The Journal of

Legal Nurse Consulting

Volume 22 ▲ Number 1 ▲ Winter 2011

AALNC

AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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The Journal of Legal Nurse Consulting

Purpose

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

Manuscript Submission

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

Manuscript Review Process

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

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

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LEGAL NURSE CONSULTING
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Feature Articles

Departments

A Call for Authors

Dear Colleagues,

I write to you to ask you to share your knowledge and expertise with your professional colleagues and friends by considering writing an article for *The Journal of Legal Nurse Consulting*. Our *Journal* is a wonderful vehicle that provides research-related articles, clinical information, and current topics of interest for our members and readers interested in the legal field and legal nurse consulting. Being an author benefits the profession by advancing the specialty through providing new and cutting edge information, benefits the reader through sharing knowledge-learned ideas to expand or revitalize his or her knowledge base, and benefits the author by sharing expertise to help improve practice through generating ideas and practical applications that can be tested.

The articles in this issue of the *Journal* are good examples of sharing the knowledge. Of significant interest is the article by Marjorie Pugatch and Angie Duke-Haynes that examines what approaches work best for legal nurse consultants (LNC) to gain employment or independent case work. Through a convenience sample of members and non-members, the authors provide survey data about specific strategies or approaches for both the novice and experienced LNC that seem to work best in securing work. Readers will find this information valuable to apply as they network and work with attorneys and others in securing cases.

Debra Wolf and Deborah Nellis provide an informative article that appears as Part 1 of two parts on the topic of informatics and the use of electronic records. What is particularly relevant is how the LNC needs to become critically familiar with electronic records as information stored is vital and necessary when conducting expert record reviews. How will the LNC be certain she or he has all the information needed when it is no longer in paper form? How will this affect outcomes? These questions are far reaching and can have major impacts.

Rachel Cartright delves into the importance of standards of care, the development of such standards, and how these are used in reflecting on credibility and validating what practice should be. As LNCs, we know the importance of the "standard of care", and this article provides good insight into why this is important as well as relevant resources.

The *Journal* also offers many departments to which you can contribute. Generally each issue will have a Clinical Maxim and related References and Resources contribution that focuses on a specific clinical condition; the Professional Practice, Trends, and Issues department describes important current topics or issues that our readership wants to learn more about; and the Question and Answer section identifies professional or clinical issues about which members need evidence or want clarification. The Book Review is a wonderful feature that gives our readers ideas about information that can help support or expand both professional and personal lives.

So, I would greatly appreciate hearing from you and receiving your manuscripts for possible publication in Journal We are here to help you in getting an accepted manuscript to publication. I know your contribution will be a significant benefit for all of us.

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

LNC First Employment: A Survey of Methods Used

Marjorie Berg Pugatch, RN MA LNCC EMT-B and Angela M. Duke-Haynes, RN

KEY WORDS
Employment, Marketing, Networking, In-house/Independent Consultants

Legal nurse consultants (LNCs) are employed directly as in-house consultants, or on a case-by-case basis as independent consultants in a variety of settings including law firms, government offices, insurance companies, hospital risk management departments, forensic environments, consulting firms, and health maintenance organizations. When marketing their services, LNCs will want to know what approaches work best for securing work. Using an electronic format, a cross-sectional survey of practicing LNCs was conducted to gather data about methods used to obtain LNC first employment or first consulting case. Results indicated methods rated as most helpful for obtaining a position or case were attorney referrals, internships, LNC referrals, and networking. Targeted e-mail/mailing of a résumé with a cover letter and cold calls were considered least helpful.

According to the American Association of Legal Nurse Consultants (AALNC) the "primary role of the legal nurse consultant (LNC) is to evaluate, analyze and render informed opinions about medical issues, delivery of health care and/or the health outcomes as they relate to cases or issues within the medical-legal arena." (American Association of Legal Nurse Consultants, 2009, p. 3) LNCs practice in a variety of settings including law firms, government offices, insurance companies, hospital risk management departments, forensic environments, consulting firms, and health maintenance organizations. Some LNCs are employed directly by these entities as in-house consultants, or on a case-by-case basis as independent consultants. Those who remain clinically active may be hired as expert witnesses to opine regarding the standard of care in medical malpractice cases at depositions and trials. Some LNCs offer both expert and behind the scenes consulting services.

When marketing their services, LNCs must reach out to various types of companies/firms and collaborate with professionals from other disciplines. New LNCs frequently contact experienced LNCs seeking advice on how best to make these new connections. The AALNC and local chapter-leaders also receive similar inquiries. LNCExchange, a non-fee based listserv at LNCExchange@yahoogroups.com often generates posts asking for "tips" on how to get started in the field. Anecdotal advice given to a new LNC by practicing LNCs, although important, can be limited.

One of the standards of professional practice for all LNCs is collegiality defined as contributing to the professional development of peers and colleagues (Peterson & Kopishke, 2010). Likewise, the AALNC Awareness Committee is charged with assisting LNCs to succeed in this field as well as educating the nursing community about the field of legal nurse consulting. To this end, committee members conducted a cross-sectional survey of practicing LNCs in order to gather data about methods used to obtain LNC first employment or first consulting case. The results will be of interest for new LNCs, practicing LNCs, and clinical nurses considering entering the field. Practicing LNCs may glean some strategies they can incorporate in their own marketing and networking plans. The results will also serve to educate clinical nurses who may be considering legal nurse consulting as a career change or expansion.

Methods

A cross-sectional survey design using an electronic format was chosen as a cost-effective means to reach a large community of LNCs. Survey questions were developed by committee consensus based on committee members' collective, long-standing experience, and knowledge base as LNCs in multiple different practice settings and practice areas. The survey instrument was comprised of sections including demographic and practice information (i.e., experience, education, general practice area, internships), marketing approaches, initial methods used by LNCs to secure employment, and LNC professional development activities. A five-point Likert-type scale was employed to rate the various methods used by LNCs to obtain their first employment or case. Another related question focused on methods to find work by the type of practice in which the LNC was engaged, either in-house or expert witness/independent consultant.

Sample Participants

Two LNC groups were invited to complete the survey. Group one included all current AALNC members (3,426). Group two derived from the LNCExchange listserv, contained both AALNC and non-AALNC members. In April 2009, an e-mail describing the purpose of the survey with a link to access the survey was sent to group one. Group two received a listserv message sent to exchange participants inviting non-AALNC members to contact the national organization to participate in the survey. The survey remained available online for two weeks.

Results: Demographic and Practice Information

Table 1. Demographic Description of Sample Population

Demographic	%	n[1]
Current Age		
30 or less	<1	1
31-40	8	41
41-50	35	169
51-60	46	224
60 or older	11	52
Highest Nursing Degree		
Diploma	5	25
Associate	24	116
Baccalaureate	47	226
Master	21	101
Doctorate	3	14
Years in Clinical Practice		
1-5	2	12
6-10	13	61
11-15	14	68
16-20	17	81
>20	55	266
Current Hours Per Week of Clinical Practice		
0	48	231
1-10	12	59
11-20	4	21
21-30	12	56
31-40	16	79
>40	8	39
Completion of LNC Education Course		
Yes	62	304
No	38	186
Completion of Internship Prior to First Employment LNC		
Yes	11	55
No	89	432
Location of Internship		
Law firm	45	24
LNC Mentored in their setting	38	20
Other	20	11
Years Practicing as an LNC		
1-5	44	209
6-10	27	127
11-15	13	60
16-20	9	46
>20	7	32

Demographic	%	n
Primary Practice Setting		
Independent	50	242
Law Firm	18	80
Not Working as LNC	7	36
Consulting Firm	7	34
Expert Witness[2]	4	21
Hospital	4	20
Insurance Company	3	15
Government Agency	1	7
Business/Industry	<1	4
HMO	<1	2
Other[3]	3	15
Primary Practice Area		
Medical Malpractice	47	232
Personal Injury	19	93
Expert Witness[2]	12	60
Worker's Compensation	7	35
Case Management	6	29
Product Liability	6	30
Risk Management	6	30
Elder Law	3	15
Life Care Planning	3	14
Toxic Torts	3	14
Billing/Audit Review	2	10
Administrative Health Law	2	9
Criminal/Forensics	2	12
LNC Education	1	7
Regulatory Compliance	1	7
LNC Billable Hours Per Week		
0	18	89
1-10	26	124
11-20	12	58
21-30	11	53
31-39	11	53
≥ 40	22	105
LNCs Wanting More Billable Hours		
Yes	62	302
No	38	189

Continued on page 5

1. Total number for each category does not sum to the total number of respondents (n=494) due to item non-response or missing data.
2. Expert witness was included as a choice for both primary practice setting and primary practice area.
3. Other primary practice areas included: corporate, forensic accounting firm, third-party administrator, university law school.
4. Case load promoting or developing activities include marketing, networking, administrative tasks.

Table 1. Demographic Description of Sample Population (continued)

Demographic	%	n
LNC Non-billable Hours Per Week in Promoting or Developing Case Load[4]		
1-10	87	409
11-20	9	44
21-30	2	10
31-39	1	5
≥ 40	1	3
LNC Non-billable Hours Per Week for Professional Development		
1-10	92	436
11-20	6	29
21-30	1	5
31-39	<1	2
≥ 40	<1	2

Of the 494 respondents, 92 percent were members of the AALNC and 8 percent were non-members. LNCs from 49 states participated in the survey. As shown in Table 1, more than 90 percent of respondents were older than age 41 years and more than 70 percent held at least a bachelor's degree. Nearly three-fourths (72 percent) of respondents had at least 16 years of clinical experience. Approximately one-half (52 percent) of the respondents continued in clinical practice and about two-thirds (62 percent) had completed an LNC course of study. Only 11 percent of the respondents had completed an LNC internship prior to first employment. When asked about LNC experience, 44 percent reported 1 to 5 years and 27 percent reported 6 to 10 years of this specialty experience. Approximately 50 percent of respondents were independent practice LNCs and 4 to 12 percent of LNCs identified themselves as expert witnesses. Regarding employment setting, 18 percent of LNCs worked in law firms as in-house LNCs, 20 percent were employed in all other settings combined such as, government, hospitals, and insurance companies, and 7 percent of respondents were not working as LNCs. The largest practice areas reported by nearly two-thirds of responding LNCs were medical malpractice (47 percent) and personal injury (19 percent), respectively. Remaining respondents worked in all other practice areas combined.

