

The Journal of
**Legal Nurse
Consulting**

Volume 17 ▲ Number 3 ▲ Summer 2006

- ▲ Nursing Malpractice
- ▲ Beyond Informed Consent
- ▲ Protein-Calorie Malnutrition
- ▲ Discovery in the Electronic Age
- ▲ Book Review: Medical Legal Aspects of Medical Records



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The Journal of Legal Nurse Consulting

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The Journal of

LEGAL NURSE CONSULTING

Volume 17 ▲ Number 3 ▲ Summer 2006

Features

Nursing Malpractice: Determining Liability Elements for Negligent Acts 3

Eileen Croke, EdD MSN RN ANP LNCC

Nurses must be concerned about malpractice litigation because nurses may now be held accountable for their own negligence. To protect both themselves and their patients, nurses must know relevant law and legal doctrines, and incorporate them into everyday practice. This article will review each element involved in determining legal liability for negligent acts. When reviewing a nursing malpractice case for merit, the legal nurse consultant (LNC) needs to determine if all liability elements are present. Two case analyses of nursing malpractice are presented as examples for determining nursing liability.

Beyond Informed Consent 8

Joan M. Walker, MS BSN RN ALNC

The accurate exchange of information is crucial in preventing communication problems in the health care field. As such, the issue of informed consent ranks high among the heavily debated topics in health care. This process of communication is not only an ethical obligation but a legal requirement, spelled out in state statutes and case law. Despite recognizing the obligation to provide patient information, providers still encounter situations in which they question their own involvement and responsibility in obtaining consent of treatment. This situation is becoming increasingly prevalent as the structure of the health care system changes and provider roles diversify.

Protein-Calorie Malnutrition: The Skeleton in the Litigation Closet 12

Janet S. McKee, MS RD LD/N

Malnutrition occurs when the intake of nutrients is out of balance with the body's needs. This manifests itself as both undernutrition and overnutrition. While much attention has been focused on overnutrition and its negative health consequences, untreated undernutrition can also have serious consequences for high-risk patients in acute or long-term care facilities. Nutrition is often overlooked as a contributing or causative factor in health care litigation. Recognizing the signs and symptoms can be the key for the legal nurse consultant (LNC) in determining if nutrition was a factor in the outcome of the case in question.

Departments

Editorial 2

Vacation or Vocation?

Holly Hillman, MSN RN

Point of Law 17

Discovery in the Electronic Age

Arlene D. Klepatsky, Esq RN

Book Review 23

Medical Legal Aspects of Medical Records

Beth C. Diehl-Svrjcek, MS RN CCRN NNP CCM LNCC

Vacation or Vocation?



Most American workers average just 2 weeks' paid vacation time, while European workers have 4 weeks of vacation and call it "going on holiday." In the United States, vacationers usually take time off in the summer months, when the children are not in school and climates are better for sunning and swimming. Vacations should be time for relaxing, re-energizing, and re-connecting with family and friends.

When you are at the pool or beach this summer, however, look around and see how many people have brought along laptop computers, cell phones, pagers, or other electronic devices so they can keep in touch with their work or work can contact them instantly for even inconsequential reasons. Although technology should allow us to work smarter, not harder, we now need even more baggage to carry all of the electronic equipment. How many of us will be guilty of this?

One hotel chain recently advertised "media detoxification" vacations for those who are so addicted to these devices. Guests can lock their "crackberries" (aptly titled due to owners' dependency on such a device) in safe deposit boxes so they will be "incommunicado" and are forced to just relax.

As nurses, we are concerned when patients do not adhere to prescribed therapies, yet we often do not practice what we teach patients about healing the body and mind. Especially if you have an independent practice, when was the last time you gave yourself a vacation?

In addition to your summer reading selections, this JLNC issue contains some interesting and important articles. With the nursing shortage projected to at least 2020 and the acuity level of patients, Eileen Croke's article on nursing malpractice should stimulate thought about the delivery of health care for those who also maintain clinical practice. The article discusses key elements to consider when reviewing cases, including contemplating personal and family experiences as recipients of past and future health care.

A common theme that LNCs identify while handling medical malpractice cases is the lack of communication. Failure to communicate with other health care members or patients may result in adverse outcomes. Joan Walker's article reviews a surgical case in which there was inadequate informed consent.

A basic concept learned early in nursing education is that proper nutrition, especially protein consumption, promotes wound healing. The article on malnutrition by Janet McKee, a frequent Journal author and presenter at the AALNC National Educational Conferences, will assist LNCs with nursing home and long-term care facility cases.

Arlene Klepatsky's article on the discoverability of sensitive information stored in electronic devices should make you pause before sending e-mails, sharing financial information, or using portable memory drives. The tables of electronic devices and patient care systems that generate electronic data will assist LNCs to think "outside the box" and beyond the traditional hard copies of records.

Lastly, Beth Diehl-Svrjcek reviewed the new text authored by AALNC Past Presidents Pat Iyer, Mary Ann Shea, and Barbara Levin. The book debuted at the last AALNC National Educational Conference and should be an addition to every LNC's library.

I now end this discussion, since I am soon "going on holiday" – my first cruise to tropical islands with a detour on the return home to explore another part of our country. Enjoy your holiday as well, and see you in the fall.

Holly Hillman

Holly Hillman, MSN RN
Editor, *The Journal of Legal Nurse Consulting*

Nursing Malpractice: Determining Liability Elements for Negligent Acts

Eileen M. Croke, EdD MSN RN ANP LNCC

KEY WORDS

Damages, Duty, Pecuniary Losses, Proximate Causation, Res ipsa loquitur

Nurses must be concerned about malpractice litigation because nurses may now be held accountable for their own negligence. It is important for each nurse to know relevant law and legal doctrines, and incorporate them into everyday practice as a safeguard for the health care provider as well as the health care recipient (Guido, 2006). This article will review each element involved in determining legal liability for negligent acts. When reviewing a nursing malpractice case for merit, the legal nurse consultant (LNC) needs to determine if all liability elements are present. Two case analyses of nursing malpractice are presented as examples for determining nursing liability. This article is not intended to be a substitute for contacting an attorney when questions arise about nursing malpractice litigation.

Despite ongoing efforts to educate nurses on the law and their professional responsibilities through nursing programs and continuing education courses, the number of nurses named as defendants in malpractice actions continues to increase (Croke, 2003; Guido, 2006; National Practitioner Data Bank (NPDB) Annual Report, 2004). In 1986, The Health Care Quality Improvement Act, Title IV of P.L. 99-660, authorized the Secretary of Health and Human Services to establish and monitor a national practitioner data bank (NPDB). The mission of the NPDB is to protect the public by “restricting the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance”(NPDB, 2004, p.10).

The NPDB is a central repository receiving information from private and governmental agencies under U.S. jurisdiction. Information received by the NPDB is accessible to registered entities, such as state licensing boards and professional societies, which are eligible to query. Although patients cannot access the NPDB, health care providers listed in the NPDB can access their own information to check for misinformation. The NPDB collects information on physicians, dentists, nurses, and other health care practitioners who, as a result of judgments in malpractice suits, have entered into settlements, had disciplinary action taken against them that resulted in their licenses being revoked or suspended, had their privileges to practice limited, or had to pay monetary awards (Croke, 2003). According to the National Practitioner Data Bank *2004 Annual Report*, since its inception in 1990 and continuing through 2004, there have been approximately 5,001 malpractice claims assessed against all types of registered nurses (RNs). The NPDB established the following malpractice reason categories for reporting numbers of nursing malpractice payments:

1. Anesthesia related
2. Behavioral health related
3. Diagnosis related

4. Equipment or product related
5. IV or blood products related
6. Medication related
7. Monitoring related
8. Obstetrics related
9. Surgery related
10. Treatment related
11. Miscellaneous

The NPDB classifies RNs into five categories: nonspecialized RNs, nurse anesthetists, nurse midwives, nurse practitioners, and clinical nurse specialists/advanced practice nurses. Nonspecialized RNs were responsible for the most malpractice payments (3,131 or 62.7%), followed by nurse anesthetists (1,035 or 20.7%), nurse midwives (459 or 9.2%), nurse practitioners (368 or 7.3%) and clinical nurse specialists/advanced practice nurses (8 or 0.2%). The majority of payments for malpractice claims were based upon monitoring, treatment, and medications problems, as well as obstetrics and surgery-related problems (NPDB, 2004).

Today's health care environment poses even greater liability risks for nurses. Liability risks that have contributed to the increased number of malpractice cases against nurses include: improper supervision/delegation, early patient discharge, nursing shortage, hospital downsizing, increased autonomy, advanced technology, and better-informed consumers (Croke, 2003). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines *negligence* as a “failure to use such care as a reasonably prudent and careful person would use under similar circumstances” and *malpractice* as:

improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskillful performance of duties when professional skills are obligatory. Malpractice is a cause of action for which damages are allowed (JCAHO, 2005).

In 2004, the median and mean payments for all types of registered nurses were \$100,000 and \$302, 737, respectively (NPDB, 2004). Nurses must be concerned about malpractice litigation because nurses may now be held accountable for their own negligence. It is important for each nurse to know relevant law and legal doctrines and incorporate them into everyday practice as a safeguard for the health care provider, as well as the health care recipient (Guido, 2006).

Liability Elements of Malpractice Litigation

For a nurse to become liable in a malpractice action, the law requires that certain elements be proven by the plaintiff before a successful case can be brought against the defendant nurse (Guido, 2006). The elements include duty, breach of duty, foreseeability, causation, injury, and damages, except as noted under doctrine *res ipsa loquitur*. When reviewing a nursing malpractice case for merit, the legal nurse consultant (LNC) needs to determine if all liability elements are present. If any of these elements is missing, the nurse is not liable for malpractice. The LNC must know relevant state laws and definitions applicable for each element of liability. A summary of medical malpractice laws indexed by state is located at www.mcandl.com/states.html.

