The Journal of

# Legal Nurse Consulting

Volume 19 ▲ Number 3 ▲ Summer 2008


- The Legal Implications of Risk Management
- Strategies for an Effective Medical Chronology
- Using the Nursing Process to Determine Your Candidate in the 2008 Elections
- LNCExchange: A Networking and Educational Forum for LNCs
- Medical Guidelines and Reviewing Medical Records
- Institutions and Organizations Analyzing Health Care and Public Policy Issues
- Book Review: Medical Malpractice Expert Witnessing: Introductory Guide for Physicians and Medical Professionals

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AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

**American Association of Legal Nurse Consultants**
401 N. Michigan Avenue
Chicago, IL 60611-4267
877/402-2562
312/321-5177
Fax: 312/673-6655
E-mail: info@aalnc.org
Web site: www.aalnc.org



# *The Journal of Legal Nurse Consulting*

## Purpose

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

## Manuscript Submission

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

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

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# Something Worthwhile

Dear Readers:

Ben Franklin is credited with saying, "Either write something worth reading or do something worth writing." It is fair to say the contributing authors of the Summer issue have accomplished both goals. It is my distinct pleasure to bring their written expertise to the JLNC readers.

Writing on *The Legal Implications of Risk Management*, Carol Wells shares her insight on the Enterprise Risk Management (ERM) paradigm and the implications of its ongoing evolution. The author further examines the ERM matrix as it applies to the electronic medical record. It is a well-written, contemplative article that gives rise to the need for review of current risk management policy regardless of the primary setting.

In *Strategies for an Effective Medical Chronology*, Moniaree Parker Jones has provided an instructional piece for chronology excellence. With respect to individual attorney preferences and compliance with copyright laws, the author provides practical tips and hints for enhancing your work-product to meet the attorney-client/employer needs.

A timely and thought-provoking piece is contributed by Kathleen McInnis in *Using the Nursing Process to Determine Your Candidate in the 2008 Elections*. The author reminds of our social responsibility, as well as our personal responsibility to family, friends, and self, to make an informed choice regarding the voting process. As an added bonus to this article, the author has provided the References and Resources column, which lists online resources for information on health care and public policy issues.

The Summer issue also brings two outstanding tools for the practicing LNC. The first piece is the cumulative effort of Claudia Egan, Cheryl McCracken, and Elizabeth Zorn. *LNCExchange* is a very-well moderated list-serve that provides a clearinghouse of information for LNCs and related disciplines. Watchful of adherence to confidentiality principles, members are encouraged to network, share ideas and valuable experience.

The second offering is an educated view of *Medical Guidelines and Reviewing Medical Records* by Perry Hookman, MD. The author has provided a well-informed analysis and application of using MPG in records review and, ultimately, medical-legal opinion. As someone who works on an almost daily basis reviewing clinical practice guidelines, I can attest to the value of this piece. As a side note, I was also pleased to bring you a review of Hookman's latest book, *Medical Malpractice Expert Witnessing: An Introductory Guide for Physicians and Medical Providers*.

The AALNC Annual Educational Conference in Tampa provided some incredible educational opportunities, and we are very fortunate that several of the presenters generously submitted manuscripts of their presentations for future publication. I look forward to introducing the readers to their articles in upcoming issues.

As always, I wish to thank this issue's authors and our future authors for their submissions, and I would encourage the readership to send their manuscripts to The JLNC.

Best regards,

Kara DiCecco, MSN, RN, LNCC

Kara DiCecco, MSN RN LNCC
Editor, *The Journal of Legal Nurse Consulting*

# The Legal Implications of Risk Management

*Carol Wells, MBA BS RN, Doctoral Candidate*

**KEY WORDS**
Enterprise Risk Management, Risk Management

*The role of organizational Risk Management (RM) is no longer relegated to overseeing the financial risk of the institution. Instead, the risk manager is now part of a team that also includes the quality and compliance manager. The objectives of the RM program were ultimately the control, reduction, and elimination of problems and situations that could hurt the financial status of the organization. This article provides insight into the Enterprise Risk Management (ERM) paradigm and the implications of its ongoing evolution, with an examination of the ERM matrix as it applies to the electronic medical record.*

## Traditional Views of Risk

Risk Management (RM) was traditionally seen in the context of monitoring for possible financial risk due to malpractice issues, issues regarding safety and security, and issues regarding relationships with insurers (Jones, 2007). With the evolution of risk management and the onset of the new Enterprise Risk Management (ERM) paradigm, the role of the risk manager has taken on a new context (Ching, 2004). ERM practices link organizational strategy with risk identification and the cost of risk by incorporating legal and financial oversight into RM programs in order to prevent and mitigate financial risk to the organization (Kusserow, 2007).

The traditional methods used in quality improvement are unreliable and unsustainable. Measuring quality is merely a means of identifying defects in policy and/or procedure. In other words, a systematic evaluation of quality identifies whether improvement efforts see changes in a desired direction, contribute to unintended results in another part of the system, or require that additional efforts are needed to bring the process back to where it was meant to be (Varkey, Reller, & Resar, 2007).

Quality managers were predominantly responsible for ensuring that the organization was within compliance with standards mandated by oversight agencies such as JCAHO. RM was seen as a completely separate entity. Now there is increasing recognition that these disciplines go hand-in-hand, and the oversight for the organization goes beyond standards compliance and reaches into risk prevention. This includes the design of systems and processes, some hopefully built into the administrative and clinical architecture of the organization, which provide methods to track and offset potential damage prior to it becoming a major issue (ASHRM, 2007).