With respect to billable hours, 26 percent of LNCs billed between 1 to 10 hours per week, 34 percent billed between 11 and 39 hours per week, 22 percent billed more than 40 hours per week, and 18 percent of respondents had no billable hours. However, 62 percent of respondents wanted more billable hours. Almost all LNCs spent between 1 to 10 hours per week promoting or developing a case load and in professional development activities. It generally took from one to six months to secure a first case or position.

Employment Methods

Various methods were reportedly used by LNCs to obtain first employment or a first case related to legal nurse consulting. Respondents were asked to rate each method used according to its helpfulness in leading to employment by choosing one of five possible answers (very helpful, helpful, somewhat helpful, neutral and not at all helpful). Respondents were not limited in the number of responses that could be made. As shown in Table 2, methods rated as very helpful by at

Table 2. Methods Ranked in Order of Helpfulness in Seeking First Employment or Case by LNCs

	Very helpful		Helpful		Somewhat helpful		Neutral		Not helpful	
Method	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Attorney Referral	78	(125)	19	(30)	3	(4)	0	(0)	1	(2)
Internship	61	(16)	19	(5)	4	(1)	15	(4)	0	(0)
LNC Referral	54	(89)	18	(30)	6	(10)	5	(9)	17	(28)
Networking with Others in the Field	52	(122)	23	(55)	10	(23)	7	(16)	9	(20)
Responding to an Ad	49	(48)	18	(18)	17	(17)	6	(6)	9	(9)
Exhibiting (e.g. at meetings)	37	(19)	29	(15)	15	(8)	6	(3)	14	(7)
Professional Networking (e.g. Linked-In)	34	(36)	28	(30)	8	(8)	17	(18)	14	(15)
Targeted Follow Up to Mailings	24	(36)	19	(29)	23	(35)	11	(17)	23	(35)
Targeted Mailing of Résumé with Cover Letter	17	(37)	22	(47)	25	(54)	8	(18)	28	(62)
Cold Calling	11	(12)	22	(23)	22	(23)	11	(12)	35	(37)
Targeted Email of Résumé with Cover Letter	7	(6)	27	(23)	21	(18)	12	(10)	34	(29)
Other (filled in)	77	(23)	10	(3)	7	(2)	3	(1)	3	(1)

least 50 percent of respondents for seeking a position or case were attorney referrals (78 percent), internships (61percent), LNC referrals (54 percent), and networking with others in the field (52 percent) (e.g. attorneys, LNCs, risk managers). Responding to an advertisement and exhibiting at meetings and professional Internet networking was considered very helpful by one-third to one-half of respondents. Methods considered least helpful were targeted e-mail/mailing of a résumé with a cover letter and cold calls. Combining a targeted mailing with a follow-up telephone call was reported by 24 percent of respondents as somewhat more effective than a simple mailing alone. Several write-in responses were offered by the respondents as very helpful including the AALNC directory listing (see searchable public part of the AALNC website), lecturing to attorneys, and social networking.

Table 3. Most Used Employment Methods by In-house LNCs Compared to Expert Witness/Independent Consultants

	In-house LNC (n=181)		Independent Consultant/ Expert Witness (n=235)	
Method	%	(n)	%	(n)
Responded to an advertisement	38	(69)	3	(8)
Professional networking with others in the field	21	(39)	24	(56)
Referred by another LNC	9	(17)	18	(42)
Social or personal networking with attorneys	6	(11)	8	(19)
Referred by other healthcare worker or healthcare organization	5	(9)	7	(17)
Social networking generally	4	(7)	6	(13)
LNC contact information passed from attorney to attorney	4	(7)	3	(8)
Mailing résumé via postal or email	2	(4)	18	(42)
Internship	4	(7)	0	(0)
Cold calling	0	(0)	6	(14)
Other answers uncategorized	6	(11)	7	(16)

A second set of employment questions was devoted to exploring if successful employment methods used by independent consultants/expert witnesses differed from those used by in-house LNCs (Table 3). Independent consultants and expert witnesses relied more on professional networking with others in the field (23 percent), LNC referrals (18 percent), and mailing their résumé through regular mail or via email (18 percent). On the other hand, 38 percent of in-house LNCs found their first employment positions from responding to an advertisement followed by professional networking with others in the field (21 percent). For both groups, internships and cold calling were least used (<6 percent).

Discussion

Professional networking with other colleagues in the field including LNCs and non-LNCs such as attorneys was considered almost equally valuable for in-house LNCs and independent consultants/expert witnesses. Networking opportunities can include participating in professional conferences and joining and becoming involved in local organizations where new LNCs can interface with potential employers and mentors and with individuals who might act as referral sources. Additionally, offering to lecture on a pertinent topic at law firms that specialize in medical malpractice or personal injury is another way to interface with potential clients. A lecture could also include information on the benefits of using an LNC with examples of work product.

Independent consultants who do not act as expert witnesses may have greater leeway in openly marketing their services when compared to testifying experts. As reported in the survey, mailing a résumé via postal service or e-mail to the hiring partner, trial attorney, or attorney specializing in practice areas in which the LNC has the most expertise was considered more effective when followed up with a telephone call. Other activities that new LNCs might consider to increase their potential for employment include publishing in legal journals, exhibiting at legal educational conferences, and advertising their services on the Internet through their personal website or in local legal journals.

Nurse experts reportedly relied mostly on networking and LNC referral methods to secure their first cases. Expert witnesses must remain clinically active and credentialed in their field to demonstrate clinical knowledge and current expertise. Nurse experts should be aware that any activity on the Internet (e.g. blogging, participation on listservs, social networking sites) may be used by the opposing side to undermine an expert's opinion or credibility. For these reasons, discretion in marketing and on the Internet is advised for nurse expert witnesses. Identifying and vetting an experienced clinical nurse who can serve as an expert witness sometimes is the responsibility of in-house or independent LNCs. LNCExchange members frequently use the listserv to find experts for their cases, and the AALNC's public directory is another way for attorneys and others to locate experts. Nurse experts who belong to an AALNC chapter may network with other members who may need experts for cases under investigation or in suit.

In-house LNCs are most often employed by law firms. The most frequently reported method in-house LNCs utilized to find employment was by responding to advertisements, followed by professional networking, and LNC referrals. Advertisements for in-house LNC positions are often found in nursing publications such as *Nursing Spectrum* or *Nursing Network*, and also in the help wanted section of newspapers or local legal newspapers. LNCs seeking in-house positions may find it helpful to contact employment agencies that specialize in the legal field and submit their résumés for employment consideration. These agencies keep LNC résumés on file in

anticipation of requests from companies or firms for LNC services. There are also a number of employment sites on the Internet that post LNC positions including general employment agencies and legal specialization agencies. In addition, Internet-driven LNC job blogs compile Internet advertised positions. Other LNC positions may be found on national law firm websites that have a "careers" or "hiring" section. The AALNC has recently added an LNC job openings section as a member benefit on the organization's website. AALNC chapter leaders may receive local inquiries from law firms and employment agencies which can be shared with chapter members. Occasionally, chapter websites may include an advertisement placed by an employment agency or a company. LNCExchange members frequently post requests for experts or advertise available LNC positions.

One of the most important hurdles in entering any field in business is how to overcome a lack of experience which can make finding a first position difficult. As reported in the survey, the majority of respondents completed a course of LNC study. While completing an LNC course of study (e.g., http://www.aalnc.org/edupro/Courses.cfm) is not mandatory to becoming an LNC, it may offer an advantage to obtaining a first legal case or first legal nurse consulting employment position especially when coupled with appropriate clinical experience and excellent writing and analytical skills. LNC course writing assignments can be submitted as writing samples to prospective employers as can published articles in the clinical nursing field.

Depending on the length and depth of an in-person course of study, the LNC student may build a professional and collegial relationship with the instructors and be able to secure references. Another advantage of some LNC courses is assistance in internship placement. Internships were rated very helpful by both in-house LNCs and independent LNCs. There are numerous benefits that derive from internships and employers will generally consider prior internship experience in the hiring process as the internship can result in valuable work experience. The LNC can build relationships with mentors who can provide networking contacts with prospective employers in the field, and can be an excellent reference source for potential employers. Interns may find employment with their mentoring organization because their capabilities are already known. Lastly, the internship experience can be used to build a résumé.

The majority of respondents wanted more billable hours which suggests a greater supply of LNCs than demand for their services. Market saturation may in part be attributed to lack of awareness on the part of attorneys and others who work on medical-legal matters about the value of using LNCs in the delivery of high quality legal services. Thus, LNCs need to be prepared to educate some potential attorney clients and other employers, such as insurance carriers, regarding the value LNCs bring to the adjudication of medical-legal claims. In states that have passed tort reform, this has likely adversely impacted the employment of LNCs to some extent.

Limitations

There were several survey limitations identified. The sample was a convenience sample of AALNC members and others interested in legal nurse consulting rather than a random sample. Those who responded to the survey were likely to be more interested in the survey purpose and also to respond to professional society topics.

The instrument developed was not subject to pilot testing which would have been beneficial in finding and correcting weaknesses and problem areas prior to general release of the survey to the two groups. For example, there were some issues with categorical response choices such as, the current age groupings included choosing "51-60" and "60 or older". Likewise "0" hours was not offered for non-billable hours but was offered for clinical practice and billable hours. Also, "expert witness" was included as a choice in both categories of primary practice setting and primary practice area which would make it confusing for respondents. Furthermore, instead of grouping independent consultant and expert witness together more discrete identification of types of LNCs should be used (i.e., in-house, independent consultant, expert witness). More careful attention to the construction of the instrument would have eliminated these deficits. In a future survey, the list of "most used employment methods" should be expanded to include some of the more frequently cited methods found in the write-in section of this survey.

Conclusions

This survey demonstrated that the most effective way to obtain first employment is likely to depend on whether the LNC intends to work in-house or as an independent consultant/expert witness. In-house LNCs were most likely to find employment by applying for open-posted positions while independent consultants/expert witnesses were most likely to find cases via more direct contact or through referrals. Some specific activities such as, interning, exhibiting at legal conferences, lecturing, and networking in all its forms (Internet, professional and social) can assist the new LNC to find work. For some LNCs, directory listing and mailings with follow up can lead to employment.

Experienced LNCs may also benefit by reviewing the list of activities that new LNCs used to find work such conference exhibiting, speaking at legal conferences and law firms, and joining local bar associations with the aim to integrate these new networking strategies in their employment efforts. The survey findings can help raise the awareness of clinical nurses before they enter the LNC field. Understanding the needed initiatives and efforts by new LNCs to find work and about the prevailing job market conditions for LNCs are important considerations for the clinical nurse.

