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AALNC

AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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The Journal of Legal Nurse Consulting

Purpose

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

Manuscript Submission

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

Manuscript Review Process

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

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Features

Departments

Commitment

I have a special fondness for the men and women of the armed forces. I am humbled by their courage and commitment. Political positions aside, their individual sacrifice is indisputable. So it was with great interest that I read Marjorie Pugatch's contribution of *Federal Tort Claims and Military Medical Negligence*. This informative article takes a historic look at the origins of remedy for military personnel and introduces the reader to the rights and limitations of pursuing a negligence claim in the military health care system. It is a great introduction to this type of law.

If you ever wondered how information is gathered to formulate appropriate questions and content for certification tests or board exams, authors Lynn Webb and Marianne Hallas provide one such answer. Their article, *2007 Legal Nurse Consultant Practice Analysis*, brings insight into the detailed process. Along with detailing the survey generated to practicing LNCs, these two authors share the structure and strategy that combines to determine the role responsibilities and knowledge content for inclusion in the LNCC certification exam.

Writing neither for the plaintiff nor the defense bar, Polly Zimmerman has offered observations on testifying as an expert witness. In no way does her article, *Providing Expert Witness Testimony*, profess to bring a formula approach to expert testimony. It serves only to share the observation that, at times in expert witness work, patterns and themes may emerge in attorney approaches and styles. As Ms. Zimmerman will readily tell you, the mandate of an honest, objective opinion is always at the forefront of the expert witness' duty.

To compliment our feature article, *References and Resources* offers a listing of informative Web sites on military and government matters. As I view the extent of information I am able to freely access online, I am awestruck at what freedom of information U.S. citizens enjoy. The reader may access the Pentagon and Department of Defense, view their elected officials' voting and attendance record in Congress, interactively ask a question of the White House staff, and share in-depth knowledge about our government with future generations.

My final note of appreciation this issue goes to those authors who have shown their commitment to legal nurse consulting by submitting manuscripts and those readers who have written to share ideas and suggestions for future articles. Your contributions are always welcome. I sincerely hope I get the opportunity to meet you at the AALNC conference in Tampa.

Best regards,

Kara DiCecco, MSN, RN, LNCC

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Editor, *The Journal of Legal Nurse Consulting*

Federal Tort Claims and Military Medical Malpractice

Marjorie Berg Pugatch, MA RN LNCC EMT-B

KEY WORDS
Federal Torts, Military Medical Malpractice

Federal laws govern who may bring suit for medical malpractice committed in military and veteran's health care facilities. Because this is a rather specialized area, there are plaintiff law firms that concentrate their practice in this area. Those firms would be a source for employment for legal nurse consultants (LNC), as would government agencies that handle the investigation of such claims. Knowledge of the similarities and differences between military and civilian malpractice laws would be an asset to LNCs and especially to those interested in this specialty area. This article discusses the federal health care system for military and veterans care, the history of federal laws governing military medical malpractice, the claims statistics related to military medical malpractice, how a claim is processed through the government tort system and how a lawsuit wends it way through the legal system.

There are more than 1.4 million members of the active military who, when combined with their dependents and the 26.4 million veterans, may receive medical care through the federal government either from the Department of Veteran's Affairs (VA) or the Department of Defense (DoD) (U.S. Census Bureau, 2003). The VA employs approximately 16,000 physicians and 62,000 nurses (VA Health care Statistics, 2006). These statistics make the VA health care system one of the largest in the country.

Scope of the Problem

Although military medical malpractice paid claims are submitted to the National Practitioner Data Bank (NPDB) and the Health care Integrity and Protection Data Bank the data in those interconnected data banks "is normally confidential and can be provided only to authorized queriers, such as hospitals, managed care organizations, and State licensing agencies for professional credentialing and licensing and peer review purposes" (NPDB, 2007). The data bank profile further states that "data may be released to a "'person or entity who requests information in a form which does not permit the identification of any particular health care entity'…" (NPDB 2007).

A request to access the data bank for the statistics related to the DoD and VA resulted in e-mail communication with Richard Granville, MD, a government official and author of several articles about military medical malpractice paid claims, who informed this writer that the DoD database is Quality Assurance protected under 10 U.S.C. §1102 and not available to private citizens (Granville, MD personal communication, August 28, 2007). The part of the database that is accessible to the public does not contain a separate category of military paid medical malpractice claims. Those statistics are imbedded within each State's reported numbers.

Despite that fact, some old data coupled with more current (albeit meager) information was combined to generate a sense of numbers. Between 1992 and 1998, the DoD paid out, on average, $79 million per year on approximately 350 claims per year (Granville and Rogers, 2000). The care delivered by the DoD is mostly supplied to active-duty personnel, a class of patients that are barred from submitting claims for medical malpractice as will be discussed later in this article. The DoD-paid claims would therefore be for the negligent care rendered to the dependents of active duty personnel.

Between October 1, 1992, and September 30, 1993, the VA had 770 filed claims (Fournier and Fitzsimmons 1994). The Judgment Fund, on behalf of the VA, paid $57 million in 1995 and $67 million in 1994, with 76% of those figures related to medical malpractice cases (VHA/DVA, n.d.). In 2004, the NPDB reported 17,696 medical malpractice payment reports for the entire U.S. health care system (NPDB, 2004).

Since the actual data is inaccessible, these figures conservatively suggest that there may be in excess of 1,000 medical malpractice claims per year emanating from these two federal health care programs, which may equate to $120 million per year in paid claims.

LNC Practice

These statistics support the idea that this is another avenue down which legal nurse consultants (LNCs) could seek employment. It is therefore a good practice for our profession to have some understanding of the similarities and differences between civilian and military medical malpractice laws and claims processes.

Not only would the LNC involved in such a case be expected to review, summarize, and analyze medical records, but the LNC would also be expected to understand and participate in filling out the special claim forms necessary in these cases (discussed elsewhere in this article) and to assist with educating the plaintiff-client on the procedures involved in the claims process and trial process. An LNC on the defense side of these cases would also need a working knowledge of the legal process, as well as the claims process in military medical malpractice cases.

History of Negligence Claims Against the Government

Prior to 1946, tort claims (negligence) against the government were barred by the legal doctrine of "sovereign immunity" derived from the old English law that "the King can do no wrong." Absent a waiver of the immunity, an injured person could not sue the federal government for a personal injury unless the government gave its permission. To circumvent sovereign immunity, legislators would routinely introduce private relief bills for their constituents who had been injured as a result of government negligence. The use of these private bills dates back to our earliest history as a nation and became so plentiful that "at times it dominated the legislature's work schedule" (Schamel, 1995, p. 5).

Although private claims were eventually put through a committee process, this system did not alleviate the "deluge of petitions for private legislation" (Schamel, 1995, p. 7). Not only was it a cumbersome system, but it was inherently unfair to those who did not have access to their legislators. Legislative attempts to alter the handling of such claims started in the 1920s, but all efforts failed until 1946.

