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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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Features

Departments

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

Welcoming in a New Year

Greetings to all legal nurse consultants and those interested in the field.

It is an honor for me to have been asked by President Suzanne Langroth and the AALNC Board of Directors to serve you, our readers, as the new editor-in-chief of the *Journal*. I appreciate their confidence in me to serve in this important position. I consider this a privilege and will strive to provide you with the quality *Journal* that you have come to know under the superior editorial leadership of Kara DiCecco, previous editor. I want to thank Kara for all her work with the *Journal* and for helping to mentor me in the editor role. Kara has demonstrated an unmatched commitment to the *Journal* readership through her dedication to securing evidence-based quality articles from experts in the field and providing thoughtful review and editorial critique. Kara's service as editor will be missed; however, she will remain on the editorial board and will continue to provide us with her knowledge and expertise as coordinator and contributor for the Clinical Maxim department.

The *Journal* has an outstanding editorial board whose members have wide subject expertise and a clear vision for the *Journal*. The editorial board contributes their time and talent to help make the *Journal* the premier source of information for the legal nurse consultant, both novice and experienced, about clinical practice, current legal issues, and professional development. The editorial board will be considering different ideas and perspectives on the look of the *Journal*. We also have a new managing editor, Amie Shak, who has assumed responsibility for the operational end of the *Journal* so members receive a quality product.

In this issue, we have several timely feature articles that add to the knowledge base of the specialty. Tammey Dickerson brings her expertise and experience as a labor and delivery nurse and authors an excellent and comprehensive article on vaginal birth after caesarian delivery (VBAC) and related practice issues. The article not only describes factors for decision-making for VBAC but emphasizes the importance of safety and the role of the nurse as an advocate for the patient, particularly related to informed or refusal to consent.

Readers will enjoy the article by Dr. Eileen Watson who is a paralegal professional and teaches about legal issues in health care. Dr. Watson provides an in-depth discussion on advance directives including an historical perspective, types of advance directives, and the complexities and conflicts of decision-making related to end-of-life and the use of life-sustaining treatments.

Dr. Patricia Fedorka, a well-known author and speaker in the obstetrics field, provides readers with a needed comprehensive update on electronic fetal monitoring (EFM) and how it is used in practice. Dr. Fedorka describes the evolution of EFM and the need for a consistent approach to EFM interpretation that will lead to better outcomes.

In the Journal departments, the Clinical Maxim is authored by Kara DiCecco who discusses the complex realm of reflex sympathetic dystrophy and what nurses need to know for their practice. Legal considerations and a variety of useful resources are offered. In addition, Kara also provides a description of extremely helpful Web-based tools on bioethics in the References and Resources department. These tools will be a benefit to the reader in any arena where ethical issues need exploration. This is accompanied by a comprehensive review on an ethics and contemporary nursing book by Dr. Watson in the Book Review department. For the Question and Answer department, Rose Clifford has provided an extremely valuable discussion on the need to conduct searches related to provider board certification and then how to go about doing them. Having this relevant and current information is so important in the legal arena.

As we begin the new year, I will be searching for authors, new and experienced, who would like to contribute to the *Journal*. You have much expertise to share with our readers and we can learn so much from your knowledge and experience. I encourage all of our readers to seriously consider submitting an article for possible publication. We would enjoy receiving your contribution! Also, if you have thoughts about what you would like to see new or different in the *Journal*, we would welcome your ideas.

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

The Rise and Fall of VBAC in the United States

Tammey Dickerson, RNC-OB BSN FMC C-EFM

KEY WORDS
Obstetrics, VBAC, Cesarean Section, Childbirth

Vaginal birth after cesarean (VBAC) has followed a cycle of favorable to unfavorable practice that is typical in obstetric care. When obstetricians and their patients decide whether VBAC is a safe and reasonable choice for delivery, they must consider many factors including the stability of the previous uterine incision, available staff, and provisions to care for an emergency. The patient has a right to informed consent and informed refusal — third-party payers should not have any say in the decision — and nurses must be patient advocates to ensure the obstetrician is aware of abnormal labor patterns, nonreassuring fetal heart rate changes, patient concerns, and patient well-being.

Practices, guidelines, and standards in obstetrics are as cyclic as the innate rhythms of the women who are cared for within the specialty. Vaginal birth after cesarean (VBAC) has followed the same cycle of favorable to unfavorable practice that runs the gamut in obstetric care. Trial of labor after cesarean (TOLAC) is when a woman chooses to labor and attempt vaginal delivery with pregnancies subsequent to a cesarean section. VBAC would then be a successful TOLAC.

Cesarean sections have been conducted since the birth of Julius Caesar, but often were fatal for mother and infant or were done postmortem for burial purposes (Collard, Diallo, Habinsky, Hentschell & Vezeau, 2009). In the early 1900s, Dr. Edwin Cragin coined the phrase "once a cesarean, always a cesarean." His intent was to decrease the cesarean delivery (CD) rate by discouraging physicians from performing the initial CD. At the time it was thought to be too dangerous to allow a woman to attempt vaginal delivery following a CD. Due to this thinking, women were subjected to repeat CD for all subsequent pregnancies even if they arrived at the hospital close to delivery. By 1988 the CD rate had climbed to 25%, along with an increase in maternal and fetal mortality and increased health care costs (Dauphinee, 2004).

Cesarean Delivery Rates Continue to Rise

CD rates in the United States have never been higher. The decline seen in the early and mid 1990s due to VBAC has risen 46% since 1996 to an overall CD rate of 30.2% in 2005 (ACOG, 2007; Capeless & Damron, 2008; Simpson & Creehan, 2008). According to the CDC, the last reported data for CD rate showed an increase once again in 2006 to 31.1% (CDC, 2009). With the decrease in VBAC there has been a rise in CDs, possibly having to do with a trend by obstetricians to reduce exposure to medical malpractice litigation (Yang, Mello, Subramanian & Studdert, 2009). The rise in CD also has seen an increase due to the rise in rate of elective induction of labor which is up to 22.3%, doubling since 1990 (CDC, 2009). This number is significantly underreported due to inconsistency in definition of induction, and inductions that fail and are reported as CDs (Simpson, 2008). It is important to note that elective induction in a nulliparous woman will increase her likelihood of CD by 50% (Wing, 2007). Relevant to this is the impact on the economy regarding healthcare and litigation costs in obstetric care. Vaginal delivery (in spontaneous labor) offers better outcomes for the women, the neonates, and the economic costs involved in elective induction and CD.

Many obstetricians and their patients will need to decide if VBAC is a safe and reasonable choice for delivery. It is important to consider potential success for VBAC, and if standard of care can be met to keep the woman and fetus safe in her decision to attempt VBAC (Harper, & Macones, 2008). Women should be informed of all risks and benefits of TOLAC and the ultimate decision to undergo TOLAC or repeat CD should lie with the woman and her physician (AAP/ACOG, 2007).

History of VBAC and Evolving Standards

In the 1970s and 1980s the feminist movement brought about women who wished to attempt VBAC. The other significant change in practice was fewer physicians using vertical uterine incisions and a trend towards low transverse uterine segment incisions had evolved. A vertical incision has a reported uterine rupture rate of 4% to 9%, while a low transverse incision rupture rate is 0.2% to 0.5%. This clinical change decreased the risk of uterine rupture and made TOLAC a viable option for patients requesting vaginal delivery. As more women requested TOLAC and promising outcomes were reported, physicians allowed more TOLACs. As more successful VBACs occurred, the American College of Obstetricians and Gynecologists (ACOG) and the National Institutes of Health considered VBAC an appropriate method to decrease the cesarean delivery rate in the United States (ACOG, 2004).

In 1982 the first guidelines for TOLAC were published by ACOG. These guidelines included recommendations that TOLACs should occur in hospitals that could care for high-risk mothers. This meant there needed to be access to continuous fetal monitoring, 24-hour blood banking, onsite anesthesia coverage, and a surgeon in continuous presence while the patient labored. By 1988 when the next ACOG committee opinion was published, it fully supported VBAC. ACOG had noted a decrease in maternal and perinatal mortality, shortened length of stay, and less post-operative complications when VBAC was successful. ACOG decreased

the guidelines for patient safety and suggested that 50% to 80% of selected women would successfully give VBAC. In the committee opinion of 1988 TOLACs were encouraged to walk in early labor, have epidurals, and have pitocin augmentation and induction. The specific emergency sanctions of 1982 were replaced with much more general guidelines stating any VBAC should be delivered in a hospital with the ability to care for obstetric emergencies, including a physician to perform cesarean deliveries. It was also recommended that a cesarean delivery should be 30 minutes from decision to incision (Dauphinee, 2004).

In 1994 in a committee opinion, ACOG addressed uterine rupture, which occurs in less than 1% of all TOLACs. If proper surveillance were in place during labor, the serious effects of rupture could be minimized. It was recommended that a plan be in place for rapid diagnosis and emergent cesarean delivery be in place for any facility that allowed TOLAC. At this time it was stated that women should not be coerced into TOLAC, and if they had one previous cesarean delivery they should be encouraged to attempt VBAC. The committee let go of the previous 30-minute rule and stated that judicious use of pitocin and prostaglandins appeared to be safe. Over the next several years, physicians wanted to expand TOLAC to higher-risk women including those with twin gestation and those who were having larger babies than they delivered previously. Insurance providers found VBAC to be financially positive because it cost much less to do a vaginal delivery than a CD. Third-party payers often required TOLAC, and physicians felt pressured to subject higher-risk patients to attempt VBAC.

Increased Risk: More Complications

As the inclusion factors for TOLAC expanded, so did the complications seen when emergencies occurred. Many Level I and II facilities did not have the nursing staff or other provisions to provide emergent CD within the 30-minute guideline. Uterine rupture during TOLAC can be a catastrophic event. If a facility is not properly equipped to handle this risk and cannot deliver an infant in less than 30 minutes, there can be long-term maternal and neonatal consequences, or death. If the patients were not properly screened they could endure a long and arduous labor, which could lead to later gynecologic problems including urinary or fecal incontinence, pain, sexual dysfunction, and pelvic prolapse (Dauphinee, 2004).

With impending lawsuits related to cerebral palsy and fetal and neonatal death, ACOG was prompted to review its guidelines for TOLAC once again in 1999. Misoprostol was no longer recommended for those with a previous uterine scar, CD, or other uterine surgery. It was recommended that women who had large babies, multiple gestations, more than one previous CD, and post-term pregnancies be carefully screened. Inter-pregnancy interval and type of uterine closure were both thought to play a role in the increased risk of uterine rupture. ACOG now recommended that skilled personnel with knowledge of TOLAC complications, continuous fetal monitoring, and the ability to treat emergencies expediently be present for all TOLACs (Dauphinee, 2004).