In the future, the effects of tort reform on employment patterns and specific results of providing lectures to lawyers and joining local bar associations on LNC employment success should be examined along with exploring why some attorneys choose not to hire LNCs.

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Informatics: Helping the LNC Adjust to Electronic Records

Understanding the Transition – Part I: Moving from Paper to Electronic Records

Debra M. Wolf, PhD MSN BSN RN and Deborah L. Nellis, DNP RN LNCC

KEY WORDS
Electronic Documentation, Computers, Technology, Medical Records, Electronic Health Records

This article is the first of a two-part series that will assist legal nurse consultants (LNCs) to increase their understanding of Health Information Technology (HIT) and how to be proficient in reviewing and requesting electronic health records (EHRs). In Part I, a foundation of knowledge will be presented that centers on why organizations are transitioning to electronic charting, the impact of political reform, the challenges of implementing an EHR, and the various organizations involved in the protection of health information. Part II will introduce the LNC to the various types of functionality found within EHRs and present a tool to assist LNCs in requesting an EHR for review. Being able to speak the language and request detailed selected documents will assist the LNC in reviewing medical records needed for legal litigation.

Introduction

Change is a process of transitioning from one state to another (Merriam-Webster, 2010). Sometimes we have no control over this transition. Change can occur in one's personal life as well as one's professional life. Within our professional life we sometimes have no say in dealing with or accepting change, but must adjust in order to be successful in our professional responsibilities. Over the past several years, healthcare professionals and healthcare organizations have been altering processes in an attempt to change from paper to electronic documentation. A study conducted by Whittaker, Aufdenkamp & Finley (2009) revealed that 68 percent of hospitals surveyed were using some type of electronic health record (EHR). This movement has rapidly impacted multiple disciplines in a variety of ways resulting in a multitude of change. As a LNC one must be proactive in understanding the change brought about by electronic documentation and make the appropriate adjustment to one's job performance. This article is the first of a two-part series that will assist the LNC to better understand health information technology (HIT) and how to be proficient in requesting and reviewing EHRs, while adjusting to the various types of functionality or capabilities of software found within EHRs.

Traditionally, clinicians within various healthcare settings spend a significant portion of their time completing forms and documenting patient care. Historically, manual paper documentation was the main form of charting used within healthcare settings. Reviewing these paper charts/documents can be very time consuming due to the patient record being incomplete or containing illegible handwriting (Turisco & Rhoads, 2008). As a result, HIT has emerged as an essential component to further transform the health care system in focusing on safety, quality, and efficiency (Virapongse et al., 2008). The use of HIT, especially EHRs has been targeted by political reform as an essential tool for ensuring the availability of patient health records across health care entities.

In 2005, the Bush administration called for the creation of a nationwide network of EHRs within 10 years (Kolodner, 2007). The main goal was for all ambulatory care practices to have universal adoption of an EHR for their patients ultimately leading to improved quality, safety, efficiency, and coordination of patient care. Many hospitals and ambulatory care centers have adopted electronic documentation to provide better patient care. Most recently, President Obama signed the American Recovery and Reinvestment Act of 2009, also known as the Stimulus Law which allocates 19 billion dollars for EHRs by the year 2014 (Privacy Rights Clearinghouse, 2010). This act provides financial incentive payments to eligible providers who can demonstrate "meaningful use" of a certified EHR within their organization. The definition and requirements for demonstrating "meaningful use" are currently being finalized by the Centers for Medicare & Medicare Services (CMS) and the National Coordinator for Health Information Technology (Bluementhal & Tavenner, 2010; U.S. Department of Health & Human Services, 2009).

Electronic Documentation

Some of the main capabilities of an EHR includes electronic documentation of patients' current and historical health history; personal demographics; insurance and billing information; laboratory and diagnostic tests results; referrals; medical treatment plans as well as enabling healthcare practitioners to order tests and medications electronically (Zandieh et al., 2008). Multiple benefits have been documented as a result of electronic documentation. Turisco & Rhoads (2008) have listed some of these benefits as:

- Electronic work lists – an electronic helping hand to manage multiple tasks

- Electronic alerts or reminders – provides helps prioritize what needs to be completed
- Reduced documentation redundancies – captures information only once
- Standardized templates – ensures complete data collection
- Faster retrieval of historical data – provides better and more efficient care
- Reduced medical errors – provides legible information about medications through electronic medication administration records (eMAR)
- Better compliance – documents care to meet regulatory requirements for patient safety (e.g., Joint commission)

Table 1. ANA Reasons for Documentation

Communication	Aim is to share accurate, concise, thorough, and current information about patients.
Credentialing	Assess process and outcome measures that are specific to the performance of healthcare practitioners.
Legal	Reports and clinical records can be used as evidence in courts of law.
Regulation & Legislation	Audits of reports and records can indicate if regulatory or legislative changes are required.
Reimbursement	Agencies involved in reimbursement can determine the illness and intensity of service for which reimbursement is being sought.
Research	Analysis of data from reports and records is essential for attaining the goal of evidence -based nursing practice and quality health care.

Note. Adapted from "ANA Reasons for documentation." American Nurses Association, 2005, p. 2-3.

In an ideal electronic setting, patient information is captured only once, in real time, and often at the point of care, with the goal being "record once, read many times" (American Nurses Association [ANA], 2005, p6; Turisco & Rhoads, 2008). As EHRs continue to evolve, so must the involvement of nurses in designing and influencing change in how documentation occurs. The American Nurses Association's publication *Principles for Documentation* (2005) provides six reasons why documentation of patient care is so important (Table 1). More recently the American Nurses Association (2008) revised the *Nursing Informatics: Scope and Standards of Practice* which serves several functions and/or purposes, including being "a source document for legal opinions, funding agencies and others seeking to improve health through nursing informatics" and assisting "with developing position descriptions, determining required informatics competencies" (p.3).

Challenges

The challenges of implementing an EHR system not only focus on documentation needs, but also include cost, selecting a system, technical support, Internet connections, reconfiguration to accommodate workstations, printers, interoperability, and adequate amount of training for individuals in order to create a comfort level with information technology (Zandieh et al., 2008). These challenges cause each healthcare entity to have a different strategic plan in how it will fully transition to an EHR. Some organizations may transition using a big bang approach (meaning the organization will convert all documentation and all departments at one time). Others will use a hybrid approach by converting portions of the paper medical record one section at a time or one department at a time resulting in the formal medical record being in both an electronic and paper format. These varied approaches can result in confusion for the LNC when requesting and reviewing the medical records. Knowing the current state or approach an institution is using will assist the LNC in knowing how to request and view copies of a patient's medical record.

To add to the challenges listed above, the LNC must also understand that each vendor that develops or implements EHRs has his/her own format, look, and functionality which results in greater confusion as no two vendors' products look or perform the same. The LNC needs to be familiar with these products. In an effort to standardize EHR, the Certification Commission for Healthcare Information Technology (CCHIT) was founded in 2004 to develop and evaluate certification criteria, inspection processes for EHRs, and the networks through which they operate (Kolodner, 2007). The CCHIT is an independent, nonprofit organization approved by the Office of the National Coordinator. On June 18, 2010, the Department of Health and Human Services (HHS) established a temporary certification program for EHR technology where organizations can become an authorized testing and certification body (Health Information Technology, 2010).

As hospitals and ambulatory centers convert to EHRs there will be increased emphasis on protecting a patient's medical information. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted to protect the patient's medical record (U.S. Department of Health & Human Services, 2003). HIPAA defines how medical information may be obtained by certain entities such as personal injury lawyers. An authorization must be obtained before the medical records will be released. The authorization must be in plain language, disclose the reason for request, have an expiration date, and have the ability to revoke the request (Ouelett & Reider, 2007; U.S. Department of Health and Human Services, 2003). Health information privacy and requesting records will need to be redefined or clarified as the nation moves toward EHRs stored on shared networks (Privacy Rights Clearinghouse, 2010).

The challenge for a LNC is whether a complete EHR has been received for legal review. One does not necessarily know what health information may be relevant to the lawsuit prior to receiving the medical record (Rothstein & Talbott, 2007). For this reason, it is imperative to receive a complete medical record when first requested whether it is a plaintiff law firm or a defense law firm requesting the record. For a plaintiff's law firm there is a time frame in which a medical

malpractice claim can be filed. This time frame is called statute of limitations. Time is of the essence because the records need to be reviewed to determine if negligence occurred before the statue of limitations expires. For a defense law firm, if portions of a patient health record are missing which may be equally relevant for the plaintiff, a proper review of the allegations is compromised; hence, the time in requesting and reviewing medical information is crucial. Knowing how to request a medical record is now critical for the LNC to understand.

A major step an LNC can take is to educate him or herself to better understand the terminology associated with the electronic documentation movement. Being able to speak the language and request in detail, selected documents will assist the health information management department or medical record staff in providing the LNC with the documents that are requested. Relevant terminology and their sources are shown in Table 2. The LNC will also want to know what level or stage of EHR implementation the healthcare organization