Federal Tort Claims Act

In 1946, Congress enacted the Federal Tort Claims Act (28 U.S.C. §1346 (b) and 28 U.S.C. §2671-2680). The FTCA made the United States liable for the torts of its employees acting within the scope of their federal employment "to the extent that private employers are liable under state law for the torts of their employees" (Cohen, 2001, p.1). It is important to note that not all medical care providers in federal facilities are federal employees. Because they may be independent contractors with their own medical malpractice coverage, this is another area that will have to be investigated before deciding if civilian laws apply or the FTCA is applicable.

The FTCA is applicable to all such claims, running the gamut from motor vehicles accidents with post office vehicles to the claims of Vietnam Veterans exposed to Agent Orange to medical malpractice claims by members of our armed forces, their dependents, and veterans. This act essentially waived the Federal government's right to sovereign immunity. Unlike civilian law, the government would not be liable for accrued interest or punitive damages related to those cases (28 U.S.C. §2674). This initial waiver also contained an exception to claims arising out of combat (28 U.S.C. § 2680).

Feres Doctrine Limits FTCA

In 1950, the Supreme Court further limited the use of the FTCA in cases involving active military as decided in *Feres v. United States* (340 U.S. 135), which has become known as the *Feres* Doctrine.

Feres involved the case of a soldier who died in his barracks due to a fire. The executor of *Feres'* estate claimed that the United States was negligent in housing the active duty serviceman in a barrack with a defective heating system. The court rejected the claim for several reasons. The court concluded that the relationship between the government and the serviceman in this instance was not the same relationship that would exist between private employers and their employees, and the suit was therefore barred. The Supreme Court also noted that Congress had established a generous "no-fault" compensation system that included free medical care for active duty personnel, unlimited sick leave with full pay, a comprehensive disability retirement system for permanent injuries in the line of duty, and survivor death benefits insurance. The third reason, noted by the Court, included the necessity to maintain military discipline. Lawsuits, it was argued, would foster an adversarial relationship between the soldier and his superiors and would also divert the resources of the armed forces from their primary function of defending the nation.

One of the central issues in determining whether the *Feres* Doctrine is applicable in a case is ascertaining what constitutes "active military service." Courts generally decide this issue only after considering all of the facts and circumstances of each case. The *Feres* Doctrine barred claims for injuries to *active duty* members of the armed forces emanating from activities incident to military service, including claims of medical malpractice, that occurred during their service. Not only were combat situations exempt from suit, but now all activities of an active duty member were exempt from suit.

The *Feres* Doctrine would also bar claims by service members where the injury did not become apparent until many years after the service member had been discharged. An example of this exception is found in Agent Orange exposure cases, which occurred following the Vietnam War.

The *Feres* Doctrine does not bar claims where the negligence was committed after the active-duty soldier was discharged from the service. For example, if the active duty serviceman suffered an injury during his service but received additional care to this injury from a VA hospital after discharge and negligence occurred during that treatment, he would be able to bring a claim (348 U.S. 110). The *Feres* Doctrine does not bar a claim by a dependent of any active duty person for negligence committed to the dependent. Medical malpractice cases brought by either veterans (for after active duty medical malpractice) or military dependents are two areas where the LNC might be called upon to assist in the litigation process.

Handling Claims for Non-Active Duty Persons

As a condition to the waiver of sovereign immunity, the FTCA requires presentation of a claim "administratively" to the agency responsible for the alleged negligence as the first step. The claim form, Standard Form 95 (28 C.F.R. §14.2), must strictly comply with the requirements of the FTCA (28 U.S.C. § 2401). The FTCA requires that all claims must be filed within 2 years (strict statute of limitations) of "knowing of the existence and cause of the injury."

Among other things, the claim must contain a "sum certain" dollar amount. Once a claim has been filed, the agency has 6 months to conduct an investigation, reach a settlement, or deny the claim. If a claim is settled administratively,

the amount awarded will not be greater than the stated "sum certain" figure and could conceivably be settled for considerably less than the "sum certain" amount. A lack of response by the agency within this time period is deemed a denial. If the claim is not settled within 6 months or the claim is denied, the claimant must file suit against the government in Federal District Court within 6 months of the denial or refusal of any settlement offered (28 U.S.C. §§ 2401, 2675). Unlike civilian cases, minors are not afforded any extension to the 2-year statute of limitations. There is no tolling for minors (Grasso, 1987).

Should the plaintiff, after their claim is administratively denied, decide to bring suit against the federal government, there is *no right to a jury trial*. The judge acts as both judge and jury. Contingency fees for representation are 20% of any settlement during the administrative phase and 25% if the case proceeds to trial and the plaintiff prevails.

Although it might sound as though Feres makes the whole area of military medical malpractice final in terms of who can and who cannot sue, as well as who can be sued, the Feres Doctrine is continually being tested through various lawsuits that ask the court to define what constitutes active military activity under a given scenario and who is considered an employee of the federal government. There have been attempts by the House of Representatives to pass several bills to allow active military personnel to pursue lawsuits regarding injuries caused by improper medical care, but the bills have failed to win approval in the Senate.

As recently as 2002, the United States Senate Committee on the Judiciary held a hearing entitled *The Feres Doctrine: an Examination of this Military Exception to the Federal Tort Claims Act* (Tort Trial and Insurance Practice, 2003). Veterans' groups strongly support legislative action to overturn the *Feres* decision. They believe it imposes an unfair legal disability on military members and veterans by depriving them of the right to obtain relief for injuries suffered as a result of government negligence. To date, *Feres* remains intact.

Medical Claims Act

U.S. military medical care is also offered in foreign countries to active military and their families members, but neither the FTCA nor the Feres Doctrine are applicable where negligent care has occurred in an overseas facility. The Military Claims Act (MCA) governs claims in such facilities but only for non-active duty personnel (10 U.S.C § 2733). The MCA allows an administrative claim to be filed, but if a claim is denied, an individual does not have a right to sue the federal government. Rather he/she has the right to appeal the decision to a senior official within the DoD, but the decision of the senior official is a final decision.

Conclusion

Potential military medical malpractice cases require intricate legal analyses because of the complexity of the federal laws that control such cases. LNCs should have a basic understanding and appreciation of the intricate laws and processes that govern in order to participate fully in such cases. An LNC with life care planning experience is in a good position to assist with filling out the initial claims forms and in providing the "sum certain" figure along with supporting documentation of that figure. Likewise, an LNC with life care planning experience would be in a good position on the defense side to analyze the sum certain figure and provide documentation to mitigate the sum certain figure.

If a claim is not settled, the LNC would be an asset in the process of case development by performing the tasks she/he would do in a civilian case including reviewing, analyzing, and summarizing medical records, as well as educating attorneys on the medicine involved and participating in trial support.

Researching this article and specifically trying to find out how many claims of military medical malpractice are made each year has lead the researcher to the National Practitioner Data Bank. The statistics from the DoD and the VA are intentionally not available to the public through the data bank. Additionally, because active military cannot bring suit, the real number of military medical malpractice is not known. If the current laws are changed due to the efforts of veteran's groups, the field of military medical malpractice litigation may grow and, with it, offer more opportunities for LNCs.