A decision must be made how quality will be assessed and what is defined as quality. This means deciding whether that assessment will include practitioner contributions, health system contributions, patient responsibility, and/or the individual and social definitions of satisfactory levels of health. "Quality" is defined by three categories:

1. Structure – health care is actually given
2. Process – how care is given; and
3. Outcomes – the effects of care on patients and how the return to health is achieved.

Understanding the relationship between these three categories must be accomplished before quality assessment can be done (Donabedian, 1997).

## Reducing Risk

Risk reduction is the process where risk is identified and steps are taken to reduce the likelihood of its occurrence. No longer are organizations waiting to address risk after the fact. The trend now is to monitor and review to prevent the possibility of risk prior to its occurrence. Processes are reviewed for lapses, compliance standards are integrated into policy, and team effort is moved down the line to include floor management (Cassirer, 2004). If a sentinel event, as defined by JCAHO, or a breach in OSHA standards, for example, occurred, it could impact the health and wellbeing of a patient, visitor, or staff member. This may turn into a financial liability for the organization. Claims and litigation management rely on the healthcare professional adhering to a standard of care, whether that is through an outside agency or internal policy and procedure (West, 2004).

"Best practice" is a phrase used to describe the ideology of professionals using sound clinical judgment resulting from experience and education, by the use of a system of medical management, collaboration, and communication (Barton, 2004). A graphical representation of the potential risk, called risk mapping, shows a relationship between the frequency, the severity, and the consequences of each risk. Data can be obtained from actual events or generated in a simulation. This method provides an evaluation of the variation between the real outcome, the projected outcome, and the acceptable limit (Zuckerman, 2004).

The definition of "risk mapping" is the identification of significant risks, which may impact the organization in a specific or per-loss basis for a defined time period, identification of how risk is managed, and analysis of risk for RM approach and further analysis. The process begins with the identification of project goals including the scope of the project and the support of upper level management. Goals are set by the RM who then selects a team composed of

individuals from the departments of legal, quality assurance, performance improvement, finance, etc (Zuckerman, 2004). The team then gathers historical data by use of physical inspection, interviews with key personnel, incident reports, occurrence screens, loss prevention reports, industry benchmarks, and insurance checklists (Martin, 2004). The benefit of this method is that it identifies significant risks, encourages a multidisciplinary approach to solving them, quantifies the magnitude of risk and the need for risk control and financing, and focuses attention on risks that could have a negative effect on the financial status of the organization (Zuckerman, 2004).

## Changing Trends

The historical trend in RM had been to compartmentalize operations into silos or separate operating environments, such as financial, operations, support, and clinical services. This way, the risk was segregated and allowed complex organizations to address issues and tasks by breaking them down to a controllable size (Ching, 2004). The realization now is that, with the onset of additional regulations and regulatory agencies, this structure actually exposes the organization to liability (Jones, 2004).

As the environment became more complex, quality management saw its own shift toward patient safety, and new theories were developed to incorporate organizational culture into the mix. Quality and Performance Initiatives were based on standards from regulatory agencies and incorporated the design of processes, monitoring of performance by data collection, analysis of performance, and improvement measures (Ching). This resulted in the duplication of efforts by quality managers, compliance officers, and risk managers to solve the same problems.

Similar concerns were identified through audits, root cause analyses, or malpractice claims. Areas of risk exposure identified include inadequate documentation, poorly executed informed consent, inadequate patient education, poor physician patient communication, lack of medical necessity for performed medical services, and improper performance of medical services (Jones, 2004).

The conclusion is that "compliance" has moved from a reimbursement regulation to one that combines regulation, quality, and risk as important components. Litigation of medical liability has shown an increase in the number of serious cases with a proportionate increase in the cost of medical malpractice insurance, legal representation, and defense. Compliance and quality management now must include medical liability risk as part of Risk Management programs (Jones, 2004).

## Enterprise Risk Management

ERM is a process that identifies and eliminates the financial impact of risk. It requires an understanding that risk can be managed, used for capital gain, and uses a process of assessment, evaluation, and measurement. This procedure takes risk and looks at it from the perspective of an organization-wide problem, as opposed to a singular environment/operating problem (Ching, 2004). This perception allows the organization to analyze risk relative to each department, no matter where in the organization it occurs, and then to develop new strategies to manage it. In the new RM programs, consideration is given as to how the whole organization defines risk, how it selects its core metrics, and how it utilizes information to evaluate strategic issues; what tools are used to take the framework through financial planning, forecasting, and market assessment; and what the focus is when identifying and implementing solutions for ERM problems (ASHRM, 2005a).

The development of ERM begins with an assessment of risk definition, measurements, metrics, and methods of information recovery. Identification of risk begins with a multidisciplinary approach to discuss an episode and agree on measurement techniques. Data collection and root cause analysis is done to determine the how and why of the episode. The interdependent cost of risk is determined later. Finally, the development of a means of reducing the reoccurrence and/or prevention of possible future loss is accomplished (McCaffrey & Hagg-Rickert, 2004).