Duty. The duty of care that is owed to a patient is when an individual engages in an activity where that individual is under a legal duty to act as a reasonable and prudent person would act (Guido, 2006). Two aspects are involved in the duty of care. The first aspect that must be shown is that a duty was owed to the patient. This aspect is created by a legal nurse-patient relationship, not just by employment status; a legal nurse-patient relationship must exist before a lawsuit can commence. Examples of such a relationship include instances when the nurse accepts a patient care assignment, receives a report on a patient, or gives telephone advice to a patient. The LNC may be asked by the attorney to research the nature of the relationship between the plaintiff and alleged defendant nurse (Iyer, 2003).

The second aspect of duty that must be proven is the scope of care that was owed to the patient. The standard of care owed to the patient is that exercised by a reasonable and prudent nurse with like training and experience and under the same or similar circumstances. Nurses are held accountable to the standard of care that was in existence at the time the care was rendered. Various sources for standards of care include JCAHO, State Nurse Practice Act (NPA), National League for Nursing (NLN), American Nurses Association (ANA), nursing specialty organizations, institutional policies and procedures (P&P), hospital nursing job descriptions, nursing journals and textbooks, and expert witness testimony.

Breach of Duty. This occurs when a nurse's care falls below the acceptable standard of care owed to the patient. The deviation can occur by an act of omission or commission. For example, a nurse omits giving an ordered insulin dosage to a known diabetic patient, and the patient lapses into a diabetic coma. Or a nurse gives an ordered insulin dosage to a known diabetic patient, fails to monitor his subsequent lack of oral

intake, and the patient suffers a debilitating hypoglycemic reaction. Whether a nurse has satisfied or breached the duties of care owed to the patient is determined by the applicable standard of care.

Due to the fact that medical and nursing knowledge is "more technical than the scope of common knowledge," most state laws require the use of expert witness testimony for establishing the standard of care at issue in a medical or nursing malpractice lawsuit (Iyer, 2003). The expert witness must be qualified by reason of education, training, or experience to opine about a given subject matter (Testimony by Experts, 2000). If the negligence action falls within the common knowledge exception, such as when the subject matter is within the ordinary, common knowledge and experience of the layperson, expert testimony may not be required. Together, the attorney and LNC must determine the applicable standard of care owed to the patient in existence at the time the nurse rendered the patient care.

The LNC reviews the entire medical record, "comparing and contrasting care with published standards determining whether or not there was a breach in the standard of care in a given subject matter" (Iyer, 2003, p. 262). The review also facilitates determining case issues and selection of qualified experts.

Foreseeability. In this area, the nurse has a responsibility to foresee harm and take actions to eliminate the risk. The nurse does not need to foresee events that are "merely possible," but only those that are "reasonably foreseeable" (O'Keefe, 2001).

Could the nurse in the preceding example reasonably foresee that not monitoring a patient's lack of oral intake subsequent to receiving insulin would result in a hypoglycemic reaction? "The challenge is to show that one could reasonably foresee a certain result based on the facts as they existed at the time of the occurrence rather than what could be said based on retrospective thinking and results" (Guido, 2006, p. 75).

Causation (proximate cause). This area is more difficult for the plaintiff attorney to prove. Causation builds upon cause-in-fact and foreseeability. In cause-in-fact (also known as the "but-for" test), the plaintiff must show that the nurse's breach in the standard of care actually resulted in the plaintiff's injury and that these injuries were reasonably foreseeable. For example, a nurse may administer a wrong drug dosage to a patient in breach of standard of care, but there was no subsequent injury; therefore, the plaintiff does not have a cause of action.

When determining a nurse's negligent action in relation to the alleged injury, Iyer (2003) recommends that the LNC should ask the following questions:

1. Did the negligence cause the injury?
2. Did the breach cause all or part of the plaintiff injury?
3. Is there any reason why the result would have been the same absent the deviation?

Legal definitions for causation are found in jury instruction guides for the jurisdiction in question. "The jury instruction guide states the precise language that a judge will

read to the jury when instructing them about the information to consider when rendering a verdict. The information that the jury will be asked to consider is what the attorney will have to prove in court” (Iyer, 2003, p. 282). State-by-state jury instructions can be located online at www.llrx.com/columns/reference38.htm.

Injury. In malpractice litigation, the plaintiff must prove that the injury claimed was directly related to the negligent act of the professional defendant. Categories of injuries are physical, financial, or emotional, with the later two usually accompanying physical injury. Together, the attorney and LNC must distinguish a “proximately caused injury” from the injury that the plaintiff would or did suffer irrespective of any breach (Iyer, 2003). The LNC reviews, interviews, researches, summarizes, and evaluates all medical documentation relevant to the alleged injury.

Damages. Monetary awards are given to compensate the plaintiff for the injury proximately caused by the negligent action of the defendant. Categories of damages include:

1. **General Damages:** monetary compensation for a loss that cannot be measured in “nominal amounts.” Types of losses may include disfigurement, disability, and past, present, and future pain and suffering.
2. **Special Damages:** monetary compensation for losses due to injury. Types of losses may include medical expenses, lost income, and past, present, and future losses due to injury. (General and Special Damages may be grouped together into one category called Compensatory Damages).
3. **Emotional Damages:** monetary compensation for anxiety or emotional distress associated with injury.
4. **Punitive Damages:** monetary compensation for intentional or grossly negligent misconduct. Punitive damages are awarded to “punish” the individual and to deter similar future actions.

Two classification awards for damages are economic and non-economic. Economic damages concern pecuniary losses, such as medical expenses or lost wages, and non-economic damages concern non-pecuniary losses, including pain and suffering, and loss of consortium. State laws vary on awarding damages, with some capping the award amounts. For example, in 1975, California wrote into law the Malpractice Injury and Compensation Reform Act (MICRA), limiting non-economic damages in medical malpractice cases to \$250,000. Additionally, 24 states have enacted laws limiting caps on non-economic damages. When an LNC or life care planner is involved in assisting the attorney with calculating economic damages, having knowledge of relevant state laws is a necessity.

Doctrine Res Ipsa Loquitur: “The thing stands for itself.” Under this doctrine, the plaintiff does not need to prove how the injury occurred or who was responsible. The basic premise is that, without negligence, the injury would not have happened. In most states, the plaintiff does not need the testimony of an expert witness. For the doctrine to apply, the plaintiff must prove the following three elements (Guido, 2006, p. 86):

1. The accident must be the kind that ordinarily does not occur in the absence of someone’s negligence;

2. The accident must be caused by an agency or instrumentality within exclusive control of the defendant; and
3. The accident must not have been due to any voluntary action or contribution on the part of the plaintiff.

The following two case analyses of nursing malpractice are examples for determining nursing liability. They are not intended to be a substitute for contacting an attorney when questions arise about nursing malpractice litigation.

#1 Case Analysis

Lunsford v. Board of Nurse Examiners, 648 S.W.2d 391; 1983 Tex. App. LEXIS 4087

Case Scenario: A patient, Donald Floyd, was brought by a friend, Miss Farrell, to Willacy County Hospital with complaints of chest pain accompanied by numbness and pain radiating down his left arm. Miss Farrell left Mr. Floyd in the hospital waiting room and went in search of medical assistance for Mr. Floyd. Within the facility, Miss Farrell spoke with a physician who subsequently referred her to seek help from the registered nurse on duty, Nurse Lunsford. Nurse Lunsford was ordered by the physician to send the patient and his companion to Valley Baptist Hospital, 24 miles away. The hospital had a policy to send all patients to Valley Baptist Hospital unless the patient had a physician on the hospital’s staff or unless it was a “life-death situation.”

Upon entering the waiting room, Nurse Lunsford found Mr. Floyd lying on a table complaining of chest pain that also had radiated to his arms. After questioning Mr. Floyd, Nurse Lunsford learned that he had not undertaken any strenuous exercise or eaten anything unusual that day that may have influenced the onset of his symptoms. Despite suspecting “cardiac involvement,” Nurse Lunsford did not take Mr. Floyd’s vital signs. Nurse Lunsford gave the following instructions to Miss Farrell: take Mr. Floyd to Valley Baptist Hospital; speed there; drive with the automobile’s emergency flashers on; and use the automobile’s citizens’ band radio to call for help on the way to Valley Baptist Hospital. Nurse Lunsford also asked Miss Farrell about her knowledge of cardiopulmonary resuscitation (CPR), as there might be a chance that she may need to use it during transport. Mr. Floyd died five miles from Willacy Hospital on the way to Valley Baptist Hospital.

The Texas Board of Nurse Examiners (1983) conducted a hearing on the actions of Nurse Lunsford relating to Mr. Floyd death. The Board, citing Texas Rules of Evidence 4525 (B) (9), found that Nurse Lunsford’s conduct had been “unprofessional and dishonorable... likely to injure patients or the public” and suspended Nurse Lunsford’s Texas RN license for one year. The District Court of Travis County, 200th Judicial District affirmed the Board’s decision. Nurse Lunsford appealed, citing she did not owe a duty to Mr. Floyd because a nurse-patient relationship had not been established between the parties. The Court of Appeals of Texas, Third District, Austin affirmed the judgment of the District Court.

Elements of Liability:

- **Duty.** Nurse Lunsford cited she did not have a nurse-patient relationship with Mr. Floyd, as he had not been

admitted to the hospital and was not a patient of the staff physician. The Courts found that Nurse Lunsford automatically owed a duty to Mr. Floyd through the receipt of her Texas Registered Nurse licensure and that a nurse-patient relationship existed when she met Mr. Floyd in the hospital waiting room in need of life-threatening emergency care. Texas Board of Nurse Examiners Rule 22 T.A.C 217.11(1)(M),(3)(A)(i) requires an RN to assess the health status of each patient and institute appropriate nursing actions that might be required to stabilize the patient's condition and/or prevent further complications.