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2007 Legal Nurse Consultant Practice Analysis

Lynn C. Webb, EdD, and Marianne Hallas, MBA BS RN LNCC

KEY WORDS
Certification, Practice Analysis

In 2007, the American Legal Nurse Consultant Certification Board (ALNCCB) and the American Association of Legal Nurse Consultants (AALNC) commissioned a study regarding the role of legal nurse consultants (LNCs). Previous practice analysis research was reviewed by a panel of experts to develop a survey of incumbents that was offered electronically to the membership of the AALNC. The response rate was 11%. The data were collected on the frequency and importance of 169 LNC tasks and the importance of 49 LNC knowledge statements. The test blueprint was confirmed in general, although some indications for slight shifts in content domain emphasis and deletion of test question topics were shown. The 2007 study will be valuable in updating and confirming aspects of the certification program.

Legal nurse consultants (LNCs) are registered nurses who perform a critical analysis of clinical and administrative nursing practice, health care facts and issues, and their outcomes for the legal profession, health care professions, consumers of health care and legal services, and other groups as appropriate. LNCs have strong educational and experiential foundations and are qualified to assess adherence to standards and guidelines of health care practice as it applies to nursing and health care professions.

Background

The American Legal Nurse Consultant Certification Board (ALNCCB) offers the Legal Nurse Consultant Certified (LNCC) examination and is accredited through the American Board of Nursing Specialties (ABNS). The ABNS accreditation standards cite practice analyses as one of the most important methods for demonstrating content-related test validity, and suggest updating these studies every 5 years (ABNS, 2004).

The test development for the certification examination reflects best practices through psychometric standards. For example, the test blueprint is based on a job analysis as called for in the joint standards of the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education (1999) in Standard 14.10. The standards explain that the validity evidence for test content should include a description of the job characteristics that are to be sampled, including the relative frequency, importance, or criticality of the tasks. Other popular standards in certification and licensure testing, such as the ones delineated for accreditation by the National Commission for Certifying Agencies (NCCA) or the American National Standards Institute (ANSI), similarly cite practice analyses as a necessary foundation for testing programs. The practice analysis results are used to update the test blueprint, ensuring that the certification examination reflects the current practice of legal nurse consulting.

In 2007, the practice analysis reported herein was conducted to ensure that the certification examination remains a valid assessment of the knowledge and skills required for safe, effective practice by LNCs. This study built upon a previous study (Magnusson and Garbin, 1999) and a logical analysis reviewed by the Board in 2003. The 1999 study used a combination of logical analysis and a mailed questionnaire that collected data on the frequency and importance of legal nurse consulting activities. The 2007 study included an expert panel review of the knowledge, skills, and abilities covered in the previous study, a pilot test of an electronic survey, and an electronic survey of LNCs.

Methodology

Design and Sample Selection

The certification examination for LNCs is built upon a solid foundation of previous practice analyses. This study was designed to maximize the benefits from the previous work, while ensuring that any changes in the field would be reflected. The study used information from the previous research as a starting point for a representative panel of LNC leaders. Work from the panel was formatted into an electronic survey that was pilot-tested, fine-tuned, and distributed electronically to incumbent LNCs. The AALNC has e-mail addresses for its membership, which led to a decision to send the invitation to all members rather than sampling. In this way, all AALNC members were encouraged to participate in the basis for the certification program.

Expert Panel

The ALNCCB and AALNC convened a panel of 10 certified LNCs to review the tasks and knowledge statements used in the previous study. The meeting was held on April 24-25, 2007, and about half of the participants represented the Certification Board. The ALNCCB sent materials from the previous studies to the panelists prior to the meeting. Panelists were asked to review the materials for general familiarity prior to the meeting. Because the initial number of task statements was large (145), it was efficient to work in small groups to review subsets of the tasks and then report back to the full group with changes. A group of statements reflecting knowledge required to work as an LNC was also reviewed by the panel. Review of the previous work consisted of updating terminology, clarifying terms, deleting outdated material, and incorporating new knowledge, skills, and abilities. The

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panel provided input about which demographic variables would be helpful to recognize if the survey respondents are representative of the field.

Electronic Survey

From the work of the expert panel, a draft form of the survey was developed and entered into a software package for electronic delivery. The panel members nominated additional LNCs to participate in the pilot study, for a total of 22 LNCs. Through this process, directions and survey statements were clarified. A key piece of information from the pilot study was the time required for completion. It was feared that if the questionnaire took over an hour to complete, there would be an adverse effect on the response rate. The average time for completion was well under one hour, so it was decided to administer the full set of questions to each participant, rather than breaking the content into separate forms.

Data Collection

Invitation to Participate in Survey: The survey link was sent to the AALNC membership on September 21, 2007. The survey consisted of an introduction and instructions for rating the tasks. Each task was accompanied by two scales: frequency and importance. The instructions were as follows: *Please read each task statement carefully, then use the drop-down scale to indicate how frequently you perform the task in your work as a Legal Nurse Consultant. (Click on your preferred response.) Then use the second drop-down scale to indicate how important the task is to your work as a Legal Nurse Consultant. Some tasks will be performed more frequently than others, and some tasks will be more important than others.*

The frequency scale consisted of five options:

1. Over 10 times per month
2. 6-10 times per month
3. 1-5 times per month
4. <1 time per month
5. Do not perform task

The importance scale consisted of four options:

1. Very important
2. Important
3. Somewhat important
4. Not important

The tasks were organized under eight content domains:

1. Collect and investigate records, research literature, standards, guidelines, laws, costs, etc., related to a case, concerning issues of liability, causation, and/or damages
2. Analyze data from records, research literature, standards, guidelines, laws, costs, etc., related to a case, concerning issues of liability, causation, and/or damages
3. Facilitate communication with: (a) clients, (e.g., attorney, claims manager, agency), (b) parties (i.e., claimant, plaintiff, defendant), and (c) experts, witnesses, and vendors
4. Draft documents in health care related cases, including attorney work product or expert witness
5. Educate self and others involved in the legal process regarding medical and health care facts. Educate health care providers regarding legal issues. Pursue continuing education for self and provide it to others
6. Develop case strategies or plans
7. Support the process of adjudication of legal claims (e.g., trial, hearing, arbitration, or mediation)
8. Testify as an expert witness or as a fact witness

Additionally, respondents were asked the extent to which the survey tasks covered what they do as LNCs. Respondents were given an opportunity to enter any additional tasks that they perform that were not addressed in the survey.

Another section of the survey asked about a variety of knowledge topics associated with legal nurse consulting. The instructions were as follows: *This brief section asks you to make just one rating about the importance of knowledge or abilities needed to perform the tasks of Legal Nurse Consulting.*

Respondents rated the importance of 49 knowledge topics, using a 4-point importance scale that included choices of:

1. Essential
2. Important
3. Useful
4. Irrelevant

Results

Response Rate

The Internet URL for the practice analysis survey was sent to the membership of the AALNC via e-mail, and 3,487 messages were delivered. There were 369 responses, giving a response rate of 10.6%, or 11%. This rate is comparable to what is currently seen in certification and licensure literature.

Demographic Data

A demographic section was included at the end of the survey to ascertain how well the respondents represented the population. Based on the data collected, it appears that the survey respondents are representative of the membership on key variables. However, about one-third of the respondents skipped the demographic items, making firm comparisons from the respondents to the population of interest difficult. It is a common survey technique to place the demographic items at the end of the survey, especially in lengthy questionnaires. However, the anticipated gain in fresh responses to the core of the subject matter can bring attenuation by the final section of the survey.