Falling Rates of VBAC

The mid-1990s saw the highest rates of VBAC; the incidence has dropped 67% since 1996 (Simpson & Creehan, 2008). Martin, et al. (2006) state there is an increase in repeat cesarean deliveries upwards of 90%, and this trend will continue to increase as the VBAC rates decrease. The same study purports the decrease in VBAC may be related to associated risks, physician and patient preference, and more conservative guidelines regarding ability to provide emergent care. There is ongoing discussion regarding risks and benefits of vaginal delivery vs. CD, and potential litigation relating to delivery outcomes. In a study by Weaver, Statham, and Richards (2007) 785 obstetricians were interviewed and 67% of these felt the rising rate of CD was related to the fear of litigation. The study by Yang et al. (2009) suggests that tort reform and malpractice caps may increase TOLAC and subsequently increase successful VBAC while decreasing CD rates.

Risk Related to TOLAC

Table I compares the risks and benefits of elective repeat cesarean delivery (ERCD) to VBAC or successful TOLAC. There will always be proponents to each option, but by comparison vaginal delivery is preferable to CD. The most devastating complication of TOLAC is uterine rupture. The rate of uterine rupture with TOLAC is approximately 1% (ACOG, 2004; AAP, 2007; Simpson & Creehan, 2008). There are many variables that have been considered in regards to uterine rupture including type of previous scar, induction of labor, maternal age, interval between pregnancies, and postpartum fever with previous CD, prior vaginal birth, and number of previous CDs. There is inconsistent definition of uterine rupture and scar dehiscence making it difficult to get accurate statistics (Simpson & Creehan, 2008).

Uterine rupture can be catastrophic and the presentation can vary between patients depending on the location and extent of the rupture. The most consistent sign of uterine rupture are nonreassuring FHR changes. "Fetal bradycardia is the most common clinical characteristic" (Welischar & Quirk, 2008). Prior to bradycardia, recurrent variable and late decelerations are often seen with minimal or absent variability. These FHR changes can signal impending or worsening uterine rupture. Sudden onset bradycardia may also occur. Any infant who is partially or fully extruded into the maternal abdomen have greater risk of brain damage, intrapartum death, and death within a year of birth (Kirkendall, Jauregui & Phelen, 2000). Uterine rupture is associated with maternal hemorrhage, need for hysterectomy, need for blood products, hypovolemia, hypovolemic shock, injury to proximate organs, and complete or partial placental abruption (Simpson & Creehan, 2008). Uterine rupture constitutes an obstetric emergency and rapid response is required.

Table I

Elective Repeat Cesarean Delivery (ERCD)	Vaginal Birth After Cesarean Section VBAC (Successful TOLAC)
Benefits Convenience/Choice of provider Avoid emergency cesarean section Avoid failed TOLAC – Decreased risk of urinary and fecal incontinence – Decreased risk of uterine rupture/scar dehiscence – Decreased risk of hysterectomy	**Benefits** Less overall recovery time Hospital stay of two days or less Baby's lungs clear during the birth process Decreased risk of cesarean with subsequent pregnancies Less risk of infection Overall morbidity and mortality, and rehospitalization are decreased
Risks All risks associated with abdominal surgery: – Thrombosis of legs and pelvis – Injury to uterus, bladder, bowel, or adjacent organs – Infection of incision, uterus, bladder – Longer overall recovery – Hospital stay of at least four days – Ongoing pain/discomfort at incision site – Anesthesia complications – Increased risk of post partum hemorrhage – Increased economic costs for all stakeholders – Subsequent fertility issues – Increased risk of placenta previa, accreta, scar dehiscence, uterine rupture, placental abruption, endometriosis – The more surgeries a woman is exposed to the greater the risk of complications – Increased risk of hospital readmissions	**Risks** (TOLAC) Increased risk of uterine rupture: hemorrhage, blood loss, emergency cesarean section, hysterectomy, and all other associated risks of surgery Failed TOLAC Risk of infection doubles if failed TOLAC to cesarean section Possible vaginal laceration or episiotomy
Neonatal Risks Iatrogenic prematurity Difficulty adapting to extra-uterine life Increased risk of respiratory issues at birth Increased risk of life time respiratory issues such as asthma Delayed/impaired breast feeding and bonding	**Neonatal Risks** Increased risk of morbidity with failed TOLAC Weak evidence of: – Fetal mortality – Intercranial hemorrhage – Asphyxia – Encephalopathy/cerebral palsy – Birth injury – Laceration – Infection

Sources: Collard et al. (2009); Simpson and Creehan (2008); Welischar and Quirk (2008); Wing (2009)

Patient Counseling

Though vaginal delivery is optimal in most situations, it is important for the provider and the patient to analyze all of the factors before coming to a delivery decision. The patient has a right to the safest delivery; if there is any doubt about the previous uterine incision, available staff, or provisions to care for an emergency, it may be necessary to choose ERCD over TOLAC. The patient has a right to informed consent and informed refusal. Third-party payers should not have any say in the decision, but may require the patient to deliver in a tertiary-care facility and not a birth center. Informed consent should be written and performed in the physician's office prior to admission. If upon admission the patient has questions or concerns, the nurse should have the physician review all information until it is clear to the patient. Once in labor, if a patient changes her mind and withdraws consent for TOLAC, it needs to be discontinued and a cesarean section needs to be initiated (Dauphinee, 2004).

Inclusion/Contraindication Criteria for TOLAC

According to ACOG Practice Bulletin # 54, published in July 2004, the following candidates are eligible for TOLAC.

- One previous low-transverse cesarean birth
- Clinically adequate pelvis
- No other uterine scars or rupture
- Physician immediately available throughout active labor capable of monitoring labor and performing an emergent cesarean birth
- Available anesthesia and nursing personnel for emergency cesarean birth

Possible appropriate candidates include:

- Two previous cesarean section deliveries and a previous vaginal delivery (studies have shown a vaginal delivery prior to a cesarean increases success rate by 50% [Welischar & Quirk, 2008]).
- Suspected macrosomia if there has been a previous vaginal delivery
- Post-dates gestation

- Low vertical incision, one that only involves the lower uterine segment
- Unknown uterine hysterotomy (most hysterotomy incisions are low transverse)
- Twins (not much data to support or not support TOLAC in twins)

Contraindications for TOLAC are women who are at higher risk of uterine rupture. TOLAC should not be attempted under these circumstances:

- Prior classical or T-shaped incision or extensive transfundal uterine surgery (ectopic surgery in the uterine cornua increases risk of fundal rupture)
- Contracted pelvis
- Medical or obstetric complications that preclude vaginal birth (placenta previa, worsening abruption, genital herpes)
- Inability to perform an emergent cesarean birth because of unavailable surgeon, unavailable anesthesia provider, or insufficient personnel or facility
- Multiple gestation greater than twins
- Breech presentation
- Two prior uterine scars and no vaginal births
- (ACOG, 2004; Simpson & Creehan, 2008; Welischar & Quirk, 2008; Wing, 2009)

Recommended Management of Women Attempting TOLAC

Hospital standards and policies need to include a surgeon immediately available to respond to acute emergency by performing a CD within a short amount of time (ACOG, 2004). "Immediately available" and "short amount of time" have different meanings to those who use the terms. ACOG does not quantify immediately available. Simpson and Creehan (2008) point out that in lay terms, immediately is "at once, right now, without delay, instantly." An institution might define it as "in-house, or on campus and not engaged in any activity that would preclude leaving immediately to attend to a potential TOLAC emergency, such as scrubbed in for another surgery" (Simpson & Creehan, 2008). It should not include being on call from home, at the office, or without backup if another delivery is occurring.

Not all obstetricians have the time to devote to TOLACs or the desire to stay in-house during the entire labor. Community hospitals doing 500 or less deliveries per year often don't have the resources to pull together a team quickly enough to handle catastrophic events (Simpson & Creehan, 2008) and therefore should not offer TOLAC to patients. Patients wishing to attempt VBAC need to be referred to obstetricians and hospitals that can facilitate safe and emergent care as needed. Uterine rupture can occur rapidly and stealthy, and needs to be diagnosed immediately by staff to avoid fatalities.

Other management considerations (Gilbert, 2007) should include:

- IV access and available blood products, and appropriate number of type and screens to procure blood quickly if necessary.
- Assessment for scar separation is needed, which might include variable fetal heart rate decelerations that could evolve into late decels and/or bradycardia with blood stained amniotic fluid. Less common signs might include hematuria, vaginal bleeding and abdominal pain unrelated to contractions (ICSI, 2007). Fetal monitoring by staff experienced in reading and interpreting the tracing is essential to safe care for VBACs.
- Epidurals are not contraindicated and may be an enticement to women afraid of labor pain. Uterine rupture pain is not generally masked by epidural anesthesia. Patients may have abdominal, shoulder, or back pain with uterine rupture.
- Labor progress needs to be monitored and patients should progress at 1cm per hour in active labor, and push no more than two hours in second stage. Loss of fetal station is a possible sign of uterine rupture. Station is the level of the presenting part in the birth canal in relation to the ischial spines. If there is a sudden negative descent or the fetus becomes ballotible (presenting part is no longer engaged in the pelvis), it is likely the uterus has ruptured and the fetus may be outside to the uterus (McDermott & Aumann, 2007).
- Pitocin augmentation is acceptable, with care not to cause hyperstimulation which is an increase risk for uterine rupture. Prostaglandins are not recommended for TOLAC.
- Repeat CD may be necessary in the event of fetal distress, failure to progress, maternal complication, placental abruption, or uterine rupture.

Nurses must be patient advocates and be sure the obstetrician is aware of abnormal labor patterns, nonreassuring fetal heart rate changes, patient concerns, and patient well-being.

Legal Implications of TOLAC/VBAC

According to Simpson and Knox (2003), common allegations are seen in VBAC cases:

- Failure to give full informed consent including risks and benefits of VBAC compared with ERCD
- Use of prostaglandins in woman with previous scar or uterine surgery
- Use of excessive doses of oxytocin for induction and augmentation
- Failure to be aware of signs and symptoms of uterine rupture
- Failure to recognize and treat uterine rupture in a timely manner, failure to adequately monitor, and failure to respond appropriately
- Failure to have appropriate equipment and personnel to treat uterine rupture
- Failure to consider contraindications to TOLAC
- Failure to monitor and document labor progress

Clinical Study I

JD was a 38-year-old gravida 4 para 3 (G4P3). JD had three previous cesarean sections in 1974, 1976, and 1978. Her children ranged in age from 14 to 18. When JD delivered her first three children, she was in the care of an obstetrician who used pelvimetry (evaluation of female bony pelvis to determine if it is large enough to deliver a fetus). He assured her that she could not deliver vaginally and should have cesareans without any trial of labor. JD had private insurance at the time and this was a common practice. In 1992 JD experienced an unplanned pregnancy (14 years had passed since her last child) and her husband was unemployed at this time; therefore, they did not have insurance. JD was a patient of the Women's Health Clinic and due to the sanctions of the state paying for her care, she was required to attempt a TOLAC. JD labored well, without complications and subsequently delivered an 8 pound, 6 ounce baby boy vaginally. He was the largest of her four children.

