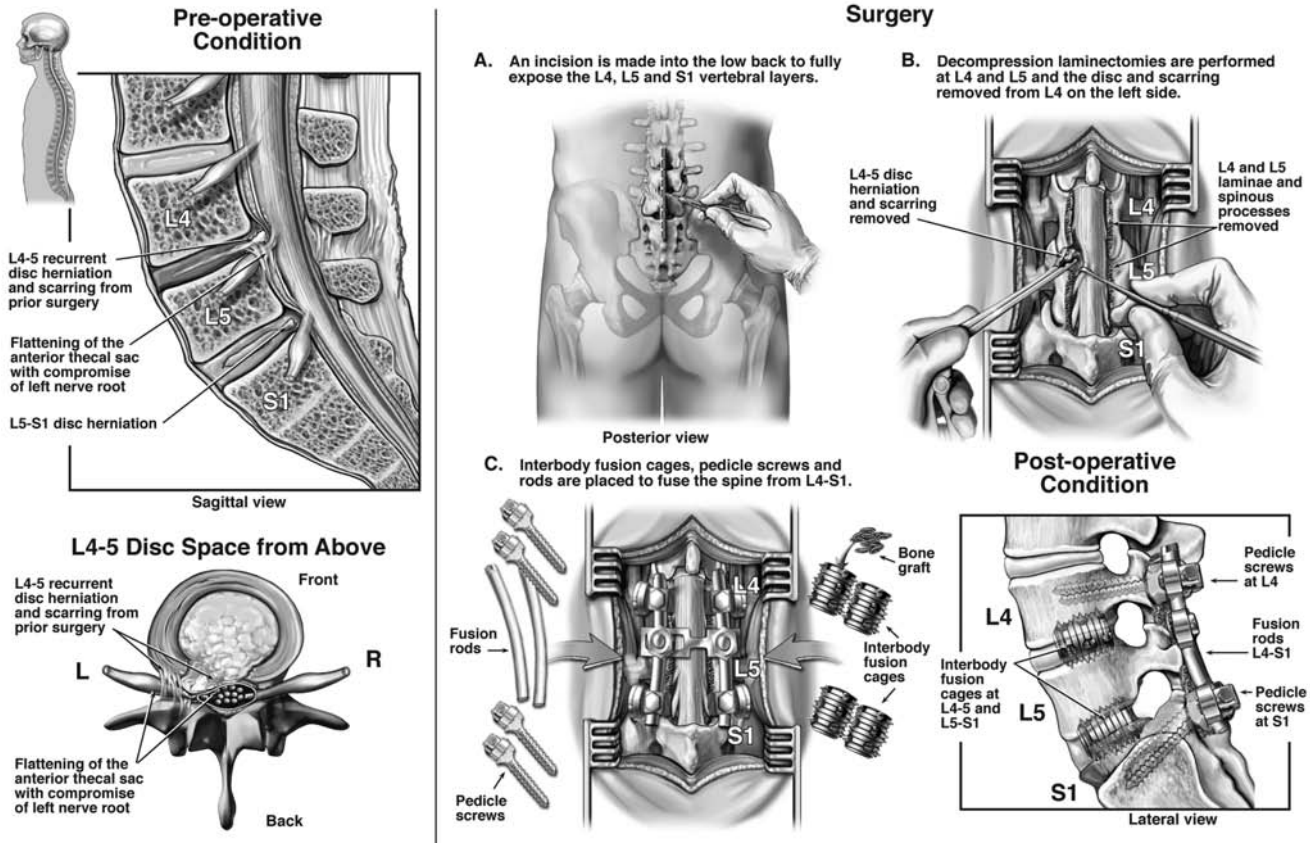



- L4 Nerve root: Fibrillation or sharp waves in the resting tibialis anterior muscle is an abnormal finding.
- L5 Nerve root: Fibrillation or sharp waves in the resting extensor hallucis longus is an abnormal finding.
- S1 Nerve root: Fibrillation or sharp waves in the resting peroneus longus and brevis is an abnormal finding (Hoppenfeld, 1997).

• Dermatomal Distribution Examination: To asses for presence of a nerve root lesion (for example, pressure from a herniated disc), the LNC should examine the client's medical records to determine if the physician assessed the muscle strength, reflex and sensation that correlates with a specific dermatome and correlates with the patient's report of symptoms (i.e. radiating pain, numbness, tingling and/or weakness). The distribution of symptoms may be matched to the body part supplied by that nerve root, however, atypical presentations may be noted. For example, if there are two adjacent herniations. See figure 1.1

1) Motor (Test and contralaterally compare extremity muscle groups. Grading 5/5 movement against gravity with full resistance, 4/5 movement against gravity with some resistance, 3/5 movement against gravity only, 2/5 movement with gravity eliminated, 1/5 visible/palpable muscle contraction but no movement, 0/5 no contraction)
   - L1 motor function is evidenced by the patient's ability to flex the hip (T12-L3).
   - L2 motor function is evidenced by the patient's ability to adduct the hip, i.e. bring towards the midline of the body. (L2-L4)
   - L3 motor function is evidenced by the patient's ability to demonstrate knee extension and testing the quadriceps muscle. (L2-L4)
   - L4 motor function is evidenced by the patient's ability to turn the sole of the foot inward (inversion) and as a separate assessment maneuver, extend the toes up and backward (dorsiflex). This tests the strength of the tibialis anterior muscle. Weakness in this muscle may also result in "drop foot" or steppage gait.

**Figure 1.2: Surgical**




- L5 motor function is evidenced by the patient's ability to extend the toes (pull up and backward) This is testing the strength of the extensor hallucis longus muscle.
- S1 motor function is evidence by the patient's ability to turn the sole of the foot outward (eversion) and bring the foot downward (plantar flexion). This is testing the strength of the peroneus longus & brevis muscle.