Representation by state. The largest numbers of respondents perform most of their work in the states of Florida, California, Pennsylvania, Texas, Illinois, Arizona, New York, Ohio, and Missouri. Of the 50 states, 38 states and the District of Columbia were represented, and one "nationwide." As mentioned above, it could be that the other 12 states were represented through respondents who skipped this question.

Hours per month. Respondents were asked to indicate approximately how many hours per month (on average) they work as LNCs. The largest group indicated working over 160 hours per month, which supports ABNS Standard 1: Definition and scope of nursing specialty. This standard requires a pool of nurses who concentrate their practice in the specialty, defined as spending 50% or more of their work time, functions, or professional roles in the specialty (ABNS, 2004). It is interesting to note that there were almost as many selections for 140-160 hours per month, 40-69 hours per month, and 10-39 hours per month. There were several selections for less than 10 hours per month, 70-99 hours per month, and 100-113 hours per month. These data indicate a complete representation of part-time and full-time work in the field.

Years worked. Respondents were asked to indicate the number of years they have worked as LNCs. The largest group of respondents had 6-10 years of experience, but other categories were similarly popular. All levels of experience from less than one year to beyond 16 years were represented in the survey responses.

Years RN. Respondents were asked to indicate the number of years they have been licensed as RNs. A great majority of respondents indicated the longest option, of over 20 years. There were no respondents who indicated receiving their license within the shortest time frame of 1-5 years.

Clinical setting. Respondents were asked to indicate if, at the present time, they practice in a clinical setting. About 65% of respondents indicated that they are not employed in a clinical setting at the present time. Those who are employed in a clinical setting were asked how many hours per month (on average) they practice in a clinical setting. The majority of respondents indicated working 10-39 hours per month in a clinical setting, but all options from less than 10 hours per month to over 160 hours per month were selected.

Work as LNC in past 3 years. It was found that 89% of respondents have worked as LNCs during each of the past 3 years, and 77% of these respondents have worked at least 2000 hours cumulatively over the past 3 years. These hours constitute the practice requirement for the certification examination.

Education. Respondents were asked to indicate the highest level of education they have attained. The most popular response was the baccalaureate degree in nursing, although other popular responses were masters' degrees (nursing and non-nursing), an associate's degree in nursing, and a diploma in nursing.

Practice setting. Respondents were asked to indicate the setting where they practice as LNCs. If respondents practice in more than one setting, they were asked to indicate all settings where they spend at least 1/3 of their time. About half of the respondents work as solo practitioners, and about 1/3 work in law firms.

Practice areas. Respondents were asked to indicate the area in which they usually work as LNCs, and were invited to indicate all areas that applied. Medical malpractice, expert witness, and personal injury were the most popular areas of practice.

Other nursing certifications. Respondents were asked if they are certified in any other nursing specialty. Only 39% of respondents indicated having another nursing specialty certification. A follow up question of which certifications they have was asked. Certified case manager and critical care nursing were popular selections, but most respondents entered a certification, and those entries were quite varied.

Analysis of Tasks

The survey data show great variety in both the frequency and importance ratings. Although most ratings are at the higher ends of the two scales, there are many responses in the lowest categories, which are "Do Not Perform Task" in the frequency ratings, and "Not Important" in the importance ratings. However, the very same tasks with responses in the lowest ratings also have responses in the highest ratings (which are "Over 10 times per month" for frequency and "Very Important" for importance). It would be inadvisable then, to cull the list of tasks merely for a significant number of responses in the lowest categories, because those very tasks are of high frequency and/or importance to others. Although the data is technically ordinal in nature, comparing means of the data per task allows for simple comparisons across tasks. Numerical values were applied to the points along the two scales as follows:

Frequency:
- 5 Over 10 times per month
- 4 6-10 times per month
- 3 1-5 times per month
- 2 <1 time per month
- 1 Do not perform task

Importance:
- 4 Very important
- 3 Important
- 2 Somewhat important
- 1 Not important

The specific values for Frequency and Importance were multiplied for each task to establish a "Criticality" rating. In this way, both aspects of the ratings could be considered when looking across tasks. Missing data remained coded as missing, rather than zero, as it is unclear what the respondents intended when leaving ratings blank. This process translates to respondents' single rating being their default Criticality rating when they skipped one of the ratings for a task. If a respondent did not indicate both ratings, perhaps the best assumption would be a low rating (1). Using a zero value for missing data would have negated the one present rating. The maximum possible Criticality rating is 20 (5 Frequency x 4 Importance) and the lowest possible Criticality rating is 1 (1 Frequency x 1 Importance). Using the mean criticality ratings (Frequency multiplied by Importance), the tasks can be listed in priority sequence by the 8 domains and overall.

Table 1 shows for each of the 8 content domains the current percent of test questions (Axis II), the number of tasks,

Table 1. Criticality Ratings Summarized by Domain.					
Domain	**Current % of Test**	**N Tasks**	**Criticality Range**	**Criticality Mean**	**Criticality Rank**
Collect and investigate records…	16-20%	27	12.96 – 1.98	6.48	2
Analyze data…	16-20%	28	11.85 – 3.08	6.96	1
Facilitate communication….	15-19%	24	13.14 – 1.56	4.84	4
Draft documents…	14-18%	21	10.56 – 1.30	3.38	6
Educate self and others…	8-12%	12	8.18 – 2.20	5.77	3
Develop case strategies or plans	8-12%	24	8.12 – 1.84	3.55	5
Support the process of adjudication…	4-8%	25	3.22 – 1.01	1.88	8
Testify as an expert/fact witness	3-7%	8	6.74 – 2.07	3.14	7

Table 2. Domain Criticality Ratings Shown with Percent of Total Tasks Times Mean.					
Domain	**Current % of Test**	**Criticality Mean**	**% of Total Tasks**	**% times Mean**	**Rank**
Collect and investigate records…	16-20%	6.48	.16	1.03	2
Analyze data…	16-20%	6.96	.17	1.15	1
Facilitate communication….	15-19%	4.84	.14	0.68	3
Draft documents…	14-18%	3.38	.12	0.42	5
Educate self and others…	8-12%	5.77	.07	0.41	6
Develop case strategies or plans	8-12%	3.55	.14	0.50	4
Support the process of adjudication…	4-8%	1.88	.15	0.28	7
Testify as an expert/fact witness	3-7%	3.14	.05	0.15	8

the criticality range across the domain's tasks, the criticality mean, and the rank based on the mean. One can see that the first two domains, abbreviated as Collect and investigate records…and Analyze data… are the highest rated. The two final domains, Support the process of adjudication... and Testify as an expert/fact witness…received the lowest ratings. The other content domains were in the middle of the ranking, although we see great spread of ratings in domains 3 and 4, which are Facilitate communication and Draft documents, respectively. Using only the Criticality means and ranks, it would appear that more emphasis in the test blueprint should be given to Domain 5: Educate self and others, and also to Domain 8, Testify as expert/fact witness. However, we also see that these two domains have significantly fewer tasks than the other domains.