Considerations:

- Three previous cesarean deliveries put her at very high risk for uterine rupture. In 1992, the number of previous cesarean deliveries was not an issue for VBAC.
- Because it was 1992, JD was treated like any other laboring patient and not required to be monitored any more than anyone else.
- Because 14 years has passed between the pregnancies, the scar was well healed and, therefore, at less risk to dehisce or rupture.
- Her lack of private insurance directed her care, not informed consent or personal wishes.

Fortunately the standards have changed. No longer is pelvimetry used to evaluate a woman's ability to deliver vaginally. Insurance or lack thereof does not define or direct TOLAC or ERCD. The standards ACOG encourages are more stringent regarding safety for the individual patient during inclusion, evaluation, and labor.

Clinical Study II

SS is a 28-year-old G3P2. Her first infant (now 4 years old) delivered vaginally; the second (18 months old) delivered by cesarean for failure to progress. SS wanted to deliver the third baby vaginally to decrease her recovery time. She arrived at the hospital in labor at four centimeters, and complained of severe abdominal pain in the supine position that lessened when she turned on her side. The fetal monitor strip (FMS) showed multiple variable decelerations (seen with cord compression), minimal variability, and contractions every two minutes of moderate strength on palpation. SS did not progress so pitocin was started to augment her labor. Her obstetrician had office hours so he left the facility and another physician assumed her care. Her labor continued and the FMS became more ominous. There continued to be variable decels with intermittent late and prolonged decels (placental insufficiency), and contractions every two minutes. After an hour of this fetal heart tracing, there was a bradycardia that recovered, but overall the FHR was nonreassuring. The decision was made to perform a CD but it was put off for 80 minutes. At that time there was a sustained bradycardia and SS had a stat CD.

Baby girl S was delivered with no evidence of life. She was resuscitated with intubation and medication and subsequently transferred to another hospital. She began seizing immediately upon delivery and remained mentally unresponsive. A few weeks later she was extubated and died shortly there after. Her autopsy report stated she died of intrauterine anoxia, secondary to uterine rupture. SS sued for malpractice citing lack of informed consent, failure to recognize signs of uterine rupture, and failure to timely perform a CD allegedly had all contributed to the death of her baby girl.

Considerations:

- The patient felt she was not fully informed of the risks of TOLAC/VBAC and the informed consent was not documented in the medical record.
- SS was showing signs of uterine rupture when she arrived at the hospital; this continued and labor was augmented to increase the strength of her contractions.
- The fetal monitor tracing showed the cardinal signs of uterine rupture; they were not recognized or treated in a timely manner. There was failure to perform emergency CD at the first sign of severe variable decelerations or prolonged bradycardia.
- SS was delivered by cesarean in the previous pregnancy due to failure to progress; this is a significant indication that TOLAC will not be successful. This was a failure to consider contraindication to attempt VBAC.

Safe Care and Standards for TOLAC/VBACs

Obstetrics will always be unique in that care involves the safety and well-being of two individuals. What constitutes nonreassuring signs in fetal surveillance may not affect the mother physically, but can be long-term or life-threatening to the fetus. What is catastrophic to the mother is usually catastrophic to the fetus as well. Careful screening of women who are eligible and desire TOLAC significantly decreases the risk of catastrophic events. Following prescribed standards and management in the care of TOLAC and VBAC is essential for the well-being and safety of both patients. Having experienced, educated staff available to perform emergency surgery quickly, and provide neonatal care are all necessary to ensure optimal maternal and neonatal outcomes.

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Advance Directives: Self-Determination, Legislation, and Litigation Issues

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KEY WORDS
Advance Directives, Self-Determination, End-of-life Care, Living Will

An individual's right to refuse or remove life-sustaining treatments is well established by common law and legislative enactments. Under the fundamental right of self-determination, advance directives enable competent individuals to give medical instructions or appoint an agent, or proxy, to make healthcare decisions, should the individual become incompetent. Even with state immunity statutes for healthcare providers for withdrawing or not implementing life-sustaining treatments in accordance with an advance directive, lawsuits and research studies demonstrate that healthcare providers often don't implement patient's advance directives. The information addressed in this article may be used by the legal nurse consultant when evaluating a medical record for merit, which alleges a breach in the standard of care relating to advance directives. Included are historical perspectives on advance directive laws, types of advance directives and do-not-resuscitate orders, reasons identified for nonimplementation, and common cause-of-action claims against healthcare providers for nonimplementation of their patients' advance directives. The article also identifies relevant guidelines that the LNC can use to evaluate a medical record and associated documents for a case alleging damages caused by a healthcare provider's failure to implement a patient's advance directive.

In today's healthcare delivery system, attitudes toward end-of-life care issues have taken on new dimensions due to advanced technological, economical, and societal factors. Very often, the advances in medical technology can merely neutralize the effects of certain diseases without healing. An individual can be placed into a sort of human limbo — kept from dying but deprived of a quality of living. Individuals facing death are concerned with losing autonomy, having medical decisions made by strangers, pain, becoming a burden, dependency on others, unwanted intrusion of futile treatment, the emotional and financial impact upon them and their families, and having their religious concerns denied or not honored (Croke & Daguro, 2005; Stanley, Blair & Beare, 2005).

Historical Perspectives on Advance Directive Laws

"The common law concept of informed consent, buttressed by constitutional principles of privacy and liberty [has] formed the primary platform from which advance medical directives spring" (Sabatino, 2007). The doctrine of informed consent is based on the fundamental right of self-determination and the fiduciary nature of the patient-healthcare provider relationship. In 1891, Supreme Court Justice Horace Gray recognized the fundamental right of self-determination: "No right is held more sacred, or is more carefully guarded, by common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" (*Union Pacific Railway Co. v. Botsford*, 1892, at 251). An application of this fundamental right was rendered by Justice Benjamin Cardozo in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable for damages" (*Schloendorf v. Society of New York Hospitals*, 1914, at 93).

End-of-life care issues — such as competency, incompetency, persistent vegetative state, substituted judgment, best interest standards, clear and convincing evidence standards, living wills, and withdrawal of medical care — came to the social, medical, and legal forefronts in the 1970s. The first case to challenge the guardian issues of withdrawing medical care was *In re Quinlan* (1976). Joseph Quinlan sought a court order to have his daughter removed from a ventilator, as she had long been in a persistent vegetative state. The New Jersey Supreme Court ruled that "the state's interest…weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the progress dims. Ultimately there comes a point at which the individual's rights overcome the State interest" (at 647)…"The only practical way to prevent destruction of (individual's right to privacy) is to permit the guardian of Karen to render their very best judgment…as to whether she would exercise it in these circumstances" (at 664).

In 1976, California was the first state to legalize living wills. Subsequently, all remaining states passed legislation legalizing living wills, although not without medical, legal, and social concerns. Various state courts, such as Missouri and New Jersey, began examining an individual's right to die, using such standards as clear and convincing evidence (e.g., substituted judgment). Clear and convincing evidence standards were developed as "litigation safeguards" for individuals in vegetative states.

The first right-to-die case brought before the United States Supreme Court was *Cruzan v. Director, Missouri Department of Health* (1990). The Court ruled that "the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment" (at 241). There was a strong

inference that an appointed surrogate decision-maker (proxy or agent) would have the same right. The Supreme Court sent the case back to the trial court, which found that Nancy Cruzan's statements made to friends years before her accident "about not wanting to live in a vegetative state" met the clear and convincing evidence standard. The Supreme Court further made explicit that right-to-die issues would be decided by each state with limited interference from the U.S. government (constitutional law) as to what each state could decide to do (Guido, 2006).

In response to the Cruzan case, the U.S. Congress passed the Patient Self Determination Act (PSDA) in 1991. This federal law underscored public concern regarding patients' rights and decisions regarding end-of-life care treatment. The PSDA requires all healthcare facilities and/or providers receiving Medicare or Medicaid funding to implement the following regulations:

- Ask the patient, upon admission to the facility, about the existence of an advance directive
- Provide written information to all patients, upon admission to their facility, about the rights to accept or refuse medical or surgical treatments/procedure following state law
- Give patients the right to complete an advance directive, although the law does not mandate that the patient execute an advance directive
- Document advance directives in each of the patient's records
- Provide education to staff, caregivers, patients, and the community on advance directives
- Prevent discrimination in care for or against patients with an advance directive
- Establish and communicate to staff, caregivers, and patients a policy about implementing advance directives
- Include a clear and precise explanation of any conscious objection that a provider, facility, or provider's agent may have to following an individual's advance directive. Only the conscious objections permitted under state law may be included in the facility policy

(Croke & Daguro, 2005; Painlaw, 2004).

Types of Advance Directives and Do-Not-Resuscitate Orders

Advance directives inform healthcare providers what type of care the individual would want to have or not have if the individual becomes unable to make healthcare decisions. Types of advance directives include the living will, the durable power of attorney for healthcare (DPAHC), and a combined healthcare directive.

- **The living will** is also known as "the five wishes." This only comes into effect when the patient is terminally ill, which is usually defined as less than six months to live. The living will provides directives to healthcare providers, surrogates, and family members regarding the individual's wishes of future medical care he or she wishes to receive or not receive when he or she can no longer make the decision for him/herself.
- **The DPAHC** allows an individual (patient) to appoint someone (agent, proxy, surrogate) to make healthcare decisions for the individual. It becomes effective when the patient becomes unconscious, loses the ability to make decisions, or is incapable of communicating his or her wishes. The healthcare agent is responsible for carrying out the patient's wishes as they are written in the advance directive or expressed in discussions with the agent. The healthcare agent may not change the patient's wishes expressed in the DPAHC (Croke & Daguro, 2005).
- **A combined healthcare directive** is a combination of both living will and DPAHC. A newer form of advance directive, the Physicians Order for Life-Sustaining Treatment (POLST), is currently being passed by state legislatures (e.g., California AB 3000, 2008) to help with honoring patient's end-of-life care wishes. This form requires a physician's order and may be used in conjunction with an existing advance directive. The brightly colored POLST form is intended to be "portable" and move with the patient from one healthcare facility to another (e.g., from nursing home to acute care facility). POLST forms address four areas: CPR, antibiotic use, artificial nutrition, and

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degree of medical intervention desired by a patient when not in cardiac arrest (e.g., intubation). "More important, (POLST forms) also translate the patient's wishes into the doctor's written orders, written onto medical charts. The forms are recognized by medical personnel from emergency medics to nursing staff and physicians at hospitals and nursing homes" (Parker, 2006a, p. 1)

Oral advance directives are allowed in some states (e.g., California, Maryland, Virginia) if there is "clear and convincing" evidence of the patient's wishes. Advance directives can be revoked at anytime by the patient, either verbally or in writing. A physician's order in a patient's medical record is required to execute the end-of-life care issues expressed by the patient in the advance directive. All 50 states have a form of advance directive legislation. A list of the various state laws pertaining to advance directives is available from the American Bar Association Web site at **www.abanet.org/aging/legislativeupdates/home.shtml**.