Table 2. Terminology

Alerts – "Term used in an EHR for a message or reminder that is automatically generated from the data. Usually based on programmed logic, rules about what message to use when two or more conditions are met" (Gartee, 2007, p.7).
Bar Code Medication Administration (BCMA) – Term referred to the scanning of barcodes (on patient and medications) for the administration, storage, dispensing, returning, restocking and crediting of medications (Hebda & Czar, 2009, p. 24).
Computerized Provider Order Entry (CPOE) – "An order entry system that allows clinicians (e.g. nurses, pharmacists and physicians) to enter orders directly into an electronic healthcare information system" (Joos, Nelson & Smith, 2010, p. 561).
Computer Literacy – "Refers to the ability to use computers to do practical tasks" (Joos, Nelson & Smith, 2010, p.581).
Electronic Medical Record (EMR) – "An electronic record of health-related information on an individual that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization" (National Alliance for Health information Technology, 2008, p.6).
Electronic Health Record (EHR) – "An electronic record of health-related information on an individual that confirms to nationally recognized interoperability standards and that can be created, manage and consulted by authorized clinicians and staff across more than one health care organization" (National Alliance for Health information Technology, 2008, p.6).
Electronic Medication Administration Record (EMAR) – "Contains all medication orders including one time, scheduled, unscheduled and prn medications, IV additives, and any other pharmaceutical or homeopathic therapy" (Saba & McCormick, 2006, p.433).
Health Information Exchange (HIE) – "The electronic movement of health–related information among organizations according to nationally recognized standards" (National Alliance for Health information Technology, 2008, p.22).
Health Information Organization (HIO) – "An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards" (National Alliance for Health information Technology, 2008, p.22).
Health Information Technology (HIT) – Allows comprehensive management of medical information and its secure exchange between health care consumers and providers (U.S. Department of Health and Human Services, 2010a).
Health Information Technology for Economic and Clinical Health (HITECH) Act – Provides HHS with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health information technology (HIT), including electronic health records and private and secure electronic health information exchange (U.S. Department of health and Human Services, 2010b).
Health Literacy – "The degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health" (Joos, Nelson & Smith, 2010, p.587).
Informatics – "The science and art of turning data into information" (Hebda & Czar, 2009, p. 529).
Informatics Nurses (Ins) – "Generalist nurses who have experience but are not educated at the graduate level" (American Nurses Association, 2008, p.2).
Informatics Nurse Specialist (INSs) – "Nurses formally prepared at the graduate level in informatics or a related field" (American Nurses Association, 2008, p.2).
Information Literacy – "The set of skills needed to find, retrieve, analyze, and use information" (Joos, Nelson & Smith, 2010, p.588).
Literacy – "The ability to locate and use printed and written information to make decisions and to function in society, both personally and professionally" (Joos, Nelson & Smith, 2010, p.590).
Nursing Informatics (NI) – "A specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge, and wisdom in nursing practice. Nursing Informatics facilitates the integration of data, information, and knowledge to support patients, nurses, and other providers in decision making in all roles and settings" (American Nurses Association, 2008, p.65).
Personal Health Record (PHR) – "An electronic record of health-related information on an individual that confirms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual" (National Alliance for Health information Technology, 2008, p.6).
Regional Health Information Organization (RHIO) – "A health information organization that brings together heath care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community" (National Alliance for Health information Technology, 2008, p.22).
Clinical Decision Support (CDS) – Tools that "provide clinicians, staff, patients, or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care" (Osheroff et al, 2007, p.141).
Rule Based Logic (RBL) – "Is a form of electronic algorithms using step-by step- problem solving and the evidence from which decisions are made comes from best practice guidelines. Example of a RBL - if 1, 4, and 7 apply, then do A; if 2, 5, and 8 apply, then do B" (Saba & McCormick, 2006, p.173).

is. Has the organization completely transitioned to an EHR or is it in the process of transitioning so that both electronic and paper records are being used? If a facility is in a hybrid state, then one must ask what documents remain on paper and what is now documented electronically.

Having both computerized provider order entry and paper order sheets when caring for patients is not uncommon for healthcare organizations. Thus, a LNC must know to request or expect copies of both paper and electronic provider orders. If the organization has completely transitioned to an EHR, then the request for printed records must be reconstructed to include more detail. For example, nursing notes are no longer specific forms that can be copied as in the traditional paper format. Electronic documentation consists of several screens of discrete data elements that are stored on servers. In order to print the data elements (e.g. vital signs, medication record, nursing assessment notes) reports must be written requesting the specified data in a predefined template. Once the report is created or coded, the report is run to select the data elements from the EHR database in order to be printed and viewed on paper. These reports are usually predetermined by the individual organizations or vendors in an attempt to produce a paper chart upon request. Each healthcare organization has different systems with various types of reports that can be printed or viewed electronically. The LNC must understand this unique report writing functionality which exists within most EHR systems. Knowing that one is viewing a report that provides preselected data should alert LNCs that additional data may be missing.

Finally, the LNC needs to understand when clinicians use an EHR they each have different levels of abilities, computer skills/literacy, and information literacy which could ultimately impact their ability to document accurately and/or care for patients in a safe manner. For example, having poor computer skills to properly use a computer may lead to poor documentation; or lacking the knowledge of knowing where to find information within computer files could result in serious adverse events impacting patient outcomes. LNCs need to question the level of education or preparation clinicians were given prior to implementing an EHR, as the content found within a printed report generated from an EHR, of which LNCs will use to evaluate a legal case, may be jeopardized by the various levels of computer and information literacy of each clinician.

Conclusion

In conclusion, a LNC must be proactive in understanding changes brought about by electronic documentation. This level of understanding is a critical step that must be taken in order to fully understand how systems function and where error or clinician negligence may have occurred. Through further education about the phase of EHR deployment of a facility, and by knowing that documentation may exist in both traditional and electronic format, a LNC is in a better position to question if current policy is followed by clinicians or if negligence has occurred. Being proactive in understanding electronic documentation will assist the LNC in accepting the changes that will be encountered now and in the near future.

Part II of this series will assist the LNC in asking critical questions that must be considered when reviewing an EHR document, introduce the LNC to various types of functionality, and present a tool that will assist the LNC in preparing a formal request for printed electronic records.

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Standards of Care

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KEY WORDS
Standards, Standards of Care, Litigation, Legal Nurse Consultant, Expert Witness, Reasonable Person

All legal nurse consultants (LNCs) have a duty to know standards of care that represent the care in question. Knowing the breadth of resources available for obtaining information applicable to the care issues is a major component in developing a solid case for litigation. This article will provide information and resource references that will guide a novice and expert LNC in their practice whether functioning in the expert witness role or case development role.

Introduction

Registered nurses have more professional accountability than at any other time in the history of nursing. As a result, nurses must realize they owe a higher duty of care to their patients and are more vulnerable to claims for professional negligence and possible malpractice than ever before (Weld & Bibb, 2009). The plaintiff's attorney must demonstrate that the defendant health care provider (e.g., physician, nurse) departed from an established medical or nursing standard of care in a medical malpractice cause of action law suit. The standard of care is established by documentation in the medical record and through testimony of the defendant healthcare provider(s), fact witnesses, and expert witnesses. The testimony must address the healthcare issues in question in relation to the current standard of care at the time of the alleged injury. At trial, the jury is asked to render a decision as to whether the defendant's (healthcare provider) conduct breached the established standard of care (Satiani, 2006) based upon the documentation, testimony, and other admitted evidence presented.

Discussion of Key Terms

It is important for the legal nurse consultant (LNC) working with a plaintiff or defense counsel to know the difference between laws, regulations, and standards in order to be most effective in assisting the attorney with developing a case. The LNC must be able to appropriately apply the acceptable standards of care to the issues at hand; therefore, key terms are discussed to enhance understanding.

Laws and regulations. Laws are legislation passed by Congress, state, or local legislative authorities and once signed by the president, governor, or local executive, the legislation becomes law. The Nurse Practice Act is state law that regulates nursing. Regulations, on the other hand, are developed by governmental agencies. According to Shandell, Smith & Shulman (2007) regulations have the weight of law but they are not passed by the legislative authority nor signed by the executive authority. In some cases laws require the development of regulations thus providing a framework for the governmental agency to follow. Federal regulations for staffing Medicare and Medicare services have influenced the development of standards.

Standard. Standards can be developed by both governmental and non-governmental consensus committees. After a public review, the recommendations from the agency become standards. Some standards can be applied with the weight of law. Peterson & Kopishke (2010) define a *standard* as "a model accepted as correct by custom" (p. 590). Garner (2009) similarly defines a standard as "a model accepted as correct by custom, consent, or authority; a criterion for measuring acceptability, quality or accuracy" (p. 1535). Standards may be defined as local standards or national standards.

Nursing standards are not laws; however, the allegation that a nurse failed to meet the standard of care, and that breach of these standards caused harm to the patient, is the basic premise of every nursing malpractice lawsuit. *What would a reasonable prudent nurse, with like training and experience, do under these circumstances?* Weld & Bibb (2009) contend that nurses are more often held to national standards because of the uniform nursing educational requirements and standardized medical treatment regimens. Thus, national standards are gaining increasing favor with the courts. These trends have made the American Nurses Association standards for nursing practice more influential than local standards or standards of other organizations.

Standard of care. According to Garner (2009), a standard of care in the law of negligence, is the degree of care that a reasonable person should exercise (p. 1535). Shandall et al. (2007) contend a standard of care refers to the rule against which the conduct of a health care provider such as, a physician or nurse is measured. Care as defined under the law of negligence is "the conduct demanded of a person in a given situation that typically involves attention to possible dangers and mistakes and to ways to minimize those risks" (Garner, 2009, p. 240). A *reasonable person* is a hypothetical person used as a legal standard to determine whether someone acted with negligence. More specifically, "a person who exercises the degree of attention, knowledge, intelligence, and judgment that society requires of its members for the protection of

their own and of others' interests" (Garner, 2009, p. 1380). Peterson & Kopishke (2010) define a standard of care as the degree of care a reasonably prudent person should exercise under the same or similar circumstances. In the case of a professional (e.g., nurse, doctor, lawyer), it is the degree of care a reasonably prudent person in the profession should exercise under the same or similar circumstances. (p. 590).

Medical malpractice is another term for professional negligence which means a health care provider did not meet the standard of care expected of reputable and careful healthcare providers under similar circumstances (Garner, 2009). Therefore, one can logically deduce why *reasonable care* is the test of liability for negligence. It is the degree of care that a prudent and competent person engaged in the same line of business or endeavor would exercise under similar circumstances (Garner; Iyer, 2003). A duty of care is a legal obligation imposed on an individual requiring the healthcare provider adhere to a standard of reasonable care while performing any acts that could foreseeably harm others (Shandell, Smith & Shulman, 2007). A nurse is required to provide the ordinary degree of skill and care exercised by his or her peers (Shandell et al. 2007). If a nurse's actions are questioned, another nurse must testify that the nurse being sued failed to do something that he or she should have done, or did something which he or she should not have done.

Standard of practice. A standard, standard of care, or standard of practice is often a challenge to define by many disciplines in healthcare. The American Nurses Association (ANA) (2010) states that standards are authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable. Standards reflect the values and priorities of the profession and provide direction for professional nursing practice and a framework for the evaluation of this practice. They also define the nursing profession's accountability to the public and the outcomes for which registered nurses are responsible.

ANA's official position on this issue is that the public has a right to expect registered nurses to demonstrate professional competence throughout their careers, and to be individually responsible and accountable for maintaining professional competence. The nursing profession has the responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public; however, the employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders. In the case of nursing, using the nursing process of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation would be key components within the standard for practice (Magnusson, 2010). It is also important to know that many specialty organizations develop standards for practice within the specialty area of practice.

Importance of Standards of Care

Standards simply define patient care and healthcare provider functions that prevent everyone from doing their own thing and a violation of the standard of care may involve negligence on the nurse's part (Iyer, Taptich & Bernocchi-Losey, 1986). Standards of clinical practice may be developed though research or clinical trials as found from the National Guideline Clearinghouse (NGC), and the clinical outcomes may support the most efficacious treatment or lead to a change in clinical practice guidelines.