Risk is now recognized as cutting across organizations. Even organizations that maintain the silo approach to RM have to acknowledge that risk is not an isolated event. Issues that could impact an organization's ability to function well include financial loss due to medical malpractice issues, decrease or loss of accreditation, increased regulatory oversight, and a decline in equity. The Sarbanes-Oxley Act of 2002 requires financial links to risk management in the for-profit sector (Driver & Troyer, 2004). Nonprofit organizations have adopted its tenets, reporting methods are becoming standardized, and the focus is one of efficiency related to strategy (Kusserow, 2007).

The need is great to have the system able to assimilate decision support with compliance management, and the ability to identify potential risk to compliance, design and track risk mitigation techniques, simultaneously monitor and report areas of risk, and identify areas of risk probability. While this would require system-wide support, the next step would be a collaboration of Risk Management, Corporate Legal, and Quality Management teams to design such a system (ASHRM, 2005b).

## Risk Issues in Health Care

The 1996 enactment of the Health Insurance Portability and Accountability Act (HIPAA) provided for the development of a system of electronic medical records. When adopting electronic charting and electronic records, the organization must ready itself for the possibility that their records will be accessed at some point if a liability issue does occur. The Federal Rules of Civil Procedures passed in 2006 requires that electronic records be included in any discovery disclosure and response, and 12 states passed similar legislation. The point of the amendment was to push

the discovery phase into high gear and so organizations could not withhold information in the course of pretrial discovery (Cosgrove, 2008a).

Discovery must be prudent, whether for plaintiff or defense, and therefore must not be subjected to obstructionist ploys. Discovery is the process of identification of possible causes for litigation and goes through several phases, the investigation of medical records and related information being the most predominant form. This is done to review for possible breach of duty and non-adherence to hospital policy, and is also contingent on what a similarly prepared professional would do in a similar situation (Barton, 2004).

If, in the discovery process, it is realized that records have been lost, the burden of proof is on the party who fails to provide the record to prove the record was lost in the course of normal operations, and not due to an ulterior motive. Since state law and professional standards dictate the length of time the chart is held, if there is not a physical policy in place to cover the organization regarding destruction of the chart, it would be difficult for the organization to prove that it was destroyed in normal operating procedures. If this cannot be proved, penalties could come in the form of fines or claims of "spoliation" of evidence, which could ultimately hurt the case (Cosgrave, 2008a).

Issues related to health records are two-fold. In federal court and in some states, they are considered business records (Cosgrave, 2008b). HIPAA requires organizations to develop policies to distinguish which records are included in a medical record; some records deserve more stringent privacy procedures due to the inclusion of mental health records, HIV/AIDS, or substance abuse. In the discovery process, rulings allow litigants to review records to see whether they are worth pursuing as evidentiary. With the privacy constraints allowed to health records, however, the provider will have to issue the information in a truncated form if the sampling of information cannot be issued (Cosgrave, 2008b).

Some electronic records may not have the capability of reproducing information in a logical order, and a reproduction of the chart in print form may produce a chart that is out of sequence. The rulings regarding discovery also include electronic records on medication delivery or prevention of medication errors. The organization should review how it handles its e-discovery issues on a routine basis, both as technology upgrades occur and as part of its risk management strategic plan (Cosgrave, 2008b). Some positive aspects of the adoption of a computerized system include the integration of data for executive strategy. Integration of an enterprise system with a claims system assists with health delivery decision making and provides information necessary to negotiate with payers, increased efficiency, and increased access to complete picture in terms of health service delivery during patient visit (Kongstevdt, Quinn, & Shaman, 2007).

Privacy laws will always be an issue, especially as the use of electronic medical records increases. Additionally, organizations that decide to invest in electronic clinical records will need to address how they intend to provide for the privacy of patient records organization wide (Cosgrave, 2008b).

While HIPAA provides for a mechanism of ensuring privacy in health-related records, the Health Information Privacy and Security Act of 2007 (HIPSA) legislation is HIPAA on steroids. To be brief, HIPSA provides the patient with the means to control how, when, and if their information is included in electronic health systems, requires a consent to do so, and provides the patient with notification of who or how their information is used. It further imposes penalties for the organization who violates the ruling (Senterfitt & Ferrer, 2008). If enacted, this legislation would require revisions to HIPAA to add heightened requirements. HIPSA would have enforcement powers to impose criminal and civil penalties for unauthorized disclosure of patient information.

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**Carol Wells, MBA BS RN**, currently works as a LNC in independent practice. She has extensive background in Antepartum and High Risk Perinatal Home Health and has also worked extensively in High Risk Obstetrics and other general med/surg areas including ICU/CCU. She has functioned as patient educator, case manager, supervisor, and in-services provider to hospital staff. She has also worked as an Adjunct professor for Health Administration at NJCU, Jersey City, New Jersey. Wells earned her BS in Health Care Management and her MBA in MIS from St. Peters College, Jersey City, New Jersey, as well as her MBA in Health Care Management and Marketing from American Intercontinental University. She is currently working on a Doctorate in Health Administration at the University of Phoenix. She is a member of AALNC and an Associate member of AWHONN. She can be reached at **cwcarolwells@hotmail.com**.