Table 2 repeats for each domain the current emphasis in the test, and the criticality mean from the survey, but then also presents the percentage of tasks within the survey (n/169) multiplied by the criticality mean, and then a rank. Now we see that the fifth domain of "Educate self and others…" shows average ratings higher than one might anticipate based on the test blueprint, but it included only 12 tasks in the survey, which is about half of the other middle domains. The rankings in Table 2 are tempered by the number of tasks per domain. In this way, domains with fewer task statements, like 5. Educate self and others…. will be lower than in Table 1. In testing, it is important to consider the number of questions that can be written to address a content area. For example, it is vitally important that all drivers recognize the function of a stop sign. We wouldn't want anyone who doesn't recognize a stop sign to be licensed. However, there is a limited number of ways we can ask about the stop sign in each driving test. We see Domain 5 would rank third in test emphasis if we used only the criticality ratings, but it would be 6th in test emphasis if we tempered that rating with the number of tasks.

Unlike Table 1, the ranks tempered by the number of tasks in Table 2 do not suggest changes to domains 5 and 8. However, from this perspective one could argue that Domain 6, "Develop case strategies or plans" could be increased in emphasis within the test.

It is interesting to note the individual tasks that were given the highest Criticality ratings. Table 3 lists the top 10 tasks and includes a notation of the domains under which the tasks were listed.

As noted earlier, many of the tasks in the survey appeared in the 1999 study, however some tasks were added for this study, or revised for clarity or updating. Additionally, the 1999 study used a different formula for criticality, so longitudinal comparisons are general, rather than specific. In this study, the most highly rated task was "Maintain confidentiality" and this task was also the most highly rated one in the 1999 study. In fact, 4 of the 10 most highly rated tasks in this study also ranked in the top 10 in 1999, and they are marked with asterisks next to their ranks.

Survey respondents were asked to what extent the survey covered the tasks they perform as LNCs. This question validated the work of the expert panel in that 44% indicated that the survey 'completely covered' the tasks and 49% indicated that the

Table 3. Highest Rated LNC Tasks.		
Rank	**Domain**	**Task (Criticality Rating)**
1*	3	Maintain confidentiality (13.14)
2	1	Identify adherence to or deviations from the standard of care (12.96)
3*	3	Maintain professional written or oral communication (12.94)
4	1	Conduct medical/health care literature searches for the client (11.95)
5	1	Conduct literature searches for case analysis (11.86)
6*	2	Extrapolate key information from health care documents (11.85)
7	1	Obtain applicable standards and guidelines for case analysis (10.76)
8*	4	Summarize medical records and other case documents (10.56)
9	1	Obtain applicable standards, regulations, and guidelines for the client (10.41)
10	1	Identify types of experts needed (9.86)
**Indicates top 10 ranking in 1999 and 2007*		

survey 'adequately covered' the tasks. Adding these categories, we would see that 93% of the survey respondents indicated that the survey covered the tasks they perform as LNCs. The survey also provided an opportunity for respondents to add any tasks they perform that were not addressed by the survey. Those tasks and the complete prioritized list of 169 tasks will be reviewed by the Examination Committee for implications of updating the test questions.

Analysis of Knowledge

One would anticipate that most of the ratings for the knowledge statements would fall into the first three categories of the scale provided, which were:

1=Essential
2=Important
3=Useful
4=Irrelevant

In fact, there were no knowledge statements that received an 'Irrelevant' rating from a majority of respondents, or even as the modal rating. Table 4 shows the top 10 knowledge statements in prioritized order according to the survey ratings. As was true for the task ratings, the scales are actually ordinal data, but the use of means offers a way to compare the statements simply. Only one of the top 10 knowledge statements did not appear as a top 10 statement in 1999. The knowledge statements correspond to categories of Axis I in the test blueprint.

Table 4: Top 10 Knowledge Ratings.	
Importance	**Knowledge**
1*	Analytical thinking skills
2*	Rules of confidentiality
3*	Ethical principles
4*	Written communication skills
5*	Rules of professional conduct
6*	Medical terminology
7*	Verbal communication skills
8*	Organizational skills
9	Knowledge of own strengths and limitations
10*	Anatomy and physiology
**Indicates top 10 ranking in 1999 and 2007*	

Discussion and Recommendations

The 2007 practice analysis of LNCs produced data that will be important in updating the certification examination. The range of ratings across and within content domains is significant. Further exploration of the data may indicate whether this variability in ratings is based on setting, practice area, or other variables. The variability of responses suggests that respondents worked carefully through the survey, considering each task, rather than giving uniform ratings.

Next, a look at the general emphases within the data could be made to ascertain if the highest ratings are in concert with trends and emphases in the certification examination and the field. Finally, scrutiny of the low-rated variables may guide deletion of any questions in the pool that address topics not emphasized by the survey data (bottom 10 tasks). Because certification testing is always a sampling of knowledge, the sampling should focus on the most critical topics as shown through the ratings of this study.

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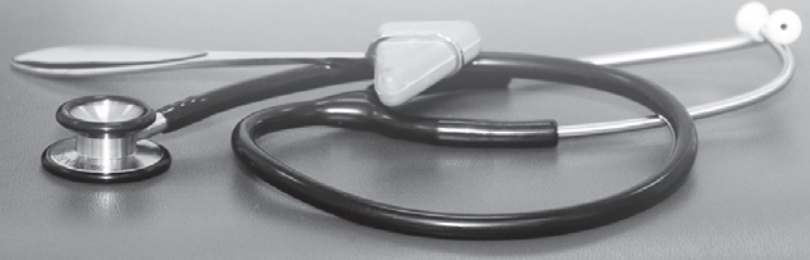

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Providing Expert Witness Testimony: Lessons Learned

Polly Gerber Zimmermann, MBA MS RN CEN FAEN

Providing expert testimony at a deposition is different than anything else nurses do professionally. The discovery deposition is the opposing attorney's opportunity to ask questions and obtain "information" about the case. This is not, however, always a cooperative strategy for truth. The underlying purpose is also to obtain some information that can be used at the trial to make the witness confused or less credible to the jury. It involves different approaches, words, and finesse.

The retaining attorney usually meets beforehand with the nurse expert for preparation. Topics covered include expected questions regarding background (education, work experience), materials reviewed, and the standard of care applicable in this case. However, in addition to the subject matter, it is important for the nurse expert to understand how different the manner of this "artificial" conversation is from nursing or society's typical conventions.

