

The Journal of
**Legal Nurse
Consulting**

Volume 15 ▲ Number 4 ▲ Fall 2004

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The Journal of Legal Nurse Consulting

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Change in the Wind

It is appropriate that, as I write the last column for my term as JLNC Editor, I am sitting on a friend's porch contemplating the end of summer. Part of me is sad to see the summer and my editorship completed, but part of me looks forward to a fresh start with a new Editor and the renewal of all things that the fall season brings.

In my tenure with the JLNC, first as an Editorial Board member and most recently as Editor, I experienced great challenges and great opportunities. As an Editorial Board member, I honed the skills associated with reviewing and editing manuscripts for the JLNC. I had the privilege to meet some wonderful authors who unselfishly shared their expertise and experiences with fellow LNCs. I was enriched by the topical content of the articles that I reviewed and cheered when the author was placed into print. It was particularly enriching to see first-time authors published. I remembered my delight at seeing my work in print for the first time, and I enthusiastically celebrated each new author's achievements and contributions to the profession.

As the Editor of the JLNC, I developed the skills needed to handle multi-tasking at its best (and sometimes worst). Juggling production schedules with author re-writes taught me the value of patience and the need for professional support for our authors. The Editorial Board's suggestion to implement a mentoring program for first-time authors has expanded the role of each Editorial Board member and increased the need for additional staff resources. At the same time, this initiative has created new opportunities for individuals who want to share their expertise but need assistance along the path of publishing. The strong support of the Editorial Board has enhanced the experiences of new authors and continued to help develop professional topics that mirror the variety of practice settings in which LNC's deliver services.

As I finish this editorial journey, I recognize there are many challenges left behind for the new editor to face. Developing a backlog of accepted manuscripts to reduce the stress of publication deadlines is in its infancy stages. This will continue to develop thanks to the generous contribution of LNCs who take the lead in highlighting this specialty practice. Expanding the mentoring program to meet the needs of more potential authors is a goal that will reap rich rewards for the future. Recruiting additional Editorial Board members to carry the strategic plan forward remains a high priority as well.

As I indicated at the start of this column, I anticipate many new beginnings with the start of the crisp air of fall. The new Editor will help shape new directions and plans for the JLNC. New opportunities will arise to meet the challenge of publishing a journal that fulfills the needs of our members and sets the tone for the profession of legal nurse consulting. I am proud to have participated in the growth of the JLNC and will continue to celebrate the accomplishments of authors, the Editorial Board, and the new Editor.

In closing, I want to thank the Editorial Board for your commitment to the JLNC and for the support I received from each of you as Editor. I also want to thank you for the contribution you make to grow the field of legal nurse consulting. It was a pleasure to serve with you, and I know that each of you will help to make the transition an easy one for the new Editor.

Respectfully signing off,

Attention Interested Reviewers!

Are you looking to get involved with *The Journal of Legal Nurse Consulting*? The Editorial Board is seeking readers interested in acting as content reviewers for specialized topics within the legal nurse consulting field. For more details and responsibilities, contact Journal Management at JLNC@aalnc.org or 877/402-2562.

Sciatic Nerve Damage from Intramuscular Injections: The Preventable Injury

Jayne K. McGrath, MS RN CCRN

KEY WORDS

Intramuscular Injections, Malpractice, Preventable Injury, Sciatic Nerve Damage

Sciatic nerve damage is one potential consequence of poor technique in medication administration from an intramuscular (IM) injection. A significant body of literature supports a safer technique of administration for an IM injection. Despite this growing body of research that supports a safer technique, legal complaints are commonly seen from sciatic nerve damage or other injuries.

Medication errors are second among most prevalent incidents and the second most expensive procedure involving malpractice claims, reported Harney (1998), from information compiled by the Physician Insurers Association of America. Approximately 150 deaths occur each day and 1.3 million injuries each year from medication errors (Phillips, Pierce, and Cohen, 2000). These errors can occur anytime during the process of medication administration. This process begins the moment a medication is prescribed and continues through packaging, administering, and monitoring for short- and long-term side effects. Phillips, Pierce, and Cohen (2000) cite the following frequent causes of errors:

- Poor communication;
- Ambiguities in product names;
- Direction for use;
- Poor technique; and
- Knowledge deficit.

Historical Background

During the late 1960s, nurses became predominately responsible for administering IM injections rather than physicians (Beyea and Nicoll, 1995). Even before this, legal complaints surfaced against hospitals and nurses alleging injury caused by IM injections. In *Graham v. St. Luke's et al.* (1964), the plaintiff recovering from a hysterectomy alleged that she received her injury ten days post-operatively. In describing the incident, which occurred in 1952, the plaintiff alleged that the nurse administering an injection "...lifted her pajama top and hurriedly injected a hypodermic needle in her back" (*Graham v. St. Luke's et al.*, 1964, *2). The patient screamed and experienced severe pain. Treatment measures included many physician visits in the U.S. and Canada, surgeries, and a nerve block for "...severe pain and physical deformity" (*Graham v. St. Luke's et al.*, 1964, *2). This case returned a verdict for the defendants and was upheld at the Appellate Court of Illinois, which cited that lacking expert testimony did not describe a breach in the standard of care.

Separate cases where liability was established and outcomes include verdicts for the plaintiff are cited. The plaintiff in *Wilmington General Hospital v. Nichols* (1965),

recovering from stomach surgery, was receiving injections in the buttocks. He testified that, shortly after an injection, he felt "...pain down the back of his buttock, down his left leg on the outside, and across the top of his right foot, with a tingling sensation running from his knee down to the end of his toes" (p. 759). He also developed foot drop. Court evidence and testimony demonstrated that the injections' incorrect locations "...were the proximate cause of the plaintiff's injuries" (p. 759).

In a different incident, *Honeywell v. Rogers* (1966), an 11-year-old girl sustained paralysis after receiving an IM "...injection into the area of the sciatic nerve administered by a nurse" (p. 759). The hospital was deemed liable for the injection given in the area of the sciatic nerve.

Both the legal and medical literature are replete with complaints and complications from IM injections. Greenblatt and Allen (1978) studied a number of patients receiving IM injections. Their findings indicate that, although a small percentage, some patients experienced local complications from their IM injections. More recently, in *Lovett v. Lorain Community Hospital et al.* (2004), a patient suffered a sciatic nerve injury from an IM injection administered by a student nurse while the nursing instructor was present.

Supporting Evidence-Based Nursing Practice

Many complications and injuries have been reported with IM injections such as abscesses, skin slough, necrosis (Beyea and Nicoll, 1996; Taylor, Lillis, and LeMone, 2001), muscle contraction, and gangrene (Beyea and Nicoll, 1996). Characteristics of IM injection sites are described in Table I.

Despite a long history of patient injuries, particularly sciatic nerve damage, there is strong evidence that supports a safer technique for administering IM injections. The ventrogluteal site has been the only IM site without complications of nerve damage (Beyea and Nicoll, 1995; Beyea and Nicoll, 1996). Only one incident has been reported of a local reaction at the ventrogluteal site. This was believed to be a reaction to a mixture of medications including phenylbutazone and not caused from improper administration technique (Nicoll and Hesby, 2002).

The ventrogluteal is the safest site for IM injections for adults and pediatric patients older than seven months (Beyea and Nicoll, 1995; Hall, 2004), and has been recommended by numerous authors and researchers (Craven and Hirnle, 2003; Beyea and Nicoll, 1995; Beyea and Nicoll, 1996; Hall, 2004; Keen, 1983; Nicoll and Hesby, 2002; Taylor, Lillis, and LeMone, 2001). This site is known to be free from major nerves, specifically the sciatic nerve, as well as major blood vessels (Beyea and Nicoll, 1996). Potential contraindications to using the ventrogluteal site are obvious deformities and apparent scarring.

For the correct technique on palpating and locating the ventrogluteal site, the reader is encouraged to consult a nursing skills text such as Perry & Potter (2004).

Ventrogluteal vs. Dorsogluteal: Dissecting a Name

To clarify the nomenclature of the IM sites in the buttocks, an understanding of the origin of the name helps to illustrate the location of the muscles. The gluteus is any of the three muscles—gluteus maximus, gluteus medius, and gluteus minimus—that form the buttocks. Ventral is

defined as “pertaining to a position toward the anterior surface of the body; frontward” (Mosby, 2002, p. 1802). The ventrogluteal site involves the gluteus medius and gluteus minimus, both in the more anterior part of the buttocks. The dorsogluteal injection site targets the gluteus maximus muscle. Dorsal describes the posterior area or back of something (Mosby, 2002). The sciatic nerve, a long nerve in the body that extends through the leg and foot, is located in the posterior area of the buttocks. Thus, the dorsogluteal site is in close proximity to the sciatic nerve. The superior gluteal artery is also located near this site (Craven and Hirnle, 2002).