# Strategies for an Effective Medical Chronology

*Moniaree Parker Jones, RN COHN-S CCM*

**KEY WORDS**
Medical Chronology

*The medical chronology is an important part of a LNC's work. The purpose of this article is to explore one way to do an effective, attorney-friendly, medical chronology, as well as learn how to add professional touches to enhance the work product and give impact to case outcomes. Chronology preparation involves careful analysis of sometimes-voluminous sets of medical records that are difficult for the layperson to decipher. Health care professionals are known to have a unique language of their own. This article attempts to give insight into one way to provide the necessary organization needed for legal case preparation. Knowing how to manage, organize, and set forth information for concise review is of ultimate importance to the attorney.*

Medical chronologies are an important part of a legal nurse consultant's (LNC's) daily activities. A "chronology" is defined as a written document that consists of a verbatim summary of pertinent information from medical records that may include the date and page number of the referenced information (Iyer, 2003). Preparing the medical chronology involves careful analysis of numerous sets of records filled with medical terminology and jargon. The language of the health care profession can be difficult to decipher without the assistance of a skilled medical professional. There are many ways to organize a chronology, and this article merely addresses one way.

## Obtaining Medical Records

Once a case has been assigned, the LNC must first identify what records are needed for review. The initial step is to identify every provider the client has seen. When working for a plaintiff's firm, this will be completed by interviewing the client for the information concerning all medical providers. It may be beneficial to have a form or checklist to assist in obtaining the information. When working for a defense firm, this information will be obtained by reviewing the responses to the interrogatories in the case. This may well be an ongoing process when performing the actual record review.

**Table 1. Objects/ Subpoena Report.**
**John Doe Case (M1622-8713): Key Facts Chart 12-2000 to 3-2001**
**CONFIDENTIAL ATTORNEY WORK PRODUCT. DO NOT REPRODUCE.**

| Object Type | Full Name | Short Name | Role In Case | Subpoena |
|---|---|---|---|---|
| Person | Edward Johnson, M.D. | JohnsonE | Internal Medicine<br>1101 Main Street<br>Pelham, Alabama 35124 | Yes |
| Person | Joe Chinook, M.D. | ChenookJ | Unknown Address<br>Bates BAN-02-06 | No |
| Person | David Cosentino, M.D. | CosentinoD | Physiatrist<br>268 River Road<br>Biloxi, MS 39533 | No |
| Person | C. Cartwright, EMTA | CartwrightC | Medical STAT EMS<br>1606 Indian Crest Rd.<br>Biloxi, MS 39533 | Yes |
| Person | Erica Graham, M.D. | GrahamE | Orthopedist Specialists<br>132 River Road<br>Biloxi, MS 39533 | Yes |
| Place | Rehabilitation Specialist, Inc. | JonesD | Rehabilitation Specialist, Inc.<br>Riverwest Medical Center<br>132 Medical Center Drive<br>Biloxi, MS 39532 | Yes |
| Person | Janet Cason M.D. | CasonJ | Family Physician<br>Riverwest Medical Center<br>132 Medical Center Drive<br>Biloxi, MS 39532 | Yes |
| Person | Dana Winston, PT | WinstonD | Therapist performing FCE<br>Bates DW236 | No |

*Note: All listed providers are fictional names for sample purposes only.*

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Keeping an objects list or spreadsheet (see Table 1) will be necessary in order to organize this data, regardless of whether you have a plaintiff or defense client. Include all contact information such as names, addresses, phone numbers, and type of provider. Including the type of provider assists the attorney in the identification of the specialty area of the practitioner, hospital or clinic, which allows the attorney to determine the relevance of the information.

## Confidentiality

Health care providers are required, by law, to maintain confidentiality of records and are prohibited from releasing information without the patient's consent and authorization. Authorizations must also comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. It is important to obtain attorney review and evaluation of any questions about compliance in obtaining medical records.

Once a list is started, the LNC can provide this information to the team paralegal or designated person for the issuance of subpoenas or the requests for medical records. Providers are added to the list as more providers are identified in the process. It is common that names of providers are not obvious on first check and are often hidden in the records. Certain records may be harder to obtain, such as psychiatric records. State law also dictates the consent that is required for special types of patents, such as minors and incompetents.

Another important step is to ascertain that you have complete records. Sometimes this can only be assessed once the record review has begun. It is particularly important to obtain a signed certificate of record certification from each provider in order to avoid any record disputes.

## I Have the Records, What Next?

*Get on the Same Page:* One of the most important roles for the LNC is to determine what critical information the attorney will need to develop the case. This crucial factor guides the LNC in determining the critical elements of the summary. This is what makes the LNC indispensable because the skills required to perform proficient, targeted, pertinent summaries comes with the training and experience of the seasoned nurse. Having a nice-looking report is ineffective if the analysis is not accessible, useful, and accurate.

Interviewing the attorney or attorneys for preferences prior to working on a chronology is beneficial to both attorney and nurse. The attorney may have certain wishes that are known only to them, and the nurse may have suggestions for the chronology that the attorney may have not considered or knew possible. Starting work on a chronology and later having to change things to meet these preferences can cause the loss of valuable billable hours, result in waste of effort, and delay the finished product.

It is extremely important for the nurse to obtain a copy of the case Complaint prior to reviewing any records. This allows the nurse to understand the issues involved in the case and know what to look for in the record analysis. The review of a case without having seen and read the Complaint is like opening a mystery novel to find there are no contents.