Much malpractice today involves lack of defined standards, which if in operation, probably would have protected the patient, staff, and facility. According to Fullbrook (2008), the absence of standards is what makes healthcare providers and facilities vulnerable to liability. Professionals and health care facilities will always be held accountable to the established standards in place. Several factors to take into consideration when determining applicable standards of care are the respective professions' established standards of care, the current clinical practice, and what is currently published in the literature at the time of the incident. For example, a nurse may be subject to a cause of action for malpractice if the nurse performs a service for which he or she is licensed in a negligent manner. The claim of professional negligence requires proof of a departure from accepted standards of care. The departure and proximate cause injury must also be established. The standard of conduct applicable to the nurse is provided by expert testimony as long as such testimony is limited to the opinions regarding nursing care and does not encroach upon the areas of a physician (Shandell, et al. 2007). Mavroforou & Michalodimitrakis (2008) argue it is also plausible the defendant may be held to a higher level of skill and knowledge required by the specialty they represent.

Standard of Care Sources

Standards of nursing practice are not found in one book in a library. The applicable standards may be found in different resources depending on the issues in a particular case. By researching the issues at hand the LNC will be directed to the most applicable standard of care to support the legal position of a specific case. The following listing is not meant to be comprehensive, but only serves as a baseline for initial investigation by the LNC when dealing with medical negligence cases.

Nurse Practice Acts define a professional nursing standard within each state. The National Council of State Boards of Nursing (NCSBN) can be found on line (http://www.ncsbn.org) and provides access to contact information regarding nursing licensure and professional practice respective to each state.

The NGC (http://www.guideline.gov) is a public resource for evidence-based clinical practice guidelines. It is an initiative of the Agency for Healthcare Research and Quality (AHRQ) within the U.S. Department of Health and Human Services (DHHS). The agency provides physicians,

nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines, and to further their dissemination, implementation and use.

The Joint Commission (TJC) and Det Norske Veritas Healthcare (DNV) (www.dnv.com/industry/healthcare) are private, non-governmental agencies that establish guidelines for the operation of hospitals and healthcare facilities. These agencies are independent organizations that accredit and certify more than 17,000 health care organizations and programs in the United States. Most recently in 2008 the DNV has been granted deeming status by the Centers of Medicaid and Medicare Services (CMS) to accredit organizations according to the Conditions of Participation (CoPs).

Local and state health departments and accreditation agencies draw up regulatory standards for purposes of licensing and accreditation. The CMS develop CoPs and Conditions for Coverage (CfCs) that healthcare organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs (Table). These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of the public.

The Food and Drug Administration (FDA) (www.fda.gov) is an agency within the DHHS U.S. It consists of six product centers, one research center and two offices. The FDA regulates a breadth of items such as, food additives, infant formulas, dietary supplements, vaccines, blood products, cosmetics, and many food products just to name a few.

The Centers for Disease Control and Prevention (CDC) is one of the major agencies of the DHHS that works to "create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats". CDC issues evidence-based recommendations and guidelines to protect the public health. (http://www.cdc.gov/about/organization/cio.htm). The Occupational Safety and Health administration (OSHA) has regulatory authority and can develop and issue standards regarding potential exposures, for example, bloodborne pathogens, biohazardous waste, and lead just to name a few (http://www.OSHA.gov/index.htm). The Occupational Exposure to Bloodborne Pathogen Standards was written in 1991 to protect workers from the risk of exposure to human immunodeficiency virus (HIV) and hepatitis B virus (HBV) through blood and body fluid exposure. Requirements for healthcare facilities derived from this standard included the formulation of a detailed exposure control plan which has several components. (http://www.hercenter.org/rmw/osha-BPS.cfm). Professional standards of practice are developed by professional associations such as the ANA and other specialty fields in the practice of nursing such as, the American Association of Critical Care Nurses, the Emergency Nurses Association, and the Academy of Medical Surgical Nursing just to name a few (AJN Career Guide, 2009).

Every healthcare facility drafts documents outlining, defining, or identifying processes or procedures that are expected in response to particular situations. Most healthcare providers and organizations identify these documents collectively as policies and procedures but may also identify protocols, caremaps or critical pathways, and guidelines. Each category of documents has a defined function.

A policy is a course of principle or action set forth and adopted by a business (Garner, 2009; Smith-Marker, 1988). A policy tells when actions are to be taken. For example, a policy in a healthcare organization might state when a patient presents to the emergency room with symptoms of jaw pain, shoulder pain, chest tightness, or chest pain, the patient automatically and without delay is to be transported to the back and an I.V. is to be started.

Procedures are documents that regulate the formal steps in an action (Garner, 2009). Smith-Marker (1988) is the original recorder of process standards in the field of nursing. She describes a procedure as an outline of how to perform a psychomotor skill that has a technical or theoretical basis. It is a step-by-step way of doing something. How to start an intravenous catheter access is an example of a procedure.

Protocols define the management of broad patient care problems (Smith-Marker, 1988). It is the plan of treatment and rules for procedures (Garner, 2009). A protocol in a healthcare organization is the written document based upon a plan or an algorithm of patient outcomes designed to decrease care variations between healthcare providers (Smith-Marker, 1988). For example, protocols for sliding scale insulin, fall prevention, management of skin breakdown, or coumadin dose adjustment may be in place. Other protocol examples are standing physician orders that are signed by the physician for implementation, and generally considered physician's orders because a physician must authenticate them before they are implemented in a facility. For example, if a nurse fails to follow signed protocols, allegations for failing to follow physician orders can be brought against the nurse.

Critical pathways, also known as critical paths, clinical pathways, caremaps or care paths, are management plans that display goals for patients and provide the sequence and timing of actions necessary to achieve these goals with optimal efficiency (Pearson, Goulart-Fisher & Lee, 1995). These documents may also be considered the patient's plan of care. The pathways aim to standardize the care of patients with common conditions (Lipley, 2006). For example, optimized perioperative pathway protocols implemented in orthopedics surgery (e.g. hips and total knees) have been utilized for some time (Rankowitz et al., 2010).

Guidelines are an important model for clinical collaborative practice and can help foster communication between disciplines. Guidelines provide for goal-directed outcomes, guide the systematic collection of data, maximize clinical decision-making, improve the quality and consistency of care, and foster accountability (Rogers, Randolph, & Mastroianni, 2009).

Job descriptions of healthcare providers define the duties expected by an individual hired for a specific role. For example, a registered nurse would have in the respective job description care-related expectations that are associated with the role such as, the nursing process will be utilized to deliver patient care and the plan of care reflects the needs of the patient. The job description should align with the licensed individual's scope of practice for a defined role.

Equipment manuals outline the manufacturer's recommendations for safe and proper use of medical equipment. The documents provided with medical equipment can be in the form of policies and or procedures depending on the purpose of the equipment.

Current literature obtained from authoritative journals (peer-reviewed) that represent the current practice in place at the time of the alleged injury is a common source for standards of care. Clinical practice may change over time; however, the appropriate clinical practice at the time of the injury is what is required to determine whether health care providers breached the prevailing standard of care. Babitsky & Mangraviti (2002) contend textbooks are not generally accepted as authoritative in their entirety because the peer review process is not present with all textbooks. However, textbooks do offer foundation for background education and training that determines a level of minimal expectations for skills and knowledge.

Standards of Care in the Court Room

As Babitsky & Mangraviti (2002) and Mavroforou & Michalodimitrakis (2008) demonstrate, much litigation relies upon the testimony of experts. The expert witness interprets the findings from review of the medical records, current literature, and testimony rendered. Based on his/her knowledge, training, experience, and expertise he or she then renders a professional opinion.

Many occasions the expert witness will generate a written report at the request of counsel. This report is used to state the opinion regarding the issues of a case. The written report communicates his or her opinion the expert expects to express at trial. Citations to authority that support the expert's opinion will bolster this credibility of the report and the testimony (Mavroforou & Michalodimitrakis, 2008). Research of the applicable standards of care and referencing the resources will bolster the testimony of an expert rendering an opinion regarding adherence to or deviations from a standard of care.

The LNC will enhance the credibility of research conducted as a part of case development if authoritative resources are cited in LNC's work product. The most important aspect of comprehending standards of care is for the LNC to know where to locate applicable standards of care that will create a solid foundation for any case prepared for litigation.

Table 1. Healthcare Agencies Accountable to CoPs and CfCs

Ambulatory Surgical Centers
Comprehensive Outpatient Rehabilitation Facilities
Critical Access Hospitals
End-Stage Renal Disease Facilities
Federally Qualified Health Centers
Home Health Agencies
Hospices
Hospitals
Hospital Swing Beds
Intermediate Care Facilities for Persons with Mental Retardation(ICF/MR)
Nursing Facilities
Organ Procurement Organizations
Portable X-Ray Suppliers
Programs for All-Inclusive Care for the Elderly Organizations (PACE)
Providers of Outpatient Services (physical and occupational therapists in independent practice; outpatient physical therapy, occupational therapy, and speech pathology services)
Psychiatric Hospitals
Religious Nonmedical Health Care Institutions
Rural Health Clinics
Skilled Nursing Facilities (http://www.cms.gov/CFCsAndCoPs/)

Note: Adapted from the Centers of Medicare and Medicaid Services (http://cms.gov)

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Centers of Medicare and Medicare Services. *http://www.cms.gov/CFCsAndCoPs/*

Det Norske Veritas Healthcare. *http://www.dnv.com/industry/healthcare*

Food and Drug Administration. *http://www.fda.gov*

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The Clinical Maxim: Depression

Kara DiCecco, MSN RN LNCC

It is difficult to think of any mental disorder that so permeates the law as significantly as depression. The diagnosis of major depression has established precedent in the mitigation of criminal sentencing, provided fodder for domestic disputes, victimized children at the hands of a despondent parent, traumatized the workforce, and is almost inseparable from debilitating personal injury. It is a stealth and formidable opponent with tentacles that are far-reaching and non-discriminate. At its most destructive, depression restrains and squeezes its victims to the point where death can seem a welcome yet tragic relief to the unrelenting pain. According to the World Health Organization, depression is the leading cause of disability worldwide (WHO, 2010). It is unrealistic to cover all the dimensions and considerations of depression here. What follows is a brief insight into the diagnosis, treatment, research, and legal ramifications of the disorder.