- **Breach of Duty.** The Board found and Courts affirmed that Nurse Lunsford failed to assess and implement appropriate nursing actions. Specifically, the following breaches in the standards of care were cited:
 1. Failure to assess Mr. Floyd's medical status;
 2. Failure to inform the physician of Mr. Floyd's cardiac condition and potential life-death medical status; and
 3. Failure to institute appropriate nursing actions, such as taking vital signs and placing the patient on electrocardiogram (ECG) machine, to stabilize Mr. Floyd's medical condition and prevent further complications and, ultimately, his demise.
- **Foreseeability.** Nurse Lunsford should have been able to reasonably foresee the potential complications related to Mr. Floyd's complaints, especially since she admitted to have suspected "cardiac involvement." Nurse Lunsford also questioned Miss Farrell about her knowledge of CPR, which demonstrates Nurse Lunsford's foreseeability of a cardiopulmonary arrest.
- **Causation.** Nurse Lunsford's breach in the standards of care proximately caused the injury. If she had assessed the patient, communicated to the physician about the patient's life-threatening condition, and implemented nursing interventions, his death could have been prevented.
- **Injury.** Nurse Lunsford's breach of duty and failures to assess the patient's condition, to communicate his condition to the physician, and to implement nursing interventions to help stabilize his condition resulted in the cardiac event that lead to his death.
- **Damages.** Nurse Lunsford's RN license was suspended for 1 year.

#2 Case Analysis

Muskopf v. Maron, 764 N.Y.S.2d 741; 2003 N.Y. App. LEXIS 10050

Case Scenario: Susan Muskopf, a patient of Dr. Barry Maron, was admitted to Wyoming County Community Hospital for a unilateral hand repair due to carpal tunnel syndrome. At the time of admission, Ms. Muskopf had been diagnosed with bilateral carpal tunnel syndrome, although her left hand was asymptomatic at the time of surgery. Prior to the surgery, Ms. Muskopf questioned the hospital nurse about the location of the surgical procedure, stating that she thought the surgery was to be performed on her right

hand. Subsequently, the hospital nurse reviewed all the pre-operative medical documents in the patient's chart, including the physician's records and informed consent form signed by the patient, and all the documents indicated that the surgery was to be performed on the patient's left hand. The hospital nurse did not notify the physician of the patient's concern regarding the site of the surgery and did not document this conversation in the patient's medical record.

The patient brought a medical malpractice action suit against Dr. Maron, the Wyoming County Community Hospital, and the County of Wyoming, seeking damages for injuries she allegedly sustained when the physician operated on her left hand instead of her right hand. The patient also brought an independent negligence cause of action collectively against the hospital and the county for the failure of the hospital nurse to prevent the surgical error despite having been informed by the patient that she thought the surgery was to be done on her right hand. The Supreme Court, Wyoming County, granted a cross motion of the Wyoming County Community Hospital and County of Wyoming defendants for summary judgment, dismissing the complaint against them (765 N.Y.S.2d 537; 2003 N.Y. App. LEXIS 10047). On appeal to the Supreme Court of New York, the plaintiff contended that the Supreme Court, Wyoming County, erred in granting the defendants' cross motion for summary judgment. The defendants maintained the contention that they were shielded from tort liability, based on the fact that the hospital nurse had reviewed and followed the physician's pre-operative orders. On review by the State Supreme Court of New York, it was cited that the defendants had met their initial burden of proof, based, in part, upon affidavit testimony provided by a nurse expert witness, who opined that the nursing care rendered by the hospital nurse met the standard of care: once the hospital nurse was questioned by the patient concerning the surgical site, the hospital nurse reviewed all the preoperative physician records, as well as the informed consent form signed by the patient, and all the records indicated the surgery was to be performed on the patient's left hand.

An issue of fact was raised by the plaintiff through affidavit testimony provided by the physician expert witness, who opined that the hospital had breached "the accepted standards of medical practice by failing to undertake a comprehensive review of the plaintiff's case, including a specific inquiry to the attending physician and documentation of the results of that inquiry, when the hospital nurse learned of plaintiff's doubts concerning the site of the surgery" (*Muskopf v. Maron*, 2003, p. 2). The plaintiff's physician expert's opinion was based, in part, on the hospital nurse's own deposition testimony: "If a patient had a question concerning the side on which surgery was to be performed, she [the nurse] would document that she [the nurse] had called the doctor and that he would be in to speak to the patient" (*Muskopf v. Maron*, 2003, p. 2). The Supreme Court of New York found the issue of fact undisputable, in that the hospital nurse did not follow through with notifying the physician of the patient's concern

and denied the defense's motion that they were shielded from tort liability. The judgment was reversed on the law with costs, the cross motion was denied, and the complaint against the Wyoming County Community Hospital and County of Wyoming defendants was reinstated.

Elements of Liability:

- **Duty.** A legal nurse-patient relationship existed between the patient and the hospital nurse. The hospital nurse owed a duty to the patient to ensure that the physician was notified of the patient's concern regarding the surgical site. In the hospital nurse's own deposition testimony, she stated, "If a patient had a question concerning the side on which the surgery was to be performed, she [the nurse] would document that she [the nurse] had called the doctor and that he would be in to speak to the patient" (Muskopf v. Maron, 2003, p. 2).
- **Breach of Duty.** The hospital nurse breached the standard of care with an act of omission by not informing the physician of the patient's concern regarding the surgical site.
- **Foreseeability.** The hospital nurse should have been able to reasonably foresee the potential complication of wrong site surgery related to not informing the physician of the patient's stated concern.
- **Causation.** The hospital nurse's breach in the standard of care proximately caused the injury. If the hospital nurse had

notified the physician of the patient's concern about the surgical site, the surgical error could have been prevented.

- **Injury.** The patient had surgery on the wrong hand. The left hand was asymptomatic at the time of surgery.
- **Damages.** For the appellants, the Supreme Court of New York unanimously reversed the appealed judgment on the law with costs, the defense's cross motion for summary judgment was denied, and the complaint against the Wyoming County Community Hospital and County of Wyoming defendants was reinstated.

Summary

When evaluating a nursing malpractice case for merit, the LNC must evaluate each liability element for possible negligence. The first element that must be determined is the existence of a legal nurse-patient relationship between the parties and based upon the relationship what was the scope of care owed to the patient by the nurse [defendant]. The LNC must then determine whether or not there was a breach in the standard of care, identify proximate causation and injury. Once the evaluation is complete, the LNC must be able to provide the attorney with a precise report (verbal or written) based upon each liability element.

continued on page 24

Having Trouble Getting Started?

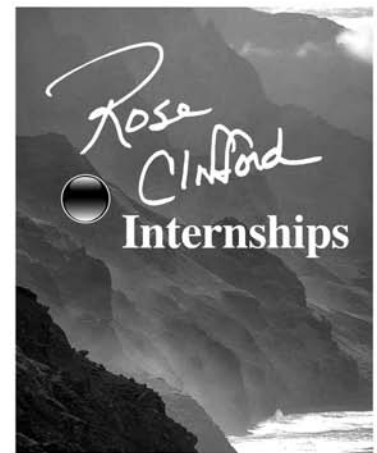
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Beyond Informed Consent

Joan M. Walker, MS BSN RN ALNC

KEY WORDS

Informed Consent, Patient Information

The accurate exchange of information is crucial in preventing communication problems in the health care field. As such, the issue of informed consent ranks high among the heavily debated topics in health care. This process of communication is not only an ethical obligation but a legal requirement, spelled out in state statutes and case law. Physicians have long recognized the obligation and the need to provide patient information. Still, at some time in practice, providers will encounter situations in which they question their own involvement and responsibility in obtaining consent of treatment. This situation is becoming increasingly prevalent as the structure of the health care system changes and provider roles diversify.

This article addresses the competent adult patient's consent to therapeutic procedures. In this scenario, a 50-year-old male alleges malpractice against the surgeon for improperly treating his back condition. Specifically, the plaintiff alleges failure to obtain informed consent, negligence against the hospital for failure to properly supervise the surgeon, and failure to treat the plaintiff in accordance with accepted standards. The patient underwent surgery in 1998 and subsequent surgery a year later. He claims that the surgeon failed to detect and properly diagnose that instrumentation had failed, which severely aggravated his preexisting back injury and led to the need for subsequent surgery. He further alleges chronic debilitating pain and total disability from gainful employment.

Upon initial consultation, the surgeon noted discussing his findings with both the plaintiff and his wife, recommending a posterior spinal decompression and fusion with inter-body graft and stabilization. The surgeon's initial consultation simply states, "Risks and benefits were discussed," with no comment regarding his impression of the patient's level of understanding of the recommended surgical treatment or possible alternative treatments. Rozovsky (2004) notes that the physician's "documentation of the exchange with the patient is essential for the purpose of legal defense of an action that may arise out of treatment" (p. 2:31). Unfortunately, the lack of detailed documentation of the conversation calls into question what was disclosed and if the physician disclosed information consistent with the legal standard of informed consent.

Exactly what risks of surgery did the physician review with the plaintiff? Were they communicated in a manner that enabled the plaintiff to make an informed decision? Unfortunately, in the scenario provided, the physician's records are not specific regarding this matter. Such risks, which may have been discussed and viewed as "material," include fracture of pedicle screws causing nerve root irritation or injury requiring surgical revision, screw malposition producing nerve irritation injury requiring additional surgery, post-surgical healing need to remove painful instrumentation, additional surgery or fusion because of stress-related

transitional changes, and instrumentation artifact not allowing meaningful follow-up magnetic resonance imaging (MRI).

Need for Communication

The physician has a duty to inform the patient of the nature and effect of the proposed treatment. Prudent health care providers need to understand the principles involved in informed consent and to recognize the legal ramifications or potential for litigation. Only after the patient's informed consent is obtained can treatment be started and continued. This quintessential right of the patient is exemplified by the case of *Schloendorff v. New York Hospital*, in which Justice Cardozo opined: "Every human being of adult years and sound mind has a right to determine what should be done with his own body" (*Schloendorff v. Society of New York Hospital*, 1914).

The American Medical Association (AMA) recognizes a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention (AMA, 2005). Generally, the physician is required to discuss treatment options and alternatives, but not necessarily provide details about those alternatives outside their specialty or experience. The duty of a referral physician is to discuss relevant risks of treatment. The goal of informed consent is that the patient is an informed participant in his/her health care decision. It is generally accepted that, to obtain informed consent, the physician should disclose and discuss the following with the patient:

- The diagnosis, if known;
- The nature of the proposed treatment/procedure;
- Reasonable alternatives to the proposed intervention;
- Relevant risks, benefits, and uncertainties related to each alternative;
- An assessment of patient understanding; and
- The acceptance of the intervention by the patient (AMA, 2005).