*Software Programs:* There are many software programs available for the LNC to use. It is a personal and firm decision based on your computer usage, skill level, and desired product appearance. The following are some examples listed in no particular order: CASEMAP, LIVENOTE SR™, STEADMAN'S LEGAL MED WARE, SUMMATION, MICROSOFT WORD, and THE MASTER LIST. Many companies offer free trials before deciding to purchase (Dawson, 2005). (Please note: The aforementioned list is not an endorsement of any product or company, but merely an overview of some of the tools that are available.)

## Preparation, Analysis, Summary

The advantage of using most software programs is the ability to have the computer sort the records in date order as you enter them. Some records, such as voluminous nursing home files, may need to be sorted prior to entering and review. These types of records are sometimes better utilized in notebooks with dividers. This is especially true if the patient has been a long-term resident and many years of care are involved.

Unless otherwise specified by your attorney, all medical records should contain an identification number on each page. This is done by scanning or manual production. Bates numbering (also known as Bates Stamping or Bates Coding) is used in the legal field to sequentially number documents for easy marking and exhibiting during the discovery stage, as well as in trial preparation. The name is the result of a machine patented in 1891 to Mr. Bates, which automatically shifted the next number after pressing (Wikipedia, 2008).

The process of interpreting medical records is second nature to the nurse who understands this seemingly foreign medical language. During the assessment phase, the LNC looks for areas of concern regarding care received, breach of standard of care, tampering of records, inappropriate care, documentation errors, missing records, red flags, and more, depending upon the types of issues involved. The ability to place this information into a useful format is the key to an effective chronology.

## Formatting the Chronology

There are many ways to format a medical chronology. (See Table 2 for one example of how to create an attorney-friendly chronology). Columns are created with headings indicating categories of critical information. These headings are titled: date & time (indicates date of service or date of care on record as well as the time if indicated), source or provider (source of care), facts (pertinent information found on medical record page), LNC comments (red flags, important issues found on page), and Bates number (number of page in medical record where the information is found). The information to be written under each section will include the important information found on the designated page of the record. Sometimes the information will need to include specific

**Table 2. Critical Facts Summary Case**
**Baby Boy (H3200-86442)**
**CONFIDENTIAL ATTORNEY WORK PRODUCT. DO NOT REPRODUCE.**

| Date & Time | Source(s) | Fact Text | LNC Comments | Bates Number |
|---|---|---|---|---|
| Wed 02/21/2006 3:10 a.m. CT | Southern Medical Center | **Nurse Narrative Notes NICU:** White male infant transferred over to NICU after hour of observation in well baby nursery. History of meconium and decreased activity in well baby nursery with low chem. Strip < 30 (Normal =>40). Changed to open heated server controlled warmer. Under 1.0 Fi02 oxyhood (oxygen). IV to right hand. 8 cc D10W (Dextrose 10% water) bolus given. D10W to infuse at 10.5 cc per hour. Infant intubated with 3.5 ETT (endotrach tube) by S. Johnson, M.D. and tolerated well. | **Nurse Narrative Notes NICU:** White male infant transferred over to NICU after hour of observation in well baby nursery. History of meconium (First stool of newborn which can be swallowed by the infant causing respiratory distress from aspiration) and decreased activity in well baby nursery, low chem. strip <30 (N=>40) (indicating glucose level to be low). Initial antibiotics given. D10W at 10.5cc per hour. **(Note: These look like entries from Carol Brown, CRNP (Certified Registered Nurse Practitioner) but could be Carl Brown, CRNP (writing is difficult to read).** | 00143 |
| 3:30 a.m. CT | | Mechanical vent as tolerated. 7 cc D10W bolus given for low chem strip. Initial antibiotics given. **(Note: These entries look like from Carol Brown, CRNP but it could be Carl Brown, CRNP (writing is difficult to read).** | | |
| Wed 02/21/2006 | Southern Medical Center | Mother's Graphic Flow Sheets<br>Epidural order flow sheet | | 00029 |

*Note: The above chart is fictional and for sample purposes only.*

**Table 3. Key Facts Chart.**
**John Doe Case (M1622-8713): 12-2000 to 3-2001**
**CONFIDENTIAL ATTORNEY WORK PRODUCT. DO NOT REPRODUCE.**

| Date & Time | Source(s) | Blood Sugar Med | Glucose Level | Hgb A1c | Blood Pressure | Blood Pressure Med | BP Med? Filled | Cholesterol | Bates No. |
|---|---|---|---|---|---|---|---|---|---|
| Sun 12/03/2006 | Havenwood Medical Center | | | | | | Rx: Atacand, Atenolol | | HMC00063 |
| Tue 12/05/2006 | Capitol Medical –Surgical Clinic | Glucophage #60 | | | 150/90-188/119 | | | | HMC00020 |
| Tue 12/05/2000 | Medicine Chest | | 128 (N= 65-109) | 6.1 (N=4.5-5.7) | | Atacand #30 Atenolol #30 | | 218 (N=100-199) LDL 143 (N=0-129) | MC00005; 26 |
| Mon 01/01/2007 | Havenwood Medical Center | | | | | | Rx: Atacand, Atenolol, Glucophage | | HMC00063 |
| Thu 01/04/2007 | Medicine Chest | Glucophage #60 | | | | Atacand #30 Atenolol #30 | | | MC00005; 27 |
| Wed 01/31/2007 | Medicine Chest | | | | | Atenolol #30 | | | MC00007 |
| Fri 03/02/2007 | Medicine Chest | | | | | Atenolol #30 | | | MC00008 |