Although formats of advance directives vary by state law, most reference the following areas:

- Define the condition the patient must be in for either the healthcare declaration to become effective or empower the agent/surrogate
- Define the type of treatments that can be foregone
- Require various certification procedures to ensure that the patient is in the requisite condition
- Define who can serve as agent or surrogate decision-maker

(Clark, 2004).

A do-not-resuscitate (DNR) order allows an individual to declare that he or she does not want certain resuscitative measures performed. DNR orders require specific written orders from a physician. Documentation must be noted in the patient's medical record of the factual discussion between the patient and physician (and family members, if present). If the patient is a resident of a nursing home or is at home, a DNR order alerts healthcare professionals and emergency medical personnel (EMS) not to perform emergency resuscitative measures and not to transfer the patient to a healthcare facility for CPR. Depending on state DNR statutes, a patient's DNR order is not appropriate for use by EMS providers, as most states mandate EMS personnel to attempt resuscitation. An individual may complete a valid Emergency Medical Services Pre-Hospital DNR Form and should also wear a bracelet alerting EMS personnel to a DNR order. If a Med-Alert bracelet is worn, it must include the individual's name and address, as well as the name and telephone number of the individual's attending physician.

All healthcare providers must know their state's DNR laws, and their healthcare organization's policies and procedures for implementation of DNR orders (Croke & Daguro, 2005; Medi-Smart, 2004). In *Wendland v. Sparks* (1998), a family brought a wrongful death suit against a physician who ordered nurses to cease their cardiopulmonary resuscitative efforts and the patient was pronounced dead by the physician. Neither the patient nor the family had ever requested a DNR order. The husband had requested that, if it became necessary to help keep his wife alive, she was to be placed on a ventilator. The court found fault with the physician but not with the nursing staff for following the physician's instructions.

Nonimplementation of Advance Directives: Reasons and Cause of Action Claims

Advance directives are used to inform healthcare providers, family members, and surrogates about an individual's refusal or desire for of end-of-life treatment(s) in future situations, even though they may lead to unintended consequences. Although advanced directives are reassuring to individuals who complete them, legal literature and research studies have shown that completion of advance directives does not necessarily ensure that an individual's end-of-life wishes will be followed.

In all 50 states, healthcare providers who follow an advance directive in "good faith" are not subject to criminal or civil liability or discipline for unprofessional conduct. Failure to implement an advance directive (see Table 1) may result in the healthcare provider's liability for damages and for liability cause of action claims based on tort or constitutional theories of law (see Table 2).

Table 1: Reasons for Nonimplementation of Advance Directives

- Fear of litigation
- Ambiguous language
- Existence unknown to healthcare provider and/or facility:
  - Failure to document in medical record
  - Failure to communicate between physician-patient
- Medical futility
- Failure to complete valid advance directive by state advance directive law
- Physician paternalism:
  - Patient's wishes are in opposition to the healthcare provider's own clinical judgment (healthcare provider's belief in using his/her judgment as the best for the patient, a type of "for your own good" reasoning);
  - The healthcare provider may not believe in patient autonomy
- Conscious objection – Personal ethical principles
- Emergency circumstances

(Croke & Daguro, 2005; Lens, 2001; Morality of Advanced Directives, 1997; Weiler, Eland & Buckwater, 1999)

Table 2: Common Cause of Action Claims for Nonimplementation of Advance Directives

- Medical battery
- *Breach of contract*
- Negligence
- Lack of informed consent
- Intentional infliction of emotional, physical, and /or financial distress
- Wrongful life/prolongation of life

Reasons Identified for Nonimplementation of an Advance Directive

Fear of litigation from family members for not listening to their opposition to the patient's advance directive is a common fear among healthcare providers. "…Who does the physician have to answer to? The living, of course. This is why when the family disagrees with the advance directive, the family's decision usually win out" (Morality of Advance Directives, 1997). Ambiguous wording such as "heroic measures" often make the advance directive difficult to interpret, thus making it difficult to apply by healthcare providers (Lens & Pollack, 2000).

Approximately 20% to 29% of Americans have completed an advance directive (Maxfield, Pohl & Colling, 2003; Pew Research Center, 2006; Robinson, Eagen, and Price, 2008; Salmond and David, 2005). Even though completed, the existence of advance directives remains unknown to many healthcare providers or facilities (Lynch, Mathes & Sawick, 2008; Support Investigators, 1995). In *Neumann v. Morse Geriatric Center* (2007), Mrs. Neumann's daughter brought suit against the nursing home for negligence, battery claim for nonconsensual medical care, and breach of contract. Neumann had been a resident of the nursing home for three years. On admission, she had completed a living will in which she declined cardiopulmonary resuscitation by specifying that she didn't want any "life-prolonging care." There was no "do-not-resuscitate" order written by the physician in her medical record. When her condition deteriorated, the staff called the paramedics, who began resuscitative measures and transported her to a medical facility, where she died six days later after several life-prolonging measures had been attempted. The jury awarded the estate of Neumann $150,000, finding that the nursing home lacked proper protocols for ensuring that their residents' advance directive would be implemented when the resident could no long speak for herself (Snyder, 2008).

Medical futility theory issues were involved in the legal cases of *Howe v. Massachusetts General Hospital (MGH)* (2005) and *Livadas v. Strong Memorial Hospital* (2008). In each case, there were several legal disputes involving the medical plans of care between the healthcare providers and the patient's durable power of attorney for healthcare. In *Howe*, the patient had amyotrophic lateral sclerosis (ALS or Lou Gehring's disease) and was admitted to MGH five years before her death. Her daughter, appointed as proxy, stated that her mother wanted aggressive care. Over the next five years, MGH and the patient's family had several court disputes, with MGH trying to discontinue aggressive treatments. In 2005, a settlement was reach between MGH and family members. The patient died 26 days before the court settlement would have allowed the ventilator to be shut off. In *Livadas*, the court replaced the patient's daughter, who was the original durable power of attorney for healthcare, with Catholic Family Center (CFC) as guardian. In doing so, the court identified that the patient's daughter lacked objectivity, failed to identify her mother's true medical condition, and had insufficient insight to make necessary medical decisions. The patient had a living will, which stated no life-support; in appointing CFC, all barriers to removal of her ventilator were removed (Pope, 2008). Medical Futility Care Laws have been enacted in various states (e.g., California, Texas, and Virginia) to enable doctors and healthcare facility watchdog groups to overturn decisions of the family who, despite the realism of the patient's medical situation, still want to keep the patient alive when there is no chance the patient can survive (Legal Helpmate, 2008).

Although all 50 states have advance directive legislation, if an individual does not execute an advance directive according to the state laws, then the advance directive is invalid and needs not be implemented by healthcare providers or healthcare facilities. Only 11 states guarantee that a validly executed advanced directive will be followed by healthcare providers and healthcare facilities (Datiles, 2008). In *Haymes v. Brookdale Medical Center* (2001) and *Terry v. Red River Center Corporation* (2006), court rulings invalidated patients' advance directives because they did not comply with their state advance directive laws. In *Haymes*, only one signature was noted on the living will, although New York State law requires two signatures. In *Terry*, the Court found on three separate occasions, 1996, 2001, and 2002, that Mrs. Lee's advance directive was "defective" under Louisiana state law.

Advance directives pose a direct challenge to a physician's medical judgment. "While the paternalistic model of the physician-patient has been supplanted by one based on shared decision making and informed consent, remnants of the old model still remain. Physicians who see their primary goal as saving lives may also be less willing to yield to the patient's judgment, especially when it is difficult to predict with certainty whether life supports will enhance the patient's life or render dying more painful" (Lens, 2001). Table 3 identifies important points for an LNC to consider when evaluating records and documents in cases involving non implementation of advanced directives.

Common Causes of Action Claims for Nonimplementation of Advance Directives by Healthcare Providers

Advance directives are not used to inform others about risks and benefits before treatments in a particular situation. They are intended to inform others about an individual's end-of-life care treatment decisions in the event that the individual becomes incompetent and unable to articulate his or her wishes. Medical battery constitutes an intentional tort — due to the unauthorized (without informed consent) treatment by a healthcare provider — and as such, courts may compensate the individual by awarding him or her damages for injuries and other expenses. To be successful in establishing medical battery, in addition to intent, the plaintiff must prove the following negligent elements: harmful contact, lack of consent, and causation and damages. Medical battery must be distinguished from a cause of action claim of "wrongful living," which is

a cause of action claim based upon a healthcare provider's intentional or negligent interference with an individual's right to refuse medical care (Guido, 2006).

In *Leach v. Shapiro* (1984), Mr. Leach brought a cause-of-action claim based on lack of informed consent against a hospital and physician for wrongfully placing and maintaining his wife on life-support, which was contrary to his wife's expressed wishes and without obtaining his informed consent, as her appointed agent. An Ohio trial court awarded summary judgment to the defendants, ruling that Mr. Leach had failed to meet a cause of action claim under Ohio state law. On appeal, an Ohio appellate court ruled that there had been harmful contact when Mrs. Leach was placed on a ventilator without her consent (while in a vegetative state) and reversed the trial court's ruling. The cause of action claim was remanded for further proceedings. The Court also ruled that a patient has the right to refuse treatment and that such refusal cannot be overcome by implied consent (at 397). The lower court ruling had allowed only the claim for medical battery (Croke & Daguro, 2005).

Osgood v. Genesys Regional Medical Center (1997) was the most notable case involving an advance directive based upon a cause of action claim of medical battery. In 1996, a jury awarded $16.5 million dollars to the family of Brenda Young, who had been kept on life support for more than four years after a seizure had left her incapacitated, despite her written instructions directing her healthcare providers to "let her die" in such a situation. The award was reduced to $1.4 million, although a Michigan appellate court upheld the finding of medical battery. In 1997, the hospital and family agreed to an undisclosed settlement that included voiding the medical battery finding (Parker, 2006b).

In *Duarte v. Chino Community Hospital* (1999), the California Court of Appeals found no civil liability for a physician who had refused to withdraw life-sustaining procedures against the Duarte's family wishes and in the absence of an advance directive. No award for damages was made for the refusal by the physician or hospital to comply with the family's instructions, as they found that the sole remedy was to request the court for an order forcing compliance. The family had filed suit for professional negligence as well as negligent and intentional infliction of emotional distress (Croke & Daguro, 2005).

In *King v. Crowell Memorial Home* (2001), a son brought suit against a nursing home, alleging that his mother had been incorrectly classified as a "No CPR" patient despite his requests for lifesaving measures. The Nebraska Supreme Court found that the son, his mother's durable power of attorney, failed to produce any evidence supporting his allegations that he had requested the nursing home staff make his mother a full code status.