Common sense tells us it is not possible or feasible to disclose all information about risks, benefits, and alternatives. In the case of *Henderson v. Milobsky*, it was found that the surgeon does not need to disclose a 0.0001% risk of loss of sensation (Henderson v. Milobsky, 1978). The requirement focus is on what is “material.” Taking this position assumes that the patient has some inherent knowledge or “common knowledge” such as knowing an elevated body temperature is a sign of an infection. Nevertheless, one must keep in mind the extent of common or inherent knowledge varies with each patient and situation. The amount of inherent knowledge should not be assumed, and it does not preclude physician disclosure of material facts or risks of the proposed treatment.

What Is “Material?”

A material risk is a risk that a physician knows would likely influence a reasonable person who is deciding whether or not to undergo a procedure or treatment. Information is material when a reasonable person would attach significance to it in making a decision. Examples of material information would include:

- Nature of the procedure;
- Commonly associated risks;
- Risks that have a small chance of occurring but grave consequences;
- Risks that would be of particular concern to the patient; and
- Viable alternatives to treatment.

This begs the question of what information qualifies as “material.” Material information can be described by using the following standards:

1. Reasonable physician/professional standard: What would a typical physician say about this intervention? This standard, found in *Craig v. Boricky* (1990), allows the physician to determine what information is appropriate to disclose. The amount of disclosure is largely a matter of the physician’s professional medical judgment. As Rozovsky (2004) notes, however, minimizing known facts or withholding necessary information cannot be excused.
2. Reasonable patient/objective standard: What would the average patient need to know in order to be an informed participant in the decision? This standard focuses on considering what a patient would need to know in order to understand the decision at hand. The ruling in *Canterbury v. Spence* (1972) found that “it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interest seem to lie.”
3. Subjective Standard: Rasansky (2004) describes this standard as the most challenging to incorporate into practice because it requires tailoring information to each patient. This focuses on what the patient would need to know or what can be regarded as significant by a reasonable person in order to make an informed decision.

The Centers for Medicare and Medicaid Services (CMS) recently issued interpretive guidelines concerning the requirements for obtaining informed consent from surgical patients, including revisions to the required contents of the informed consent form. These guidelines require that (1) the patient will be informed of who will actually perform the planned surgical procedure, and (2) when a practitioner other than the primary surgeon will be performing “significant surgical tasks” (even if under the primary surgeon’s supervision), the patient must be made aware of the identity of the other practitioner(s), as well as the specific tasks assigned to each. This information should be documented on the informed consent form. As defined by CMS, “significant surgical tasks” include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues (Centers for Medicare and Medicaid Services, 2005).

Most institutions have policies that outline which health interventions require a signed consent form. Obviously, surgery, anesthesia, and other invasive procedures are in this category. These signed forms should be the culmination of a dialogue required to foster the patient’s informed participation in the clinical decision. Obtaining a patient’s consent for a procedure or operation goes beyond obtaining a signature on a form. It is a process that enables professionals to explain to the patient what to expect from the treatment or procedure. It should inform the patient of the risks and benefits of any proposed procedure, and of any alternatives that might be available, while at the same time demonstrate respect for patient autonomy.

Finally, to help prevent legal action against physicians, the communication process should be well-documented and, where possible, include a signed consent in the health record. In light of these new CMS guidelines, Fairfield County Physicians Management Corporation revised the sample office form (Figure 1) offered to physician members to include an additional section into the surgical consent form at the top to include the names of any assistant surgeons, physician assistants, etc., who may be involved in the surgery.

Practically speaking, physicians should give patients sufficient information about the nature, risks, and benefits of the proposed treatment to encourage active and informed participation in one’s care. Informed consent is more than a signed piece of paper in the medical records. It requires the physician to go beyond the process of consent and consult with the patient. Medical decisions can and should be made in collaboration with the patient. Gone are the days when patients were treated as if they were in too poor health or “too feeble and delicate” to handle the truth. Patients are often right to push for explanations. This means that patients must be given essential, key information about their condition in order to become informed participants in their health care decisions.

Figure 1: Sample Consent Form for Office Surgery/Procedure.

I, _____
Authorize Dr. _____
And his/her assistant, Dr. _____
to perform the following operation/procedure under local anesthesia:

Alternatives have been explained to me and I understand that any operation/procedure involves some risks. The more common risks include infection, bleeding, nerve injury, and allergic reaction that occur in less than three (3) percent of all office operations/procedures.

I have read and understand this consent form, and my questions have been answered.

Date: _____
(Patient/Responsible Party): _____
Date: _____
(Witness): _____

PHYSICIAN DECLARATION: I have explained this operation/procedure, risks, alternatives, and expectations to the patient and believe he/she has been adequately informed and has consented.
(Physician's signature): _____
Date: _____

This sample form does not constitute legal advice and should be adapted to the individual practice.

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Protein-Calorie Malnutrition: The Skeleton in the Litigation Closet

Janet S. McKee, MS RD LD/N

KEY WORDS
Malnutrition, Nutrition

Malnutrition occurs when the intake of nutrients is out of balance with the body's needs and includes both undernutrition and overnutrition (Beers and Berkow [Eds.], 2005). With our abundant food supply and the global prevalence of obesity increasing in virtually all populations and age groups, much attention has been focused on overnutrition (Eckel et al., 2004) and its negative health consequences. Untreated undernutrition can also have serious consequences for high-risk patients in acute or long-term care facilities. Even in the legal arena, nutrition is often overlooked as a contributing or causative factor in health care litigation. Recognizing the signs and symptoms can be the key for the legal nurse consultant (LNC) in determining if nutrition was a factor in the outcome of the case in question.

More than 30 years ago, Dr. Charles Butterworth coined the term “the skeleton in the hospital closet” in his landmark article that drew attention to the prevalence of malnutrition occurring in hospitalized patients (Butterworth, 1974). Even though Dr. Butterworth believed that the malnutrition seen in hospitals was as a result of nutrition neglect, studies show that as many as 40% to 55% of hospitalized patients are still either malnourished or at risk for malnutrition (Gallagher-Allred, Voss, Finn, and McCamish, 1996). At the time of Dr. Butterworth’s article, no one had yet documented the equally dangerous skeleton found in nursing homes. Since then, numerous studies have documented the prevalence of malnutrition in nursing homes as ranging from 23% to 85% (Thomas, Ashmen, Morley, and Evans, 2000). In addition, as many as 44% of home health patients are estimated to be malnourished (Morley, Thomas, and Kamel, 2004).

Role of Nutrition in Health Outcomes

Nutrition plays a key role in health outcomes. Surgical patients who are malnourished are two to three times more likely to have complications and increased mortality, and their length of stay may be 90% longer than that of well-nourished patients (Gallagher-Allred et al., 1996). Implementation of nutritional management protocols has been shown to improve clinical outcomes in critically ill patients (Barr, Hecht, Flavin, Khorana, and Gould, 2004). Involuntary weight loss and the development of non-healing pressure wounds are common complications of malnutrition (Collins, 2000; Collins, 2004). Nutrition has even been shown to affect the quality of life of long-term care residents (Crogan and Pascovel, 2003).

Today, there is ample evidence to support the idea that medical nutrition therapy can save lives and reduce morbidity and that nutrition support can improve outcomes (Gallagher-Allred et al., 1996). The role of nutrition in health maintenance and healing is often overlooked, however, as health care professionals focus on surgical procedures, medications, and reimbursable services. Nutritional therapy often is not considered as part of medical care, but rather as part of

basic room and board provided for all patients or residents (Gallagher-Allred et al., 1996). In addition, there is a lack of consistent reimbursement for nutritional assessment and therapies (Gallagher-Allred et al., 1996), and services provided by hospital and long-term care dietitians are often viewed as “non-revenue-producing.” Even in the legal arena, nutrition is often overlooked as a contributing or causative factor in health care litigation. More and more cases have nutrition-related issues, including cases involving weight loss, pressure wounds, enteral and parenteral nutrition, bariatric surgery, aspiration, dehydration, choking, malnutrition, diabetes, and falls.

Types of Malnutrition

There are two types of protein-calorie malnutrition: marasmus and kwashiorkor (Morley et al., 1998). Marasmus results from prolonged inadequate intake of calories, protein, and vitamins and minerals (Collins, 2000). The most common form of malnutrition seen in developing countries, marasmus is associated with starvation (Beers and Berkow [Eds.], 2005). Individuals with marasmus present with severe weight loss and wasting, although visceral protein levels are near normal.

Kwashiorkor results from poor protein intakes, illness, or infection (Collins, 2000). Individuals with kwashiorkor may appear well-nourished but have rapidly declining visceral protein levels characterized by low albumin levels of 1.0-2.5 g/dL (Beers and Berkow [Eds.], 2005). Malnutrition in hospitalized patients and long-term care patients most commonly presents with features of marasmus, or a combination of marasmus and kwashiorkor (Collins, 2000; DeSanti, 2000), which is generally referred to as “protein-calorie” (or “protein-energy”) malnutrition (PCM).

Consequences of Malnutrition

As noted previously, malnutrition is a common occurrence in the acute and long-term care setting. Its consequences can be serious. Involuntary weight loss is the hallmark of PCM. Loss of lean body mass in particular is associated with profound weakness, decreased immune function, and impaired wound

healing, and cell damage becomes irreversible once a large percentage of body weight is lost (Demling and DeSanti, 2000). Impaired immune response occurs when loss of lean body mass reaches 10%, increasing the risk for urinary tract infection and pneumonia (DeSanti, 2000) and escalating the risk of mortality.