*Note: The above data is for sample purposes only.*

times. This is especially true with cases involving alleged surgery errors, obstetrical delivery records, emergency room records, or any case where timelines are important. The source or provider section should include the name of the physician, hospital, clinic or healthcare provider. Information placed in the fact section should be what is important on that particular page of the medical record. This would include things such as vital signs, medications, chief complaint, assessment, plan of treatment and any other matter of interest. Many times the nurse will find hand-written comments by staff, phone call information, refills on narcotics or drugs of interest, wound size data and other information of importance which should be entered in this section. The LNC comment section can be optional, although some attorneys like this section as it can be helpful in pointing out red flags or important data without having to read the entire chronology, such as when an attorney is preparing for a deposition and needs a quick review of the most important data the night before or morning of the scheduled meeting. All that is required for a fresh briefing is a quick reading straight down that one column. The Bates number is most important because finding the source of the information will be extremely difficult if this section is not included. This is especially true when the records are voluminous. It is important to label the work product as attorney-client privileged. Chronologies are written for in-house use and should not be produced to experts, outside attorneys or anyone other than the working attorneys on the case for the firm by which you are employed.

## Extra Touches

The LNC can increase the value and significance of the medical chronology by adding additional information. Once the chronology spreadsheet is completed, a new page can be started titled "LNC Comments." Photos of medical care providers can often be obtained from hospital Web sites. Diagrams of anatomy related to the problem, definitions of procedures, information on medications, timelines, and pertinent charts can add value to your work product. Many of these extras can be found on the Internet. "Cutting and pasting" into documents is a simple way to provide valuable information to the attorney in the chronology, as well as add value and picture definitions.

One such example is to provide a picture of the internal structures of the knee if the case you are summarizing is related to a knee injury or surgery. Including visual and educational information in your review enhances the value of the report to the attorney. Table 3 is an example of spreadsheet usage in a chronology where blood pressure, cholesterol, and blood glucose levels might be important for case fact comparison. The LNC can add definitions and medical background knowledge to the chronology that allows attorneys of all experience levels to better understand and evaluate the records.

The LNC must be knowledgeable in many areas. The LNC acts as case manager, researcher, analyzer, risk assessor, and valuable member to the legal team. The work product is a reflection of the LNC's expertise. It is important for case assessment to be objective and unbiased. The LNC has the ethical obligation to inform the attorney of negative aspects in a case, as well as any critical information that could impact a case either positively or negatively (Iyer, 2003). There are many ways to analyze medical records, making no one way the right way. The LNC has the opportunity to use expertise and creativity to make a major contribution to the positive outcome of a case.

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**Moniaree Parker Jones, RN COHN-S CCM**, is a LNC with the law firm of Bradley Arant Rose & White LLP, in Birmingham, Alabama. Prior to assuming her current position, she worked as a LNC with Haskell Slaughter Young & Rediker. She has worked previously as an occupational health nurse in a large commodities chemical plant in Louisiana and has experience in emergency room nursing and public health. Jones received her ADN from Troy University, a BSN from the University of Alabama, and will graduate August 2008 from the Masters in Nursing program at the University of Alabama Capstone College of Nursing. She is the 2007 recipient of the Robert M. Barksdale Memorial Endowed Scholarship and an Alabama State Nurses Association Scholarship, and the 2008 recipient of the Sigma Theta Tau Most Outstanding Masters in Nursing Student award at the University of Alabama. She holds certifications in occupational health and case management. She is a member of the American Association of Occupational Health Nurses and current President of the Central Alabama Association of Occupational Health Nurses, a member of the American Association of Legal Nurse Consultants, President Elect of the AALNC Greater Birmingham Chapter, and a member of the Case Management Society of America and the local Birmingham chapter. Jones serves on the University of Alabama at Birmingham Deep South Center for Occupational Health and Safety planning committee. She is a frequent lecturer and guest speaker. She can be reached at **nightingalempj@bellsouth.net**.

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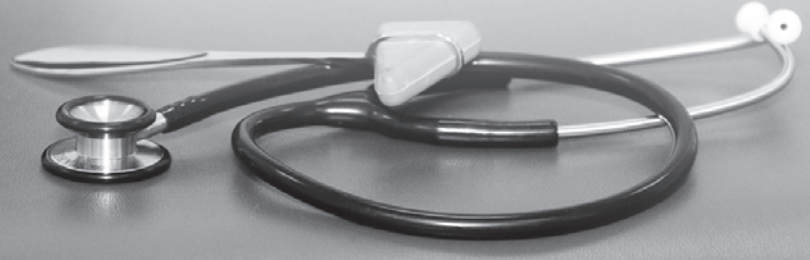

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# Using the Nursing Process to Determine Your Candidate in the 2008 Elections

*Kathleen M. McInnis, MS RN*

**KEY WORDS**
Nursing Process, Voting

*This summer, the political heat will be turned up. Evenings will be bombarded with television and radio advertisements, touting this candidate or that. Nurses are experts at following the nursing process in determining the best course of action using assessment, diagnosis, planning, implementation, and evaluation. All nurses should consider this method in evaluating who is best suited to be our next President and Congressional leaders. Legal nurse consultants (LNCs) adapt the nursing process for use in review of medical-legal documents. In the same way, we can study available data and come to the best conclusion in determining who should lead the new health care movement.*