2) Reflex – reflexes are graded (0) absent, (1+) diminished/ hypoactive, (2+) normal, (3+) hyperactive, (4+) hyperactive with clonus. Clonus is a repetitive jerking after stimulus of the reflex by reflex hammer. Abnormal findings warranting further investigation would be 0, 1, 3 or 4.
   - L1-L2 Cremasteric reflex (tested on men only). Inner aspect of the thigh is stroked with the handle of the reflex hammer downward causing the scrotal sac to contract upward on the same side.
   - L4 reflex is tested at the patellar tendon (knee reflex).
   - L3 and L5 no associated reflex to evaluate.
   - S1 reflex is tested at the Achilles' tendon (ankle reflex).
3) Sensation to determine nerve root lesion (the examiner may use a pinwheel, pinprick, light stroke and/or temperature evaluation) See Fig. 1.1 on previous page.
   - L1- below inguinal ligament
   - L2- middle thigh
   - L3- lower thigh
   - L4- medial leg, medial foot
   - L5- lateral leg, dorsal foot
   - S1- lateral foot (Hoppenfeld, 1997, pg. 51)

- MRI uses magnetic fields and radio waves for visualizing soft tissues, such as the spinal cord, discs, and nerves, as well as the bones. MRI will show tumors and disk disease.
- Computer Assisted Tomography (CAT) scan is a diagnostic test that enables the spinal canal to be imaged and assessed for specific conditions. A computer is used to reformat the image into cross sections of the spine. CT scans provide excellent visualization of bony detail in a three-dimensional perspective. When combined with a myelogram, a dye injected into the area of the spine being examined, CT scans provide for excellent detail of spinal nerves.
- X-rays provide for bony detail imaging due to the calcium content of bone blocking the penetration of the X-ray. Discs and nerves do not contain calcium, so X-rays are used to evaluate other pathology, such as fractures and degenerative changes of the spine.

## Terminology

It is important for healthcare providers to use universal terminology in defining conditions of the disc but there remains a wide disparity among the correct usage of terms. The following is based on the Recommendations of the Combined Task Forces of the North American Spine Society, American Society of Spine Radiology, and American Society of Neuroradiology (Fardon & Milette, 2001). This article (cited in resources below) provides visual diagrams of the disc classifications.

- *Bulge:* greater than 50 percent non-focal extension of disc material beyond the vertebral body.
- *Intervertebral Disc Herniation:* (a.k.a. Schmorl's node) disc extends vertically into the vertebral body through a weakness in the endplate.
- *Foraminal Disc Herniation:* disc material extending into the neural foramen.
- *Prolapse:* term nonspecific and not recommended by authors.
- *Herniated Disc:* localized displacement of nucleus, cartilage, fragmented apophyseal bone, or fragmented anular tissue beyond the intervertebral disc space (interspace). See Fig. 1.2 on previous page.
- *Protrusion:* can be either focal (<25 percent) or broad-based (25-50 percent). Focal extension of disc material is where the base is the broadest part of the herniation and there is no caudal or cranial migration.
- *Extrusion:* refers to a disc where the base is narrowed in comparison to the distal part of the protrusion. Additionally refers to caudal or cranial (vertical) extension of disc material. Migration: displacement of disc material away from the parent disc.
- *Sequestration (free fragment):* no continuity with the parent disc. Material that has separated away from the parent disc.
- *Annular Tear (a.k.a. fissure):* tear or disruption in the intergrity of the layers fibrous tissue surrounding and supporting the intervertebral disc material.

## Select Operative Procedures for the Surgical Low Back

- *Discectomy:* surgical procedure to removal all or part of the disc material. Done to relieve pressure on a nerve root.
- *Microdiscectomy:* using surgical microscope and microsurgical techniques.
- *Laminectomy:* surgical removal of a portion of the lamina (bony arch) on the dorsal surface of the spinal vertebra.
- *Foraminotomy:* surgical procedure to enlarge the space (passageway – neuroforamen) where a spinal nerve exits the spinal canal. The bone or tissue that is obstructing the passageway is removed.
- *Fusion:* Process using bone graft to cause two opposing bony surfaces to grow together.
- *Spinal Instrumentation:* Surgical procedure to implant titanium, stainless steel, titanium-alloy or non-metallic devices into the spine to provide stabililzation.
- *Bone grafts:* Two common types of bone graft are allograft (cadaver-donor or demineralized bone matrix) and autogenous (patient's own bone).

| Level | Weight Lifted | Frequency of Lift |
|---|---|---|
| Sedentary | 10 lbs or less | *Occasional |
| Light | 20 lbs<br>10 lbs | *Occasional<br>*Frequently |
| Medium | 50 lbs<br>25 lbs or less | *Occasionally<br>*Frequently |
| Heavy | 100 lbs<br>50 lbs or less | *Occasionally<br>*Frequently |
| Very Heavy | In excess of 100 lbs<br>50 lbs to 100 lbs | *Occasionally<br>*Frequently |

## Select Considerations

Exertional levels: Post surgical restrictions with regard to activity level are generally outlined by the surgeon. Levels range from sedentary to light to medium to heavy to very heavy, with variations also falling in between the classifications.