Table 3: Points for Use by an LNC When Evaluating a Medical Record and Associated Documents for a Case Alleging Damages Caused by a Healthcare Provider's Failure to Implement a Patient's Advance Directive

1. Know federal laws on advanced directives, as well as state advanced directive laws where the alleged breach in the standard of care occurred. Does the healthcare facility receive Medicare or Medicaid funding?
2. Review policy and procedures (P&P) of the healthcare facility relating to advanced directives, which may assist the LNC in investigating if documentational evidence indicates that the healthcare facility followed its own P&P. If advanced directives are violated, the LNC may be able to show that the healthcare facility breached the standard of care relating to advanced directives.
3. Know the alleged cause of action claim(s). The patient or personal representative may have co-existing claims of medical battery, negligence, malpractice, breach of contract, intentional infliction of emotional, physical and /or financial distress, or wrongful life/ prolongation of life.
4. What was the type of advanced directive executed by the patient?
5. Was the advanced directive document readily visible in the patient's medical record?
6. Was there documentation in the patient's medical record that the physician reviewed the contents of the advanced directive with the patient, family, caregiver, or agent?
7. Was the advanced directive in the patient's preferred language? If an interpreter was used, was the advance directive signed by the interpreter?
8. Was there any type of patient discrimination noted in the medical record documentation?
9. Were there any medications taken by the patient that might alter his or her competency status?
10. What were the patient's medical diagnoses? Are there any known medical diagnoses that may alter his or her state of competency?

(Croke & Daguro, 2005)

Summary

Advance directives cannot anticipate every scenario. Most conflicts over directives stem from emergencies when end-of-life-care decisions are made rapidly and family and/or patients may change their minds despite prior instructions (Shepard, 2006). End-of-life care issues, such as death and dying, are among the most difficult subjects for healthcare providers, patients, family, and caregivers to openly discuss. To help decrease potential liability for nonimplementation of advance directives, it is important for healthcare providers to know the existence of their patients advance directive, review the document with the patient and family/agent for clarity of the patient's desired end-of-life care wishes, be willing to implement the advance directive and, if unwilling or unable, transfer the patient to another healthcare provider who is willing to implement the advance directive, and know federal and state advance directive laws (Croke and Daguro, 2005).

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Electronic Fetal Monitoring: An Update

Pat Fedorka, PhD MPH BSN

KEY WORDS
Electronic Fetal Monitoring, Labor and Delivery, Obstetrics

In 1997, in an attempt to foster some consistency to the interpretation of electronic fetal monitoring, the National Institute of Child Health and Human Development Task Force made recommendations addressing three important components of fetal heart rate monitoring. In 2008, the National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring (EFM) not only confirmed the prior work, but also added a management component to the recommendations. Now widely accepted, these standards for terminology, interpretation, and management provide a consistent basis for analysis and outcome comparisons that should lead to relevant evidenced-based practice interventions — and increased consensus in determining whether the standard of care was met.

Electronic fetal monitoring (EFM) plays a significant role in many obstetrical litigation cases. Yet there are few, if any, areas of litigation in which a screening tool, such as EFM, is utilized as a diagnostic indicator as the basis for nursing/medical interventions.

The evolution of EFM has been plagued by multiple interpretations of what constitutes the previously used terms of reassuring, nonreassuring, or ominous fetal status. The lack of uniformity in terminology and interpretation stems from the origin of electronic fetal monitoring: EFM developed over the decades, in different countries, where different terms were used to describe some of the same characteristics and/or patterns (Liston et al., 2007; Parer & Ideda, 2007).

In 1997, in an attempt to foster some consistency to the interpretation of EFM, the National Institute of Child Health and Human Development (NICHHD) Task Force made recommendations addressing three important components of fetal heart rate monitoring. These components were:

1. The development of standard definitions for FHR patterns
2. The description FHR patterns that reflected an absence of asphyxia
3. The description of heart rate patterns that are predictive of current or impending asphyxia

The 2008 NICHHD Workshop Report on Electronic Fetal Monitoring committee built upon the work of the 1997 committee. Not only did the 2008 committee confirm the 1997 committee's work, but also added a management component to the recommendations.

The updates and recommendations of the committees have been accepted by the American College of Obstetricians and Gynecologists (ACOG), the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN), and the Society of Obstetrics and Gynaecologists of Canada (SCOG). These updates should serve as a basis for better communication between health care providers that, hopefully, will result in more timely interventions and improved fetal outcomes. Naturally, the new guidelines also serve as the basis for the standard of care for interpretation of FHR tracings for labor and delivery room nurses.

A summary of the data published by the NICHHD (2008) is presented. The concepts are categorized using the following categories:

1. Terminology
2. Interpretation
3. Management

The Purpose of EFM

The primary objective of EFM is to provide information about fetal oxygenation and prevent fetal injury that could result from impaired fetal oxygenation during labor.

Assumptions Accepted by the Committee Pertaining to Electronic Fetal Monitoring

1. All clinically significant FHR decelerations reflect disruption of oxygen transfer from the environment to the fetus at one or more points along the oxygen pathway.
2. Fetal neurologic injury due to disrupted oxygen transfer does not occur unless it progresses at least to the stage of significant metabolic acidemia (umbilical artery pH <7.0 and base deficit > or equal to 12 mmo/L).
3. Significant metabolic acidemia is highly unlikely in the presence of moderate FHR variability and/or accelerations.

Terminology

A full description of an EFM tracing requires a qualitative and quantitative description of the following six components:

1. Baseline fetal heart rate
2. Baseline FHR variability
3. Presence of accelerations
4. Periodic or episodic decelerations
5. Changes or trend of FHR patterns over time
6. Uterine contractions

Fetal Heart Rate Patterns and Definitions

Pattern	Definitions describing the fetal heart rate
Baseline	Mean FHR rounded to increments of five beats per minute (bpm) during a 10-minute segment excluding periodic or episodic changes, periods of marked variability, or segments of baseline that differ by > 25 bpm. The baseline must be recorded for at least two minutes in any 10-minute segment (not necessarily contiguous).
Normal range	110–160 bpm
Tachycardia	> 160 bpm (for at least 10 minutes)
Bradycardia	< 110 bpm (for at least 10 minutes)
Variability	Irregular fluctuations in the baseline FHR. Measured as the amplitude of the peak to trough in bpm.
Absent	Fluctuations range undetectable.
Minimal	Fluctuations range observed at ≤ 5 bpm.
Moderate (Normal)	Fluctuation range 6–25 bpm.
Marked	Fluctuation range > 25 bpm.
Accelerations in the fetal heart rate	
Acceleration	Abrupt (from onset to peak < 30 seconds) increase in FHR.
Gestation:	
Less than 32 weeks	Increase of bpm ≥ 10 bpm above baseline and lasts ≥ 10 seconds
More than 32 weeks	Increase of bpm ≥ to 15 bpm above baseline and lasts ≥ 15 seconds but < 2 minutes; prolonged acceleration that last ≥ 2 minutes but < 10 minutes.
Decelerations in the fetal heart rate	
Variable	Visually apparent abrupt decrease in the FHR. The decrease in FHR is calculated from the onset to the nadir (deepest part of the deceleration) of the deceleration. The decrease in FHR ≥ 15 beats per minute, lasting ≥ 15 seconds and < two minutes in duration. When variable decelerations are associated with uterine contractions, their onset, depth, and duration commonly vary with successive uterine contractions. *Associated with cord compression* An "abrupt" FHR decrease is defined as a drop in FHR from the onset of the deceleration to the nadir in ≤ 30 seconds.
Early	Visually apparent, usually symmetrical, gradual decrease and return of the FHR associated with a uterine contraction. The nadir occurs at the same time as the peak of the contraction. In most cases the onset, nadir, and recovery of the deceleration are coincident with the beginning, peak, and ending of the contraction, respectively. Early decelerations associated with intracranial pressure and/or cerebral blood flow caused by intrapartum compression of the fetal head. *Not associated with fetal compromise.*
Late	Visually apparent, usually symmetrical, gradual decrease and return of the FHR associated with a uterine contraction. The deceleration is delayed in timing, with the nadir of the deceleration occurring after the peak of the contraction. In most cases, the onset, nadir, and recovery of the deceleration occur after the beginning, peak, and ending of the contraction respectively. *Associated with fetal uteroplacental insufficiency.* A "gradual" FHR decrease is defined as from the onset to the FHR nadir of ≥ 30 seconds. The decrease in FHR is calculated from the onset to the nadir of the deceleration. "Recurrent" decelerations are defined as decelerations that occur with at least 50% of contractions in a 20-minute period. "Intermittent" decelerations are defined as decelerations that occur with < 50% of uterine contractions in a 20-minute period.
Prolonged	FHR ≥ 15 bpm below the baseline lasting ≥ 2 minutes but ≤ 10 minutes.
Sinusoidal	A specific FHR pattern that is defined as having a visually apparent smooth, sine wave-like undulating pattern in the FHR baseline with a cycle frequency of 3-5 bpm that persists for ≥ 20 minutes.

Fetal Heart Rate Patterns Not Defined by the NICHHD Committees in 1997, 2008

- Wandering baseline
- Lambda pattern
- Shoulders
- Overshoots
- Variable decelerations with a late component
- Mild, moderate, and severe variable decelerations
- Reassuring and nonreassuring

Pattern	Definitions Describing Uterine Activity
Normal	≤ 5 contractions in 10 minutes, averaged over a 30-minute period
Tachysystole	> 5 contractions in 10 minutes, averaged over a 30-minute period

Characteristics of the uterine contractions are described in terms of duration, strength, and frequency. The terms "hyperstimulation" and "hypercontractility" are not defined and should not be used.

Interpretation

A three-tier fetal heart rate interpretation system has replaced the terms "reassuring" and "nonreassuring," which were formerly used to categorize and interpret fetal heart tone patterns.

Category I (Normal):
All of the following components must be present in the FHR pattern to be considered a Category I tracing.

- Normal baseline
- Moderate variability
- Accelerations present (spontaneous or induced)
- Decelerations absent
- No significant changes over time

Normal parameters

- Baseline rate 110–160 bpm
- Baseline FHR moderate variability
- Late or variable decelerations: absent
- Early decelerations: present or absent
- Accelerations: present or absent

Category II (Indeterminate):
Category II FHR tracing include all FHR tracings not categorized as Category I or Category III. Category II tracings represent the majority of FHR tracings encountered in a clinical setting.

Fetal neurologic injury due to disrupted oxygen transfer does not occur unless it progresses at least to the stage of significant metabolic academia (umbilical artery pH < 7.0 and base deficit ≥ 12 mmo/L).

Any of the following components can be present in the FHR pattern to be considered a Category II tracing.

- Baseline rate
  - Bradycardia not accompanied by absent baseline variability
  - Tachycardia
- Baseline FHR variability
  - Minimal baseline variability
  - Absent baseline variability not accompanied by recurrent decelerations
  - Marked baseline variability
- Accelerations
  - Absence of induced acceleration after fetal stimulation
- Periodic or episodic decelerations
  - Recurrent variable decelerations accompanied by minimal or moderate baseline variability
  - Prolonged deceleration > two minutes but < 10 minutes
  - Recurrent late decelerations with moderate baseline variability
  - Variable decelerations with other characteristics, such as slow return to baseline

Category III (Abnormal):
Any of the following components can be present in the FHR pattern to be considered a Category III tracing.