Ground Rules

Guiding principles for an expert witness testimony include the following:

- *Any discussion or "research" of the topic for the case will be discoverable.* Only the state of knowledge in print at the time of the incident will be considered valid.
- *No text is an absolute authority.* Otherwise, the nurse expert can be questioned about any content within the book. Indicating many references are useful.
- *Control the pace.* Do not allow rapid-fire inquiries or a demanding, intense tone of voice to elicit a rushed answer. Your response will set the pace.
- *Pause two seconds or one full breath before answering any question.* This allows the retaining attorney a chance to object or to instruct not to answer.
- *Listen to and incorporate the retaining attorney's objections.* If the attorney says the question is too vague, ask the opposing attorney to be more specific or restate the question.
- *Do not answer a compound question with a single answer.* Indicate that two questions were asked. Ask which question the attorney wants answered, or identify the two different answers as they are given.
- *Do not use qualifiers.* Added comments, such as "I believe," "I think," or "To the best of my knowledge" weaken the testimony. Preceding an answer with, "To tell the truth" can be construed as a lack of telling the truth before. A direct statement may seem abrupt in everyday conversation, but this conveys an expert's confidence in his or her opinion.
- *Limit testimony to the essential.* Focus on what is related to the specific case's causation. The expert is not presenting the entire scope of knowledge.
- *Ask to see any documentation referred to by the attorney prior to answering a question about it.* Read the section before it and after it to make sure that it is not taken out of context.
- *Clarify if the question is a hypothetical or this particular client.* Attorneys often ask about what would be done in certain situation or signs/symptoms. Be clear if this is a "textbook" discussion or a particular individual patient's variances.
- *Avoid repetitious cadences.* Vary the word choice, sentence structure, and length of answer so answers do not look rehearsed.
- *Make the opposing attorney "exhaust" the answer.* An attorney will vaguely ask for a list, such as what did the nurse do right. Give one thing and stop. Wait to see if the attorney asks if there is anything else before offering everything possible. Often the attorney is just fishing or wants to see if you will concede an obvious point.
- *Remain silent while checking something prior to answering.* The opposing attorney could read the statement "I have to check that" at the trial to insinuate that opinions were given without being well informed.

Deposition Time

The difficulties in a deposition for the nurse expert often arise from the opposing lawyer's approach, techniques, and antics to "shape" the testimony or discredit the source. The following are some tips to help deal with such approaches.

Preparation

- *Know the standards.* This includes the professional specialty association, as well as the American Nurses Association Scope and Standards of Practice (2004). Use standards to add weight to the testimony. For example, it is not only the expert's opinion that a patient with new onset congestive heart failure should be on a cardiac monitor, but also those of the literature-based American Association of Critical-Care Nursing (AACN)'s Protocols for Practice for Noninvasive Monitoring (2006). Standards also help prevent the opposing attorney comment, "I have experts who disagree with you."

  The care – or lack of care – is actually part of the essential nursing process (assess, analyze, plan, implement, and evaluate) that is the essence of nursing. It is taught in all accredited nursing programs. This counters the argument

that "ordinary" nurses or nurses in this type of institution, location, etc., do not know national standards.

- *Prepare a formal statement of standard of care.* Write out, edit, polish, memorize, and practice articulating how the standard of care (SOC) was or was not met. Familiarity with key points of the standard of care helps incorporate them in answers throughout the deposition.

Approach During Deposition Testimony

The attorney wants to render the opposing expert's testimony meaningless. To accomplish this, they will use disapproving mannerisms to cause self-doubt or a modification in the answer. It can feel like a death of a thousand little offense cuts from the terms or gestures intertwined in each question.

- *Know that they seek to destroy (but it is not personal).* Some attorneys roll their eyes with disgusted expressions, express disbelief ("Is that your answer?!"), or use a demeaning, angry tone of voice. Attorneys may insinuate that you don't know anything (about this type of care), you know too much (for a "regular" nurse), or you are needlessly taking too long to answer the question. Attorneys employ these tactics because they know that it is human nature to feel uncomfortable and less assertive when others are openly critical of you.

  Prepare mentally beforehand to remain poised during this type of interaction. This process does not use life's or nursing's usual rules. Some experts make a personal rule to have no social engagement on a personal level with the opposing attorney to help keep them from slipping into a social, sharing mode.

  On the other hand, make every attempt to project a warm, caring persona before and after the deposition. Attorneys are always evaluating the witness' presence, as well as the answers. You want them to realize that the jury is going to realize that you are a kind nurse and, indeed, a credible witness.

- *Enjoy the sound of silence.* It is a natural tendency to elaborate when having a conversation. The therapeutic nurse "senses" when people want to know more and "helps out" by telling them. Good nurses are always teaching, and the opposing attorney will take advantage of the typical uncomfortable feeling with a prolonged unexpected silence. They wait with an expectant look after the answer to imply that it is incomplete or deficient. Another version of this approach is to make a statement and wait for a reply. Remain unperturbed and wait silently.

Potential Expert Answers

Overall, the goal of the expert witness is to present the information in a clear, concise, and compelling manner. Use some of these guidelines to accomplish that when answering difficult questions.

- *"It depends."* Attorneys try to get agreement with a generalization, often phrased as a yes or no question. For instance, "Is it not true that patients with cardiac problems have chest pain?" In reality, life is rarely pure black or white. Answer with conditions or restrictions. An appropriate answer is "Some patients do." A variation is to answer with a complete sentence, such as "A patient with cardiac problems may have…" and put in the qualifiers. Other ways to respond include asking the attorney to be more specific, to rephrase the question, or to clarify if the question relates to all patients or this particular patient.
- *"I can't answer that with a 'yes' or 'no'."* Sometimes the attorney insists that the expert witness just say "yes" or "no." An answer is always weakened with a "Yes (or no), *but*…" response. Indicate that the question cannot be answered that way. Often the attorney will follow up with "Why?" that then gives an opportunity to give an explanatory answer.
- *"At this point."* The nurse expert is often asked to indicate if that is all of the testimony that the expert plans to give about a topic. The best answer is "At this point." For example, in one deposition, the opposing attorney pulled out documentation that the expert witness had never seen before to discredit the previous answer. Obviously, new material may require a refinement of the opinion.
- *"You are interrupting."* Interrupting the expert during the answer can be a maneuver to disrupt the train of thought or to weaken the answer. The tendency is to stop without saying anything more. The difference is that interruptions are inadvertent in social setting compared to a deliberate strategy in a deposition. Insist on finishing, but first ask for the original question and your partial answer to be reread. It helps to renew the direction and purpose that the original answer was going.

Attorney Approaches

Attorneys use some characteristic tactics to weaken the impact of the nurse expert's testimony. Watch for them.

- *Error in attorney restatement or summarization.* Mischaracterization of testimony can be either an honest mistake or a trick to get the nurse expert to agree to something that wasn't really said. It is more likely to happen toward the end of the deposition when fatigue is setting in. Socially, it is normal to let these types of little "slip-ups" slide by, as most people are well-intentioned. In a deposition, however, identify it and correct it immediately.

  Example:
  Nurse: "I would assess for slurring of words."
  Attorney: "So you look for slowed speech."

  In another case, the nurse witness explained the need to sometimes restrain an intoxicated patient who is out of control for safety reasons. The attorney concluded; "So you restrain patients when they are intoxicated.", and moved on to the next point. A good response is "That is not what I said." or to repeat the original answer.

Clearly point out the distinction, but avoid volunteering more unless asked. It is not the nurse expert's job to teach nursing to the opposing attorney.

- *One more time.* Many attorneys will ask the same question again and again, and then again. They want to see if the witness will modify or concede the answer over time. One tactic is to thank the witness for the testimony and physically gather papers to signal the deposition is concluded. Then, while the reporter is still transcribing, spring the question again as an afterthought. Handle the repetition by stating that the question was already answered or by asking to have the previous answer read back. If the opposing attorney insists, clearly indicate the finality of the answer and that there is no need to repeat it or to change it.
- *You are ignorant:* Attorneys will sometimes cater to the human tendency to want to appear smart in order to try to have the witness feel unsure or intimidated. For instance, one attorney demanded that a nurse expert agree by exclaiming, "No doctor has ever disagreed with that statement!"