- *Occasional is defined as up to 1/3 of an 8-hour workday (cumulative not continuous) and *frequently is defined as 1/3 to 2/3 of an 8-hour workday [cumulative not continuous] (Form SSA-4734BK).
- At the lower lumbar level (L1-S1), the nerve root involved in a herniation of the disc is located above its point of exit (in contrast to its similarly named disc level). For example, the L5 nerve root crosses the disc space between L4-L5, curves around the L5 pedicle and exits the spinal canal through the neural foramen before it leaves the L5 disc space. Therefore pressure on the L5 nerve root would originate from the L4-L5 disc space above (not the L5-S1 level below) (Hoppenfeld, 1997). The exception is the far lateral herniation (into the foramen) which causes pressure on the exiting root above (Foley, n.d.).
- While considered the single best imaging study of the spine to detect herniations, MRIs may be contraindicated due to patient specifics. For example, an internal pacemaker, profound obesity, claustrophobic patients (sedation may be an option), other non-compatible metal implants.

## Legal Considerations

- Maximum Medical Improvement (MMI) from a worker's compensation perspective is usually one year post surgical intervention. The year mark is often the point at which

permanency benefits (regarding extent of recovery and/or scarring) are evaluated. MMI is defined as the point at which no further improvement is expected and often the end point of authorizing further treatment based on the insurance carrier physician's opinion in Independent Medical Exam (IME).

- Audit of Social Security Administration benefits based on a condition likely to improve. SSA may view surgical back cases as a condition that is subject to improving and may subject the benefit recipient to a random audit at or after the three years of receiving disability benefits. (Conditions not considered to improve may undergo random audits as well but not as early.) This audit may be conducted on a review of the client's medical treatment post surgery and/or generate a request for a Independent Medical Exam with the Social Security Disability examining physician http://www.socialsecurity.gov/ssi/text-cdrs-ussi.htm and POMS DI 28001.000 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0428001000).
- L5-S1 level is the most common site of Herniated Nucleus Pulposus (HNP), L4-L5 the second most common site of herniation in the lumbar spine. This is thought to be due to the fact that these two levels have the greatest mobility and therefore subject to repeated stress (Hoppenfeld, 1997).
- Fractures of the thoracic and lumbar spine may occur in epileptic seizures. Compression fractures (usually wedge-shaped from compression to the front part of the disc) may not require any surgical intervention. If the force is strong enough to completely crush the disc, it is classified a burst fracture. While rare, this type of fracture to the spine may occur in severe seizures as well (Roohi & Fox, 2006).
- Dermatome is defined as an area on the surface of the body innervated by afferent fibers from one spinal root (Glanze, 1990). Two commonly used illustrations of the dermatomal distribution are 1) distribution of the sensory spinal roots on the surface of the body; and 2) dermatomes reflecting the pattern of sensory loss following lesions of single nerve roots (for example, herniated disc material forcefully pressing against a specific nerve root) (Adams, Victor & Ropper, 1997). The distinction is subtle but important. Fig 1.1 is example of the latter.

## 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) "surgery," "low back pain," "operative," "discectomy," "failed back surgery," "MMI," "informed consent," "medical negligence/malpractice," 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 and Resources

Girards, J. E. & Gustafson, J. W. (2010) Blind Faith, Trial, May, pp. 23-27. Excellent article on Postoperative Visual Loss (PVOL). While not solely associated with back surgery, there is an associated risk with multilevel surgery on lumbar spine (Katz et. al, 1994).

Fardon, D. F. & Milette, P. C. (2001). Nomenclature and Classification of Lumbar Disc Pathology: Recommendations of the Combined Task Forces of the North American Spine Society, American Society of Spine Radiology, and American Society of Neuroradiology. An Evidence-Based Approach to Clinical Care. Spine, (26)5, pp. E93-E113.

Lerner, S. E. (no date). Failed Back Surgery Syndrome (FBSS). Retrieved May 24, 2010 from http://www.lectlaw.com/med/med22.htm Informal article on topic.

Minnesota Department of Labor & Industry
Worker's compensation guidelines for the evaluation and treatment or work related low back pain.
http://www.doli.state.mn.us/WC/TpLbp52216200_rule.asp
Resource for understanding the vertebral structures of the spine.
http://www.eorthopod.com/content/_lumbar-spine-anatomy

## Case Law

Canterbury v. Spence, (1972) 464 F. 2d 772
Hallmark case law involving a physician's obligation to provide the patient with enough information to allow the patient to make an intelligent and informed decision regarding treatment.

Smith v. Social Security Administration, Michael J. Astrue, Commissioner, D.C. Docket No. 06-04659-CV-IPJ, U.S. Court of Appeals, 11th Cir. (2008).
SSA disability claim on appeal from failed back surgery and subsequent re-injury.

### Potential Experts

- Internal medicine or family practice as treating primary physician and source of referral
- Orthopedic Surgeon
- Neurosurgeon
- Neurologist
- Physiatrist
- Physical therapist and/or muscle physiologist
- Pain Management Specialist
- Psychologist/Psychiatrist

### Damages

- Potential for inability to return to prior work based on permanent restrictions, economic damage due to loss of potential career/educational advancement and/or chronic disability due to inability to work. Consideration of displaced worker claim if unqualified to return to work force based on labor market survey.
- Sequelae of chronic pain condition, impact on psychological and psychosocial factors (such as depression, anxiety, social withdrawal).
- Potential permanency or disfigurement claim in worker's compensation based on surgical procedure.
- Potential need for future surgery due to a recurrent disc or to an adjacent disc as more stress is placed on the non-fused support.