Confusion continues to exist over identifying and naming correct IM sites. For example, if the nurse charts “left hip” as the site, the location is not specified. This would be analogous to naming an entire state when one is attempting to locate a specific town within that state. When “left ventrogluteal” is used as the site and documented, the charted site clearly identifies the precise location. Adding to this confusion, nursing documentation records still refer to IM sites as “the hip, the upper outer aspect, the thigh, the buttock, the gluteal muscle, the gluteus,” etc. Some hospital records have

Table 1: Characteristics of Selected Sites

Selected Site	Advantages	Disadvantages
VENTROGLUTEAL	Large research base supporting this site as the safest site for adults and children older than 7 months for most IM injections (Beyea & Nicoll, 1995; Hall, 2004).	Contraindicated for administration of hepatitis-B vaccine (Beyea & Nicoll, 1995).
	Free of surrounding nerves and blood vessels (Beyea & Nicoll, 1996).	Confusion exists with correctly naming and documenting the site.
	Most consistent uniform depth of adipose tissue in majority of adults. Thus, most injections will reach the intended muscle (Beyea & Nicoll, 1995; Keen, 1983).	
	Can be visualized and accessed with patient lying in supine or lateral position (Nicoll & Hesby, 2002).	
	Large and well developed muscle (Nicoll & Hesby, 2002).	
DORSALGLUTEAL		Close proximity to the sciatic nerve and the superior gluteal artery (Craven & Hirnle, 2003).
		A risk of striking the sciatic nerve exists which can cause an injury (Taylor, Lillis, & LeMone, 2001).
		Large variability of adipose tissue among general population. Therefore, the injection may be given subcutaneously rather than the intended muscle (Beyea & Nicoll, 1995; Keen, 1983).
		Numerous reported injuries of nerve damage, gangrene, contractures, abscesses, and other complications have occurred from using this site (Beyea & Nicoll, 1996).
		Not used in children younger than 3, since this muscle (gluteus maximus) develops from walking (Taylor, Lillis, & LeMone, 2001).
		If precise location is not used, injury to surrounding nerve and/or muscle may occur (Beyea & Nicoll, 1995).
VASTUS LATERALIS	Recommended for infants less than 12 months of age (Nicoll & Hesby, 2002).	Injuries such as femoral nerve and femoral artery damage have been reported with use of this site (Nicoll & Hesby, 2002).
		An increased pain is often reported from using this site.
DELTOID	Site indicated for administration of hepatitis-B and rabies vaccine in adults (Nicoll & Hesby, 2002).	Close proximity to the radial nerve and brachial artery (Craven & Hirnle, 2003).
		A small muscle that limits the administered volume to 1 ml (Taylor, Lillis, & LeMone, 2001).
		Entire upper arm needs to be exposed for correctly locating and palpating the landmarks.

these areas listed on their medication administration records as sites for IM injections. Not only are these labeled sites inaccurate, but they can also lead to a plethora of confusion for the nurses that are administering the injections.

Size Matters

Another advantage that the ventrogluteal site has over other IM injection sites is that it is a consistently well developed muscle in adults and children. Beyea and Nicoll (1995) and Keen (1983) agree that the ventrogluteal area has the most consistent depth of subcutaneous fat compared to the dorsogluteal area. When a large variation of subcutaneous tissue exists, as in the dorsogluteal site, there is more potential for the needle to never reach the muscle. A large and well developed muscle, the ventrogluteal site offers many vantage points superior to the dorsogluteal. Additionally, the deltoid (upper arm) and vastus lateralis (thigh) injection sites have been associated with reported injuries to nerves and/or muscles (Beyea and Nicoll, 1996).

Implications for Legal Nurse Consulting

Other factors that influence safe administration of an IM injection also need to be considered. The nurse must take the required time to visualize and palpate the pertinent bony landmarks when locating the ventrogluteal site. The area needs to be clearly visible to allow the nurse to correctly identify the site. Walters (1992) cites perceived causes of medication errors are busyness and frequent interruptions. The legal nurse consultant (LNC) can ascertain pertinent information through record review, recorded testimony, and interviewing witnesses to determine if correct procedures were followed.

Despite a growing body of research opposing the dorsogluteal site for IM injections, it continues to appear in current nursing textbooks and curricula. The greatest hazard of the dorsogluteal site is the close proximity to the sciatic nerve. Why choose to give an IM injection in this inferior site knowing the sciatic nerve could be injured? Potter and Perry (2004) have discontinued illustrating the dorsogluteal site and instructions on locating this site in their nursing skills text. The clinical faculty at the University of Wisconsin—Madison School of Nursing no longer teach the dorsogluteal site for IM injections as an acceptable site.

LNCs are continually asked to define and explain the standard of care in nursing practice. Galante (2000) advocates the inclusion and building of research in legal nurse consulting. As nursing practice shifts toward evidence-based practice, additional emphasis is placed on improving quality and patient outcomes. The evidence weighs heavily for a safe and acceptable way for administering an IM injection into the ventrogluteal site. The contrary is also true: there is much evidence that using the dorsogluteal site, a site that has been taught for many decades, is not at all safe and poses a great risk for injury. With the evidence supporting this, the LNC can apply this research to his or her work in defining and articulating the standard of care.

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Nursing: Qualifications for Testifying on Standard of Care

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KEY WORDS

Medical Malpractice, Nursing, Standard of Care, Testifying

Who is qualified to testify as to the standard of care of a nurse? In a medical malpractice action against a nurse, must the standard of nursing care be established by expert testimony from a nurse? In at least one state, the answer is yes. It is clear that nursing is a unique, identifiable, and autonomous profession with the right, duty, responsibility, and expertise to determine the scope and nature of nursing practice including the standard of care for nurses. It is time to clarify the law and to accord to the profession of nursing the recognition, autonomy, and respect given to every other health care profession in the United States.

On November 1, 1997, Patient B. was admitted to Edward Hospital with a urinary tract infection. Mr. B. had multiple comorbidities, including a history of two previous CVAs. He was 74 years old. On the hospital's fall risk assessment, he was found to be at an increased risk of falls. On the night of November 2, Nurse Carrie went to Mr. B.'s bed and found him trying to climb over the side rails, all of which were raised. Mr. B. seemed oriented, and Nurse Carrie instructed him to stay in bed.

After Mr. B.'s second attempt to climb out of bed, the nurse became concerned and called the attending physician, who ordered Ativan. Although Nurse Carrie asked for an order to restrain the patient, no such order was received. The Ativan was administered, and the patient fell asleep. He was checked every 30 minutes and seemed to be resting quietly. At 12:05, the patient was checked and appeared undisturbed. Approximately 5 minutes later, a loud noise was heard, and Mr. B. was found on the floor with a head injury.

The plaintiff sued both the attending physician and the hospital. The nurse was not named individually. The complaint alleged that the hospital, through Nurse Carrie, was negligent in failing to monitor, medicate, or restrain the patient.

At trial, the plaintiff presented evidence from a physician who offered opinion testimony as to the standards of care for nurses and his opinion as to how Nurse Carrie deviated from these standards. The expert opined that the nurse should have followed the chain of command when the attending physician failed to order restraints. He also testified that the nurse was negligent in failing to provide sitters or to move the patient closer to the nurse's station. The expert noted that the nurse "missed the diagnosis of delirium completely."

Discussion of Case Law before Sullivan

Negligence is the failure to use reasonable care. Malpractice is negligence by a professional. Where the alleged negligent act calls for the exercise of expert medical judgment, the action is one for medical malpractice. A medical

malpractice action is not limited to claims against physicians but includes actions against other health care professionals including nurses. The requisite elements of proof in a medical malpractice case are: (1) a deviation or departure from accepted practice; and (2) evidence that such departure was a proximate cause of plaintiff's alleged injury. Ordinarily, expert medical opinion evidence is necessary to establish the applicable standard of care and a departure there from. The expert witness in a medical malpractice action must possess the requisite skill, training, knowledge, and experience to insure that the opinion rendered is reliable.

It would seem self-evident that the only expert qualified to render expert opinion evidence against a health care professional is a member of the same profession. For example, it is well established that only a physician is qualified to render testimony as to the standard of care for a physician. Similarly, when it comes to other professions, only a member of the same profession is qualified to testify as to the standard of care. For example, only a podiatrist is competent to testify as to the standard of care for a podiatrist (*Botelho v. Bycura*, 320 S.E.2d 59 [S.C. Ct. App. 1984] *Darby v. Cohen*, 101 Misc. 2d 516, 421 N.Y.S.2d 337 [N.Y. Sup. Ct. Queens County 1979]; *Dolan v. Galluzzo*, 396 N.E.2d 13; *Craig v. Borcicky*, 557 So. 2d 1253 [Ala.] 1990). There have been similar decisions relative to physical therapists, chiropractors, and audiologists (*Kirker v. Nicolla*, 256 A.D.2d 865[1998]; *Toormina v. Goodman*, 63 A.D.2d 1018, 406 N.Y.S.2d 350 [N.Y. App. Div. 1978]; *Sheppard v. Firth*, 334 P.2d 190 [Or. 1959]; *Morgan v. Hill*, 663 S.W.2d 232 [Ky. Ct. App. 1984]).

Despite the foregoing, expert testimony by a physician has historically been routinely admitted into evidence for the purpose of establishing the nursing standard of care. In *McMillon v. Durant* (439 S.E.2d 829 (S.C. 1993)), a neurosurgeon was allowed to testify as to standard of care of a pediatric nurse caring for a child with an ear infection and pre-existing shunt. Similarly, in Texas, a physician testified as to standard of care for ICU nurse in positioning a patient in a recliner (*St. Elizabeth Hosp. v. Graham*, 883 S.W.2d

433 [Tex. App. 1994]). In Illinois, two obstetricians were permitted to testify that an RN should be able to diagnose a pending breech delivery and notify the doctor in a timely manner (*Alvis v. Henderson Obstetrics*, 592 N.E.2d 678 [Ill. App. Ct. 1992]). In *Paris v. Kreitz* (331 S.E.2d 234, 245 [N.C. Ct. App. 1985]), the court held that “physicians are clearly acceptable experts with regard to nurses.”