A study involving long-term care residents demonstrated that the 6-month risk of mortality was 48% for anergic individuals, compared to 13% for immunocompetent residents (Collins, 2000). Functioning of the respiratory muscles is diminished, leading to respiratory compromise and the decreased ability to breathe, expectorate, and clear the lungs (DeSanti, 2000). Wound healing becomes difficult as loss of lean body mass continues because the wound competes with the remaining lean body mass for protein (DeSanti, 2000).

As loss of lean body mass approaches 30%, individuals become weak, apathetic, depressed, and bedridden (Greene-Burger, Kayser-Jones, and Prince-Bell, 2000; DeSanti, 2000), increasing the risk for pressure wounds, decreasing quality of life, and reducing mental and physical functioning. Hypotension, weakness, and confusion can lead to falls and hip fractures. Mortality is about 50% in these individuals, many of whom cannot walk or sit upright (DeSanti, 2000). A loss of greater than 40% of lean body mass is usually fatal; at this point, individuals are usually so weak that they cannot clear their own secretions, putting them at severe risk for pneumonia and other infections (DeSanti, 2000).

Signs and Symptoms of Malnutrition

Recognition of the signs and symptoms of PCM (as listed in Table 1 below) can assist the legal nurse consultant (LNC) in determining if nutrition was a factor in the outcome of the case in question. A thorough review of the medical record for documentation of these symptoms for individuals with pressure wounds, involuntary weight loss, or depleted visceral protein stores can help to confirm malnutrition.

Avoidable vs. Unavoidable

Once it has been established that PCM is a factor in a resident's or patient's outcome, the key question is whether the PCM was avoidable or unavoidable. In order to make an accurate determination, a stepwise evaluation of the actions taken by the facility must be completed. There are four pertinent questions that must be posed, as follows:

1. Did the facility identify the resident's or patient's risk factors for malnutrition?
2. Did the facility implement an adequate plan of care with interventions that meet the nutritional standards of care?
3. Did the facility evaluate the response to the interventions in place?
4. Did the facility revise the plan of care if the care plan goals were not met?

Each of these questions must be evaluated in the context of the nutritional standards of care, including State and Federal regulations, the applicable Nurse Practice Act, Dietetics

Table 1: Physical Signs of Malnutrition.

Edema	Neck
Eyes	<ul style="list-style-type: none"> • thyroid enlargement • symptoms of hypothyroidism
<ul style="list-style-type: none"> • small yellowish lumps around eyes • white rings around both eyes • angular inflammation • pale membranes, dry membranes • redness and fissures of eyelid corners • ring of blood vessels around cornea 	Nails
Face	<ul style="list-style-type: none"> • spooned, fragile
<ul style="list-style-type: none"> • skin color loss, dark cheeks and eyes • enlarged parotid glands • scaling of skin around nostrils • pallor, hyperpigmentation 	Nervous system
Gastrointestinal	<ul style="list-style-type: none"> • listlessness • reduced or loss of reflexes • depression • lack of concentration, disorientation • cognitive and memory impairment • behavioral disturbances
<ul style="list-style-type: none"> • anorexia, diarrhea • decreased intake 	Oral
Hair	<ul style="list-style-type: none"> • angular stomatitis • glossitis, cheilosis • soreness or burning lips, mouth, tongue • swollen, scarlet, raw tongue • swollen or bleeding gums • decayed or missing teeth • diminished sense of taste
<ul style="list-style-type: none"> • dull, dry, thin, depigmentation, easily plucked 	Skeletal system
Involuntary Weight Loss	<ul style="list-style-type: none"> • Osteopenia • Painful bones and joints
Labs	Skin
<ul style="list-style-type: none"> • low albumin and pre-albumin • low total lymphocyte count • low total cholesterol 	<ul style="list-style-type: none"> • dryness, scaliness, atrophy • petechiae, ecchymoses • poor wound healing • psoriasis, eczema • yellow colored • pallor
Loss of subcutaneous fat	
Muscular system	
<ul style="list-style-type: none"> • muscle wasting • weakness, decreased grip strength • peripheral neuropathy • muscle twitching or cramps • muscle pain • abnormal gait 	

Morley, et al., (1998)

Beers and Berkow (Eds.), (2005, Section 1, Chapter 2)

Consultant Dietitians in Health Care Facilities (2005)

Practice Act, and the facility's own policies and procedures. Only when all of these questions can be answered affirmatively is the PCM considered unavoidable (Centers for Medicare and Medicaid, 2005). In essence, the facility must show that it did everything possible to avoid the PCM. Eliminating any one of the four steps above will result in the facility being unable to demonstrate that every possible intervention was attempted. The four criteria are further detailed:

Did the facility identify the resident's or patient's risk factors for malnutrition? The following questions can help determine if the facility attempted to provide timely and proactive interventions to address the resident's or patient's risks for malnutrition.

- Did the facility complete a nutrition screen?

A nutrition screening is used to identify characteristics known to be associated with nutritional problems and is used to identify individuals at nutritional risk or who

are malnourished (Consultant Dietitians in Health Care Facilities [CD-HCF], 2005). The screening process is used to facilitate early intervention goals and determine the need for a nutrition assessment. The Certified Dietary Manager and the nursing staff should complete an initial screening on each resident or patient admitted to the facility. This will allow an interim plan of care to be developed, and will identify residents or patients to be referred to the dietitian or other therapies on an immediate basis. During the nutrition screen, food preferences and intolerances are obtained from the resident/patient or family members to ensure that the diet provided is acceptable.

- Did the facility complete a comprehensive nutrition assessment?

A nutrition assessment is a comprehensive review by the dietitian to define nutritional status (CD-HCF, 2005) and is required by the Joint Commission on Hospital Accreditation (JCAHO) and the Centers for Medicare and Medicaid Services (CMS). The nutrition assessment includes a review of the medical history and current diagnoses, diet history and meal intake, weight and weight history, laboratory values, medications, and physical evaluation (CD-HCF, 2005). The assessment also includes a review of other disciplines' assessments that may affect the resident or patient, including physical therapy, occupational therapy, and speech therapy. Oral health status, taste alterations, chewing and swallowing ability, feeding ability and level of feeding assistance needed, positioning, and any other nutrition-related issues must be assessed for their impact on the resident/patient's ability to consume adequate nutrition (Centers for Medicare and Medicaid, 2005). During the assessment process, the dietitian uses the data gathered to identify the resident/patient's nutrition risks. Calorie, protein, fluid, and vitamin and mineral needs are assessed based on the assessment of the resident/patient. The dietitian then determines how best to provide the needs in a manner that the resident/patient will accept and tolerate. The cause for each risk factor should be identified in order to develop an adequate plan of care. The nutrition assessment is required prior to development, implementation, and evaluation of the care plan (CD-HCF, 2005). Identification of nutritional risk factors cannot be completed without a comprehensive nutrition assessment.

Did the facility implement an adequate plan of care with interventions that meet the nutritional standards of care? A plan of care must be developed for each risk factor identified following the comprehensive assessment. Risk factors identified in the initial nutritional screen should be addressed by the nursing staff prior to the comprehensive assessment by the dietitian (Centers for Medicare and Medicaid, 2005). Causes for each risk factor should have been identified by the assessment process. The nutrition plan of care must be based on the findings of the assessment

and should be individualized for each resident/patient, in accordance with the facility's policies and procedures and the nutritional standards of care. A plan of care should be developed for residents/patients with recent or current history of weight loss, poor intake of food/fluids, abnormal nutrition-related laboratory results, dysphagia, need for feeding assistance, post-cardiovascular accident (CVA) post-bariatric surgery, dehydration, constipation, depression, and medications with nutrition-related side effects (including tardive dyskinesia and extra pyramidal symptoms). The various therapies and the dietitian should be included in the interventions as indicated, and interaction should be documented by each discipline involved. Failure to develop a plan of care for a nutritional risk factor will mean that any resulting malnutrition is considered avoidable because all available options were not implemented.

Did the facility evaluate the response to the interventions in place? Crucial to evaluating the resident/patient's response to the plan of care is ensuring that the plan of care was followed. Once the plan of care is developed, the facility must guarantee that all staff members are aware of the resident's/patient's needs and the interventions in place to meet those needs. The resident/patient and/or family members must be educated on the plan of care and must agree with the goals and approaches. Recommendations by the various therapies and the dietitian must be implemented in a timely manner. Weights, laboratory results, and intakes must be monitored and documented per the plan of care. Physician's orders for changes in the diet and for supplements must be followed, and intake of supplements must be documented. If the facility fails to document the interventions, the plan of care has not been properly implemented and the response cannot be monitored. Any refusals of treatment or care by the resident/patient must be carefully documented, including education of the resident/patient on the consequences of refusal and alternative treatments or care offered.

Even when the interventions are carefully documented, the facility still has the responsibility to evaluate whether those interventions are effective. For each problem identified, the facility must determine whether the goals are being met. The care plan should include how each goal will be monitored. For instance, if the resident/patient has a goal to maintain weight, the method for monitoring the goal is to weigh the patient at specified intervals. Once the weights are documented, if the resident/patient continues to lose weight, the goal has not been met.

Did the facility revise the plan of care if the care plan goals were not met? When the facility determines that a care plan goal was not met, the goal must first be evaluated to determine if it is realistic or still appropriate. If so, the facility must revise the interventions to attempt to achieve the goal as stated. Continuing a plan of care that is ineffective will result in any future malnutrition being considered avoidable because no new interventions were implemented.

Unavoidable Malnutrition and the Standards of Care

Certain causes of malnutrition may be irreversible. Individuals with an inflammatory disease process may exhibit signs and symptoms consistent with malnutrition, such as weight loss and low visceral protein stores (Fuhrman, Charney, and Meuller, 2004). In these individuals, the symptoms of malnutrition are reflective of the body's response to injury or infection, rather than nutritional status, and may not improve until the disease process has resolved (Fuhrman et al., 2004). The injury or illness may impact appetite and gastrointestinal mobility, however, which can affect nutritional status (Fuhrman et al., 2004); therefore, the individuals still require aggressive, proactive nutritional interventions and monitoring.