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Roohi, F. & Fox, A. (2006). Burst fracture of the first lumbar vertebra and conus-cauda syndrome complicating a single convulsive seizure: A challenge of diagnosis in the emergency department.
The Journal of Emergency Medicine, 31(4). pp. 381-385.
Social Security Administration, Form SSA-4734BK
Social Security Administration (2010) POMS DI 28001.000 Introduction to Continuing Disability Review, Accessed May 28, 2010 from https://secure.ssa.gov/apps10/poms.nsf/lnx/0428001020

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*Continued from page 2*

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# Surgical Back (Disc Herniation)

*Kara L. DiCecco, MSN RN LNCC*

*The following sites provide online resources for research, education and support for the subject matter. This list is not meant to be all inclusive of the potential resources available but rather a general reference source for the LNC, and is not an endorsement of any listed sites or services. As with any online resource, the reader must confirm its authority, currency, and credibility independently.*

## Tutorial on Nomenclature

Despite the frequent interchange of terms related to disc problems, distinctions in the degree of impairment do exist. What follows are several brief tutorials to provide insight into these distinctions; however, it is critically important that the attorney clarify with the treating and testifying physician how he/she defines abnormal disc criteria since disc bulge, protrusion, and herniation are frequently (albeit incorrectly) used interchangeably.

**Chirogeek.com**
Provides basic but informative information on a variety of low back conditions and helpful illustrations.
**http://www.chirogeek.com/001_Tutorial_Birth_of_HNP.htm#Bulge**

**American Society of Neuroradiologists**
Extensive glossary for terms specific to surgical pathology and intervention.
**http://www.asnr.org/spine_nomenclature/glossary.shtml**

**Dynamic Chiropractic**
Excellent journal article on the distinction and defining characteristics of disc abnormalities. Dynamic Chiropractic - January 1, 2007, Vol. 25, Issue 01
**http://www.dynamicchiropractic.com/mpacms/dc/article.php?id=52013**

## General Resources

**Hospital for Special Surgery**
Useful reference of basic information on the overview of back pain and surgical intervention.
**http://www.hss.edu/conditions_14134.asp#Useful_Links_and_References**

**Texas Back Institute**
Wonderful and comprehensive resource on back conditions, treatment, and more. The site promotes, from the beginning, the goal to perform as a center of excellence, integrating the best of science and education with the best business practices, and continues to be the backbone of Texas Back Institute's success. More than 30 years later, Texas Back Institute is the most academic private practice in spinal care and is the largest freestanding multidisciplinary academic spine center in the world. It utilizes the latest technological advancements and medical breakthroughs while leading and participating in numerous FDA trials.
**http://www.texasback.com/**

**World Ortho**
Hard to determine what's not available here. This interactive website was started by Professor RL Huckstep and Dr. Eugene Sherry in 1997. It features a wealth of information and services. We strive to provide the most comprehensive and modern educational, research and patient care orthopaedic service in the world. This is important as there is a growing worldwide shortage of doctors and orthopaedic surgeons with a pressing need for good orthopaedic education. Worth exploring.
**http://www.worldortho.com/dev/index.php**

**Spine-dr.com**
This site promotes Spine Dr., an informal group of patient-oriented spine surgeons across the United States, who organize and develop this website. Spine Dr. provides information to people with spinal symptoms, paramedical and medical spine healthcare practitioners, and spine surgeons. To enter the site, accept acknowledgement on page one. It has a variety of peer-written information on the latest techniques and approaches in back surgery.
**http://www.spine-dr.com/site/home.html**

**Spine Universe**
Another informative site, with comprehensive animation, video, articles and patient education materials (under resources).
**http://www.spineuniverse.com/**

## Professional Associations

**American Board of Orthopedic Surgeons**
Functions to serve the best interests of the public and of the medical profession by establishing educational standards for orthopaedic residents and by evaluating the initial and continuing qualifications and knowledge of orthopaedic surgeons.
**https://www.abos.org/moddefault.aspx**

**National Association of Orthopaedic Nurses (NAON)**
Links to patient education materials, evidence-based practice documents, and more.
**http://www.orthonurse.org/**

*Continued on page 24*

# A Global Influence in Hospital Accreditation

*Kara L. DiCecco, MSN RN LNCC*

**Q: I was recently asked by an attorney about the accreditation process for hospitals. I explained that The Joint Commission for years has overseen and been the frontrunner in accreditation for hospitals. To my surprise, he also asked me to look into a company called DNV that is apparently providing direct competition in this area of accreditation. Who are they and where can I find out more?**

**A: Det Norske Veritas (DNV) is the Norwegian-based, parent company of DNV Healthcare, Inc. (DNVHC). DNVHC was granted "deeming authority" in 2008 to survey and grant accreditation status to hospitals which meet or exceed the Medicare Conditions of Participation (CoPs).**

## Historical Perspective

Established in 1864 and headquartered in Høvik (Oslo), Norway, DNV is an international risk management company and a well-recognized giant in the industry. The company promotes as its objectives "safeguarding life, property, and the environment" (Purpose, Values & Vision, n.d.). DNV's presence in the United States dates back to 1898. Despite its roots in risk management the company has branched into numerous industries and organizations expanding its services and global presence. DNV Healthcare, Inc. (DNVHC) is the operating arm of DNV for hospital accreditation. For DNVHC the goals for hospitals are to "assess compliance and educate hospitals in best practices" (DNV Accreditation FAQ, 2010). DNVHC is also proof that the globalization of healthcare is here.

## The Decision

The origin of the Center for Medicare Services and Medicaid Services' (CMS) authority to grant accreditation status to organizations is found in 42 C.F.R. (Code of Federal Regulations) 488.4 and 42 C.F.R. 488.8. To qualify for legal authority to grant accreditation status, that is, "deeming authority," an applying organization must show its expectations and requirements for hospital accreditation to meet or exceed Medicare Conditions of Participation (CoPs).