Incredibly, there are similar decisions in multiple jurisdictions across the United States. *Haney v. Alexander*, 323 S.E.2d 430 (N.C. Ct. App. 1984) allowed a cardiologist and an internist to testify as to the standard of care for a nurse in a case where it was alleged that, when a nurse called the decedent’s treating physician twice, she failed to convey the patient’s vital signs. *Crook v. Funk*, 447 S.E.2d 60 (Ga. Ct. App. 1994) held that a physician is competent to testify as to standard of care for nurses because both are members of the medical profession. *Howard v. City of Columbus*, 466 S.E.2d 51 (Ga. Ct. App. 1995) held that a physician is competent to testify as to the standard of care for an LPN. *Wingo v. Rockford Memorial Hosp.*, 686 N.E.2d 722 (Ill. App. Ct. 1997) allowed a physician to testify as to the standard of care for nurses in reporting changes in a patient’s condition to the physician. *Goff v. Doctors General Hosp.*, 333 P.2d 29, 33 (Ca. Ct. App. 1958) held a physician competent to testify as to the standard of care for an obstetrical nurse where the patient was bleeding excessively, the nurse had called the physician three times, the physician had reassured the nurse the bleeding was normal, and the nurse waited another 1 hour and 45 minutes before calling the physician a fourth time. *King v. State*, 728 So. 2d 1027 (La. Ct. App. 1999); *Fleming v. Prince George’s County*, 358 A.2d 892 (Md. 1976) allowed a physician to testify that a nurse should have been more “forceful” in conveying their concerns regarding the patient.

In some cases, the physician was allowed to testify with almost no other foundation other than the fact he is a physician. For example, the court in *Thomas v. Corso v. Miller* (288 A.2d 379 [Md. 1972]) held that a physician was “obviously” competent to testify as to the standard of care for nurses. In 1997, an Illinois appellate court noted that “from [their] review of out-of-state authority, [they] are unaware of any state that has ever found it reversible error for a physician to testify as to the applicable nursing standard of care” (*Wingo v. Rockford Memorial Hospital*, 686 N.E.2d 722 Ill. App. Ct. 1997).

Some authors have questioned the practice of routinely allowing a physician expert to testify as to nursing malpractice. *Armstrong* (1987), noting how “surprising” this practice is, writes: “[t]he status of nursing has changed, however, and not only do physicians no longer have the special knowledge required to testify in all cases of nursing malpractice, but their use as experts may create problems that could be avoided by using nurses as experts in most nursing malpractice cases. The inquiry should focus on whether the physician does indeed know the customary practice of nurses

regarding the procedure in question. Courts should not assume knowledge because nursing and medicine are two distinct disciplines, albeit with some overlapping functions.”

The Sullivan Case

The Sullivan case presented the Illinois Supreme Court with the opportunity for an in-depth look at this issue and to clarify exactly what expert is competent to offer opinion evidence as to the nursing standard of care. In addition to the briefs submitted by all sides, both The American Association of Nurse Attorneys (TAANA) and the Illinois Trial Lawyers Association submitted amicus curiae briefs. The Trial Lawyers supported the position of the plaintiff, while TAANA submitted its brief supporting the defendant hospital. In February 2004, the Supreme Court of Illinois held that plaintiff’s expert, a physician board certified in internal medicine, was not competent to testify as to the standard of care of a nurse.

Citing the Amicus Brief submitted by TAANA, the court noted: “[...] [as] TAANA persuasively reasons: ‘A physician, who is not a nurse, is no more qualified to offer expert, opinion testimony as to the standard of care for nurses than a nurse would be to offer an opinion as to the physician standard of care. *** Certainly, nurses are not permitted to offer expert testimony against a physician based on their observations of physicians or their familiarity with the procedures involved. An operating room nurse, who stands shoulder to shoulder with surgeons every day, would not be permitted to testify as to the standard of care of a surgeon. An endoscopy nurse would not be permitted to testify as to the standard of care of a gastroenterologist performing a Colonoscopy. A labor and delivery nurse would not be permitted to offer expert, opinion testimony as to the standard of care for an obstetrician or even a midwife. Nor would a nurse be permitted to testify that, in her experience, when she calls a physician, he/she usually responds in a certain manner. Such testimony would be, essentially, expert testimony as to the standard of medical care.’”

The court went on to note: “Scholars share this reasoning: ‘Physicians often have no first-hand knowledge of nursing practice except for observations made in patient care settings. The physician rarely, if ever, teaches in a nursing program nor is a physician responsible for content in nursing texts. In many situations, a physician would not be familiar with the standard of care or with nursing policies and procedures which govern the standard of care. Therefore, a physician’s opinions would not be admissible in jurisdictions which hold the expert must be familiar with the standard of care in order to testify as an expert. An example of a common situation which gives rise to allegations of nursing negligence occurs when a nurse fails to follow the institutional ‘chain of command’ in reporting a patient condition to a physician who subsequently refuses to attend to the patient condition. It is unlikely that a physician would be familiar with the policy and procedure involved in handling such a

situation. It is as illogical for physicians to testify on nursing standard of care as it would be for nurses to testify about medical malpractice” (quoting Beyer & Popp, 1990, p. 365).

This scholarly insight has spread to litigators: “Testimony from a physician about the standard of care may be subject to objection because the physician is not a nurse and does not have direct knowledge of nursing standards of care. A physician’s statement that he or she often observes nurses and therefore knows what they do may be inadequate” (quoting Sweeney, 1991, 36). Beyond scholars and litigators, courts have begun to accept this reasoning. In some jurisdictions, “the physician is no longer permitted to testify about the nursing standard of care since the physician is not a nurse and does not possess direct knowledge of nursing standards” (quoting Cavico, 1995, p. 578).

According to one scholar, “These cases represent a growing recognition on the part of courts that nursing, as a profession, has moved beyond its former dependence on the physician, and into a realm where it must and can legally account for its own professional practices. In doing so, the experts who provide the testimony, and the literature from which their opinions are derived, come from the nursing profession” (quoting Kehoe 1987, 428-29), (Sullivan v. Edward Hosp., 806 N.E.2d 645, 656 (2004).

Implications of the Sullivan Case

Registered nurses constitute the largest group of health care providers in the United States today (Cruzan amicus brief). Nursing is a dynamic profession, distinct from the practice of medicine. As The American Nurses Association (2004) has stated, “Nursing has evolved into a profession with a distinct body of knowledge, university-based education, specialized practice, standards of practice, a societal contract (Nursing’s Social Policy Statement, 2003) and an ethical code (Code of Ethics for Nurses with Interpretive Statements, 2001). Registered nurses are concerned about the availability and accessibility of nursing care to patients, families, communities and populations. Registered nurses and the profession seek to ensure the integrity of nursing practice in all current and future healthcare systems... Nursing is a learned profession built upon a core body of knowledge reflective of its dual components of science and art. Nursing requires judgment and skill based upon principles of the biological, physical, behavioral and social sciences. Nursing is a scientific discipline as well as a profession. Registered nurses employ critical thinking to integrate objective data with knowledge gained from an assessment of the subjective experiences of patients and groups. Registered nurses use this critical thinking process to apply the best available evidence and research data to the processes of diagnosis and treatment. Nurses continually evaluate quality and effectiveness of nursing practice and seek to optimize outcomes” (American Nurses Association 2004, p. 10).

The ANA goes on to say: “Self regulation by the profession of nursing assures quality of performance, which is the

heart of the profession’s social contract between the profession of nursing and society” (American Nurses Association, 2004, p. 11).

The New York State Nurses Association is unequivocal in its opinion that nursing is a distinct profession which must be defined and its standards established and upheld by nurses: “The New York State Nurses Association has repeatedly emphasized that the nursing profession has the responsibility and authority for determining the nature and scope of nursing practice... the scope of professional nursing practice is dynamic and evolves as: the patterns of human response amenable to nursing intervention evolves; nursing diagnoses are formulated and classified; nursing skills and patterns of intervention are made more explicit and patient outcomes responsive to nursing intervention are evaluated... The nature of nursing practice is that intrinsic characteristic that distinguishes nursing from other health professions. It is the essence of nursing; it is constant and remains unchanging” (2002, p.1).

Every state requires nurses to complete an accredited nursing program and to pass a national licensing examination prior to practicing as a nurse. Every state has a complex statutory and regulatory scheme including a Nurse Practice Act which defines the practice of nursing in that state and delineates the educational requirements for each branch of nursing practice (National Council of State Boards of Nursing). As the court noted in Sullivan, “By enacting the Nursing and Advanced Practice Nursing Act, the legislature has set forth a unique licensing and regulatory scheme for the nursing profession.

As TAANA observes, under the nursing act, a person with a medical degree, who is licensed to practice medicine, would not meet the qualification for licensure as a registered nurse, nor would that person be competent to sit for the nursing license examination, unless that person completed an accredited program in nursing” (Sullivan v. Edward Hosp, at 659).

As a practical matter, only nurses have the expertise to evaluate care given by another nurse. In reviewing the fact pattern in the Sullivan case, most nurse experts can clearly articulate the standards of care in this all too familiar scenario and can testify as to deviations from these standards (for example, “why were the side rails up?”) rather than offer the simplistic opinion offered by the plaintiff’s expert that the patient should have been restrained. Certainly by offering an opinion that the nurse missed the diagnosis of delirium, the expert reveals his lack of familiarity with the scope of nursing practice.

It is clear that nursing is a unique, identifiable, and autonomous profession. The nursing profession—and only the nursing profession—has the right, duty, responsibility, and expertise to determine the scope and nature of nursing practice including the standard of care for nurses. This includes those standards introduced as evidence in the legal arena.

The Sullivan case provides an opportunity for the nursing profession to change the outdated concept that nurses are mere hand maidens to the medical profession and to define and testify as to its own standards. It is time to clarify the law and to accord to the profession of nursing the recognition, autonomy, and respect given to every other health care profession in the United States.