Pathophysiology

Depression is thought to be an imbalance in the brain's naturally occurring chemical messengers (neurotransmitters) that regulate mood. Even this explanation is an oversimplification of the frequently studied but still poorly understood disorder. Research yields that an imbalance in these chemicals can be caused by genetics or traumatic/situational events. Depression may also be a side-effect of certain medications, and is twice as common in women as in men (American Academy of Family Physicians, 2010).

Signs and Symptoms

Depression may manifest as a combination of numerous signs and symptoms. While depression is a composite of many of the below, the defining criteria for specific classifications of depression are found in the Diagnostic and Statistical Manual-IV (DSM-IV) of the American Psychiatric Association. The DSM-IV-TR (text revision) is the current edition and the manual for psychiatric diagnoses. At this writing, the DSM-V is slated to be published in May of 2013 (http://www.dsm5.org/Pages/Default.aspx).

- Feelings of sadness or unhappiness
- Irritability or disproportionate frustration
- Pervasive disinterest in normal activities/anhedonia
- Fatigue/physical exhaustion
- Insomnia or excessive sleep
- Reduced sexual drive
- Changes in appetite/either lack of appetite or excessive eating
- Agitation or restlessness. Generalized Anxiety is seen as a comorbdity (Cameron, 2008).
- Slowed thinking or movement
- Feelings of worthlessness
- Decreased concentration/impaired memory/forgetfulness/impaired decision-making
- Crying spells for no apparent reason
- Thoughts of suicide or death
- Physical complaints with no known organic cause (Mayo Clinic, 2010)

Diagnostic Screening

Ruling out an organic cause for depression is essential but along with testing, standardized screening tools for depression are frequently used by the family physician and mental health specialist alike. While numerous screening tools exist, there are age-specific tools. Interview data with the patient (or where indicated, family) is a fundamental component of depression screening. It may be warranted to limit or expand individual testing based on specific clinical presentation. Among the more well-known screening tools are the Beck Depression Inventory (BDI), Cornell Scale for Depression in Dementia, Geriatric Depression Scale (GDS), Edinburgh Postnatal Depression Scale, Center for Epidemiological Studies Depression-Revised (CES-DR), (http://www.aafp.org/afp/2002/0915/p1001.pdf).

More information on depression screening guidelines/recommendations can be found by visiting: http://www.uspreventiveservicestaskforce.org/uspstf/uspsdepr.htm

Medications

Presented here is only a brief review of the classifications of the common anti-depressant medications and their mechanism of action. This list is not exhaustive. In reality, successful pharmacological treatment may require "augmentation therapy" of a combination of drugs but also carries the risk of drug-to-drug interaction. Antidepressants work to balance or normalize the brain's neurotransmitters (serotonin, norephinephrine, and dopamine). It is important to be aware of the wide range of side-effects and contraindications in the use of anti-depressants.

- Selective Serotonin Reuptake Inhibitors (SSRIs): Work to increase the levels of serotonin in the brain. *Examples:* fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), and escitalopram (Lexapro®)
- Serotonin and Norepinephrine Reuptake Inhibitors (SSNIs): Alter levels of several different neurochemicals in the brain, thought to be more successful in patients refractory to first-line anti-depressant medications.

Examples: venlafaxine (Effexor®) (may elevate blood pressure) and duloxetine (Cymbalta®)

- Tricyclic Antidepressants (TCAs): Alter levels of several different neurochemicals in the brain. (Screening for cardiac conditions by physician is essential due to risk of dysrhythmias and sudden death in high-risk populations). *Examples:* imipramine (Tofranil®), amitriptyline (Elavil®), desipramine (Norpramin®), nortriptyline (Pamelor®), and clomipramine (Anafranil®).
- Monoamine Oxidase Inhibitors (MAOIs): Work by blocking an enzyme that breaks down neurochemicals. (Avoid foods/drinks containing tyramine. Continual dietary consumption while on MAOIs may cause severe high blood pressure). *Examples:* tranylcypromine (Parnate®) and phenelzine (Nardil®)

Used in the treatment of depression but not part of the above classifications:

- Wellbutrin (bupropion): Similar action in altering neurochemicals in the brain (not serotonin) and a mild stimulant effect. (Avoid use in patients with eating disorder secondary to seizures).
- Remeron (mirtazapine): Alters neurochemicals in the brain, including serotonin (Katon & Ciechanowski, 2010).

Other Treatments for Depression

- Electroconvulsive Therapy (ECT): Invasive treatment which induces a seizure via electrical current to the brain. The exact mechanism by which this restores the brain chemical balance is not known.(http://www.mayoclinic.com/health/electroconvulsive-therapy/MY00129)
- Repetitive Transcranial Magnetic Stimulation (rTMS): Still under study, this technique uses magnetic fields to stimulate the brain. (http://www.webmd.com/depression/news/20100504/rtms-magnet-treatment-for-depression-works).
- Light Therapy: Patient's suffering from Seasonal Affective Disorder (SAD) are treated on a gradual schedule of increasing light therapy until therapeutic response is achieved. Response may be seen in a few days or take as long as 4-6 weeks. (http://www.columbia.edu/~mt12/blt.htm)
- Exercise: Research suggests that physical activity is effective in the treatment of the elderly depressed patient (Ströhle, 2008).
- St. John's Wort (Hypericum perforatum): Not approved by the FDA for the treatment of depression due to varying composition of the over-the-counter preparations. May be effective in mild depression as it is believed to alter several of the brain's neurochemicals. May reduce effectiveness of other medications if taken jointly (http://nccam.nih.gov/health/stjohnswort/).

Other Classifications of Conditions that Cause Depression and their DSM-IV code

- (http://psyweb.com/dsm_iv/jsp/dsmab.jsp)
- Adjustment Disorder with Depressed Mood (309)
- Bipolar Disorder II (296.89)
- Cyclothymia (301.13)
- Dysthymia (300.4)
- Depressive Episode not otherwise specified (NOS) 296 core code used with specific identifiers for disorders below:
  - Bipolar Disorder I
  - Postpartum Depression
  - Psychotic Depression
  - Seasonal Affective Disorder (SAD). Major depressive episodes that exhibit a specific seasonal pattern. Research has recorded two types: Fall-onset, the more common "winter depression" thought to be due to reduction in daylight, and summer-onset (may be related to temperature changes) (Wehr, Sack & Rosenthal, 1987).

Legal Considerations

- Clients may prolong treatment with a primary physician for symptoms of depression despite lack of improvement. Chronic depression may require the expertise of a specialist in mental health.
- Key to the defining diagnosis of the specific depression is the 3 digit diagnosis code, but there is further classification in the form of "specifiers" following the end of the 3 digit code. For example, Major Depressive Disorder is (296) followed by the fourth digit denoting occurrence (2 for single episode, 3 for recurrent) and the fifth digit denoting severity ranging from mild (0) to severe with psychotic features (4) to in partial remission (5) or in full remission (6) or unspecified (0). (DMS-IV, 1996). There are numerous classifications of depression in the DSM-IV.
- Lack of compliance with medical treatment for depression may be a manifestation of the disorder due to feelings of hopelessness or disinterest.
- Medications for the treatment of depression make take several weeks (2-6 weeks or longer) to reach therapeutic levels (Katon & Ciechanowski, 2010).
- Antidepressant side-effects may include insomnia, fatigue, gastrointestinal disturbance, sexual dysfunction, dry mouth, low mental alertness, or mental "fogginess." Certain anti-depressant medications will require frequent monitoring by the prescribing physician (see http://www.rxlist.com and search by medication name).
- Non-formulary use of antidepressants may confound the reimbursement process, for example, Wellbutrin in the use of smoking cessation.
- While prescribed for depression, some patients may experience a "rebound effect" which may potentiate the likelihood of increased suicidal thoughts. Adolescents are thought to be at higher risk for this phenomenon than the general population (American Psychiatric Association, 2010).

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) "depression," "psychiatric disorders," "mental disorders," "worker's compensation," "mitigation", "domestic law", "litigation," and "case law" in alternating string searches. A review of the information retrieved provided both formal and informal sources. Cases were found on a variety of specific law such as, cyber-bullying, criminal defense, divorce, child abuse. A sampling of the preliminary results via internet retrieval is provided here.

Andrew J. Lizotte v. Dacotah Bank et. al
Case law regarding disability under the American Disabilities Act and North Dakota Human Rights Act.
http://www.employeerightspost.com/uploads/file/Westlaw_Document_10_23_37Lizotte.pdf

Middleton v. Northwest Airlines and Kemper Insurance Company
Minnesota Supreme Court holding on worker's compensation appeal regarding compensability of death benefits secondary to mental injury.
http://www.lawlibrary.state.mn.us/archive/supct/9910/c6982418.htm

Sylvia I. Calero-Cerezo v. United States Department of Justice, et. al
http://www.lexisone.com/lx1/caselaw/freecaselaw?action=OCLGetCaseDetail&format=FULL&sourceID=gdif&searchTerm=eCGY.Tjja.aadi.YbiZ&searchFlag=y&l1loc=FCLOW
Addresses question of how far the Rehabilitation Act of 1973 ("Rehabilitation Act") requires an employer to go to accommodate an employee whose diagnosed major depression affects employee's ability to function in the workplace.

http://www.harpergrey.com/assets/attachments/50.pdf
Interesting article titled Depression and Disability: A Primer on Predisposition from the law firm of Harper Grey, LLP in British Columbia.

2008 Review of Case Law from the 21st Annual National Workshop for Lawyer Assistants Programs
(section on court's holdings on depression claims)
http://www.texasbar.com/Content/NavigationMenu/ForLawyers/TexasLawyersAssistanceProgram/SupportforLawFirmsLawyers/2008CaseLawReview.pdf

Depression Research Clinic from Stanford University.
http://psychiatry.stanford.edu/
ALLPsych Online
The Virtual Psychology Classroom
http://allpsych.com/disorders/dsm.html

National Institute of Mental Health
Government resource for mental disorders
http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#MajorDepressive

Study Finder at Vanderbilt Hospital in Nashville, Tennessee
Link to studies in depression research
http://kc.vanderbilt.edu/site/services/studyfinder/studyindex.aspx?id=13

Link to the PhysicianMedGuide for Childhood and Adolescent Depression from the American Psychiatric Association
http://www.psych.org/Share/Parents-Med-Guide/HTML-Physician-Depression.aspx

Potential Experts
- Psychiatrists
- Psychologists
- Primary Physicians/Internists
- Psychopharmacologists
- Pediatricians (based on age-related symptoms)
- Gerontologists (based on age-related symptoms)
- Licensed Therapists/Counselors
- Psychiatric/Mental Health Nurse Specialist

List of medical specialists at Massachusetts General Hospital by specific disorder
http://www.mgh.harvard.edu/search.aspx?st=0&q=Mood Disorders

Resource for locating psychiatrists specializing in child and adolescent psychiatry
http://www.aacap.org/cs/root/child_and_adolescent_psychiatrist_finder/child_and_adolescent_psychiatrist_finder.