On September 29, 2008, the CMS announced its decision to approve DNVHC as a qualified provider in accreditation of hospitals seeking to participate in the Medicare program [73 Fed. Reg. 56588 (September 29, 2008)]. DNVHC's initial approval from CMS is for a four-year period (September 26, 2008 through September 26, 2012) and grants the company deeming authority for accreditation. The National Integrated Accreditation for Healthcare Organizations or NIAHO℠ for short, is the name of DNVHC's program for accreditation (DNV Accreditation FAQ, 2010). DNVHC joins The Joint Commission (JC) and the lesser known Healthcare Facilities Accreditation Program (HFAP) as accreditation providers.

## A Unique Survey

Some similarities exist between the NIAHO℠ program and those of its predecessors. DNVHC's process will require the applicants for accreditation to meet or exceed the Medicare Conditions of Participation (CoPs). NIAHO℠ will conduct onsite surveys, make recommendations, and render a decision regarding accreditation (DNV Accreditation FAQ, 2010).

Unlike the competitor's process, DNVHC's accreditation process incorporates two criteria; the Medicare CoPs criteria and the International Quality Standards (ISO) 9001. ISO 9001 standards are international quality standards that define the minimum requirements for a quality management system. A quality management system (QMS) is a set of policies, protocols, and procedures to consistently deliver quality results with continual improvement processes. ISO 9001 is also a part of a family of standards (collectively known as ISO 9000) and is the document that itemizes the specific requirements to become ISO 9001 Certified* or at the very least be ISO 9001 compliant. ISO 9001 *compliance* is ultimately one of the required components of the NIAHO℠ accreditation. The hospital does not have to be ISO 9001 compliant to be accredited for the first 3 years. ISO 9001 compliance is mandatory by the 4th year of accreditation and the facility will be judged for ISO 9001 compliance, or if elected by the hospital, certification at that time. **ISO 9001*

*Certification is recommended but optional and does entail an additional fee* (DNV Accreditation FAQ, 2010).

This inclusion of ISO 9001 is what makes the DNVHC survey unique. Updating the standards no more frequently than every six years, the current standard is ISO 9001:2008 and enhances the requirements for meeting customer expectations and satisfaction over the prior, now obsolete, ISO 9001:2000 (What is ISO 9001?, n.d.).

## Highlights of the NIAHO[sm] Process

- Annual surveys with two surveyors for small hospitals and three to five surveyors for larger hospitals (the Generalist surveys larger hospitals).
- NIAHO[sm] standards are either Mandatory (CMS CoPs and changes to these are an example) or Discretionary (survey recommendations and ISO 9001 implementation are examples). CMS changes are required to be made within 30 days of the new CoP effective date.
- There are three classifications of surveyors: Clinical (physician or registered nurse), Generalist (healthcare experience, may be non-clinical), and Physical Environment (specialist in safety and facilities). Surveyors are recruited from hospitals and the private sector and receive training in the NIAHO[sm] process.
- DNVHC has a Standards and Appeals Board (SAB) for changes and appeals of decisions.
- NIAHO[sm] standards, interpretive guidelines, and/or accreditation process are free for non-commercial use. They can be downloaded at **www.dnvaccreditation.com**. There is a charge for ISO 9001 standards located at **www.iso.ch**.
- Fee and time for survey depends on: a) size of facility, based on average daily census and number of full-time equivalents (FTEs), b) complexity of services offered, c) type of survey and, d) whether the facility has special care units or off-site clinics (DNV Accreditation FAQ, 2010).

## The Joint Commission Reign

The statutory advantage that JC enjoyed, namely standing deeming authority and exemption from disciplinary action by CMS, is effectively removed July 15, 2010. Until that time, JC retains its standing deeming status [Pub. L. 110-275 (July 15, 2008)]. Anticipating the need to address its obligation to now apply to CMS, JC submitted its renewal for deeming authority to CMS on February 9, 2009 and an ongoing dialogue regarding revisions related to CMS feedback is taking place (Hospital Accreditation in the Post-MIPPA Era, 2009).

Among the criticism of JC are observations of excessive expense related to the accreditation process and standards that are too directive and require repeated revision (Blackmond & Zarone, n.d.). Other issues have arisen, such as announced visits and the effectiveness of its intended purpose to ensure patient safety (DDHS, 1999). The Office of the Inspector General (OIG) (2004) found "The Joint Commission survey process failed to identity serious deficiencies that were found by State Survey Agencies." (OIG, 2004).

Trying to determine congressional intent in a law such as ERISA preemption defies explanation but, an invitation to a new approach in accreditation may be a step toward improving patient safety.

## Learn More

**http://dnvaccreditation.com**

Home page of DNVHC accreditation. Two other services offered are Primary Stroke Center Certification and the Critical Access Hospital Accreditation.

**http://www.dnv.us.industry/healthcare/hospital_accreditation/resources/index.asp**

Series of downloads available (overview, articles, comparison charts of accreditation programs, FAQs and more). Includes a search function for hospitals currently accredited by DNVHC and standards.

**http://dnvaccreditation.com/pr/dnv/hospitals.aspx**

**http:///www.hfap.org**

Home page of the Healthcare Facilities Accreditation Program. Interestingly, no obvious mention of the program's founding source, the American Osteopathic Association (AOA).

**http://jointcommission.org**

July 15, 2008 Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA) which revoked The Joint Commission's (JC) exclusive deeming status and requires any organization wishing to attain deeming status for accreditation to apply for this authority through CMS.

**http://www.iso.org**

Home page of the International Organization for Standardization. The organization was established in 1946 with the seat of the organization based in Geneva. Because the standards are a global product, the name ISO was chosen to avoid the inevitable confusion that would occur as a result of different countries using different acronyms. ISO is derived from the Greek word isos which means equal.