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Joining the Bar: A New Opportunity for Legal Nurse Consultants

Karen J. Huff, BSN RN LNCC & Pryce M. Haynes II

In June 2002, the West Virginia Bar Association (WVBA) invited Legal Nurse Consultants (LNCs) to join the organization as associate members, becoming the first statewide Bar to create a special membership category for LNCs. The WVBA has taken a proactive approach to embracing all participants of the legal profession. Although the main core of membership remains judges and attorneys, the recent inclusion of LNCs has completed the legal mosaic for the bar, enhancing the collegiality and network of the membership. The synergy among the diverse membership is rewarding to the members and provides an improved awareness of the distinct challenges faced by each component of the overall legal profession.

The official founding of the LNC Section, including the drafting of bylaws and installation of officers, generated a great deal of interest in the legal nurse consulting community. As a result, LNCs in other areas of the country expressed an interest in learning more about this, in particular how to achieve similar success with the Bar in their state. The purpose of this article is to provide the reader with suggestions for achieving LNC membership in a bar association and organizing an LNC Section once membership status is attained.

Mandatory & Voluntary Bar Associations

When deciding whether to approach a Bar Association about LNC membership, the informed LNC should first determine whether the organization is likely to allow non-attorneys to join. For example, it may be best to target voluntary Bars, since they are more likely to allow non-attorney members. Voluntary Bars often look for ways to increase membership. The situation is different for mandatory Bars because attorneys are required to belong to practice law in that location. Additionally, mandatory Bars often have regulations that restrict membership to attorneys and are unlikely to allow LNC members. To facilitate an understanding of the differences between voluntary and mandatory Bar Associations, a brief overview is given below.

Legal Bars come in many shapes (national, state, and local membership base), sizes (large to small), and flavors (mandatory and voluntary). Mandatory Bars are often referred to as “integrated” or “unified” bars, referring to the fact that mandatory Bars are integrated into the state government and fall under its jurisdiction. There is not a mandatory federal Bar; however, there are many national voluntary Bars, perhaps the most notable being the American Bar Association (ABA), the largest Bar in the

USA. It was founded on August 21, 1878, in Saratoga Springs, NY. All 50 states, the District of Columbia (DC), and Puerto Rico have at least one Bar, either voluntary or mandatory, and a few states (North Carolina, Virginia and West Virginia) have two Bars, with one being voluntary and the other being mandatory.

Voluntary Bars were the first Bars to be established in states. Around the middle of the last century, a movement began to license attorneys and require conduct and practice standards. This led to a number of states establishing mandatory Bars which operate as a state agency. Not all states followed this trend, although those that do not have a mandatory Bar do have some form of licensure for resident attorneys who practice in their domain. In addition to national and state Bars, there are numerous “local” Bars comprising membership of counties, and there are organized voluntary bars in several large municipalities.

West Virginia is one of the three states and DC which has “dual Bars,” one voluntary and one mandatory. This resulted when the integrated, mandatory Bar was established in 1947 and the voluntary Bar, The West Virginia Bar Association (founded in 1886), was maintained. In order to have a license to practice law in a state with a mandatory Bar, an attorney must be a member of that Bar. On the other hand, voluntary Bars, not integrated with their respective state’s judicial branch of government, have more latitude in their mission and goals. Having both types of Bars in one jurisdiction makes it particularly challenging for the voluntary Bar. One of the ways The West Virginia Bar Association has met this challenge is by opening its membership to non-attorney legal professionals: paralegals and legal nurse consultants.

Gaining Membership Status

Create a Foundation: Networking

Many LNCs, perhaps unknowingly, may already be laying the foundation for LNC membership in Bar associations across the country. For example, the importance of networking cannot be over emphasized, as such activity strengthens the relationship among members of the legal community. Networking can have many purposes, e.g. educating attorneys about the value LNCs bring to a case, exchanging information with attorneys about the medical aspects of the law, or facilitating the acceptance of LNCs as members of the legal profession. Attorneys who are already aware of the ben-

efits of working with an LNC are more likely to support associate membership status for LNCs. To create opportunities for networking with attorneys, LNCs may want to exhibit at bar events, recruit attorneys to give presentations at LNC functions, or offer to write medical articles for Bar association publications.

Target Voluntary Bar Associations

As mentioned, it is best to seek out voluntary Bars for LNC membership. The ABA has resources that can help the LNC identify whether a particular location has a voluntary Bar association at the state level and includes information about other voluntary Bars at the local level. Access this information under “Division for Bar Services” on the ABA Web site at www.abanet.org/barserv/stlobar.html. This section has a map that easily identifies which state bars are voluntary versus mandatory: states in green have voluntary state Bars; states in gold have “unified” or mandatory state Bars. The directory makes it easy to locate basic information about each organization and identify the initial point of contact when inquiring about LNC membership.

One of the benefits of joining a state or county Bar is that membership includes both plaintiff and defense attorneys. This may be particularly beneficial to members of a local chapter who wish to create an LNC Section of interest to all chapter members; however, LNCs who limit their practice to either plaintiff or defense work may also wish to join voluntary organizations that cater to special interest groups. For example, the American Trial Lawyers Association (ATLA) is the national organization for attorneys who primarily represent the plaintiff, and the Defense Research Institute (DRI) is the national organization for defense trial lawyers and corporate counsel.

Obtain a Sponsor

After identifying the specific Bar association to approach about LNC membership, try to locate an attorney member who will support associate member status for LNCs within the organization. The best scenario is one where the attorney is willing to endorse LNC membership and available to discuss this option with other members of the organization. Once a sponsor is obtained, the next step is to draft a proposal to present to the leadership. If an attorney sponsor is not available, it is possible that another Bar association with LNC members may be willing to provide an introductory statement to the leadership briefly describing the benefits of including LNC members.

It may be easiest for LNCs to work on the proposal together, especially as members of a local chapter of the American Association of Legal Nurse Consultants (AALNC). When drafting the proposal, include a request for membership and an explanation on how the Bar association will benefit from LNC membership. As a reference point, it may also be helpful to identify other Bar associations with LNC Sections. See Table I for bullet points.

Draft a Proposal

Table I: Drafting a Proposal for LNC Membership

Include information about membership:
• Request associate member status
• Suggest eligibility requirements for membership
• Offer to assist with screening of new member applications
• List other bar associations with LNC Sections as a reference
Include benefits to the Bar association:
• Increased membership
• Increased revenue
• Authors for newsletter articles
• Assistance with educational programs and conference planning

When discussing membership, include the following points to authenticate your interest:

1. *Request associate member status.* It should be clear from the beginning that LNCs are requesting associate member status. In some Bar associations, the bylaws may stipulate that only attorneys can join the different Divisions of the organization. It may therefore be best to create Sections for associate members (rather than Divisions). Such is the case in The West Virginia Bar Association, where two Sections have been created for non-attorney members: The LNC Section and The Legal Assistant/Paralegal Section. As associate members, LNCs are only eligible to vote on matters which are brought before the LNC Section.
2. *Suggest eligibility requirements.* The Bar association may want to protect the integrity of the organization by developing associate member eligibility requirements. The LNC group drafting the proposal may be in the best position to recommend such criteria. To belong to the LNC Section of The West Virginia Bar Association, for example, a candidate must be a licensed registered nurse actively practicing as an LNC and a member of AALNC, our professional nursing organization.
3. *Offer to assist with screening of new member applicants.* It is also a good idea to offer to assist the Bar by screening new member applications to determine if eligibility requirements are met. In the WVBA, all requests for LNC membership are first sent to the LNC Section Membership Committee for verification. The Membership Committee notifies the WVBA whether an applicant meets the criteria, and the application is processed accordingly.
4. *List other Bar associations with LNC Sections as a reference.* One successful example is the West Virginia Bar Association. For more information about other bar

associations with LNC Sections, contact AALNC Headquarters.

Additionally, the proposal should focus on how the organization will benefit from opening up associate membership status to LNCs. Although the LNC group drafting the proposal may have additional ideas unique to their location, some of the benefits to the Bar include:

- *Increased membership for the organization:* new member recruitment is necessary for the viability of any organization, including Bar associations. Voluntary Bar associations in particular are often looking for ways to increase membership and may not have considered opening membership to non-attorney members. Although some Bar associations may allow LNCs to join in the paralegal category, it is preferable to create a separate section for LNCs as a way of recognizing the distinction between the two professions.
- *Increased revenue for the organization:* by inviting LNCs to join the organization, the Bar association will benefit from an increase in revenue through the collection of dues, as well as fees to attend Bar events. If possible, provide an estimate of the number of LNCs likely to join once membership is approved.
- *Authors for newsletters:* voluntary Bars, especially the smaller organizations, may be in need of authors for Bar publications. Given their medical training and expertise, LNCs are uniquely qualified to write medical articles on topics of interest to attorneys.
- *Assistance with educational programs and conference planning:* LNCs are adept at locating medical experts for cases, and many of these experts are also excellent speakers for conferences. LNCs can assist the Bar association by locating medical-legal speakers for joint educational sessions. In the WVBA, for example, such sessions are eligible for continuing education credit for attorneys and LNCs.

Once the proposal is completed, consider the best way to present the proposal. Depending on the situation, the best strategy may be an introductory letter or phone call to express an interest in discussing LNC membership. The proposal would then be presented during a follow up call or meeting. The Executive Director is typically responsible for managing new member inquiries, with the Bar association leadership giving approval once initial details are worked out. If a sponsor is available, ask for a written recommendation to present to the Executive Director along with the proposal.

In some situations, the entire process may be slow. A periodic reminder from the group may be appropriate to keep the lines of communication open.

Organizing an LNC Section

Gaining membership status in the Bar association is a big step. Depending on the size of the organization, the number of LNCs involved, and the geographic location of the members, it may be desirable to advance to the next level. To accomplish this, bylaws need to be drafted and approved, and a Board of Directors elected and installed. This process may not be necessary if only one chapter is involved and the chapter leadership manages LNC Section activities. If several chapters are involved or membership is open to LNCs outside the local chapter, however, leaders devoted to the LNC Section will be needed. While the process may sound a little daunting, the end result is worthwhile and will ultimately result in the creation of many new and exciting opportunities.