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American Psychiatric Association (2010). PhysicianMedGuide for Depression (Children and Adolescents). Retrieved January 15, 2011 from *http://www.psych.org/Share/Parents-Med-Guide/HTML-Physician-Depression.aspx*

Cameron, O. G. (2008). The comorbidity of anxiety and depression. Retrieved January 16, 2011 from *http://www.uptodate.com/patients/content/topic.do?topicKey=~aWsFDHl64M/Nq&source=see_link*

Depression (2010) Mayo Clinic. Retrieved January 18, 2011 from *http://www.mayoclinic.com/health/depression/DS00175*

Katon, W. & Ciechanowski, P. (2010). Patient Treatment Options: Depression. Retrieved January 15, 2011 from *http://www.uptodate.com/patients/content/topic.do?topicKey=~JTAkFC48.6GfV&selectedTitle=1~150&source=search_result*

Sharp, L. K. & Lipsky, M. S. (2002). Screening for depression across the lifespan: A review of measures for use in primary care settings. Retrieved January 22, 2011 from *http://www.aafp.org/afp/2002/0915/p1001.html*

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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 is admonished to consult the services of a medical and/or legal professional, respectively. The reader is also reminded to critically analyze and evaluate the sources offered here and confirm their reliability independently.

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Depression

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This list is not exhaustive nor an endorsement of any commercial sites. As with any online resource, the reader must independently confirm its authority and credibility. Because of the diversity of law this disorder encompasses, as with all laws and regulations, the reader must verify the currency of the information as well as resolve any questions of a state's jurisdiction over the federal government's authority.

Resource for Suicide Prevention

http://www.metanoia.org/suicide/depressd.htm
http://www.metanoia.org/suicide/
Homepage of Metanoia (Greek for "change of mind") with resources for depression and suicide prevention. Homepage does not provide an "About Us" link and does advertise services for counseling; however, resources for suicide prevention link to hosting by PsychCentral (see below Portals for Depression Resources). The link for "Suicide, Read this First" is especially compassionate and compelling.

Glossary of Terms Common to Depression

http://depression.about.com/lr/depression_terms/280208/2/
Commercial site of About.com with a comprehensive list of commonly used concepts and terms related to depression.

http://depression.about.com/lr/dsm-iv_multi-axial_system/280208/1/74
http://depression.about.com/od/glossary/g/axial.htm
Commercial site of About.com with definition and links to understanding the DSM-IV (currently used) and the implications of the Multi-Axial System for diagnosis.

http://www.psyweb.com/DSM_IV/jsp/Axis_V.jsp
Commercial site of PSYweb.com. Excellent explanation of the Global Assessment Functioning (GAF) scale. Essential to understanding Axis V of the Multi-Axial System and reviewing admission/treatment/discharge criteria of the depressed patient.

Professional Associations

http://www.apna.org/
Homepage for the American Psychiatric Nurses Association (APNA). Excellent resources and exceptional link to Psych Nursing Specialty Areas and Topics, which include Emergency Nursing, Geropsych Nursing, Military and PTSD; Multiple Chronic Conditions; and Recovery to Practice Resources.

http://www.apa.org
Homepage of the American Psychological Association (APA). Clearly well-known for its publication format, this site also brings a wealth of information on education and diagnosis-based information.

http://www.psych.org/
Homepage of the American Psychiatric Association (also known as APA). Provides links to practice guidelines by disorder, found under "Psychiatry Practice" link in top toolbar. Excellent resource, very detailed information provided.

http://www.assn-ama.org
Homepage of the American Medical Association. Enter "depression" in the search box for a variety of pertinent resources and educational materials found at this link http://search0.ama-assn.org/search/search?database=public+amnews&query=depression

Governmental Resources

http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#MajorDepressive

http://www.ada.gov/
Homepage of the American with Disabilities Act.

http://www.dol.gov/compliance/laws/comp-fmla.htm
Webpage of the Department of Labor (DOL) explanation of the compliance parameters for the laws of Family Medical Leave Act. While still under construction and updating to reflect the FMLA Final Rule of 2009, comparisons available for State versus Federal laws at http://www.dol.gov/whd/state/fmla/index.htm.

http://www.eeoc.gov/policy/ada.html
Homepage of the U.S. Equal Employment Opportunity Commission (EEOC). Links to laws, regulations, and topic specific information for disabilities.

Advocacy/Support

http://www.bazelon.org/
Homepage for the site of Judge David L. Bazelon Mental Health Center. Site promotes on its webpage "The Bazelon Center for Mental Health Law is a nonprofit organization devoted to improving the lives of people with mental illnesses through changes in policy and law." Provides unique insight into the evolving laws and regulations affecting people with mental disorders.

http://www.ifred.org/about.html
Homepage for the International Foundation for Research and Education on Depression (iFred) that promotes as its primary purpose "Bring depression hope." Interesting backstory on the site's founder, Kathryn Goetzke, and her grassroots movement.

http://www.nami.org/
National Alliance on Mental Illness (NAMI). Established resource for those with mental disorders and educational resources for the public and professional alike. Fascinating link to "Grading the States" on their performance in categories of Health Promotion and Measurement; Financing & Core Treatment/Recovery Services; Consumer & Family Empowerment; and Community Integration and Social Inclusion. A fundamental resources for consumers of mental health services.

Standards/Guidelines/Defining Criterion

http://www.psych.org/mainmenu/psychiatricpractice/practiceguidelines_1.aspx
Practice guidelines of the American Psychiatric Association (see topic specific diagnosis)

http://www.socialsecurity.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm

http://www.socialsecurity.gov/disability/professionals/bluebook/112.00-MentalDisorders-Childhood.htm#112.04 Mood Disorders
Disability evaluation guidelines (listings) under the Social Security Administration (SSA). Link provided for both adult and childhood depression/mood disorders. Explore the SSA homepage for links to all qualifying criteria for Social Security Disability Income (SSDI) and/or Supplemental Security Income (SSI).

http://www.opm.gov/oca/leave/html/fmlafac2.asp
Government site of the U.S. Office of Personnel Management. Sample only of how the FMLA applies to Federal Employees.

Portals for Depression Resources/Links

http://www.webmd.com/depression/guide/depression-resources
Webpage of WedMD for depression guide. Information on diagnosis, treatment, testing options, resources, and more.

http://psychcentral.com/resources/Depression/
Promotes on its webpage: "Psych Central is the Internet's largest and oldest independent mental health and psychology network." "About Us" link at bottom of page. Webpage displays endorsements of New York Times columnist, Tara Parker-Pope; listed in 2008 as one of "The 50 Best Websites" in *Time Magazine* and displays the HONcode.

http://depression_resources.tripod.com/mentalillness/index.html
Good support information however, no obviously lead to originating source without joining forums for chat. "How to Get Involved" and "Links" worth viewing.

About Medications for Depression

http://www.rxlist.com
http://www.rxlist.com/depression/article.htm
Webpage of rxlist.com providing comprehensive information on depression and medications used to treat depression. You may also search by medication name. Additional searchable pages on age-specific depression, episodic depression, and seasonal depression.

http://www.medlineplus.gov
Homepage for medlineplus.gov, enter depression into the search box. This link http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=depression&x=9&y=18 provides numerous resources on depression, including specifics related to pharmacology and medication related treatment.

Suggested Reading

http://www.psychologytoday.com/blog/the-shrink-tank/201002/dsm-v-offers-new-criteria-personality-disorders
From Psychology Today.com blog article discussing the development of the DSM-V manual (and interim DSM5 website (see below) by Jared DeFife, Ph.D). Approaches article from an informative, tutorial perspective of the anticipated changes in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

http://www.dsm5.org/Pages/Default.aspx
Webpage of the American Psychiatric Association addressing the expected changes and controversial process of the projected May 2013 publication of the DSM-V.
Primer of Drug Action: A comprehensive guide to the actions, uses, and side effects of psychoactive drugs. Authors: Robert M. Julien, M.D., PhD.Clare D. Advokat, PhD. and Joseph Comaty, PhD. 12th Edition. Worth Publishers. ISBN-13: 978-1-429-23343-9. Excellent textbook resource for understanding the pharmacology of depression medication.
Up to date information available at http://www.aprimerofdrugaction.blogspot.com/

Subcontracting: Employer and Employee Perspectives

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

Subcontracting is an effective strategy for both the legal nurse consultant (LNC) employer and the employee. Subcontracting is the delegation or out-sourcing of tasks, services, or even entire cases to another individual or individuals. There are advantages for both the employing contractor and the subcontractor:

- Developing career skills for the novice LNC
- Utilizing experts in the respective clinical specialty
- Managing excess workload
- Sharpening mentoring skills

As with any new career, the first step is finding someone willing to hire the prospective employee. While the novice LNC may have considerable experience in health care, a beginning LNC may not be as well-versed in the legal aspects. Local chapter meetings or conferences are sources for netowrking and locating potential contractor LNCs. For a neophyte LNC, subcontracting is a valuable technique to start this new career while gaining experience under the guidance of the mentor employer.

The seasoned LNC may also consider subcontracting as a means to expand his or her business servioces beyond the LNC's own area of expertise. Subcontracting can also be valuable when the LNC needs additional expertise about a condition or situation. The LNC may suggest hiring a subcontractor to help in preparation of case that is highly complex and/or time consuming. Having a subcontractor may also be essential for a case that occurs in another state or jurisdiction. Utilizing clinical experts for cases in which the employer LNC is unfamiliar is cost-effective in time as well as financially.

An independent LNC with an established practice is well aware that workload can be variable. The LNC can hire subcontractors during busy periods to manage the excess cases simultaneously, rather than maintaining additional employees during periods when the workdload is minimal. Again, this can prove to be another cost savings advantage.

When the LNC is engaged with a subcontractor, this can be an opportunity to hone his or her mentoring and leadership skills while gaining additional colleagues. The LNC can provide guidance related to case management in utilizing and integrating information provided by the subcontractor. Consequently both the LNC and subcontractor benefit from the experience.