  Example:
  Attorney: "Did you assess the patient for parody?"
  Nurse: "I don't know that term."
  Attorney: "You don't know that term?!" Pause. Sigh. "Well, do you assess for rate and rhythm of speech?" (Parody is rate and rhythm of speech.)

  Another approach is to ask how the attorney defines that term or to use another term instead. Not knowing one morsel of information has nothing to do with overall expertise.

  Another version of this maneuver is for the attorney to ask about something related in the field of nursing but not directly relevant to the case. Experts have been asked to name all of the specialties at the hospital involved in the incident, the circulation numbers of a nursing text, and the existence of any research on an unrelated nursing topic. The questions can be used to imply that there must be copious amounts of other information that the nurse expert doesn't know since these details aren't known.

  The nurse expert witness is not required to know the answers for everything in life. Indicate matter-of-factly that that information is not known and was not considered relevant to the professional opinion in the case.
- *You have nothing to say that I need to hear.* Attorneys will stare at the wall, appear bored, or gather papers while the expert witness is answering the retaining attorney questions. The purpose is to give the impression the attorney has no interest in what the expert witness thinks or says. An attorney may chuckle and insinuate that the opinion is ridiculous when the expert testifies to something that does not support his or her case. Recognize it as a ploy to make the witness feel impotent and continue to effectively present the testimony.

Summary

No tricks of the trade for expert testimony can compensate for a lack of education, training, knowledge, experience, or expertise in testifying about the standard of care. Awareness of some of the deposing attorney's techniques and approaches, however, can help prepare a potential arsenal of appropriate responses. The expert witness is then able to present the professional opinion in an effective manner.

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The War Room

Kara DiCecco, MSN RN LNCC

The traditional "war room" is rich in history. Historical films such as *Braveheart* and *Elizabeth: The Golden Age* have given audiences a voyeuristic look at the debates and rehearsals of military attack. Replicated ships set upon intricately painted castle floors mimic the engagement of defense and counterattack. More contemporary settings find a trilogy of formidable powers (Hollywood, The Pentagon, and Silicon Valley) using their collective knowledge to provide combat simulations in electronic war rooms via virtual 3D representations of invading forces. While the function of a war room in trial is admittedly less theatrical, the analogy to battle is fitting. The purpose of this column this issue is to introduce (or reacquaint) you with the war room and the feature role it plays in the trial process.

What Exactly is the War Room?

In true military definition, the war room is a headquarters to which the current status of military operations is reported and evaluated through maps pinning the exact location of friendly and hostile forces. Formulation of tactics and strategy are commonplace in this room. In business vernacular, it identifies the center of operations for an enterprise or organization. The space frequently is supplied with special equipment, maps, charts, or computers to assist in planning and strategy.

In litigation, the war room is a designated space that is reserved solely for the purpose of serving as a centralized location for litigation related activity when the trial team is not in court. The base camp of the war room can be a conference room in a law firm reserved for the duration of trial or an off-site location near the court house if you are litigating a case out of town (such as a hotel room or rented office space).

What Equipment is Needed for the War Room?

What constitutes the essential components of a war room can vary dramatically for each trial. A general rule of thumb: the more complex the trial, the more technology will assist you. War rooms can be as sophisticated or as basic as the individual needs of the lead attorney.

Below is just one example of a war room set-up:

- Chairs and several large tables.
- Flip chart and marker (for debriefing and brainstorming). The results are often posted to walls.
- All trial team notes generated during trial each day.
- Jury diagram.
- LCD projector/Video/DVD Monitor/Projection screens (or blank wall).
- Computer(s), trial software*, monitors and high-speed Internet and email access.
- Printer, fax machine, copier, and scanner.
- Conference call capability.
- All Office supplies.
- Open account with an outsourcing facility for last minute projects (such as high volume copying) and key contact person with vendor services.
- On-call staff support (such as typists, runners, law clerks for legal research, IT support with back-up capability)
- Mock up of all exhibits (PowerPoint®, photos, medical illustrations, model, etc.) and copies of all depositions and testimony (i.e., Live Note or "daily" e-transcripts).
- Contact list of all trial team members, witnesses, experts (and the office contact), opposing counsel, clients and Judge and Judge's staff (this includes faxes, cell phones, emails and alternate emergency contact numbers).
- Arrangements for food (caterer or delivery service)

Our firm uses Lexis-Nexis Casesoft® software for case analysis: CaseMap for case management, and TimeMap for timeline exhibit creation. These can be viewed at* ***www.casesoft.com**.*

If you are litigating a case out of town, the needs of the "virtual" war room become much more complex and require more attention to detail. A project manager or trial consultant may be a good investment. These experts anticipate what you will need and are able to address the inevitable last minute issues/crisis in trial. They will make a site visit to the proposed location to determine the feasibility and limitations of your set up. They will work with your IT support to ensure remote access capability to the firm's server (such as Citrix), confirm the technological capabilities of the courtroom (including the Judge's receptiveness to technology in trial), and address any technical glitches that arise. In addition, they will determine the location of the nearest 24-hour copy service, time zone changes, transportation services, airline schedules, witness accommodations, food services, and local vendors for outsourcing needs.

What Happens in the War Room?

Each trial brings unique properties that underwrite the script of activity. In general, the war room serves to meet the needs of the lead attorney and their staff by providing a place for planning, rehearsing, preparing, organizing, and debriefing of the day's events in trial.

The war room is invaluable in saving time and energy by allowing documents, legal research, and mock exhibits to

remain undisturbed until the team reassembles at the end of the day. The dedicated equipment assures that the team will be able to work unhindered by barriers to availability. Witness preparation and rehearsal of opening and closing may be conducted in this private area. Debriefing allows all team members the opportunity to contribute their observations, ideas, and suggestions with the lead attorney. For example, a jury diagram may serve to clarify exactly which juror was noted to demonstrate attention or disinterest to salient points in the team's strategy. Based on unfolding dynamics of the individual trial, presentation decisions are often reevaluated or confirmed in these sessions.

Perhaps the most important function of the war room is the efficient sense of order and predictability it brings to the otherwise chaotic nature of the trial process. You can learn more about the available services and software for war room set-up and operation by using keywords "the war room" and "trial" via a Google search (use quotes). Many vendors, such as CaseSoft, offer a free trial period and online Webinars (tutorials) to familiarize you with their product and its advantages.

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Government/Military Links

The references presented here are meant to provide information for the LNC interested in expanding the database of online references. They are not offered as the definitive source of practice tools and/or information. The reader is reminded to consult current case law, legislative reform, and, where appropriate, attorney guidance in contrast to relying solely on this information. JLNC makes no endorsement as to the reliability of the information obtained from these references.