Drafting Bylaws

When drafting bylaws for the LNC Section, the first step is to identify resources to use as templates, such as the bylaws for the Bar association and AALNC bylaws. A new document specific to the LNC Section can be drafted, combining key elements from each.

Next, decide how to organize the content into different articles or sections, e.g. Name, Purpose, Membership, Board of Directors, Officers, Meetings, Committees, Books and Records, and Amendments. For example, the WVBA LNC Section included the definition of a legal nurse consultant as approved by AALNC in the bylaws under the section for Membership. The bylaws also contain a section at the end with the date the LNC Section was founded, and a list of founding members.

When drafting the content, careful consideration should be given to the criteria for membership. It is recommended that membership be limited to LNCs currently working in the legal arena. The WVBA LNC Section requires that members be actively licensed as a registered nurse and a member of AALNC at the national level. Membership in a local chapter of AALNC is recommended but not mandatory. LNCs in any state may join, as long as criteria are met.

The actual process of drafting bylaws may occur through a series of meetings between acting leaders of the LNC Section or may be delegated to a bylaws committee. In some situations, it may be necessary for the Bar association to appoint a leader to guide the group through the process of drafting bylaws and organizing the Section. Once the draft is completed, it should be submitted to the LNC Section members for approval. After approval by the members, the bylaws are submitted to the Bar association leadership for final approval. Revisions may be needed along the way before the procedure is completed.

Installing a Board of Directors, Creating Committees

An election should be held to install a Board of Directors. This activity may be planned to coincide with approval of the bylaws. Once the Board is installed, the duties for each member should be established. Bylaws typically have general information about the duties of each position but do not include a lot of detail.

Depending on the needs of the organization, the activities of the Section may be carried out by committees, similar to those found in AALNC chapters. For example, the initial committees created for the WVBA LNC Section included a Membership Committee, Education Committee, Marketing Committee, and a Web site Committee. Each committee is led by one of the Board members. Additional committees or task forces may be established as the need arises.

Drafting a Strategic Plan

After primary committees are established, the next important project is to develop a strategic plan. The plan may be developed by the Board or during a meeting of the entire membership. The process can be very exciting, with lively discussions about important goals and strategies.

When drafting the plan, it is essential to determine ways in which the LNC Section can assist the Bar association with the goals of the organization. It is also inspiring to develop LNC Section activities designed to complement goals found in the AALNC strategic plan. For example, one of the key strategies in the AALNC plan is professional recognition and validity. Joining the Bar association is viewed by many as the gold standard for achieving professional recognition within the legal community.

As an example of what a plan may contain, Appendix I at the end of this article contains a copy of the WVBA LNC Section Strategic Plan approved by the Board of Directors for 2003-2005.

Conclusion

In summary, LNCs wishing to approach the Bar in their state should first determine its voluntary or mandatory status, as voluntary Bars are more likely to accept non-attorney members. When requesting membership status for LNCs, remember to ask for associate member status, and consider drafting a proposal outlining benefits the Bar will enjoy upon creating an LNC Section. Additionally, if the Bar association approves, it may be possible to further organize the LNC Section by drafting bylaws and installing a Board of Directors.

Joining the Bar association is a new and exciting opportunity for LNCs. The West Virginia Bar Association was the first statewide Bar association to include LNCs as associate members. Although the WVBA initiated the process by inviting LNCs to join the organization, the success of the LNC Section has exceeded the expectations of the Executive Committee. The inclusion of LNCs in the organization has enhanced collegiality within the WVBA and added value for the entire membership. Perhaps by following the recommendations in this article, LNCs in other areas of the country will continue the trend and achieve similar success.

For more information, please visit the WVBA LNC Section Web site at www.wvbarassociation.org/lncsection.

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APPENDIX I

THE WEST VIRGINIA BAR ASSOCIATION LEGAL NURSE CONSULTANT SECTION STRATEGIC PLAN 2003 - 2005

Mission: The Legal Nurse Consultant Section promotes the professional advancement of registered nurses practicing in a consulting capacity within the legal arena by providing access to membership in the West Virginia Bar Association, and by providing a forum for networking with all members of the Bar.

Vision: The Legal Nurse Consultant Section is a role model for other legal nurse consulting groups, and sets the standard for achieving professional recognition within the Bar Association.

Purpose: The purpose of the Legal Nurse Consultant Section is to promote the professional advancement of registered nurses practicing in a consulting capacity within the legal arena, to provide educational opportunities related to legal nurse consulting, and to provide a forum for networking.

GOALS AND STRATEGIES

I. Professional Development

A. Education

1. Develop an educational program for legal nurse consultants (coordinated by Education Committee)
2. Recruit speakers to present educational sessions, mandated by LNC Section and other sessions coordinated by Education Committee

B. Publications

1. Submit scholarly journals for publication in the following:
 - a. LNC Section updates of NC Section Proceedings
 - b. Medical articles coordinated by Marketing Committee

II. Recognition and Validity

A. Professional Recognition

1. Develop a plan to promote and increase the specialty practice of legal nurse consulting within the Bar Association.
 - a. Submit articles to the WVBA newsletter (see procedure schedule 11/1/2004)
 - b. Promote the LNC Section and legal nurse consulting at WVBA events and NC Section Board of Medical Medicine
 - c. Provide opportunities for networking between LNCs and other members of the West Virginia Bar Association
2. Promote the American Association of Legal Nurse Consultants (AALNC) as the professional nursing organization for legal nurse consultants.
 - a. Continue to request that LNC Section make networking to AALNC at educational level
 - b. Accept AALNC position statements for the LNC Section as applicable to LNC Section Board of Directors
 - c. Provide information about AALNC and LNC Section on the Marketing Committee Website (committee website)
 - d. Promote affiliation in legal nurse consulting (Website Committee)

B. Validity

1. Promote validation of the legal nurse consulting profession within the Bar Association.
 - a. Continue to provide opportunities for access to associate membership status in the West Virginia Bar Association and membership in the LNC Section
 - b. Act as a resource for the creation of LNC Sections in other areas of the country by using applicable LNC Section materials and AALNC credentials

C. Visibility

1. Develop a strategy to promote the LNC Section and the legal nurse consulting profession (Website Committee)

III. Growth and Financial Viability

A. Growth

1. Develop strategies to recruit the West Virginia Bar Association new members.
 - a. Assign program managers and assign tasks concerning the application process (Marketing Committee)
 - b. Develop LNC Section brochures to distribute to prospective members (Marketing Committee)
 - c. Coordinate mailings campaign to recruit new members
 - d. Submit publications (updates of LNC Section) to medical legal publications
2. Develop strategies to promote legal nurse consulting to other LNC Sections.
 - a. Develop a poll to solicit suggestions from members for future LNC Section activities
 - b. Invite LNCs who do not attend the membership to encourage them to register

B. Financial Viability

1. Create a membership fund managed by the WVBA.
 - a. Approve membership policy
 - b. Register and WVBA membership

Retaining Qualified Medical Experts: The Legal Nurse Consultant's Role

K. DeAnn Taylor, RN

Legal nurse consultants (LNCs) are often called upon to assist in location and retention of medical expert witnesses. With a medical area of expertise in mind, the LNC goes in search of the witness. The LNC may know just the right person, poll her fellow chapter members, select from a file of previously used experts, or employ the services of a medico-legal consulting firm. Once found, this witness may have all the right medical credentials, i.e., right field of medicine, well-published, well-known, and respected. But what about the ethical side of expert testimony?

Experts & Ethics

Take, for instance, a recent case in California: A 50-year-old male underwent a cervical laminectomy performed by an orthopedic spine surgeon with the unfortunate outcome of quadriplegia. A medical malpractice suit was brought against the surgeon, and the plaintiff's attorney had found the "perfect" witness. This witness had more than 40 years of experience as a neurosurgeon, had performed innumerable cervical laminectomies (although none in the last 10 years and not using the same approach/technique as the defendant), and had been a professor of neurosurgery in a well-known medical school.

It is important to note that, while an orthopedic surgeon is trained to deal primarily with the bones and joints and a neurosurgeon is trained to deal primarily with the nervous system (brain, spinal cord, nerve roots, and nerves), when it comes to matters of the spine, their fields of expertise often overlap. It is therefore appropriate for one to testify in a matter involving the other. After a review of the medical records, this neurosurgery expert agreed with the plaintiff's view that medical negligence on the part of the orthopedist was the direct cause of the quadriplegia.

An LNC working for the defense firm was asked to research ethical guidelines regarding physician expert testimony. After a review of the guidelines published by the California Medical Association, the American Academy of Neurosurgery, and the American Medical Association, the plaintiff's "perfect expert" did not look so perfect after all.

The American Medical Association (AMA) has published minimum statutory requirements for qualification as an expert witness. The AMA guidelines (AMA Policy H-265.994) state: "The AMA believes that the minimum statutory requirement for qualification as an expert witness should reflect the following: (i) that the witness be required to have comparable education training, and occupational

experience in the same field as the defendant; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; and (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim." (This policy can be found online at www.ama-assn.org.)

The AMA policy also documents a precedent set by the Illinois Supreme Court in the case of *Trower v. Jones*, 121 Ill. 2nd 211 (1988), wherein cross examination regarding the amount of compensation for the expert's consultation and testimony, the frequency of the physician's expert activities, the proportion time the expert devotes to legal work, the income derived from such activities, and the frequency with which he or she testified for either plaintiffs or defendants can be questioned.