***Editor's note:*** *As this goes to press, Hillary Clinton is preparing to deliver her concession speech for the Presidential seat. With this in mind, it remains crucial to familiarize yourself with and thoroughly research your political candidate's platforms as we head into the next step of appointing our leaders. You will choose not only the President but also those who serve with him in office. Your political affiliation is not the issue; your informed vote is.*

In November, we will have the privilege of voting for the next president of the United States, as well as Congressional and local leaders. Health care is a looming issue for this country, which finally needs to be addressed without rhetoric or politics. Chronic disease is the leading cause of death and disability in the United States and the leading driver of health care costs. According to the Partnership to Fight Chronic Disease (2008), 75% of health care expenditures are related to diseases such as cancer, diabetes, and heart disease. Obesity has reached epidemic proportions. Health insurance expenses have increased, while coverage has decreased. Nursing and physician shortages decrease quality of care.

The contenders will talk about how they will fix health care in this country, but we have heard all of this before. Every 10 or 15 years, candidates declare the same thing: this time, they will fix the broken system, if only given the chance. And no significant changes occur. In order for true change to come about, we need to understand why reforms have not been successful in the past: political leaders, at odds about how to change, prefer to do nothing rather than concede to their counterparts' alternatives; 85% of Americans are insured and fear change; advocates for each type of change claim their ideas will result in more efficiency and quality, yet these claims lack scientific evidence; stakeholders/potential losers of reform will mount huge efforts to block action (Aaron, 2007). More than likely, "healthcare reform will not come from a single bill that transforms a $2.5-trillion industry, but from repeated legislation of modest scope, enacted over many years. The next president can articulate a vision, but like Moses, he or she is unlikely to see the Promised Land" (Aaron, 2007, paragraph 11).

Other health policy experts believe that making small changes will not fix the system and that a huge overhaul needs to take place. Elise Gould, PhD, a health economist at the Economic Policy Institute in Washington, DC, believes that one model to improve health care and increase access would be the Medicare model – it has low administrative costs and a large risk pool (Krisberg, 2007). Providers report, however, that reimbursement rates do not cover the cost to provide services and therefore they limit the number of Medicare patients they will treat. These and other issues need to be addressed by the candidates.

Through voting, citizens make their priorities known, and the desire for change can mobilize leaders on both sides of the aisle to work together (Aaron & Butler, 2007). One proposed solution, the Baldwin-Price Bill (HR 5864: Health Care Partnership Through Creative Federalism Act), though currently stalled in committee, would allow states to achieve federal funding and fast-tracking to test their own health care initiatives. Stipulations of the bill would mandate inclusion of clear, measurable goals for improved coverage and access over a 5-year period, as well as determining bottom-line costs. This way, various delivery systems could be attempted, tested, and evaluated. Once the theories have been tested, they will prove or disprove their merit.

Regardless of who become our leaders in the 2008 elections, the deep divisions between liberals and conservatives regarding the best way to fix the system will more than likely cause gridlock and reduce the chance for real change unless the process moves toward the center of the aisle and in small steps (Altman, 2008). Many states are already researching methodologies to institute health care plans. These ideas should receive federal encouragement and support.

## Using the Nursing Process in Voting

Nurses are experts at following the nursing process in decision-making. Whenever a problem arises, we determine

**Table 1. Comparison of Candidates.**

| Hillary Clinton | John McCain | Barrack Obama |
|---|---|---|
| • Lower costs by promoting wellness and disease prevention.<br>• Increase quality of health care<br>• Introduce a "groundbreaking National Prevention Initiative."<br>• Improve the HIT system.<br>• Transform care of the chronically ill.<br>• Create an independent "best practices" institute.<br>• Lower health care disparities.<br>• Spend money to increase participation in preventive care programs. | • Control costs to stop erosion of affordable health insurance.<br>• Make the patient the center of care.<br>• Continue federal research on the basis of sound science, focusing on the care and cure of chronic disease.<br>• Enhance the HIT; improve technology.<br>• Personal responsibility is key in preventing chronic disease. More needs to be done to prevent disease and adhere to treatment once a diagnosis is made. Teach kids how to live healthy lifestyles. Public health initiatives to stem obesity/diabetes and deter smoking. | • Modernize the health care system to contain costs.<br>• Promote prevention.<br>• Increase use of the HIT system.<br>• Require plans that participate in the new public plan, Medicare, or FEHBP to utilize proven disease management programs.<br>• Reward employers who offer workplace programs.<br>• Use "medical homes."<br>• Utilize school-based programs.<br>• Consolidate efforts of federal, state, and local agencies. |

*Reprint permission granted by Partnership to Fight Chronic Disease (2008), www.fightchronicdisease.org.*

the best course of action using assessment, diagnosis, planning, implementation, and evaluation.

From the time we enter nursing school, the process is drilled into us. Eventually, the experienced nurse uses this process in the confrontation of any problem, professionally and personally. Legal nurse consultants (LNCs) adapt the nursing process for use in review of medical-legal documents, and the "patient" is the name on the stacks of medical records. Even if we never meet the "patient" in person, we make knowledge-based decisions using systematic analysis. In the same way, we can study available data and come to the best conclusion in determining who should lead the new health care movement.