The cachexia (or body wasting) seen in heart failure patients is thought to result from an imbalance of different body systems (Anker and Coats, 1999). More than 80% of patients with cancer or acquired immunodeficiency syndrome (AIDS) develop cachexia before death (Bruera, 1997). This cachexia is usually caused by metabolic abnormalities due to the production of tumor products and cytokines by the immune system (Bruera, 1997). Intensive nutrition may be appropriate in certain situations, such as in patients recovering from surgery and awaiting chemotherapy. Researchers also believe that the etiology of loss of lean body mass seen in end-stage renal disease is very complex and may include numerous factors apart from poor food intake, such as delayed gastric emptying, hormonal derangements, inadequate control of acidosis, co-morbidity, and inflammation (Stenvinkel, Heimbürger, and Lindholm, 2004). In addition, weight loss and malnutrition may be an unavoidable part of the progression of Alzheimer's disease and other dementias (White, 2004). Lastly, a resident/patient's refusal to eat or to accept alternative nutritional support may lead to unavoidable malnutrition.

Even in circumstances where malnutrition is the result of a catabolic illness or resident/patient refusal, the facility must still ensure that it has done everything possible to prevent and/or address malnutrition. As noted, the body's response to inflammation or disease can produce side effects that increase the risks of poor intake and weight loss. In addition, the psychological aspects of cachexia can be the most important for patients and their caregivers.

Education and practical interventions that are consistent with the resident/patient's and family's stated goals should be provided. When a resident/patient refuses treatment, education on the consequences of refusal and alternatives should be provided and documented. Federal regulations require the facility to ensure that each resident/patient's needs are met. Included in this requirement is the responsibility of the facility to guarantee that the resident/patient and family members understand all options available and the consequences of choosing each option, even when the patient and/or family has expressed a desire for no further treatment. An evaluation of the clinical benefits and burdens of enteral and parenteral feeding, which incorporates the patient's wishes and goals for

treatment, should be conducted (Hospice and Palliative Nurses Association, 2003).

Legal Responsibility

Virtually all health care providers involved in patient care are legally responsible for nutrition care, including physicians, physician's assistants, nurse practitioners, dietitians, nurses, nursing assistants, pharmacists, speech therapists, occupational therapists, physical therapists, wound care specialists, and administrators. As facilities begin to carry only limited liability coverage, individuals with malpractice insurance are being named in law suits more frequently. Currently, administrators, directors of nursing, nurses, Minimum Data Set (MDS) coordinators, dietitians, and certified nursing assistants are co-defendants in law suits, while administrators and directors of nursing have been criminally convicted in Florida, Hawaii, Missouri, and Texas.

Juries understand the importance of nutrition, and poor provision and documentation of nutritional care can easily be tied to negative outcomes by an experienced nutrition expert. Documentation of proactive, coordinated multidisciplinary nutritional care plans and implementation of approaches is essential in avoiding nutrition litigation.

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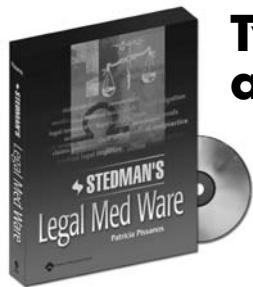
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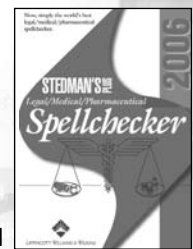
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Discovery in the Electronic Age

Arlene D. Klepatsky, Esq RN

We live in an age in which technological advancements continue to flourish. Many of these advancements have impacted the way in which information is managed in our society. For example, much of the information that once was created and stored on paper is now created and stored electronically. In fact, “most companies store up to 70 percent of their records in electronic form” (Lange and Nimsger, 2004, p. 2). In addition, “93% of all new corporate information is presently created in digital [electronic] form” (Antcheva, 2006). In addition, electronic information is being gathered and stored, sometimes without our knowledge. The purpose of this column is to explore the sources of electronic data that could potentially serve as relevant evidence in a legal dispute.

Electronic Discovery

After a case is filed, discovery begins. Discovery is the process of gathering evidence to prove or disprove the legal elements of a case (Klepatsky, 2005). Now that so much information is kept in the electronic format, the likelihood that such evidence would be helpful to a case must be considered. The discovery of electronic information is referred to as electronic discovery. Electronic discovery is the subject of many recent law books, articles and cases. According to an American Bar Association law book, *Electronic Evidence and Discovery: What Every Lawyer Should Know*, lawyers in the 21st century, in order to discharge their duties to clients, “must now be prepared to handle this modern form of evidence, along with all the new and unique technical and legal issues that come along with it” (Lange and Nimsger, 2004, p. 4).

Electronic discovery is currently being used in many different types of cases. It is used in complex corporate litigation involving theft of trade secrets, computer sabotage, copyright/trademark cases, and claims of discrimination. Electronic discovery is used in smaller cases as well. These include such cases as breach of contract, personal injury, medical malpractice, and product liability. In addition, electronic information frequently plays a role in the prosecution and defense of criminal suspects in cases such as those alleging murder, identity theft, stalking, and possession of child pornography. Electronic evidence will only increase in importance as the 21st century progresses.

The federal government and some states have drafted amendments to their existing discovery statutes to address issues related to electronic discovery. The Federal Rules of Civil Procedure (FRCP) will soon be amended to acknowledge “that electronic information may be sought through a

subpoena, as well as through other traditional discovery requests” (Antcheva, 2006). Other proposed amendments to the FRCP will address such issues as preservation and loss of electronic information as well as the form of production of the requested information.

Discovery Requests for Computers

Computers (desk tops, lap tops, and hand-held computers called personal digital assistants or PDAs) have become commonplace for both professional and personal use. As a result, investigation of the computer has become a critical factor in almost any case (Lange and Nimsger, 2004). Among the more commonly requested items on the computer are e-mail, documents, spreadsheets, research, and other downloaded data. These electronic files are discoverable even when the information has been previously produced in hard copy format (Lange and Nimsger, 2004).

The Importance of E-mail

E-mail is widely used as a vehicle for communication. The International Data Corporation estimated that 31 billion e-mails were sent daily in 2002, with the expected number to be 60 billion a day by 2006 (Farrell, 2002). An interesting phenomenon about e-mail is that many people tend to regard it as a private and transient communication. Even those in high level business positions tend to fire off an e-mail without considering the fact that it may come back to haunt them in the future. In fact, it is this casual attitude about e-mail that makes it such a potential gold mine for the opposing side. “E-mail has become such a fertile ground for lawyers in search of a smoking gun”, that there are now investigative firms that specialize in “digging dirt out of company hard drives” (O’Neill, 2005, ¶ 3).

In general, e-mail is discoverable if it is relevant to the dispute and is not subject to one of the legal privileges. In other words, unless an email is between an attorney and a client or between a physician or psychotherapist and a patient, chances are it will be admissible as evidence. (There may be a few additional privileges depending on the jurisdiction where the case is filed.) Because deleted material is also discoverable to the extent it can be recovered, deleted e-mail is also discoverable (see Forensic Computer Examination). In addition, e-mail remains discoverable even if it exists only on back up tapes or on storage devices.

Case Examples: In a class action lawsuit, saved company e-mails were the subject of a discovery request. Among the e-mails produced was one that stood out. An administrator

of a manufacturer of the diet drug Phen-Fen had sent the following e-mail: "Do I have to look forward to spending my waning years writing checks to fat people worried about a silly lung problem?" (Lange and Nimsger, 2004, p. 3). Not only was this e-mail admitted into evidence in the case against the manufacturer, it is frequently quoted as an example of one of the major e-mail blunders.

A former investment banker was convicted of obstructing a federal investigation into stock offerings because of an e-mail that he sent to employees. When he learned of the investigation, he sent an e-mail that became central to the case. In this email, he told employees to clean out their files (O'Neill, 2005).

In litigation involving care in a nursing home, Beverly Enterprises was ordered by the Arkansas Supreme Court to file a \$20 million dollar bond because the company failed to produce requested e-mails and other electronic evidence as requested. The judge had also threatened Beverly executives with jail time after he found them to be in contempt for failure to produce the requested e-mails and other electronic evidence (Cody, 2005).

Other Information Requested from Computers

In addition to e-mails, discovery requests are made for databases, documents, spreadsheets, programs, downloaded files, searches, and other research that was performed on the computer.

Case Examples: In the 2004 California murder trial of Scott Peterson, prosecutors used as evidence the fact that a husband had searched maps and tidal charts of the San Francisco Bay on his computer (Ryan, 2004). A few months following the searches, the bodies of his wife and unborn son washed up on the shore of San Francisco Bay.

In another case, investigators found a copy of a wife's suicide note on the husband's computer. However, when the computer was examined, it was determined that the document had not been created until a few months after the wife had been found dead in the bathtub. Investigators also discovered that a search about "bathtub accidents" had been performed on his computer prior to the wife's "accident."

Forensic Computer Examination

A computer may be seized for forensic examination off site. In the alternative, a forensic computer examiner may make an image of the data on the hard drive leaving the computer at its usual location. It is a myth that information can be deleted from a computer at the user's command. In fact, it is very difficult to delete information from a computer. When the user "deletes" data, it remains on the hard drive until, eventually, other data is written over it. Even when data is overwritten, fragments of the data remain and can be extracted by a forensic computer expert. Even reformatting the hard drive does not make the previously stored data irretrievable by a forensic computer expert.

In addition to information on the computer itself, discovery requests may include backup tapes or information

from other types of backup and storage devices including portable hard drives and optical discs.

Case Example: One of the major cases in electronic discovery is a federal discrimination and retaliation case. Plaintiff knew that some e-mails had circulated throughout the company that would support her allegations, but they were not in the materials already produced in response to a discovery request. Apparently, the key e-mails were stored on back up tapes. These back up tapes were requested. Defendant fought the production of the e-mails, claiming that the cost of extracting them from backup tapes would be prohibitive. The judge ordered the e-mails on the back up tapes to be produced. The court said it would apply an analysis later in the litigation to determine which party should bear the cost of extracting the e-mails from the back up tapes. In the federal jurisdiction, this case is important because, not only does it hold that information that exists only on back up tapes is discoverable, it additionally states that deleted material is as much discoverable as undeleted material (Zubulake v. UBS Warburg, 2003).