**http://www.the9000store.com/ISO-9000-Tips-ISO-9001-Bakery.aspx**

Clever and informational tutorial explaining ISO 9001 by drawing an analogy to making cookies.

Other helpful, downloadable resources at

**http://www.the9000store.com/what-is-iso-9001.aspx**

## References


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Blackmond, B. & Zaron, P. (n.d.) *Hospital accreditation: Alternatives to The Joint Commission.* Retrieved June 12, 2010 from http://www.healthlawyers.org/Events/Programs/Materials/Documents/HHS09.blackmond.pdf

Department of Health and Human Services (1999). *The external review of hospital quality: A call for greater accountability, Report from the Office of Inspector General.* Retrieved June 11, 2010 from http://oig.hhs.gov/oei/reports/oei-01-97-00050.pdf


*Continued on page 24*

## References and Resources

*Continued from page 21*

**American Association of Neurological Surgeons (AANS)**
Possible to retrieve archived, online articles. Links to extensive reference for medical and specialty organizations nationwide are available. **http://www.aans.org/**

## Social Security Administration (SSA)

**Department of Labor, Administrative Law Judge site**
Online version of the former Dictionary of Occupational Titles, now O*Net. Provides information regarding specifics to any job in the national economy, including but not limited to exertional levels and occupational preparation, and for determining job classifications.
**http://www.oalj.dol.gov/LIBDOT.HTM**

**Continuing Disability Review (CDR)**
For medical disability that is likely to improve, SSA may conduct a continuing disability review and if found no longer disabled based on this review may terminate benefits. Surgical intervention for back pain may be viewed as a condition likely to improve. Learn more about the auditing process here.
**https://secure.ssa.gov/apps10/poms.nsf/lnx/0428001020**

## Articles

**Emedicine**
Low back pain and sciatica
**http://emedicine.medscape.com/article/1144130-overview**

**Up-to-Date for Patients**
Subacute and Chronic Low Back Pain: Surgical Treatment
**http://www.uptodateonline.com/patients/content/topic.do?topicKey=~C9D93s_Rdusxr9&source=see_link**

**Emedicine**
Disc Herniation
**http://emedicine.medscape.com/article/340014-overview**

**Spine**
Established in 1976, the journal provides reliable information on the latest spine surgery and advancing technology. Can use online archives for free, partial access, and purchase articles.
**http://journals.lww.com/spinejournal/pages/default.aspx**

**Wheeless' Textbook of Orthopaedics**
Reliable information pertaining to orthopaedic injuries, procedures, and surgery. Good anatomical illustrations and information hyperlinked to originating source of information.
**http://www.wheelessonline.com/**

**Jim Lubin's home page**
As a C2 quadriplegic, Jim has provided this resource since 1994. A wealth of pertinent information.
**http://www.makoa.org/jlubin/home-t.htm**
Broad reference to disability resources.
**http://www.makoa.org/index.htm**
Broad reference for resources in spinal cord injury (SCI).
**http://www.makoa.org/sci.htm#gen**

**Zimmer Spine**
Commercial site of products but provides explanation and visual support for understanding surgical technique.
**http://www.zimmerspine.com/z/ctl/op/global/action/1/template/MP/id/560/**

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## A Global Influence in Hospital Accreditation

*Continued from page 23*

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Government Accounting Office (2004) *Medicare: CMS needs additional authority to adequately oversee patient safety in hospitals report to Congressional requestors.* Retrieved June 11, 2010 from http://www.gao.gov/new.items/d04850.pdf

Purpose, Values & Vision (n.d.) Det Norske Veritas. Retrieved June 6, 2010 from http://www.dnv.com/moreondnv/profile/pvv/

What is ISO 9001? (n.d.) Retrieved June 11, 2010 from http://www.the9000store.com/Step1-what-is-iso-9001.aspx

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# Advanced Practice Registered Nursing: Licensure, Education, Scope of Practice, and Liability Issues

*Eileen Watson, EdD RN MSN ANP GNP LNCC*
*Holly Hillman, MSN RN*

In today's healthcare delivery system, advanced practice registered nurses' (APRNs) roles are expanding to include increased autonomy and responsibility which can lead to increased legal liability. Advanced practice registered nurses are registered nurses (RNs) with advanced levels of education, knowledge, skills, and scope of practice. There are four general types of advanced practice nurses: nurse anesthetists, clinical nurse specialists, nurse practicioners, and nurse midwives (see tables on following pages).

## Licensure

Fifty states and the District of Columbia have different laws/nurse practice acts governing advanced practice nursing. Each nurse practice act specifically defines licensure requirements, educational training, national certification, licensure renewal and continuing education, scope of practice including oversight requirements, practice authorities, prescriptive authorities, and grounds for disciplinary actions for advanced practice nursing. The APRN Joint Dialogue Group Report (July, 7, 2008) written by the APRN Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee was endorsed by several nursing organizations in January 2009, including the American Association of Legal Nurse Consultant(AALNC). The report discusses how APRNs are currently regulated by state licensing boards and there is no uniform model of APRN regulation of APRNs across the states. Three states, Iowa, Utah, and Texas, have passed legislation authorizing joining the APRN Compact—a basically seamless border for APRN practice—but no date has been set for implementation. Until implemented, APRNs are required to obtain licensure in the state(s) where they practice (Schlachta-Fairchild, Varghese, Deickman, & Castelli, 2010).