Ethical Guidelines

In 1997, the California Medical Association (CMA) adopted guidelines and qualifications for experts testifying in medical malpractice cases. Ethical guidelines may vary by state and, like California's guidelines, may be based on the minimum statutory requirements published by the AMA. The CMA's guidelines clearly state that the physician expert "must be qualified by training, current experience and demonstrated competence in medical care at issue in the case."

The CMA guidelines also state that a physician should have provided direct patient care "at least eighty (80) hours per month in the same medical specialty as the defendant, or a specialty appropriate to the subject matter of the litigation for three (3) years immediately prior to the incident at issue in the case. The physician expert should affirm that not more than 20% of his/her professional activities involve serving as an expert witness in professional liability cases." (A copy of the CMA guidelines can be purchased through CMA On-Call, www.cmanet.org; document #0910 "Expert Witness Issues.")

Additionally, professional associations such as the American Academy of Neurology and the American College of Emergency Physicians have adopted their own ethical guidelines for testifying medical experts in accordance with those set forth by the AMA.

Discovery & the LNC

During the discovery phase of litigation, each party has the opportunity to find out almost everything about his opponent's case before the trial begins—hence the term

“discovery.” Included in this discovery period is an opportunity for either party to make a demand for expert witness lists. Once demanded, all parties must exchange their lists of experts including the expert’s names, addresses, qualifications (curriculum vitae including area of expertise, relevant education, employment, and experience, and a summary of professional associations and any publications), and the general substance of the expert’s testimony. It is during this phase that the LNC has the opportunity to perform research on opposing expert witnesses.

Upon cross-examination of the aforementioned neurosurgeon by the defense counsel, it was discovered that the neurosurgeon had not practiced surgery in the last 10 years and had never performed the procedure using the same technique as the defendant. Furthermore, it was discovered that this physician spent a greater amount of time, and earned a greater amount of money, working as an expert witness than working in his medical practice. He was of an advanced age, and his most recent publication was dated 1968.

Despite objections from the plaintiff’s attorney, the defense attorney was able to use this information to his advantage in an attempt to discredit this witness in the eyes of the jury. Although it is not really known what impact this cross-examination had on the jury, it is interesting that the jury returned a verdict for the defense.

While the aforementioned case occurred in California, the standards for expert testimony were based on the minimum standards set forth by the AMA. It is imperative for LNCs working with attorney clients in retaining expert witnesses to know the expert’s professional history—both medical and legal—to avoid these possible pitfalls of cross-examination. The LNC should carefully examine the expert’s curriculum vitae, review any publications for consistency with the expert’s deposition and upcoming trial testimony, and compare his or her qualifications with the guidelines set forth by the AMA and the state in which the trial is to be held.

Web Sites for More Information

California Medical Association:

www.cmanet.org/bookstore/cmaoncall.cfm?templateinc=oncall3&article_id=108

American Medical Association:

www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-265.994.HTM

American Academy of Neurology:

www.aan.com/about/ethics/EXPWIT.PDF

American College of Emergency Physicians:

www.acep.org/1,560,0.html

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Q: How Should an LNC Use Language Analysis to Identify and Assess Issues in Interpersonal Deception during the Interviewing Process?

Joyce M. Crager, MSA RN CCM, Greater Detroit Chapter, American Association of Legal Nurse Consultants

A: The LNC uses communication, “a sending, giving, or exchanging of information, ideas, etc.” (Websters, 1989, p.198), on a daily basis in the form of interviewing clients, attorneys, providers, insurers, etc. Interviewing is “a meeting of persons face to face especially for formal discussion or the meet with someone to examine his qualifications or to get information from him” (Websters, 1998, p.506). Communication through interviewing is a fundamental component of the LNC and client relationship. The goal directed client interview must engage in full, open, and honest communication to effectively represent the client.

Full, open, and honest communication is not always evident due to barriers in communication. The LNC can use investigative tools that employ forensic psycholinguistic analysis. This analysis can assist in analyzing client behavior to determine if a client is being deceptive or telling the truth.

Forensic psycholinguistic analysis can extract vital clues from language. Psycholinguistics is “the study of the relationship between linguistic behavior and psychological processes of the speaker or writer that underlie that behavior” (Encyclopedia, 2004). Forensic psycholinguistics combines the practical experience of seasoned investigators with knowledge gained from the research of experts within the disciplines of psychology and linguistics.

This analysis process may offer information useful in determining clients’ identities, truthfulness, personality characteristics, and potential for violence. The clients’ language provides information about geographic origins, ethnicity or race, age, sex, occupation, educational level, religious orientation, authorship identification, and statement analysis.

Geographic Origins: Both written and spoken language have features that may reveal an individual’s geographical origin. Speech often retains remnants of the regional dialect of the area where the clients were reared. Vocabulary, word choice, and grammar can also indicate geographic origin, such as the name for a carbonated soft drink: “soda” vs. “pop.”

Ethnicity or Race: Native ethnic groups, as well as immigrants from various countries, may retain remnants of their native language. A foreign national may use a word

order with a subject-object-verb sequence rather than the typical English subject-verb-object order.

Age: Different generations preserve language that marks them to their general age group. They retain expressions and references that they used when they were younger, such as referring to the Internet as an invention rather than technology.

Gender: Research has demonstrated that men and woman may have slightly different language patterns. Females are more likely to express tentativeness, such as “it seems like.” Female language relies more heavily on expressions of feelings, use of polite speech acts, and intensifiers than males.

Occupation, Educational Level, Religious Orientation: Language sometimes contains clues as to clients’ occupation, educational level, or religious orientation. Use of nautical terms, for example, can reflect knowledge of boating or military service. Consistent use of sophisticated language, correct grammar, and advanced punctuation skills may reflect higher level of education. References to biblical figures may signal religious orientation.

The LNC may also use authorship identification and statement analysis to develop more effective client interview techniques. The authorship identification process analyses stylistic features, such as sentence construction, word choice, and spelling in documents written by the client. Compare these features with past writings of the client to verify that the client authored them. Statement analysis can determine if an interviewee is being deceptive or telling the truth. This tool examines the words that the client uses and the information that they omit. The LNC should analyze these word choices and missing information to determine the best approach to take during the interview.

The interview study by Stromwall (2001) discusses six categories of verbal cues and three categories of nonverbal cues.

Verbal cues:

1. Completeness. “The statement is complete.”
2. Confidence. “The suspect was confident in his statements.”
3. Consistency. “The statements were consistent over time.”
4. Details. “The statements were rich in detail.”

5. Statement in general. "The story was plausible."
6. Structure of statement. "The statements were given in a spontaneous way."

Nonverbal cues:

1. Credibility in general. "The suspect's behavior was trustworthy."
2. Nervousness. "The suspect was nervous."
3. Body and face. "The person made few trunk movements."

Stromwall (2001) found that consistency was the most frequently used cue to justify veracity judgments. The study assumption that consistency implies truth and inconsistency implies deception had a low diagnostic value. It is strongly recommended that the LNC should exercise the consistency heuristic with great caution. Stromwall (2001) suggests that "they avoid crediting statements that are perceived as consistent over time as well as from discrediting statements that are perceived as inconsistent over time."

The use of forensic psycholinguistic analysis may assist the LNC in determining if a client is being deceptive or telling the truth. The client's language provides information about geographic origins, ethnicity or race, age, gender, occupation, educational level, or religious orientation. Authorship identification and statement analysis may assist

the LNC in developing an effective interview technique. Lastly, the use of the six categories of verbal cues and three categories of nonverbal cues in the interviewing process may assist in deciphering lies or truth.

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Preparing a Witness for Trial: Perspectives of a Courtroom Behaviorist

Glynn Bedington

Preparing witnesses for trial involves defining for the witness his or her role at trial as defined by the lawyer's theory and themes. The legal nurse consultant (LNC) and courtroom behaviorist join forces to uncover witness strength and weaknesses. The behaviorist then helps the witness develop skills to implement his/her strengths and apply structure to the testimony while the LNC focuses their efforts on the specific needs of the case.

"Just Be Yourself"

A trial lawyer's job is to know the law and to artfully apply it as it pertains to the case at hand. Her concerns are the development of a cogent theory and the use of effective themes to sway the jury to her point of view. Both theory and themes are based, in part, on information the attorney learns from her client. The attorney depends on the client's clear, precise, and persuasive testimony. "Just be yourself," the attorney often suggests. "Just tell the truth, and relax."

With such simple and clear advice, why then are otherwise intelligent men and women (including professionals with expert witness experience) racked by fear at the thought of testifying on their own behalf? Why does a normally compassionate person appear flat and uncaring on the stand, or a person known for her precision and attention to detail become forgetful and confused? Perhaps the command, "Be yourself," requires more: more knowledge, more understanding, and more depth of purpose. Just being yourself might be easier said than done.

In truth, most attorneys don't stop with simple "Be yourself" or "Just relax and tell the truth" commands. Most add a seemingly helpful list of "Make sure to appear strong and confident but don't be arrogant," "Just answer 'yes' or 'no' during cross examination and don't argue about a point," "I can't help you out on direct so make sure you explain everything," and "Talk to the jury—I want them to get to know you." After a preparation session such as this—usually scheduled on the eve of trial—it is not surprising that a normally confident professional can be reduced to spinning a circular loop of self-limiting thoughts up to and including his time on the stand.

As well-meaning as it might be, preparation of this kind does very little, if anything, to support the needs of the witness. Granted, the attorney has certain testimony requirements to support his theory and themes. The problem develops when a client is expected to slip into a predesigned slot and act as the control gear in an elaborately constructed system of wheels and pulleys.

Not all witnesses fall apart in the courtroom. Not all witnesses make blunders during deposition that pose additional problems at trial. But some witnesses have a case that is complex enough or their presence is commanding enough that the success or failure of the case largely depends on the jurors' reactions to them. These are the cases for which a courtroom behaviorist plays a crucial role.