- Absent baseline FHR variability and any of the following
  - Recurrent late decelerations
  - Recurrent variable decelerations
  - Bradycardia
- Sinusoidal pattern

Management

Category I tracings indicate routine intrapartum surveillance. Category I tracings are usually indicative of a normally oxygenated fetus (Macones et al., 2008).

Category II tracings indicate interventions (intrauterine resuscitation) that can consist of all of the following:

- Maternal repositioning
- IV bolus of nonadditive solution
- Oxygen administration
- Reduction or cessation of uterine activity
- Correction of maternal hypotension
- Amnioinfusion during the first stage of labor
- Modification of pushing in the second stage

Category II tracings encompass the majority of fetal heart rate patterns and indicate that heightened intrapartum surveillance is required including, more frequent assessments, nursing interventions, and ongoing evaluations (Macones et al., 2008)

Interventions for Categories II and III are the same, but Category III patterns are usually indicative of a fetus acidotic and needing delivery in the most expeditious manner. Fetal neurologic injury due to disrupted oxygen transfer does not occur unless it progresses at least to the stage of significant metabolic academia (umbilical artery pH < 7.0 and base deficit ≥ 12 mmo/L).

Summary

The process of fetal heart rate tracings interpretation is truly a work in progress. However, with the use of standard terminology, interpretation, and management (provided by the NICCHD), future research dealing with EFM can have a consistent basis for interpretation and outcome comparisons that should lead to relevant evidenced-based practice interventions, and more appropriate and timely interventions. As health care professionals, we can participate in the process by utilizing accepted terminology as a basis for clinical practice. In the legal arena, one would expect a more consistent interpretation of EFM tracings and increased consensus in determining whether the standard of care is met.

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Reflex Sympathetic Dystrophy (RSD)/Chronic Regional Pain Syndrome (CRPS I & II)

Kara DiCecco, MSN RN LNCC

Often intermittent and initially subtle in presentation, RSD/CRPS may at first escape diagnosis. The patient's individual course of symptoms may remain limited or be rapidly progressive. First identified in 1872 by S. Weir Mitchell, a neurologist and Union soldier during the Civil War, "causalgia" was the precursor to the modern day Chronic Regional Pain Syndrome (CRPS). Under the umbrella of CRPS there are two classifications, CRPS I and CRPS II. In 1993, the International Association for the Study of Pain renamed RSD to CRPS I and CRPS II (causalgia). Liberty is taken with this maxim using RSD due to the fact that much of the literature continues to be published under the label of RSD. The reader is advised to use the correct and current terminology (CRPS I or II) when referencing this condition in any medical–legal sense.

Anatomy

Though the exact etiology remains unclear and contested as to precise pathology, thinking visually of the sympathetic nervous system functioning in overdrive in the affected extremity may help in defining the mechanism of RSD. This autonomic dysfunction causes a hypersensitivity to stimuli, such as intolerance to a purse strap or coat sleeve on the affected arm or the elements of wind or temperature change. Vasomotor changes ultimately lead to changes of the affected extremity including swelling, discoloration, and temperature variation, and may progress to lack of hair growth, and shiny, atrophic, leather-like skin. The progression is subject to individual presentation and possible remission.

Etiology

Suspected precipitating causes:

- Mild/moderate/severe trauma (for example, soft tissue injury or broken bones)
- Infection
- Mechanical trauma (i.e., surgery)
- Repetitive motion disorders (for example, carpal tunnel syndrome)
- Breast cancer
- Shingles
- Heart attack
- Unknown etiology

(NINDS, 2009; Shiel, 2007).

Signs and Symptoms

- Allodynia
- Hypersensitivity
- Dependent edema (at times pitting)
- Purple discoloration and prolonged blanching of the affected extremity
- Atrophic, shiny skin with no hair growth
- Subnormal temperature (i.e., cooler to the touch) than the unaffected extremity
- A "burning" pain
- Chronic pain
- Swelling
- Restricted range of motion

(NINDS, 2009)

Diagnostic Testing

Determining the progression of the disease is based on defining criteria as outlined by current medical criteria. Authoritative standards may warrant limiting or expanding individual testing based the individual's specific clinical presentation. These tests include but may not be limited to:

- Bone scan via nuclear medicine (osteoporosis may be noted)
- Thermography (Hooshmand, Hashmi & Phillips, 2001)
- Sweat testing
- EMG
- Radiography
- Sympathectomy (Hooshmand & Phillips, 2006)
- Sympathetic nerve block (may increase temperature in affected extremity without exacerbating numbness or weakness) (Hooshmand, Hashmi & Phillips, 2004).

Legal Considerations

- Misdiagnosis is common due to the complexity of the pathology and symptoms often initially reliant only on patient report and subject to inspection during symptomatic periods making diagnostic interpretation variable.
- Pictures/video of the extremity(ies) during symptomatic periods is essential. This is important since the early presentation is unpredictable and may not be exacerbated at times coinciding with medical examination. As the disease progresses, periods of remission are infrequent, if at all, but the early stages require documentation. Since a similar visual presentation of swelling and discoloration may be achieved by constricting the extremity (for instance, with a rubber band for several minutes), be sure to expose the entire extremity when documenting by photographs.
- Symptoms of RSD may initially be unilateral (one extremity) but then spread to other extremities.

- Mainstays of medication management include narcotics, analgesics, muscle relaxants. Therapy with Lidocaine drips also has been used.
- Spinal cord stimulators to block pain impulses may be used.
- Studies support that early treatment will more likely result in disease arrest or stabilization.
- As with any chronic disease, psychological impact should be considered (i.e., depression).
- Sometimes the initial diagnosis is made by the orthopedic physician due to trauma of the affected extremity.
- Pseudonyms include Causalgia, Sudek's Atrophy, Chronic Regional Pain Syndrome (CRPS, CRPS I & II), RSD, Shoulder-hand Syndrome, and Post-traumatic neuralgia.
- Further distinction in made in diagnosing disease: CRPS I precipitating soft tissue injury without underlying nerve injury; CRPS II same presentation but with underlying nerve injury.
- Psychological issues are associated with chronic disability.
- Deformity of affected extremity is possible.
- The most extreme cases may require amputation of the affected extremity if it becomes gangrenous, although the symptoms may still spread to other extremities.
- The condition may develop at any age but less common in children younger than 10 years old (Singh, Patel, Grothusen & Foye, 2009; Taylor, 2009).
- It is more common in women than men.

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) "RSD," "reflex sympathetic dystrophy," "chronic regional pain syndrome," "CRPS," "negligence," "worker's compensation," "litigation," and "case law" in alternating string searches. A review of the information retrieved provided formal and informal sources. The majority of case law located focused on the issues of competency in estate and guardianship matters. From a failure to diagnose evaluation, a window of opportunity for the successful reversal of dementia may be at issue, though this is controversial from a medical standpoint. A sampling of the preliminary results via Internet retrieval follows.

Reflex Sympathetic Dystrophy of the Face: Current Treatment Recommendations (article) The Laryngoscope, March 1998.
www.rsds.org/2/library/article_archive/arden_et_al.pdf

International Reflex Sympathetic Dystrophy Foundation (online resource)
www.rsdinfo.com/
Lots of information and articles. Personal hosting by Eric M. Phillips.

The Neurology Channel
www.neurologychannel.com/rsd/index.shtml
Neurology channel is a medical information website of Healthcommunities.com, Inc. Input provided by board-certified physicians.

Article by Angela Mailis-Gagnon MD, MSc, FRCPC (PhysMed) explaining role of bone scans in diagnosing RSD.
www.rsds.org/5/news/2005/bonescans.htm

Article by Steven D. Feinberg, MD on Complex Regional Pain Syndrome: Reflex Sympathetic Dystrophy & Causalgia
law.lexisnexis.com/practiceareas/Insights--Analysis/AMA-Guides-and-Permanent-Impairment/Steven-D-Feinberg-MD-on-Complex-Regional-Pain-Syndrome-Reflex-Sympathetic-Dystrophy--Causalgia

Clinical Practice Guidelines for RSD (3rd edition)
www.rsdfoundation.org/en/en_clinical_practice_guidelines.html
Posted by Anthony F. Kirkpatrick, M.D., Ph.D.
Chairman, Scientific Advisory Committee
The International Research Foundation for RSD / CRPS

Sandberg v. Rubbermaid Home Products
caselaw.lp.findlaw.com/data2/iowastatecases/app/8-626.pdf
Court of Appeals of Iowa on worker's compensation.

Arbogast v. Mid-Ohio Valley Medical Corp
www.state.wv.us/wvsca/docs/fall03/31314.htm
Supreme Court of Appeals of West Virginia.

Porter v. Monroe Medical Associates
www.romingerlegal.com/pacaselaw/commonwealth2/2164CD04_3-31-05.html
Pennsylvania case law on worker's compensation.

Perkins v. US Airways
www.comp.state.nc.us/ncic/pages/court/138561.htm
North Carolina case law on worker's compensation.
www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/CRPS.pdf
Interesting look at the Washington State Department of Labor Guidelines for evaluating RSD/CRPS.
Though still available on the Internet, a cross-check of the guideline was withdrawn by the National Guideline Clearinghouse www.ngc.gov/whatsnew/gawithdrawn.aspx?st=W (no update to this similar guideline was found at ngc.gov)

Potential Experts

- Neurologists (for diagnosis)
- Anesthesiologists for pain management (for symptomatic treatment)
- Pain management specialists
- Vocational rehabilitation (for job displacement)
- Geriatric specialists
- Psychologists/psychiatrist to address issues of chronic disability.
- Physical therapists
- Additionally from a diagnostic perspective, radiologists, neuroradiologists, and specialists in nuclear medicine