Although subcontracing can be advantageous for both parties, there are also certain considerations for either role. Perhaps the most crucial element for the business owner is to assess the subcontractor's writing sample. While this may seem redundant, writing styles can vary drastically. Iyer (2010) noted that increased use of electronic communication has contributed to less formal writing. Nurses are accustomed to charting in incomplete sentences, and using abbreviations and medical terminology which may not be understood by the attorney client (Iyer). A flawless written work product should be the hallmark of a flourishing LNC business. Initially, the employer LNC should request a writing sample from the subcontractor, paying special attention to spelling, grammar, and punctuation, as well as the overall flow, accuracy, and style. If the subcontractor does not have a sample work product, then the employing LNC should provide a simulated case for the subcontractor to develop in order to evaluate the writing style and quality of the work product. Once the employer is confident that the subcontractor can produce quality work, the LNC can guide the subcontractor with the format and any specific requirements for the attorney client. However, the employing LNC must always assume the responsibility of reviewing the subcontractor's work before submitting it to the client.

Communication is essential between the mentoring LNC and the subcontractor. Expectations should be clearly delineated, preferably via a written contract, at the beginning of the relationship. All telephone numbers, including home phone, cell phone, and fax numbers, should be provided by both parties with the stipulation of availability, especially in the evening and weekends in the event of an emergency. The employer LNC must verify the word processing program that the subcontractor will use, as well as the subcontractor's ability to attach and download documents sent by email. It is very frustrating and time consuming when an attached file cannot be opened. The employer LNC must also inform the subcontractor about the number of hours of preparation and the length of a written report, the deadline for completion, and the consequences or renegotiation if the subcontractor is not able to meet these requirements.

A sensitive issue in this employer/employee relationship is finances. As part of the contract, the amount of wages must be stipulated. The employer should determine what percentage of the normal rate charged to the attorney client will be allocated for the subcontractor. Reciprocally, the subcontractor must understand that it is not feasible to receive the same hourly rate as would be charged if working independently. The subcontractor must keep track of the

Continued on page 28

Reconstruction and Resurrection: A Tale of Triumph

Burned: A Memoir — By Louise Nayer

Reviewed by Kathleen C. Ashton, PhD APRN BC

It is rare that one is given so close an encounter with life after a tragedy but Louise Nayer has invited us to come near and try to understand with her the emotions and struggles that shaped her life. When she was but four years old her parents were horribly burned while the family was vacationing in New England. The event became pivotal in not only changing life as she knew it, but in shaping whom she would become.

Born into a life of privilege as the second of two daughters, her physician father and nurse mother doted on their children and provided for their development and education. It was a long-anticipated time away from their professional responsibilities when their father was able to take the family and their nanny to a quaint cottage by the sea on Cape Cod. Here they frolicked in the water and basked in the full attention of their parents. Always strong-willed and spirited, their mother insisted on descending into the basement of the rented cottage late one evening to check on a problem with the gas. With her husband just a step or two behind her, she lit a match and a faulty gas gauge led to a sudden explosion and a massive inferno. Louise's mother was burned beyond recognition and although her father's disfigurement was less severe, his spirit was irreparably destroyed. While the children slept, their parents were taken from them to endure what became months of treatment and procedures to stabilize and restore their lives. With her life hanging in the balance, Louise's mother struggled with her new appearance and the overwhelming despair and guilt of her husband. The girls were sent to live with a kindly aunt and uncle and assimilated into this family as the only contact with their parents for that interminable time was by phone.

Louise recounts the doubts and fears she experienced as her parents' slow and excruciatingly painful recovery forced the almost yearlong separation of this young family. Being given the child's perspective and understanding, the reader is taken on a pathway to a deeper appreciation for the way this horrific event colored every aspect of the girls' development. It is no wonder that Louise chose the path of a writer and poet to express all that she experienced and perhaps had no words to describe until adulthood.

As a physician accustomed to the role of decision-maker and possessing the necessary knowledge to give explanations, Louise's father remained burdened by guilt and unanswerable questions until his death well into his nineties. Only because of his wife's indomitable spirit was he able to regain some of what he lost and become functional once again. Throughout the book the author gives glimpses into his family and other relationships that shaped who he was and how he responded to the catastrophe.

Expressing her own pain and confusion leads to much understanding for Louise, but the really fascinating part of the book is the role of nursing and the fact that her mother was a highly educated and accomplished nurse. Dorothy Nayer was a graduate of Teacher's College, Columbia University and had taught at the University of Michigan before her daughters were born. It was nursing that pulled her back into the world and it was her amazing courage coupled with sheer determination that enabled her to resume a professional life once again. Louise describes the scene as her mother reenters the profession and endures the stares and questions of those she meets. Dorothy Nayer had worked with Shirley Fondiller at the American Journal of Nursing Company and had many connections with the American Nurses Association. She was able to parlay these professional affiliations into roles as an author, serving as editor of the American Journal of Nursing, and mentoring numerous nursing students in her later years. Her contributions to the profession are clearly evident.

The triumph of nursing comes through as an underlying theme of the book, not only as a means of reentry into the world, but also as displayed in the caring nurses who tenderly and skillfully render care. There is Margaret, her mother's favorite nurse, who comes in on her day off to tend her patient, and other nurses giving comfort and support throughout the years of surgeries and recovery. As a nurse, it is very satisfying to see the role nursing played in the lives of Louise and her family.

Continued on page 28

Discovery of Sentinel Events and Root Cause Analysis Documents

By Judith M. Bulau, MSN RN

Q: Are sentinel event (SE) and root cause analysis (RCA) documents discoverable in medical malpractice litigation?

A: Yes. Usually when documents are shared with third parties courts consider it to be a waiver of any privilege they may have had, and challenges to the confidentiality of SE and RCA documents may be successful if there is no protection under federal or state law.

Integrating patient safety principles in the delivery of healthcare helps prevent patient harm. The ability of healthcare organizations to improve their patient care delivery systems ensure safe patient care. To help achieve this, The Joint Commission (TJC), an accrediting agency for healthcare organizations, published its SE policy in 1998 "…to improve patient care through gaining and sharing knowledge about sentinel events and their prevention." TJC policy required its accredited organizations to investigate all unexpected patient injuries and deaths they defined as, "A sentinel event is any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The policy provided guidelines for internal SE investigations that must be done for every event with a focus on conducting an RCA of systems rather than individuals. The RCA required identification of root and contributing causes of the SE, implementation of an appropriate action plan that would improve systems and/or minimize the risk of similar SEs, and evaluation of the plan's effectiveness. TJC's policy encouraged its accredited organizations to voluntarily report SEs to TJC. However, it also had a provision that if TJC learned that an accredited organization did not report a SE it would be required to physically deliver the RCA documentation to TJC. Failure to do so could jeopardize the organization's accreditation status.

Healthcare organizations protested this provision because of fear that sharing privileged information with TJC would make investigations discoverable in legal proceedings. TJC responded by convening a task force to address this potential liability. After receiving the task force's report, TJC promised to minimize the risk of discoverability of information related to SEs by:

- Providing a more detailed definition of SE occurrences reportable to TJC on a voluntary basis
- Making procedural revisions to assist organizations in complying with the SE policy
- Continuing to explore mechanisms to close identified gaps in confidentiality protections
- Providing another option in which TJC can perform an onsite assessment of the RCA documentation at the organization's request and expense
- Granting a 30-day period to submit RCAs for organizations who do not voluntarily report
- Returning all SE documents to organizations after completing their analysis
- Pursuing federal and model state legislation ensuring confidentiality

In spite of these efforts to protect privileged SE and RCA documents, it is not enough legal protection in medical malpractice litigation. There are no federal laws that offer such protection and state laws that do exist do not sufficiently protect these documents from discovery.

For example, in Reyes v. Meadowlands Hospital Medical Center, 355 N.J. Super.226, 809 A.2d 875 (2001), a cause of action involving a claim of medical malpractice and wrongful death, the plaintiff brought a motion for a protective order. The motion was filed because the plaintiff was seeking to shield from discovery its SE and RCA documents gathered through a process it called "self-critical analysis."

Continued on page 29

Subcontracting: Employer and Employee Perspectives

Continued from page 25

number of hours spent on the case in order to submit an invoice and notify the employer LNC near the end of the allotted time if additional hours are needed.

Finally, ethical considerations must be explored. Needless to say, the subcontractor must agree to patient confidentiality. But more importantly, the subcontractor must respect the employer LNC and the attorney client relationship. A new LNC, eager to gain a client data base, may innocently solicit subsequent future cases from that attorney. The employer LNC needs to make it absolutely clear from the beginning, preferably with a non-compete written contract, that any other work-related contact with that attorney or firm is prohibited for a specified period of time, usually for one to two years. Abiding by these regulations should prove to be a mutually agreeable arrangement for both LNCs.

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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**.

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Reconstruction and Resurrection: A Tale of Triumph

Continued from page 26

Subtly woven throughout the story is the mention of litigation regarding the faulty gas valve and the way the associated delays and setbacks affected her father's fragile psyche. There are letters from the attorney and reactions by her father. This issue is never brought to conclusion, but its role in the recovery and restoration of the family is certainly an issue, nonetheless.

Louise Nayer has written a moving memoir that gives the reader an exceptional view of loss and reconstruction around what remains. She is meticulous and honest in her efforts and the result is a very readable and admirable visit with a remarkable family.

The practice of legal nurse consulting affords us the opportunity to impact nursing care on a broad scale. In reading stories such as this, we are reminded of the impact of negligence and other instances of shirked responsibility on individuals and families. The role nursing plays in all of this is truly inspiring.

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

Discovery of Sentinal Events and Root Cause Analysis Documents

Continued from page 27

The court denied the motion holding that the SE policy invoked by the defendant did not "create a self-critical analysis privilege, insulating any and all discussions and statements made and conclusions reached by the participants therein and actions taken by the Hospital pursuant thereto not subject to the Civil Rules of Discovery."

This ruling demonstrates that usually when documents are shared with third parties courts consider it to be a waiver of any privilege they may have had, and challenges to the confidentiality of these documents may be successful if there is no protection under federal or state law.

Judith M. Bulau, MSN RN is a Risk Manager and Patient Safety Specialist at Barnes- Jewish Hospital in St. Louis, Missouri, and a Legal Nurse Consultant. She belongs to Sigma Theta Tau, the National Honor Society of Nursing. She is a member of the editorial board for the Journal of Legal Nurse Consulting. She has written five health care books, contributed several chapters to other publications, and written numerous articles published in healthcare journals. She holds degrees from the University of Minnesota (MSN, BS) and the Arthur B. Ancker Memorial School of Nursing (RN) and is certified in public health nursing (PHN) by the Minnesota Department of Health.

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