Courtroom Communication

There is nothing ordinary, customary, or natural about courtroom communication. Courtroom communication is different from most other communication in that the sender is not in direct communication with the receiver. During a jury trial, there are many senders—the judge, the attorneys, and the witnesses. The only receivers, however, are the members of the jury. The witness must understand the jurors and communicate in such a way that he will be understood. But the witness has no idea who will serve on his jury until after *voir dire*.

True, the specific jurors are unknown; however, the general experience of jury service is known. The witness must understand the general experience that has gathered the jurors in service of his case. He must understand the mental and emotional shaping that takes place in preparation for service, and how that affects their views and attitudes during service.

Once a witness examines and understands the jurors' experience, his own point of view and attitude adjusts. As the witness recognizes that all actions, attitudes, nuances, and language must be shaped to pass through the jury filter—the only material receivers in the courtroom—his focus matures. As he applies that focus to each aspect of the trial, he develops the ability to move from self-conscious, self-sabotaging behavior to other-conscious, self-supporting behavior. In other words, he learns how to "be himself."

Speaking in public is the #1 fear of most human beings, for many surpassing the fear of snakes. Potential jurors are no exception. As the witness slips into the mindset of the juror, recognizing the subtle anxiety present for each juror as they responds to counsel's inquiries, the witness can understand that outward signs of judgment from the witness (even when benignly dealt) can prejudice the juror against the witness.

Innocent actions such as taking notes, disregarding juror comments, or whispering to her attorney while a juror is speaking can all be construed as negative judgment by the anxious juror. Such a juror may be inclined to consider (consciously or not) turn-about as fair play.

Instead, the witness must prepare by asking himself a series of questions.

Techniques to Improve Courtroom Communication

How do I want to be perceived by the jurors? During deliberation, what words would I ideally like the jurors to use when describing me?

In the same way that a traveler must first decide on a destination before he can map his journey, a witness must decide what aspects of her personality most support the attorneys' theme and her own truth.

What qualities do I possess that the jurors must experience in order to believe the attorney's theory and my testimony?

Once the witness has narrowed her list of critical qualities to three or four, she can use them to create an intention statement, a self-describing statement that calls her true self to the fore. Repeating her personal intention statement will keep her on track, reminding her subconscious mind of her true qualities and encouraging her subtle actions to more accurately represent the person she is, not the person opposing counsel describes.

What conclusion must the jurors come to in order to find on my behalf?

As with all decisions, there is a final element that creates cohesiveness and sways our convictions toward our ultimate decision. Define that final element. By understanding what the jurors must feel, see, or in some way experience as the final step to their conclusions, the witness identifies for himself a quality that will be supported by his intention statement.

What actions—actual and described—will lead the jurors toward my intended conclusion?

The jury must see and experience the witness as the person he says he is. The jurors measure the words the witness uses, the attitude he carries, and his described actions against what is said about him.

How can I define my personal involvement in three short statements?

The jurors must understand the witness's role. By reducing the complexities to three short interrelated statements, the witness clarifies her thought process. She finds that all details fall neatly under one of the three, and her feelings and reactions to each become more clearly defined. The witness will find numerous opportunities to insert these statements into her testimony.

In my opinion, what is the most important obstacle the jurors must traverse if they are to come to my intended conclusion?

If the witness is a health care professional, the jurors must feel safe with him. In order for the jurors to support him fully, they must say to themselves, "I would feel safe in this person's hands. I would place my wife, husband, child, mother in the care of this person." The lay witness must pass through a filter of reasonableness. The jury measures the

experience of the lay witness as if it were himself: "If I was met with this set of circumstances, how would I react?"

What is my personal viewpoint regarding this case? How do I see the events that have led to the current conflict?

The witness may have an opinion that has not been expressed. Holding an unvoiced opinion may prove counterproductive, as it has a way of seeping into the witness's testimony. Feelings of guilt affect the way a witness relates to the jury and may compromise her testimony. The witness must live his intention statement. Feelings of guilt, shame, fear, or anger cannot coexist with the truth in the intention statement. The witness must do what needs to be done to resolve any conflicting feelings she may carry.

Working with an LNC

Once the witness has answered the above questions and clarified her focus, she is ready to apply her new thought process to potential deposition or cross-examination questions. Here the LNC's contribution is vital. The LNC must prepare a line of questions that opposing counsel is likely to ask. The courtroom behaviorist assists the witness in applying his newly formed focus to the specifics of the case. His words, as well as his emotional testimony, are keenly monitored.

The behaviorist can use video as both effective feedback and training for depositions that are likely to be recorded. How the witness sits, holds himself, and maintains focus are all actions that reflect the witness's self-described intention. He learns how to imbed important concepts repetitively into his testimony. He physically presents using descriptors that draw forth appropriate and supportive images in the juror's minds.

Obstacles to Effective Courtroom Communication

I've periodically worked with a client who did not like his attorney or an attorney who confided his dislike of the client. While lasting friendship may not be essential, teamwork is. The entire trial fits together as a collection of important pieces.

The witness is a vitally important piece, controlled by how he thinks, what he says, and how he relates to jurors. After months or years of developed fear or anger, the witness deserves the support required to transform into an asset for the case. With help, he can effectively become himself.

Cultural contributions can act as a hindrance to forthright communications. In such a situation, the behaviorist must find examples in the witness's past where she was emotionally committed to an outcome and was able to override inbred barriers. The behaviorist helps the witness apply the ability she has used in the past to the current courtroom testimony.

Here again, the LNC's role is vital, as she is likely to maintain a relationship with the witness during trial. She can act as a coach for the witness by continuing to focus the witness's attention on the desired outcome as opposed to the fears or cultural concerns she is required to overcome.

Many women are submissive to male authority. In a situation where such a witness is required to testify against a male authority figure, she may react in one of two ways:

- (1) resist by using vague or non-committal language and behavior; or
- (2) become overly aggressive.

Either reaction is inappropriate and detrimental to the case. The behaviorist helps the witness find the source of the challenge, match it with times or situations when the witness has naturally overcome the problem, and helps the witness apply the effective behavior to the courtroom testimony. LNC expertise is necessary here in keeping the witness focused on applying her new awareness affectively.

Other common challenges such as soft-spoken speech, insecure behavior, and apparent lack of commitment all require similar detailed attention. It is not enough to simply make the witness aware of the problem; the witness generally is aware that there is a problem but has probably defensively adopted an attitude of "That's just the way I am." The courtroom behaviorist must convince the witness that she is not a collection of her weaknesses by exploring times and situations where the reverse is true.

The LNC can assist this transition by taking the witness into the courtroom and allowing her to sit in the witness box. If time permits, she can conduct a mock examination, direct and cross. The direct examination is often overlooked in favor of the cross-examination; however, especially in situations where the witness is shy or insecure, reminding the witness of her expertise through direct examination will add to her confidence.

Conclusion

Lawsuits are unpleasant processes, devouring time and depleting self esteem. My goal is to streamline the process toward a confident, clear, and concise presentation. Over the past 25 years and with the aid of thousands of clients and many knowledgeable LNCs, I've devised ways to help witnesses effectively present themselves and their courtroom testimony.

Suggested Reading

Testifying in Court by Stanley L. Brodsky, Published by the American Psychological Association, APA Order Department, P.O. Box 92984, Washington, DC 20090-2984

Who Do You Want to Be? The Art of Presenting Yourself with Ease by Glynn Bedington published by SilverCat. Available from the author at 1425 Glenwood Drive, San Diego, CA 92103, (619) 297-5405 x1 or by e-mail: gbedington@cox.net

Glynn Bedington has been a courtroom behaviorist for 25 years. She is a graduate (MA) from the University of Colorado. She currently resides in San Diego, but travels all over the country to assist attorneys in their litigation needs. She specializes in witness preparation as well as overall theme development and application to all aspects of trial, providing focus group and mock trial services when applicable. Areas of practice include medical malpractice (plaintiff and defense), business litigation, personal injury, and criminal defense. She can be reached at gbedington@cox.net.

Investigating Spoliation

Arlene Klepatsky, Esq. RN

Spoliation is an interesting word with an even more interesting body of cases. This column will define spoliation, discuss the various consequences of spoliation, and present some interesting cases on the subject. Finally, the role of the legal nurse consultant in discovery of spoliation will be explored.

What Is Spoliation?

Black's Law Dictionary defines spoliation as, "The intentional destruction, alteration, or concealment of evidence... If proved, spoliation may be used to establish that the evidence was unfavorable to the party responsible" (Black, 1990).

Spoliation may involve documents (such as a medical record) and occurs when the document is altered, mutilated, lost, concealed, or destroyed. Spoliation can also involve physical evidence in a case such as a pathology specimen, a vehicle involved in an accident, or a product that allegedly caused injury.

In an interesting Oklahoma case, the defendant asserted that plaintiff's surgery to correct her back injury amounted to spoliation of evidence. The defendant alleged that the surgery destroyed evidence needed to evaluate plaintiff's case. The Oklahoma court disagreed: "Medical treatment is generally not sought for the purpose of prejudicing the rights of those who may later be found to be liable for the treatment." The court went on to say that documentation of medical treatment is usually quite extensive and refused to equate the "seeking and obtaining of medical treatment to spoliation of evidence" (*Manpower v. Brawdy*, 2002).

Consequences of Spoliation

Courts have crafted various consequences for those engaged in spoliation of evidence. These range from changing the outcome of a case to the filing of criminal charges and incarceration. The particular consequence handed down depends on the jurisdiction of the case. In some jurisdictions, spoliation of evidence by the plaintiff may result in the plaintiff's case being thrown out of court.