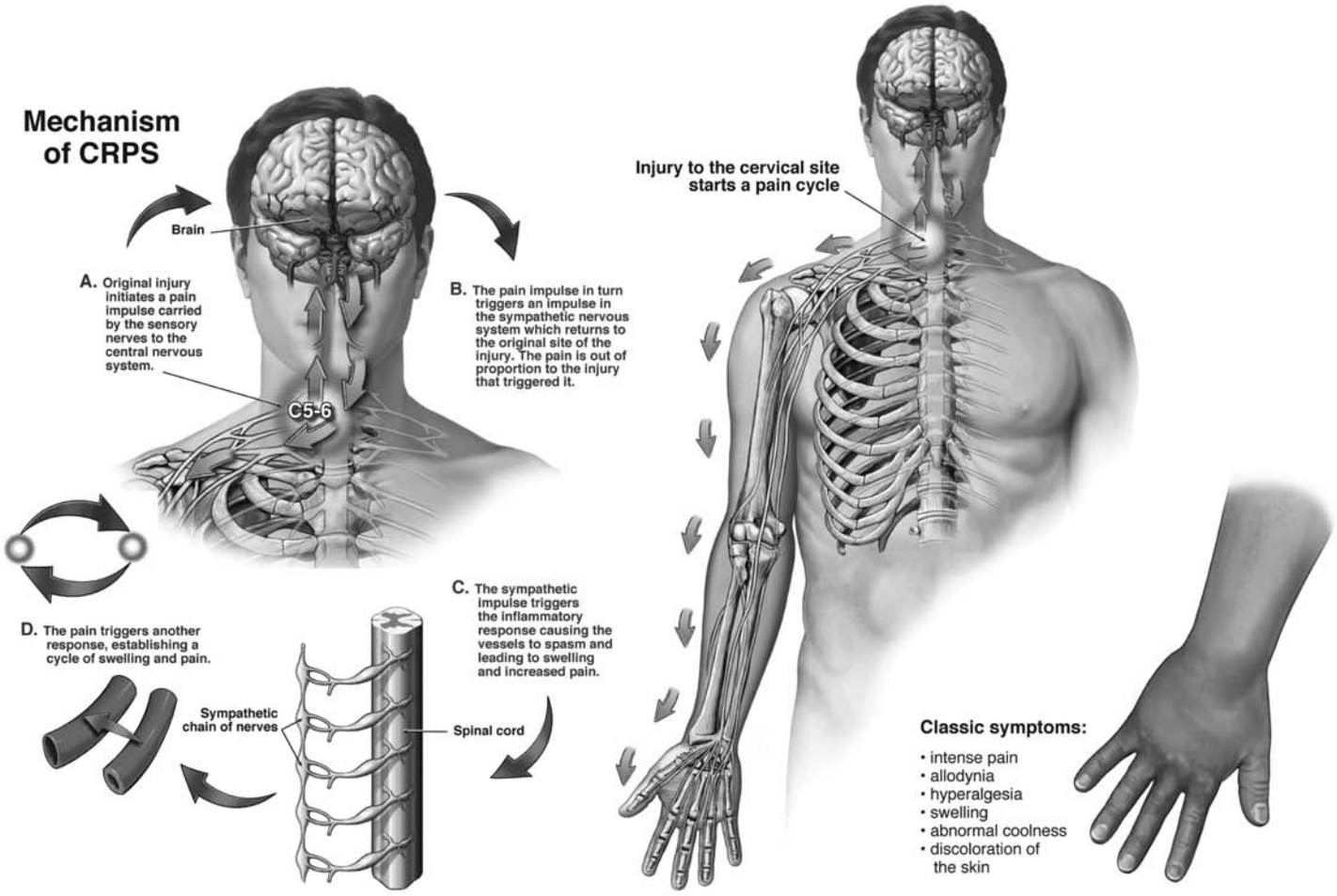

Figure 1: Complex regional Pain Syndrome (CRPS)

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Damages

- Sequelae of misdiagnosis, may include impact on psychological and psychosocial factors (such as depression).
- In severe cases, CRPS may be permanently disabling resulting in economic loss.
- Vocational options for acute or chronic presentation may be limited by the environmental factors (i.e., triggers for hypersensitivity to temperature changes or extremes), the need for position change or extremity elevation, or the impairment of concentration secondary to pain.
- Permanent deformity may result.
- Chronic pain may result.

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The topic matter offered in "The Clinical Maxim" is not meant to provide medical or legal advice, only to acquaint the reader with an overview of clinical conditions and/or diseases as well as their and their clinical/legal implications. As with any medical-legal matter, the reader should consult the services of a medical and/or legal professional, respectively. The reader is also reminded to critically analyze and evaluate the sources offered here and confirm their reliability independently. *See page 23 for author biography.*

Web-based Tools on Bioethics

Kara DiCecco, MSN RN LNCC

Editor's note: To supplement "Advance Directives: Self-Determination, Legislation, and Litigation Issues," the following sites provide online resources for research, education, and support for bioethical subject matter. This list is provided as a general reference source for the LNC, and is not meant to be all-inclusive of the potential resources available. It 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.

Code of Ethics by Profession

Illinois Institute of Technology, Center for the Study of Ethics in the Professions
ethics.iit.edu/codes/
Comprehensive listing of the Code of Ethics by profession. Click on Index of Codes > choose topic area > then search for profession.

Shaw University, Institutional Review Board
www.shawu.edu/IRB/Links.html
Numerous links to the Codes for Bioethics, including key documents at the core of bioethical research.

Glossary

The Bioethics Council
www.bioethics.org.nz/about-bioethics/glossary/index.html
Glossary of terms for bioethical subject matter.

Medical College of Georgia
wwww.mcg.edu/gpi/ethics/ph1sylbus/bioethic.htm (Glossary of Terms)
www.mcg.edu/gpi/ethics/ph2syllabus/preface.htm
The target audience is medical students, but this comprehensive Web site offers an array of information specific to bioethics and patient care. Key concepts and the application of principles via case study.

Government on Bioethics

The President's Council on Bioethics
www.bioethics.gov/
Advising the President on ethical issues related to advances in biomedical science and technology.

Institutional Review Board Forum
www.irbforum.org
Discussion and news forum.

Office for Human Research Protections (OHRP)
www.hhs.gov/ohrp/
OHRP provides leadership in the protection of the rights, welfare, and well-being of subjects involved in research conducted or supported by the U.S. Department of Health and Human Services. OHRP helps ensure protection by providing clarification and guidance, developing educational programs and materials, maintaining regulatory oversight, and providing advice on ethical and regulatory issues in biomedical and behavioral research.

National Library of Medicine, National Institutes of Health
www.nlm.nih.gov/bsd/bioethics.html
Bioethics Information Resources.

Professional Associations/Institutions

The Kennedy Institute: National Reference Center for Bioethics Literature
bioethics.georgetown.edu/nrc/resources/healthcarereform.htm
Articles and ongoing discussion regarding health issues and the healthcare reform debate.

The Hastings Center of Bioethics
www.thehastingscenter.org/
The Hastings Center is an independent, nonpartisan, and nonprofit bioethics research institute founded in 1969. The center's mission is to address fundamental ethical issues in the areas of health, medicine, and the environment as they affect individuals, communities, and societies.

American Nurses Association (ANA)
www.ana.org
Enter bioethics in search box for a wealth of information about bioethical related topics.

American Medical Association (AMA) Bioethics Web site
www.ama-assn.org
Enter bioethics in search box to access information about the AMA's Committee on Bioethics and Humanities.

American Society of Law and Medical Ethics
www.aslme.org
Reasonable fee ($20) for journal articles, educational offerings, and information about Mayday-funded projects, such as Pain and the Law.

American Society for Bioethics and Humanities (ASBH)
www.asbh.org/about/action/index.html
The purpose of ASBH is to promote the exchange of ideas and foster multidisciplinary, interdisciplinary, and interprofessional scholarship, research, teaching, policy development, professional development, and collegiality among people engaged in all of the endeavors related to clinical and academic bioethics and the health-related humanities.

Clinical Bioethics
www.bioethics.nih.gov
Information about clinical trials in bioethical research.

University-based Ethics Programs

The Center for Bioethics and Human Dignity
cbhd.org/content/human-dignity-fundamental-concept-bioethics
Bioethics Research Center from the Trinity International University; promoted as exploring the nexus of biomedicine, biotechnology, and common humanity. Access to multiple online articles, resources and webliographies.

The Center for Clinical Ethics and Humanities in Health Care
wings.buffalo.edu/faculty/research/bioethics/
An interdisciplinary academic center of the University of Buffalo; especially informative Bioethics Law link.

Loyola University (Chicago)
bioethics.net
Comprehensive listing of available articles about topic-based issues.

University of Pittsburgh Consortium Ethics Program
www.pitt.edu/~cep/
The Consortium Ethics Program is the regional health care ethics network in Western Pennsylvania. This premier network educates nurses, physicians, social workers, and others from participating healthcare institutions in the language, methods, and literature of healthcare ethics.

The Kennedy Institute of Ethics at Georgetown
kennedyinstitute.georgetown.edu/
The world's oldest and most comprehensive academic bioethics center, the institute and its library serve as an unparalleled resource for those who research and study ethics as well as those who debate and make public policy.

University of Penn Center for Bioethics
www.med.upenn.edu/bioethics/index.shtml
Excellent links and information regarding current research.

Harvard University Program in Ethics and Health
www.hcs.harvard.edu/bioethics/index.html
From homepage, click on resources in top toolbar for exceptional links and resources.

Other Resources

Public Health and Social Justice
phsj.org/
Individual Web site of Martin Donohoe; some personal bias. Mission to increase awareness regarding public health disparities. Excellent resources; for example, link on Migrant Farm Workers has links for monitoring sweatshops, information about pesticides, and healthcare resources.

Vaccine Ethics
www.vaccineethics.org/
University of Pennsylvania Web Site

Journals

Journal of Clinical Ethics
www.clinicalethics.com/index.html

Journal of Health Politics, Policy and the Law
www.dukepress.edu/jhppl/

Journal of Law, Medicine and Ethics
www.aslme.org/pub/index.php

Journal of Medical Ethics
jme.bmjjournals.com/

Yale Journal of Health, Policy, Law and Ethics
www.yale.edu/yjhple/

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How to Do A Search for Board Certification

Rose Clifford, RN LNCC

Q: My attorney asked me to research one of the defendant physicians in our case. He says the firm conducted a quick preliminary search and found that the doctor identified himself as being board certified; however, the attorney suspects the doctor is not board certified. The attorney thought that I, as a legal nurse consultant, might have other resources to research the doctor's certification status. How do I do this? Where do I begin?

A: Places to check for board certification include the state licensure Web page, the American Board of Medical Specialties (ABMS), and the doctor's own Web site or marketing materials.

Legal nurse consultants may be concerned about repeating the law firm's work, but at times it may be necessary if attorneys have not shared what sites they have already visited, or if the initial searches are incomplete. One way to avoid redundancy is to ask what sites they already have searched. The attorney might give you the go-ahead to do a complete search, or give you the sites attorneys already have explored. In either case, you will have to determine whether to revisit sites. If you do revisit sites and find nothing, you will need to determine whether to bill for those efforts. If you find more information than the attorney's initial search, your billing for the search will be reasonable.

How to Determine Board Certification

Begin with the correct spelling of the doctor's full name, city, state, and office location(s). Often there is more than one doctor "John Smith" and frequently more than one office location. Determine early in the search process the kind of doctor he or she is believed to be, such as a medical doctor, an osteopathic doctor, naturopath, chiropractor, or perhaps not licensed at all.

Start with the basics — make sure the doctor has no current or past state licensure restrictions, suspensions, or revocations. State licensing boards usually go back 10 years, listing board certifications but not verifying them. For verification, refer to the American Board of Medical Specialties. If you have access to the doctor's curriculum vitae or have knowledge of states of prior practice, make sure to check those state licensure sites. To be comprehensive, consider checking surrounding state sites as well.