Information Provided by Internet Service Providers

Questions about computer users "are asked every day of the companies that provide internet services... And even though these companies promise to protect the privacy of their users, they routinely hand over the most intimate information in response to legal demands from criminal investigators and lawyers fighting civil cases" (Hansell, 2006, p. 1). Such requests for information have become so prevalent, that large Internet companies have a formal process for subpoena management. "AOL, for example, has more than a dozen people, including several former prosecutors, handling the nearly 1000 requests it receives each month for information on criminal and civil cases." The type of information that is most commonly sought about users includes "their names, where they live, where they were last online – and, if a court issues a search warrant, what they are writing and reading in their e-mail" (Hansell, 2006, p. 1).

Information Provided by Web sites

Web sites are also asked to produce information about a person's search activity. For example, the United States Justice Department recently requested that Google, a popular search engine, and other companies, turn over searches made by its users. Though Google resisted the request, America Online, Yahoo, and Microsoft complied (Hansell, 2006).

The big news for most Americans shouldn't be that the administration wants yet more confidential records. It should be the revelation that every single search you've ever conducted—ever—is stored on a database, somewhere... Google's campus LCD [where current searches are displayed] sounds like it's just fun and games, but when a search can be linked to you (through the IP [internet protocol] address recorded by Google), that's a lot less

fun. And when, as we're seeing, it can all be demanded by the government, that's no fun at all (Wu, 2006, ¶ 2).

These companies are able to provide information even when users remain anonymous or use false identities. Many Web sites keep logs of all user activity, including the user's IP address. If an investigator is provided with the IP address, he or she "can subpoena the internet provider for the identity of the user associated with that address at a particular date and time" (Hansell, 2006, p. 1).

Case Examples: In 2001, police in St. Louis, Missouri, were searching for a serial killer. A reporter wrote stories about some of the victims, and he received a response. The alleged killer sent the reporter a map showing the location of the remains of victim #17. Skeletal remains were located at the site marked on the map. Police from the Illinois State Cyber Crimes Unit were called to assist, and they identified the map as coming from a specific Web site. The Web site company provided the police with a list of the IP addresses of computers that had requested maps along with names and addresses of the users. With this information, police obtained a search warrant and searched the home of the person who had sent the map. At the home, police found evidence of torture and murder. The user was arrested.

Among the factors that finally lead to the capture and confessions of Charles Cullen, a nurse who killed many patients in Pennsylvania and New Jersey over many years, included electronic evidence from a computerized record-keeping system and a computerized medication administration system. These systems showed that Mr. Cullen had obtained medications that were not prescribed to any of his patients and that he had looked up medical records on patients that were not in his care.

Use of Metadata

Metadata means data about data. Metadata is automatically embedded in documents, spreadsheets, e-mails, photographs, floppy discs, and other items. For example, a document created on the computer contains metadata including the date of creation of the document, the author of the document including a company name if any, dates the document was accessed, dates the document was printed, and the amount of editing time. Changes to the document may also be tracked. With the use of additional computer technology, prior versions of a document may be revealed and previously deleted comments can be restored.

Therefore, if documents are sent to an adverse party as a text attachment, the metadata will be sent with it. However, prior to using metadata against an adversary, it is important for an attorney to determine whether it is considered ethical to do so in the jurisdiction of practice. For example, a New York State Bar Opinion regarding metadata states that there is a duty to avoid exploitation of inadvertent disclosures that may involve client confidences and secrets. In addition, legal commentators suggest that there is a duty to remove metadata from a document prior to sending it to adverse counsel (What's the meta with metadata?, 2006). Metadata can be eliminated

in a number of ways, including sending a scanned document, or sending the document in a format that does not transmit metadata such as the tagged image file format (TIFF). One more important point about metadata is that it can sometimes be intentionally changed or manipulated (Antcheva, 2006). Please consult your computer consultant for more information about metadata.

Case Example: Metadata was instrumental in apprehending a long-sought serial killer. Dennis Rader, also known as "BTK" (bind, torture, kill), sent a floppy disc to the press. The metadata on the disc included information about the computer from which the data was downloaded including the name of the church where the computer was located. Law enforcement personnel went to the church and requested a list of all people who had access to the church computer. Dennis Rader's name and address was on the list (Hegeman, 2006).

Redacted Information

Redacted information is information that has been removed from document. Legal nurse consultants (LNCs) often share case-specific documents as examples of their work product with the identifying information carefully redacted. As illustrated by the following government blunder, electronic redaction is not always reliable.

Case Example: Last April, U.S. military commanders in Iraq released a long-awaited report of the American investigation into the fatal shooting of an Italian agent escorting a freed hostage through a security checkpoint. In order to give the classified report the widest possible distribution, officials posted the document on the military's "Multinational Force-Iraq" Web site in Adobe's portable document format, or PDF. The report was heavily redacted, with sections obscured by black boxes.

Within hours, however, readers in the blogosphere had discovered that the classified information would appear if the text was copied and pasted into Microsoft Word or any other word-processing program. *Stars and Stripes*, the Department of Defense newspaper, noted that the classified sections of the report covered "the securing of checkpoints, as well as specifics concerning how soldiers manned the checkpoint where the Italian intelligence officer was killed. In the past, Pentagon officials have repeatedly refused to discuss such details, citing security concerns" (Lesemann, 2006).

This experience serves as a good example that documents redacted on the computer should not be sent directly to others because the redacted information is capable of being restored. In fact, the safest way to provide exemplars of one's work is to draft hypothetical documents.

[Tip: Never share case-specific documents, even if redacted, without checking with the attorney on the case.]

Electronic Information in Health Care Settings

Electronic information is becoming more and more prevalent in health care as the trend toward computerized documentation and use of other electronic devices increases. Many facilities have a hybrid documentation system, with some

computerized charting mixed with some paper documents. Furthermore, the use of e-mail in health care is a growing trend. E-mail appears to be gaining popularity for communications between health care providers and patients, among hospital staff, and among hospital departments. According to the Joint Commission on Accreditation of Healthcare Organizations [JCAHO], “records of communication with the patient regarding care, treatment, and services, using telephone or e-mail, if applicable, are part of the medical record” (Iyer, 2005,

p. 287). The possibility exists, however, that not all relevant e-mail will make it to the medical record as required. (Please note that there are issues related to privacy, confidentiality, and consent with respect to e-mail communication with patients that are beyond the scope of this column.)

It is important to realize that even in facilities that do not use computerized documentation as their primary mode of documentation, it is becoming increasingly likely that electronic data about some aspects of patient care will exist.

Table 1: List of Electronic Devices.
Following is a list of items that may be sources of electronic evidence. This is not an exhaustive list.
Black boxes: These devices collect data from a variety of sensing devices and store information from them to be queried in case of an accident. Black boxes are used on commercial aircraft, trains, and ships. Black boxes also exist for the purpose of recording conversations in the cockpit to be used in the analysis of an accident.
Cellular phones: The location of the origin of cellular phone calls may be determined using triangulation techniques calculated from information from cellular towers. In addition, the time that calls were made, and even the time a cell phone has been turned off or on, may be documented. The cellular phone itself may be a source of data, including an address book and logs of incoming and outgoing calls. Some cellular phones may also store audiographic, photographic and videographic data.
Computers: These include hard drives of desk top computers, lap top computers, and PDAs (Personal Digital Assistants, sometimes referred to as hand-held computers). Related items include backup tapes, floppy discs, CD-ROMs, DVD-Rs, optical discs, and storage devices.
Electronic credit and debit cards: These record the times and details of bank transactions and purchases.
Electronic membership cards: These cards record information about the times of logging into a facility such as a gym. In addition, these are used at some supermarkets for the stated purpose of obtaining discounted prices. They are also used to compile information and create profiles of consumption habits of card holders. (Privacy and Consumer Information, 2004).
Electronic weather stations: These devices generate records of meteorological data. This data may be relevant in various personal injury cases involving motor vehicle collisions and even slip and fall cases.
Event Data Recorder (EDR): The “black box” is currently being used in private automobiles. In fact, some automobile manufacturers have been using such devices for over a decade. These vehicles have a variety of sensors and keep a “running record of how a car is being operated, including speed, acceleration, braking, steering and seat belt use. When there is an ‘event – usually a crash – the EDR moves the last several seconds of information into long-term storage for later downloading” (Harper, 2004, ¶ 3). Data is also kept by the airbag system regarding air bag deployment or near-deployment events. Such data has been considered to be admissible in courts and has been used as evidence against defendant drivers. These devices have raised some concern about privacy. Some states require a notice in the owner’s manual if they are in place.
Global Positioning Systems (GPS): These are devices that can be placed on a mobile object so that the position can be monitored and tracked. Signals to and from satellites allow for calculation of exact times and locations within about 30 feet. GPS devices have been used in commercial trucks to track rest stops, routes, and speeds. GPS devices have also been placed in rental cars and have been used to fine the renters for speeding. GPS devices are also used by law enforcement to track criminal suspects.
Memory cards, “flash” memory, “memory sticks”: These are used for portable data storage. They are used in many applications including in digital cameras.
MP3 devices: These are devices such as the iPod™ by Apple Computer Inc. These devices are now able to store photographic and videographic data as well as audiographic data.
Portable hard drives: As technological advances continue, hard drives will continue to get smaller while storing more data. An example of a small, portable hard drive in current use is the ThumbDrive®. This is a self-contained portable hard drive the size of a thumb that can be plugged directly into the USB port of a computer. It is able to download and store huge data files such as documents, presentations, accounting files, CAD (design) files, audiographic/music files, photographic files and videographic files. (See www.thumbdrive.com .)
Radio Frequency Identification (RFID) tags: These are small tracking devices that can be placed into products, vehicles, animals, or even humans. They can provide information about a tagged product, including price, color, date of purchase, etc. They are implanted into animals for identification purposes. When placed in vehicles, they are used for electronic toll collection. They are used in library book tracking systems. The Veteran’s Administration uses RFID technology in its “talking prescription” system, in which the information on prescription containers is read by a device to visually impaired veterans. These devices are being studied for use in other aspects of health care such as patient identification, medical record monitoring, and laboratory sample tracking. For more information on this interesting technology, including potential future applications, see http://en.wikipedia.org/wiki/RFID
Red light cameras: These are computerized digital cameras that photographically document a vehicle traveling through a red light. The electronic trigger system is connected to a central computer that puts everything together to construct proof of the violation. For more information, see http://electronics.howstuffworks.com/red-light-camera.htm
Room/cabin key cards: With an electronic key system, it is possible to generate a “lock interrogation” in the event of a security breach. A report can be run on a particular lock that shows which keys were used and at what time. The report includes the use of master keys by staff as well.
Security devices: Depending on the system in use, various data may be saved for review, including videographic and audiographic data.