The decision of a trial court in Tennessee provides such an example. In this case, a former financial officer sued his former employer for, among other things, wrongful termination. He was suing for more than \$1 million. Soon after the suit was filed, the defendant's attorney requested that the plaintiff surrender a home computer (provided for him by his former employer) without deleting any data from the hard drive.

The former officer eventually surrendered the computer, "but the hard drive had been purged of all information." The

defendant company was able to prove that the deletion was intentional and that the deleted material would have been relevant to the defense of the lawsuit. As a result of this intentional spoliation by the plaintiff, the trial court dismissed plaintiff's entire lawsuit (*Burnstein*, 2003).

When there is spoliation by a defendant, a case may end in a settlement for full policy limits, even though the case otherwise could have been defended. Spoliation may also cause the entry of a default judgment against the defendant and, in some jurisdictions, may result in the award of punitive damages.

Spoliation may also cause the court to shift the usual burdens of proof in the case. For example, in an Alaska case, the nursing notes were "lost," impairing plaintiff's ability to prove malpractice. The Alaska Supreme Court held that, because of the spoliation by the defendant, the burden of proof must shift from the plaintiff to the defendant (*Sweet Sisters v. Providence in Washington*, 1995).

Some courts have held that the plaintiff is entitled to a jury instruction when the defendant has engaged in spoliation of evidence. An important California case provides an example. A physician, the defendant in a medical malpractice case, admitted that he had recopied his medical records and did not have the originals. The physician explained that he recopied his notes because the original record would have been difficult to decipher. The defendant obtained a ruling from the trial court that any reference to the unavailability of the original records would be "unduly prejudicial." The jury verdict and the court's judgment were in favor of the defendant.

The plaintiff appealed and the judgment was overturned. The appellate court stated that there had been a miscarriage of justice in the trial court. It further stated that "suppression of evidence by spoliation is receivable against him [the spoliator] as an indication of his consciousness that his case is a weak or unfounded one." The court implied that the plaintiff should be entitled to a jury instruction stating that the unavailability of the medical records tends to discredit the MD's defense (*Thor v. Boska*, 1974).

In some states, including California and Idaho, intentional concealment of medical records by a defendant in a medical malpractice action can be grounds for extending the statute of limitations (California Code of Civil Procedure section 340.5). Also in Idaho, the cap on the recovery of non-economic damages may be waived when a physician's conduct is found to be "willful and wanton." In Hawaii, if a medical provider alters records, the plaintiff may ask for monetary sanctions to compensate for the harm.

Furthermore, in some cases, the discovery of altered records can result in the defendant automatically being found negligent. In that case, the only issues remaining would be the damages and plaintiff's comparative negligence. "The plaintiff can also file a claim for fraud, intentional misrepresentation, and punitive damages" (Medical Insurance Exchange of California, 2004).

Spoilation of evidence can also result in administrative and criminal penalties. Spoilation involving a medical record may be considered to be unprofessional conduct by a professional board. This may lead to action against the professional's license to practice (California Business & Professions Code section 2262). In some states, a health care professional who alters a medical record may be guilty of a misdemeanor (California Penal Code section 471.5). In addition, there are situations in which a spoliator may be sentenced to jail or prison.

A dramatic case in Pennsylvania illustrates the risk of incarceration. This case involves an LPN who worked in a nursing home. She changed the medical record to cover up an error. After the death of a resident, complaints were made to the Pennsylvania Department of Health. Eventually, the federal government brought criminal charges against the LPN, based on a 1996 provision of the Health Insurance Portability and Accountability Act (HIPAA) that states that it is a felony to make false statements in a matter involving federal health care benefits (such as Medicare).

In federal court, the LPN pleaded guilty to various acts of spoilation of the medical record. She faced a maximum of five years in federal prison and a \$250,000 fine. The LPN's family begged the judge not to send her to prison. However, some violations of HIPAA include a mandatory prison sentence, leaving the judge no choice. According to the judge, she was also likely to lose her LPN license (Grossman, 2001).

Independent Tort of Spoilation

In some jurisdictions, a party harmed by spoilation of evidence can sue the offender for damages in a separate tort cause of action. For instance, the District of Columbia recognizes a tort cause of action for negligent or reckless spoilation of evidence. Such a suit can be brought against a third party who is not involved in the underlying lawsuit.

The case that defined this cause of action involves a plaintiff who had been in a head-on collision while driving a rental vehicle. The plaintiff alleged that he was severely injured when the engine of the rental vehicle intruded into the passenger compartment. The rental company agreed with the plaintiff's attorney that it would hold the wrecked vehicle for a certain period of time. However, the wreck was sold for scrap metal before the expiration of the agreed-upon time period. As a result, the plaintiff's accident reconstructionist could not determine whether the plaintiff's injuries were caused by the manufacturer's negligent design of the vehicle.

The plaintiff filed suit in federal District Court against Chrysler for negligent design and against the rental company

for negligent spoilation of evidence. The District Court held in favor of the rental car company and granted summary judgment. The plaintiff appealed to the District of Columbia Court of Appeals. This court ruled that the jurisdiction of the District of Columbia does indeed support an independent and actionable tort of spoilation of evidence. It found that the District Court had erred in granting summary judgment in favor of the rental car company (*Holmes v. Amerex Rent-A-Car*, 1999).

Some courts have refused to recognize an independent tort of spoilation of evidence. In a 1999 case, the California Supreme Court articulated its reasons for rejecting the tort. The facts of the case involve a plaintiff who was injured during a surgical procedure: she alleged that while she was under general anesthesia, an electrocautery tool caused the oxygen used with the anesthesia to ignite. Her face was severely burned in the fire. Records of one of the physicians indicated that the electrocautery tool had "failed" when a flame emerged from it.

The plaintiff's counsel made various efforts to ensure the preservation of the evidence by the hospital, particularly the electrocautery tool, oxygen tank, and mask. The hospital refused to turn over the medical equipment used in the surgery and refused to allow inspection of the equipment. The plaintiff brought lawsuits against various parties, including a product liability action against the manufacturer of the electrocautery tool, but lost her suit against the manufacturer because there was no evidence presented to show that the electrocautery tool was defective.

The plaintiff also sued the hospital for intentional and negligent spoilation of evidence, asking for compensatory and punitive damages. She claimed that the loss or concealment of this evidence by the hospital caused harm in that she was deprived of evidence needed to discover and prove the cause of her injuries and to be compensated for those injuries. Eventually the issue was brought to the California Supreme Court. This court held that, "The benefits of recognizing a tort cause of action to deter third party spoilation of evidence and compensate victims of such misconduct, are outweighed by the burden to litigants, witnesses, and the judicial system that would be imposed by potentially endless litigation over a speculative loss, and by the cost to society of promoting onerous record and evidence retention policies" (*Temple Community Hospital v. Superior Court*, 1999).

The LNC's Role in Investigating Spoilation

The legal nurse consultant (LNC) is uniquely qualified to determine when spoilation has likely occurred. The LNC has an intimate familiarity with the requirements of documentation and can quickly note when something is missing. In addition, the LNC's experience will help determine when the timing and sequence of events do not make sense.

For example, this author reviewed a case in which the attorney suspected that a physician defendant had rewritten and falsified a whole day of progress notes. Before hiring a

document examiner to examine the original records, he asked for my opinion. The progress notes for the entire day in question looked uniform, as if they had been charted all in one sitting with the same pen and on the same surface. Some of the entries were highly detailed, much more than was usual for this particular physician. In addition, the handwriting was unusually neat compared to his other entries. A detailed timeline helped to confirm the attorney's suspicions. In the recopied notes, the physician extensively discussed laboratory results in the 10:00 a.m. entry; however, these results did not exist until after 2:00 p.m. This inconsistency confirmed that the notes were written after the fact and were false.

The LNC's experienced eye may also note physical irregularities in the notes such as words that are obliterated or written over, or letters or numbers that look unusual (perhaps because of alterations such as a 3 being changed into an 8, or a one being changed into a 9). There may be words or entries that are squeezed in between words or lines, or otherwise appear as though they were added after the fact. For these types of alterations, the attorney may need to have the original record examined by a document examiner. These experts are able to use various scientific techniques to find proof that an alteration has occurred.

Conclusion

The LNC is very valuable in determining when spoliation may exist. As discussed above, spoliation may influence the outcome of a case or have other important consequences. If spoliation is suspected, the LNC should inform the attorney immediately so that the suspected spoliation can be investigated and an appropriate strategy formulated.

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The Journal of Legal Nurse Consulting



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Submission Guidelines

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

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

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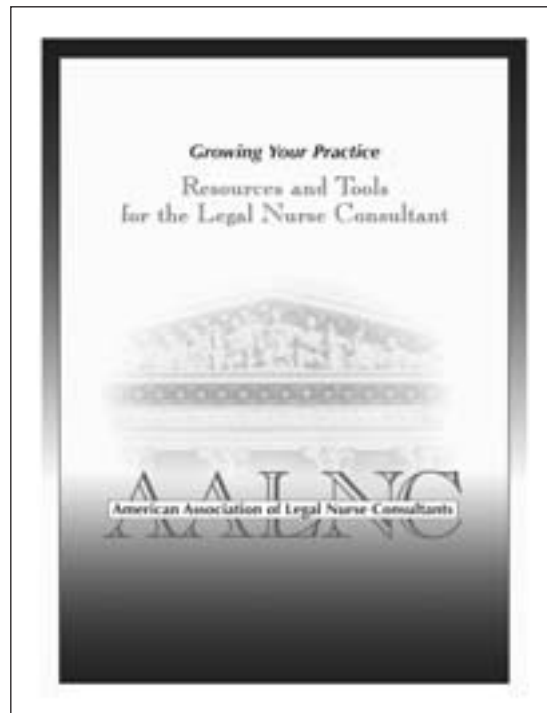
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