## Education and Certification

The American Association of Colleges of Nursing (AACN) has set a goal that master's level APRN programs will change to a doctorate of nursing practice (DNP) by 2015 (AACN, 2006). This recommendation for doctoral level APRN education "stems from three Institute of Medicine (IOM) reports, *Too Err is Human; Crossing the Quality Chasm*; and *Health Professions Education: A Bridge to Quality* (O'Grady, 2007, p. 2). Consistent standards titled *Essentials of the Doctoral Education for Advanced Practice Nursing* will guide academic institutions by identifying the foundational curriculum content and outcome-based competencies for DNP program development. The Commission on Collegiate Nursing Education (CCNE) has begun the accreditation Process for DNP programs (AACN, 2006).

National certification is required by 42 state boards of nursing to practice as an advanced practice nurse (Christian, Dower, & O'Neil, 2007). In addition, state boards of nursing require official written verification of recertification from the national specialty certification organization in order to continue to practice as an advanced practice nurse in that state (e.g. Alabama).

## Scope of Practice

Advanced practice nurses have dual legal liabilities. All APRNs must practice by their state board of registered nursing rules and regulations and also must practice by the rules and regulations of their advanced standing agency (e.g. state medical practice act). Guido (2010) identified three ways in which APRN scope of practice may be expanded: amendments to state nurse practice acts, judicial decisions, and federal enactments. For example, 14 states have implemented the 2001 "opt-out rule" of federal Medicare and Medicaid requirements for physician supervision of Certified Registered Nurse Anesthetists (CRNAs).

The role of APRN prescription privileges is expanding due to legislative changes. Prescriptive authorities include:

- Authority to prescribe without physician involvement
- Authority to prescribe with physician collaboration
- Written protocol required to prescribe
- Authority to prescribe controlled substances (Christian et al., 2007).

Nurse practitioners have some degree of prescriptive authority in all 50 states and the District of Columbia. Thirteen states and the District of Columbia allow APRNs autonomous prescriptive authority (Klein & Kaplan, 2010). The state of Oregon serves as an example for legislative APRN regulatory scope of practice changes—nurse practitioners and clinical nurse specialists. In 1977, nurse practitioners obtained independent practice and in 1979 autonomous prescriptive authority. In 2002, clinical nurse specialists became licensed

**Advanced Practice Registered Nursing**

| Definition/Scope of Practice | Website | Credentialing Agency | Re-certification |
|---|---|---|---|
| Certified Registered Nurse Anesthetist (CRNA) administers anesthesia and anesthesia-related care, provides pre-anesthetic preparation and evaluation, develops and implements an anesthetic plan from induction through maintenance and emergence from anesthesia, as well as providing post-anesthetic care, and performs perianesthetic and clinical support functions (American Association of Nurse Anesthetists, 2010). | American Association of Nurse Anesthetists<br>**http://www.aana.com**<br>Also at this website under Resources: State Legislative & Regulatory Requirements, Legal Briefs, and Practice Documents. | National Board on Certification & Recertification of Nurse Anesthetists<br>**http://www.nbcrna.com** | Every two years with 40 hours of approved continuing education, documentation of substantial anesthesia practice, current state licensure, and free of any condition which could adversely affect ability to practice |
| Clinical Nurse Specialist (CNS) is an experienced clinician in a specialized area of practice centering on a population, setting, disease or medical subspecialty, type of care, or problem. A CNS provides direct patient care, focusing on the prevention or resolution of an illness, serves as an expert consultant to the nursing staff, and implements improvements in health care delivery systems (National Association of Clinical Nurse Specialists, n.d.). | National Association of Clinical Nurse Specialists<br>**http://www.nacns.org** | American Nurses Credentialing Center (ANCC)<br>**http://www.nursecredentialing.org** offers Clinical Nurse Specialist – Board Certified (CNS-BC) in Adult Health, Adult Psychiatric & Mental Health, Child/Adolescent Psych & Mental Health, Diabetes Management – Advanced, Gerotonlogical, Home Health, Pediatric, and Public/ Community Health | Every five years; current, active registered nurse license; current ANCC certification; professional development requirements for the specialty and a minimum of 1,000 practice hours in the specialty or professional development requirements for the specialty and re-examination for those without the minimum practice hours |
| | | Oncology Nursing Certification Corporation<br>**http://www.oncc.org**<br>Advanced Oncology Certified Clinical Nurse Specialist (AOCNS) | Every four years; current certification in good standing; active, unrestricted registered nursing license; minimum of 1,000 hours of oncology CNS practice within the past 48 months or a combination of practice hours and 125 professional development points, with 75 points containing oncology content |
| | | American Association of Critical-Care Nurses<br>**http://www.aacn.org**<br>Adult, Neonatal and Pediatric Acute and Critical Care Clinical Specialist (CCNS) | Every four years; current, unencumbered registered nurse or advanced practice registered nurse license; minimum of 2,000 hours of active practice in critical care, with a minimum of 400 hours in the preceding 12 months prior to renewal date; 60 CCNS category A contact hours or continuing education, with a minimum of 15 contact hours or continuing education within the Acute and Critical Care Educational Program area or renewal by re-examination |
| | | Orthopaedic Nurses Certification Board<br>**http://www.oncb.org**<br>Orthopaedic Clinical Nurse Specialist-Certified (OCNS-C) | Every five years; unrestricted registered nurse license; 125 contact hours, with a minimum of 100 contact hours related to orthopaedic nursing; or by re-examination |