Government Web Portals	
USA.gov	**http://www.usa.gov**
FedStats	**http://www.fedstats.gov/**
Library of Congress' Legislative Web Site	**http://www.thomas.gov** Look up current bills in Congressional debate, see your elected official's attendance record in Roll Call, explore Government Resources for exceptional educational resources, and more.
Government Printing Office	**http://www.gpo.gov/**
The White House	**http://www.whitehouse.gov/**
U.S. Senate Homepage	**http://www.senate.gov/**
U.S. House of Representatives	**http://www.house.gov/**
Department of Veteran's Administration	**http://www.va.gov** Use search box to enter search terms: for example, "medical malpractice claims," then scroll down to scan documents returned for specific information. **http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1101** Sample of directive outlining notifying the medical practitioner of medical negligence claim.
United States Army	**http://www.army.mil/**
United States Air Force	**http://www.airforce.com/**
United States Marine Corps	**http://www.usmc.mil/marinelink/mcn2000.nsf/homepage?readform** Choose links to view the Uniform Code of Military Justice.
United States Navy	**http://www.navy.mil/swf/index.asp**
The National Guard	**http://www.ngb.army.mil/default.aspx**
United States Coast Guard	**http://www.uscg.mil/**
Department of Defense	**http://www.defenselink.mil/** Choose Web Sites in top toolbar to access Publications (from which you can choose a dictionary of military terminology, Freedom of Information Act (FOIA), videos, and more).
Military Reserve Divisions	**http://www.defenselink.mil/sites/g.html#GuardandReserve** Access all forms of military reserve and the National Guard.
DeployMed Research LINK	**http://www.deploymentlink.osd.mil/deploymed/** Link to research/medical library on service connected illness.
Department of Defense Military Health System	**http://mhs.osd.mil/**
Pentagon	**http://www.defenselink.mil/sites/p.html#Pentagon**
TRICARE Military Health Insurance	**http://www.tricare.mil/**
Resources for clinical practice tools with a military focus	**http://www.medtrng.com/index2.html** Check out "Quizzes," "Tutorials/Simulators" & "Flashcards". **http://www.cs.amedd.army.mil/ddl/links.asp *** Many choices need password or military clearance; however, there is still a wealth of freely accessible informational tools. Respect those sites that are "locked" or for Official Government Personnel, and do not attempt to enter. You will be cautioned on which sites are restricted.

Beyond a Reasonable Doubt

Edited by Larry King and Henrietta Tiefenthaler
Copyright 2006
Publisher: Phoenix Books (www.phoenixbooksandaudio.com); ISBN: 1-59777-503-7; Cost: 27.95

Reviewed by Kara DiCecco, MSN RN LNCC

I acquired my appreciation for books from my mother, and I inherited an innate curiosity to learn about how things work from my father. My need to understand is the predictable offspring of their union. This genetic trait creates an almost primal drive to put into perspective conceptual information that others might regard as society's unassailable rules. I have never been quieted or satisfied with the authority responses that resonate from childhood ("because I said so") or in adulthood ("because that is the way we have always done it"). The need to reconcile this affront to my sense of fair play leaves me wanting further explanation and a need to know exactly why. Not surprisingly, the legal field has provided fertile ground for exploring and challenging the legitimacy of long-held standards.

To me, the legal burden in criminal prosecution is, at best, unsettling. Hotly debated and poorly defined, its interpretation seems at home with manipulation and misunderstanding. What exactly happens in the courtroom that leads juries to render verdicts that seemingly escape logic and rebuff common sense? I acknowledge that media exposure often gives us less than the complete picture, and that the middle range truth may be less attractive to the viewing audience than the sensational snapshot that the sound bit provides. I can reconcile that the attribute of celebrity status may have an untoward influence on the average juror or that there is an understandable reluctance to sit in judgment of another human being.

I also readily accept that my "gut reaction" to the accused may be nothing more than a severely skewed composite of personal experiences and exposures. After all, human foibles are inherent to the judicial system. But this recipe of rationality tastes no less bitter when judges or juries, presented with *overwhelming* evidence of violent crime, allow offenders to go free as if they were trout to be restocked into society's pond until caught again on another hook of criminal intent. Fortunately, what I found in the pages of *Beyond a Reasonable Doubt* was, at least, a palatable chaser to wash down a series of questionable verdicts. The following example best illustrates my point.

Enter the concept of a jury nullification verdict. Despite incontrovertible evidence favoring conviction and legal admonishment aside, in an effort to compensate for past miscarriages of justice, the jury dons an ill-fitted coat of reasonable doubt to exact its vindication. Much like the enforcement of affirmative action in years past, the jury may take the position that the pendulum must swing to the extreme of one side to eventually right itself. Restoring balance, however, is not without cost. Not all victims receive justice, and the guilty do go free. However misguided the action, at least there was a reason, a semblance of order amidst the chaos.

Beyond a Reasonable Doubt is a collection of observations and essays by gifted legal minds, celebrity authors and journalists, controversial characters, and present-day philosophers attempting to translate and explain this elusive legal concept. The forward by author and television personality Larry King introduces the reader to evolution of the work and the history of the legal standard in defending the accused or winning a conviction. It presents no apparent bias in its selection of contributors. It appreciates no particular argument in total. It merely instructs the reader on the basis of the burden's meaning, influence, and longevity. It does what any good book should do: it calls you to self-reflect and reexamine what you are certain is truth and summons you, if only for a moment, to glimpse the value of an alternate view. You won't agree with or even appreciate every opinion, but that is not the publisher's intent. You are only invited to entertain the diversity of thought and human emotion so intrinsically linked to determining guilt or innocence.

In eight sections, the essayists expound views on the imbalance of justice and funding, threats to veracity, celebrity influence, forgotten victims, voices of the incarcerated, the intractability of securing a conviction, the finality and fallibility of capital punishment. They conclude with the concept in abstract interpretations. In viewing what literary ground is covered, it is easy to imagine that the authors were given only the instruction of defining what the concept of reasonable doubt meant to them personally.

Interestingly, there is a universal civility in the writing, no matter how inflammatory the subject matter. The book is a history lesson, a political instruction manual, a primer on lofty idealism, and a passionate guide on social commentary. The pages and passages of *Beyond a Reasonable Doubt* leave the reader with something more. The book leaves the reader with clear evidence of the human capacity to care about their fellow human beings in taking seriously their social responsibility.

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The Journal of Legal Nurse Consulting
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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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Functional Testing: Approaches, Injury Management Integration

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

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

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

Employment Law
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Dental Litigation: Temporomandibular Disorders
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Use of EKG and Cardiac Enzymes
Delayed Diagnosis/Treatment of Stroke, CVA: Heparin/TPA
Emergency Room Law
Paramedic Litigation
Legal Considerations in Pre-hospital Care
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Plastic Surgery: Complications, Liability, Plastic Surgeon vs. Cosmetic Dermatologist
Avascular Necrosis: Complications, Liability, Malpractice, Legal Outcomes
Pap Smears: Malpractice in Gynecology
Imaging Liability: Radiologists
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Obstetrical Malpractice
Nucleated Red Blood Cells: Timing of Brain Injury at Birth
Medical-Legal Aspects of Placental Pathology/ Examination
Vaginal Birth after Caesarean Birth: Standards
Contraception, Morning-After Pill
Infertility Practices
In-Utero Drug Exposure

Personal Injury
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Repetitive Stress Injuries

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

Toxic Tort
Carbon Dioxide Poisoning
Mercury poisoning
Lead Poisoning

Miscellaneous
School Disability Litigation, IEPs
School Nurse Standards
Autopsy Findings/Terminology
Pharmacy Responsibilities for Patient Education, Informed Consent
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