Table 2: Examples of Patient Care Systems that Generate Electronic Data

Automated anesthesia monitoring/record-keeping systems: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10846393&dopt=Abstract
Blood glucose monitoring systems: http://www.pointofcare.net/procedures/GlucoseProcedure.htm
Computerized physician order entry systems/Computerized medication administration systems: http://www.medical.siemens.com/webapp/wcs/stores/servlet/PressReleaseView?langId=-1&storeId=10001&catalogId=-1&catTree=100005,13839,17711&pageId=33153
Digital storage of diagnostic imaging studies: http://www.infoway-inforoute.ca/en/WhatWeDo/DiagnosticImaging.aspx , http://www.eclipsys.com/Solutions/diagnostic_image.asp
Electronic management of antepartum care, labor and delivery units, nurseries, etc: http://www.siteofcare.com/
Electronic management of critical care: http://www.informationweek.com/story/showArticle.jhtml?articleID=10000106
Electronic management of surgery department including management of supplies: http://www.eclipsys.com/Solutions/surgery.asp
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For example, in some facilities, there is an electronic record of perioperative anesthesia care. This documentation might not be included in the medical record (though it clearly should be). In such a case, if it is determined that an electronic anesthesia recording system is in use, the records should be requested or subpoenaed.

There are other systems that generate electronic data that may or may not find its way to the medical record. These include medication administration systems (such as Pyxis systems), blood glucose testing devices (such as AccuData systems), and computerized physician order systems. Diagnostic images are often stored electronically. In addition, some facilities use electronic call bell systems and nurse locator systems. With nurse locator systems, the various classifications of nursing staff wear badges that generate electronic data about their location throughout the shift. Electronic systems leave a trail of data that can be obtained and used to analyze patient care issues. (See Table 2 for information about some of these electronic systems.)

As the health care industry continues to move toward electronic patient care systems, the greater the chances are that electronic discovery will be of critical importance in a case involving patient care. The LNC assisting with interrogatories and depositions should advise the attorney to ask about the existence of electronic systems in use in health care facilities or offices when patient care is at issue. The LNC can then determine whether or not key electronic data has likely been generated and whether or not such data would be helpful to the case.

Conclusion

The federal statutes and cases make it clear that 1) electronic data is discoverable just as paper evidence is discoverable, 2) electronic data that has been “deleted” is

discoverable, and 3) electronic data residing on back up media or storage devices is also discoverable. Since civil procedure laws of the states often mirror those of the federal system, it is likely that the laws regarding electronic discovery in the individual states will be similar. The LNC should, however, determine the relevant laws in the state of practice.

Not only does the attorney have a duty to be knowledgeable about electronic evidence, this knowledge increases the chances of prevailing in a case (Lange and Nimsger, 2004). Since electronic evidence has become so important in litigation in the 21st century, it would behoove the LNC to become proficient in recognizing when evidence may exist in electronic form. Furthermore, in cases involving medical/nursing issues, the LNC should keep abreast of electronic devices used in health care that may yield electronic information to support or refute key issues in a case.

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Medical Legal Aspects of Medical Records

Reviewed by Beth C. Diehl-Svrjcek, MS RN CCRN NNP CCM LNCC

Medical Legal Aspects of Medical Records

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ONC LNCC & Mary Ann Shea, JD BS RN

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Upon turning the initial pages of this textbook, one becomes acutely aware that this publication is an incredible compilation of information essential to the practice of any legal nurse consultant (LNC). Penned by authors well-known for their extensive involvement and long term commitment to legal nurse consulting, Patricia Iyer, Barbara Levin, and Mary Ann Shea, the book has exceptional depth and breadth. It provides a structural foundation for medical legal record review and analysis that encompasses regulatory issues and multiple clinical specialty areas.

In addition, the reader is privy to the shared knowledge and clinical expertise of 50 contributing authors. These authors represent various disciplines: nursing, law, emergency medicine technology, medicine, pharmacy, chiropractic, dentistry, forensic document examination, and epidemiology. Given the vast array of contributors, the reader may surmise that the flow of the text could be somewhat erratic; however, that is not the case. The authors have clearly provided a uniform concept and context upon which the book is written.

This text is architecturally sound, with an outlay of information that proceeds in a methodical fashion from fundamental principles of medical record structure/format to a subsequent detailed discussion of clinical specialty areas and forensics. Given that the medical record is the keystone for clinical practice, one cannot underestimate the importance of being thoroughly familiar with how best to interpret, analyze, scrutinize, and reference all of the crucial information contained within such a document. This formidable task is simplified by referencing "Medical Legal Aspects of Medical Records."

The book is divided into four major parts that independently cover the essentials of all medical legal aspects of documentation. The four parts are:

- Part I: Overview
- Part II: Outpatient Specialty Areas
- Part III: Specialty Areas
- Part IV: Forensic Aspects

Interestingly, each chapter leads off with a detailed synopsis referencing specific points of discussion so that the reader can quickly seek desired information. Throughout the text, tables, illustrations, photographs, and graphic templates of documents serve as practical examples. The frequent "Tips" on virtually every page are refreshing and effective anecdotes to highlight salient pieces of information. Chapter "Endnotes" provide the reader with an alternate listing of resources, if further exploration is needed.

Part I, which consists of fourteen chapters, sets the stage for the remaining three parts by reviewing some aspects of medical record acquisition, organization, and preservation. LNCs learned these fundamentals in nursing school, but given the sweeping changes that have impacted health care documentation systems and medical record technology over the past decades, this is an excellent refresher. All aspects of the nursing process are thoroughly outlined, with a review of the types of charting systems currently utilized nationwide in health care settings, i.e. narrative, SOAP, PIE, FOCUS, FACT, or charting by exception. With the push toward computerized medical records per the 1991 Institute of Medicine report, this text examines the present status of this endeavor, focusing on advantages and disadvantages of computer-based systems as the transition to paperless technology continues.

For the LNC who is not as familiar with billing and coding, chapter 10 provides a comprehensive tutorial for either the novice or experienced LNC in terms of bill generation, coding references, and fraudulent billing. The final portion of Part I deals with regulatory influences as they impact medical records, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), The Joint Commission for Accreditation of Healthcare Organizations (JCAHO), and National Patient Safety Goals. Standards initiatives, primarily for patient safety with their concurrent documentation requirements, will serve as a welcomed reference to the LNC involved in evaluating a malpractice case resulting from a violation of patient safety. Presuit use of medical records in chapter 13 is an important component, as the LNC may need to interface with hospital risk management personnel and navigate the sensitive issues associated with incident reports. The final chapter on attorney use of medical records provides the reader with a greater understanding and appreciation for what is truly required from a medical record standpoint for an attorney to successfully weigh the pros and cons of a particular case.

Part II is a relatively abbreviated section of the book, which consists of six chapters and deals specifically with outpatient specialty areas. Documentation regarding chiropractic care, acupuncture, dental procedures, home care, and ophthalmology

are examined. Although these areas are not as frequently cited in medical litigation as some other clinical areas, for an LNC dealing with such, these chapters are a wonderful resource for those individuals with minimal baseline knowledge.

In addition, this section has two chapters that address topics often entangled in the litigation process: the office based medical record and the independent medical examination (IME). The IME chapter delineates the step-by-step process of an IME, culminating with final impressions and professional opinions regarding the IME. The section on office based medical records was very helpful. As many LNCs are aware, office based verbal communication may not be adequately corroborated with written documentation – and may even serve as the wavering domino leading to an unfortunate cascade of events resulting in medical malpractice litigation.

Part III, chapters 21 through 38, deal specifically with clinical specialty areas. This is the “meat and potatoes” for LNCs who are routinely involved in medical malpractice litigation. These chapters address many high-volume, high-risk areas of clinical practice, e.g. critical care, emergency department, intravenous therapy, obstetrics, orthopedics, pediatrics, skin trauma, medication administration, and psychiatric care. The reader will benefit tremendously from the expertise and experience of each contributing author. If an LNC is already clinically experienced in one of these particular fields, it is likely that the information contained within the chapter will reinforce an existing knowledge base. For the LNC without clinical expertise in one or a number of these designated clinical areas, the chapters will provide an excellent starting point to explore pertinent definitions, patient care interventions, treatment complications, and practice standards.

Part IV of the text explores forensic aspects of care. Although any LNC may encounter altered medical records or utilize a forensic document examiner, for those involved in

criminal prosecutions, chapter 41 will be highly beneficial. A detailed discussion of forensic evidence from sexual assaults, gunshot wounds, auto accidents, and poisonings provide examples. The final chapter of the book addresses autopsy reports, which may be an integral component of malpractice, product liability, or toxic tort litigation.

The book concludes with an appendix of medical terminology, Internet resources, textbook references, and a glossary. These four subcomponents, as evaluated separately from the main text, are excellent as a stand-alone reference for the practicing legal nurse consultant.

In summary, authors Iyer, Levin, and Shea have provided the legal and nursing community a comprehensive and worthwhile resource for medical record examination. Whatever your level of competence in legal nurse consulting practice, whether novice or seasoned expert, this publication will be as valuable addition to your reference library.

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Nursing Malpractice: Determining Liability Elements for Negligent Acts

continued from page 9

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