Board certifications are fairly easy to verify for medical doctors by going to the respective specialty board Web site and checking the *American Board of Medical Specialties*. Determine if the doctor is board certified, board eligible, or does not meet the criteria for board certification. Keep in mind that the ABMS only list certifications for medical doctors.

Healthgrades (**www.healthgrades.com**) is a public site that allows users to gather general background information about a doctor such as education, medical training, and credentials. It includes board certifications and is an easy way to initiate a search on a physician. The cost is minimal and access is quick. The site is reliable and a fast way to initiate a credential search.

Another often-overlooked resource is the Circuit Clerk's office in the county in which the doctor has or is now conducting business. The clerk's office is full of readily accessible public information. You can find other lawsuits filed against the same doctor, the allegations of those complaints, copies of his curriculum vitae, and prior testimony. Both the CV and prior depositions or trial testimony will give a complete listing of the doctor's educational background, training, certifications, and states of practice. It is usually located in the beginning of the deposition or trial testimony. It will also be located in defendant answers to interrogatories, request for production, or requests for admissions.

If you don't find information at the county clerk's office, call the doctor's office. Ask the staff for a copy of the doctor's CV and where he/she practices. Check the office Web site and the hospital (where he/she has privileges) Web site — or call the hospital to verify if the doctor is board certified and in what areas.

Where to Begin

Begin by conducting a Google search of the doctor's name, city, state, and phone numbers to identify if he or she has a professional practice Web site. Sometimes doctors list their board certifications and professional associations along with their education and background. This is another good place to start your search. Verify all listed board certifications and professional associations through the Web sites mentioned previously. In your report, include the history of the specialty certification, the criteria for certification, and if the certification is accredited by a certifying body. Keep in mind not all medical certifications are alike. One of the most important criteria to identify is the extent of experience that is required to be eligible to apply for certification. Do the same with any professional association listed.

Also search using abbreviated forms of the doctor's name such as nicknames and practice specialty. Keep in mind that Google searches can be helpful in unexpected ways, such as turning up newspaper articles and other areas of interests about the doctor including conferences attended, articles, and disciplinary reports.

An expanded way to search on the Internet is to use another search engine called Dogpile, which crawls more than one search engine at a time. Dogpile uses the same search terms — e.g., name, state, and practice — but reveals more than a simple Google search.

Another important tip is to search any Web site that lists Medicare- or Medicaid-excluded providers. The sites are easy to find by entering search terms such as "excluded providers" or "Medicare exclusions." As accessible as the Internet is, other sites to check include Facebook, Craig's List, Twitter, LinkedIn or blogs (disease specific blogs, injury blogs, doctor blogs) or bad-doctor sites. These sources may not reveal board certifications, but could reveal more.

Always check local newspapers or newspaper sites for any advertising or articles about the doctor (personally or professionally), articles authored by the doctor, articles identifying the doctor, or letters to the editor written by the doctor. Check for billboards and commercials. Other state licensing sites that could provide information about the doctor are those that list state hunting licenses or concealed weapons licenses. Also ask for input through lawyer listserves. You never know what information might be forthcoming: past depositions, prior CVs, or board certifications that the doctor no longer maintains.

Make a checklist so you do not have to think through the process of where and how to begin to check for board certifications. It will be easy to refer to the checklist in future searches. Revise the list from time to time as you come across newer sites.

If the defendant doctor is not board certified, list the criteria for eligibility to become board certified and the accredited boards available. Offer to start deposition question along these lines for your attorney listing the requirements in the form of question. This will help your attorney in the future.

Rose Clifford, RN LNCC, is an independent legal nurse consultant with more than 20 years of experience. She is executive director of Medical Analysis Resources, Rose Clifford LNC Internships and editor of *The Medical-Legal News*. She may be reached at **Cliffordrz@aol.com**, **www.medanalysisresources.com**, **www.roseclifforddinternships.com**, **www.medical-legalnews.com** or **rose@medical-legalnews.com**.

Book Review

Ethics and Issues in Contemporary Nursing

Margaret Burkhardt, PhH APRN BC, and Alvita Nathaniel, PhD APRN BC
Third edition; copyright 2007; 576 pages, paperback
Publisher: Thomson Delmar Learning, Clifton Park, New York
ISBN-13:978-1-4180-4274-5;cost: $74

Reviewed by Eileen Watson, EdD RN MSN ANP GNP LNCC

"What should I do?" "What is the right decision?" "Is that the right action?" "Is my action legal?"

Day in and day out, nurses are challenged as to how to answer these types of ethical questions in both their personal and professional realms. To help reduce this challenge, nurses need a knowledge base in the field of ethics as well as the ability to incorporate this field into their personal and professional lives.

Nurses have a DUTY to fulfill the promise the nursing profession has made to every member of society, "as ethics is an integral part of the foundation of nursing" (page 20). The authors of *Ethics and Issues in Contemporary Nursing* clearly provide the "how to" to meet these needs by having the reader (learner) engage in active learning chapter exercises, which are intended to facilitate self-reflection, personal and professional awareness, legal and ethical decision-making abilities using "principled (moral) behavior."

Case Presentation Exercises are based on contemporary personal and professional clinical practice issues. Think About It Exercises are structured critical thinking and ethical decision-making questions for the reader based on prior case presentation scenarios and chapter content. Ask Yourself Exercises get the reader to actively think and apply previously discussed subject content areas. Discussion Questions and Activities Exercises provide the reader with exceptional learning challenges beyond text content and readings; they direct the reader to engage in discussion and research activities with Internet, institutional, and other (e.g., patients and healthcare providers) resources. Each chapter contains several examples of these exercises.

The text is formatted into five parts, with each latter part purposely sequenced for learning and applying principled behaviors to various contemporary practice issues frequently seen in today's healthcare systems. Each chapter begins with a preview of chapter content and measurable reader objectives. Chapter content is structured moving from basic to complex learning materials with accompanying active learning exercises. Each chapter ends with an in-depth content summary and up-to-date reference list.

Part one, Guides for Principled Behavior, provides the reader with a strong foundation in ethical theories and principles — first by discussion and application of ethics to oneself, the institution, and the patient; secondly, through discussion and application of ethics to merged personal and professional realms. Part two, Developing Principled Behavior, begins with the reader learning the components of ethical decision-making followed personal application to contemporary nursing practice issues.

In part three, Principled Behavior in the Professional Domain, the reader learns how to examine professional practice care issues using the combined fields of legal and ethical decision-making. The chapter lays a strong foundation for the relationship between law and ethics, sources and types of law, legal trends in health care, malpractice insurance, and role of expert nurse witness. Professional and practice issues and legal regulations for nursing are discussed in depth.

Part four, Global Issues That Impinge on Nursing Practice, provides a detailed look at issues that affect healthcare delivery systems, nursing roles, and professional practice. Examples include health care policy, economic, transcultural, spiritual, gender, and social issues. Part five, The Power to Make a Difference, discusses the processes of empowerment for both the nurse and the patient, an important concept "… in the midst of an ever changing and challenging healthcare environment in which issues of power and control continue to affect patient care" (page 463). The table of contents and a clearly detailed cross-referenced index makes this text an easy-to-use reference.

The authors provide substantive moral insights, both personally and professionally, through the diverse content areas, active learning exercises, and resources provided in each chapter. Learning equals changed behavior. The text serves as a definitive resource for all practicing nurses (or learning to practice) by providing legal and ethical decision-making knowledge, and skills to answer the challenge when faced with contemporary practice issues.

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

The Journal of Legal Nurse Consulting
Topics Sought for Feature Articles

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

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

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

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

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

Medical Malpractice
Medication Co-prescriptions: Responsibility in Adverse Reactions, Abuse
Medical-Legal Issues in Telemedicine/Teleradiology
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Dental Litigation: Temporomandibular Disorders
Missed Diagnosis of MI
Use of EKG and Cardiac Enzymes
Delayed Diagnosis/Treatment of Stroke, CVA: Heparin/TPA
Emergency Room Law
Paramedic Litigation
Legal Considerations in Pre-hospital Care
Anesthesia Complications/Standards
Plastic Surgery: Complications, Liability, Plastic Surgeon vs. Cosmetic Dermatologist
Avascular Necrosis: Complications, Liability, Malpractice, Legal Outcomes
Pap Smears: Malpractice in Gynecology
Imaging Liability: Radiologists
Alternative Therapy and Malpractice: "Accepted Practice" vs. "Reasonable Care"
Cruise Ship Medical Guidelines
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Personal Injury
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Psychiatric Issues
Malingering: What to Look For
Lack of Supervision and Liability: Suicide

Toxic Tort
Carbon Dioxide Poisoning
Mercury poisoning
Lead Poisoning

Miscellaneous
School Disability Litigation, IEPs
School Nurse Standards
Autopsy Findings/Terminology
Pharmacy Responsibilities for Patient Education, Informed Consent
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Fraud: Medical Bill Review

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Submission Guidelines

The Journal of Legal Nurse Consulting (JLNC), a refereed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). The journal's purposes are to promote legal nurse consulting within the medical-legal community; to provide both the novice and the experienced legal nurse consultant (LNC) with a high-quality professional publication; and to teach and inform the LNC about clinical practice, current national legal issues, and professional development.

The journal accepts original articles, case studies, letters, and research studies. Query letters are welcomed but not required. A manuscript must be original and never before published, and it should be submitted for review with the understanding that it is not being submitted simultaneously to any other journal. Once submitted, articles are subject to peer review (publication is not guaranteed).

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

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

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

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- ☐ Numbers and percentages have been checked against one another and the text for accuracy.
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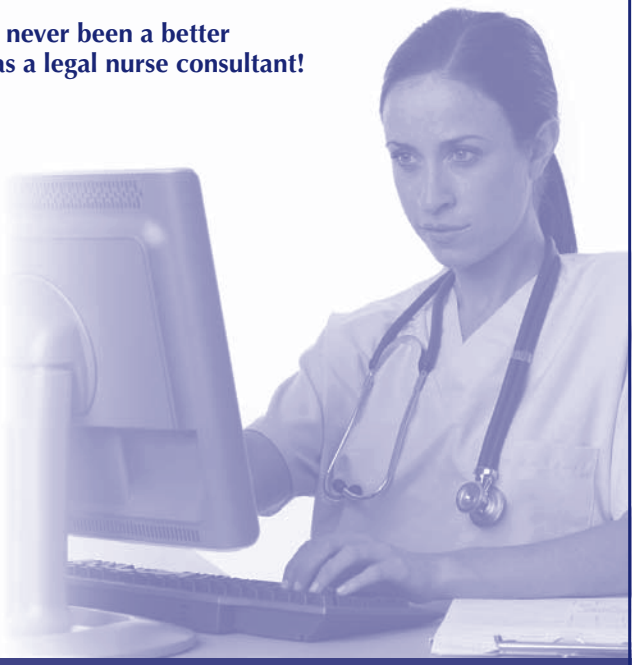

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