**Advanced Practice Registered Nursing**

| Definition/Scope of Practice | Website | Credentialing Agency | Re-certification |
|---|---|---|---|
| Nurse Practitioner (NP) is a registered nurse with graduate-level education and advanced clinical experience providing a broad range of healthcare services, including varying prescriptive authority (American College of Nurse Practitioners, n.d.). | American Academy of Nurse Practitioners **http://www.aanp.org**<br>American College of Nurse Practitioners **http://www.acnpweb.org** | American Academy of Nurse Practitioners Certification Program offers NP-C in the specialties of adult, gerontologic, or family nurse practitioner. Certification is also offered by endorsement for prior certification obtained from an approved national certification body | Every five years; 1,000 hours of clinical practice in the area of specialization and 75 contact hours of continuing education relevant to the area of specialization |
| | | American Nurses Credentialing Center (ANCC) **http://www.nursecredentialing.org** offers Nurse Practitioner-Board Certified (NP-BC) in Acute Care, Adult, Adult Psychiatric & Mental Health, Diabetes Management - Advanced, Family, Family Psych & Mental Health, Gerotonlogical, Pediatric, and School | Every five years; current, active registered nurse license; current ANCC certification; professional development requirements for the specialty and a minimum of 1,000 practice hours in the specialty or professional development requirements for the specialty and re-examination for those without the minimum practice hours |
| | | Oncology Nursing Certification Corporation **http://www.oncc.org** Advanced Oncology Certified Nurse Practitioner (AOCNP) | Every four years, current certification in good standing; active, unrestricted registered nursing license; minimum of 1,000 hours of oncology NP practice within the past 48 months or a combination of practice hours and 125 professional development points, with 75 points containing oncology content |
| | | American Association of Critical-Care Nurses **http://www.aacn.org** Acute and Critical Care Nurse Practitioner (ACNPC)<br>Certification by examination or endorsement from another nationally accredited organization certifying Adult Acute Care Nurse Practitioners | Every five years; current, unencumbered registered nurse or advanced practice registered nurse license; minimum of 2,000 hours of active practice in critical care, with a minimum of 400 hours in the preceding 12 months prior to renewal date; 150 continuing education renewal points, with a minimum of 100 points in the area of acute care or renewal by re-examination |
| | | Orthopaedic Nurses Certification Board **http://www.oncb.org** Orthopaedic Nurse Practitioner-Certified (ONP-C) | Every five years; unrestricted registered nurse license; 125 contact hours, with a minimum of 100 contact hours related to orthopaedic nursing; or by re-examination |

**Advanced Practice Registered Nursing**

| Definition/Scope of Practice | Website | Credentialing Agency | Re-certification |
|---|---|---|---|
| Certified Nurse Midwife (CNM) is a registered nurse and a graduate of an accredited nurse-midwifery program and has passed the certification examination. Education according to the ACNM core competencies and at a graduate level is required for entry into practice for both CNMs and CMs as of 2010 (American College of Nurse-Midwives, 2005).<br><br>A Certified Midwife (CM) is not a registered nurse, but may be a related healthcare professional, such as a physician assistant (PA) or physical therapist. A CM is a graduate of an accredited nurse-midwifery program and takes the same certification examination as a CNM, but receives the professional credential of CM. CMs are licensed to practice in New York, New Jersey, and Rhode Island (American College of Nurse-Midwives, 2005).<br><br>CNMs and CMs provide primary gynecologic and maternity care to women throughout the lifespan (American College of Nurse-Midwives, 2005). | American College of Nurse-Midwives<br>**http://www.midwife.org**<br>This website also is a resource for federal and state legislation. | American Midwifery Certification Board<br>**http://www.amcbmidwife.org**<br>A graduate degree will be required for eligibility to take the certification as of January 1, 2011. | Certification prior to January 1, 1996 has lifetime validation, with no expiration date. Certification after that date is valid for eight years. Renewal is obtained by completing the requirements of the Certificate Maintenance Program (CMP), consisting of 20 contact hours of Category 1 activities approved by the American College of Nurse-Midwives or the Accreditation Council for Continuing Medical Education and options of three certification maintenance models or re-examination. |

APRNs, with autonomous prescriptive authority in 2005. Prescriptive authority includes Schedule II-V narcotics (Klein & Kaplan, 2010). Oversight requirements for APRNs include:

- No physician involvement
- Physician involvement required
- Physician collaboration required
- Written practice protocol required (Christian et al., 2007).

The board of registered nursing has sole authority for nurse practitioners' scope of practice in 24 states and the District of Columbia. Sixteen states give the board of nursing sole authority for NP scope of practice issues but require physician collaboration, five states (California, Florida, Georgia, Massachusetts, and South Carolina) give the board of nursing sole authority for NP scope of practice issues but require physician supervision, and five states (Alabama, Mississippi, North Carolina, South Dakota and Virginia) require both board of nursing and board of medicine authority for NP scope of practice (Guido, 2010).

## Liability Issues

Guido (2010) identified the following as APRN liability issues:

- Unlicensed practice of medicine
- Failure to adequately diagnose
- Negligence in the delivery of health care
- Conduct exceeding physician-delegated authority—resulting in harm
- Conduct exceeding scope of practice—resulting in harm
- Failure to refer appropriately (p. 293)

As an example, in 2008, a Texas Court of Appeals upheld CRNA liability for not following the standard of care for epidural administration of the drug Duramorph. A 49 year-old patient had undergone surgery for liposuction, umbilical hernia, and abdominoplasty. The drug manufacturer's warning states that after receiving this drug, the patient should be monitored for a minimum of 24 hours in a fully equipped and staffed setting. The CRNA discharged the patient home and within the first 24 hours the patient died of a fat embolism. The CRNA and clinical facility were held liable.

## Conclusion

Licensure requirements, educational and certification requirements, scope of practice boundaries, and practice issues are expanding due to changes in today's healthcare delivery system. Each of the four types of APRNs have dual legal liability—nurse with required adherence to the state nurse practice act, then as an APRN with required national specialty certification and/or secondary licensure requirement. Expanding practice roles will likely increase the APRNs level of accountability and liability.

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