The first step in making any important decision involves assessment. As the *Legal Nurse Consulting: Principles and Practice, 2nd edition* indicates, assessment of information to determine who is best qualified to serve in the role of president involves researching available literature from online sources, newspapers, flyers, brochures, and attending local political meetings. Analyze all of the available, reliable information, especially with regards to healthcare, to "ensure a successful outcome before developing a plan of action. As data are gathered, analyzed, and interpreted, the next step in the process will begin to take shape" (Iyer, 2003, p. 172).

The next step is to compare and contrast the candidates' opinions with regards to health care. The following comparisons are taken from the PFCD Web site and are geared toward how the candidates plan to revamp health care, especially those issues related to chronic illnesses. (See Table 1.)

Once some research has been completed, identification of key issues, or *diagnosis*, can take place. In health care reform, the dozens of overwhelming issues can impede this process. Choose two or three compelling issues on which to focus. Perhaps insurance reforms are an area of interest. Read about the candidates' views on how or if to reform the insurance industry. Research health-policy organizations to discover what experts believe about reforming or not reforming the industry. Perhaps the obesity epidemic peaks interest. Again, do the research. Look into and evaluate studies that have examined this issue and how to best treat it. Examine what is being done in the local community.

The next phase involves developing a step-by-step *plan* concerning how to elect the best candidates, how to get others involved, and how to educate others. Identify long- and short-term goals. For example, what steps can be taken immediately? Start by making a call to party headquarters. Ask what needs to be done in the short-term and the long-term. What are the time constraints? Are there rallies to attend or local candidates who need yard signs disseminated? Read local publications, and watch local television to find event schedules and areas that rouse concern. List all of these, constructing a list of items that are manageable within the confines of a busy work and family life.

Now is the time to take action. *Implement the plan* by following the above guide and get started! Document your progress: share with other nurses, family, and friends, encouraging them to get involved in the process. Let them know how exciting and truly rewarding it can be to make a difference, one person at a time. Get to know local political leaders by helping them better understand the health care issues in the local community.

Even after the election, the work is not done just because the votes have been counted. *Evaluate* what has been done. Maintain your involvement in the process by working to keep politicians accountable. Attend community meetings, continue reading, and research persistently. Keep educating fellow nurses, as well as the community, about health policy. Continue to cultivate relationships with local leaders, as they may some day move to the state or national levels of government. Just as health care providers use evidence-based medicine in planning care or making patient-centered decisions, population-based data used in evidence-based health policy should also be used in decision-making or to evaluate the effectiveness of health-policy decisions (Morrato, et. al, 2008). Knowing the percentage of those insured or the obesity rate in the local community should guide decision-making in planning future programs.

## The Informed Voter

Be sure that elected officials have concrete, measurable ideas – not just grand, untested theories or lofty aspirations. Encourage state and national representatives and even the President to qualify their thoughts and ideas through evidenced-based data.

**Thoughts to ponder:**

- When the provider becomes too big (think: the US government and the VA health system), there is a greater chance for layers of bureaucracy, more opportunities for fraud, and increased difficulty providing quality care. Too much time is already spent on cumbersome paperwork, which results in lower patient satisfaction. Patient care models that personalize care should be sought out and encouraged (Kappas-Larson, 2008).
- When comparisons are made to the Canadian or European health care systems, the negative aspects of care are often left out, such as long wait times to be seen by a doctor and long waiting lists to see specialists. According to Tanner and Cannon (2007), 900,000 Brits are waiting for admission into a National Health Service Hospital; in Sweden, the average wait time for hip-replacement surgery is more than a year, forcing patients to live with chronic pain and the possibility for permanent damage to be done in the meantime. Sam Solomon, from *Canadian Medicine* (Genes, 2008), reports that long wait times are the norm in the Canadian system.
- Remember that any plan will have an enormous impact on the economy, and health care rationing will more than likely be a part of any proposed plan (Aaron, 2006).
- Trying to overhaul a massive system will not occur over night. The population of the United States is nine times greater than the population of Canada and three times that of the UK (The World Factbook, 2008).
- When candidates talk about "fixing the system," they need to let their actions speak louder than their words. They need to commit to developing reforms that address real solutions for programs already in place, such as Medicare and Medicaid reform, portability of insurance, and chronic disease management, which are key elements to lowering expenses.
- Encourage others to examine candidates who are not afraid to address the politically sensitive "personal responsibility" issue. Examining ways in which citizens can be more responsible and accountable for their own health care, both in terms of managing insurance and being responsible for their own health, could potentially bring down costs. This theory warrants further study.

- Health insurance status does not determine quality of care or better health of the patient (Tanner & Cannon, 2007). Regardless of what changes are made in the insurance or health care industries, promoting prevention of chronic diseases is key to improving the long-term health of all Americans and making U.S. health spending go further (PFCD, 2008).

Regardless of party affiliation, don't base decisions on rhetoric. Think about using the nursing process to make the best possible decisions, based on fact and science. The availability and quality of health care for future generations could be at stake. Get involved. Whether it is writing letters to Congressional leaders, stuffing envelopes at the local party headquarters, attending rallies, or going door to door educating people about your desired candidates, *you* can make a real difference.

LNCs are educators and promoters of good health. Nurses get involved in health-related issues every day and can do the same in endorsing candidates who choose to promote wellness, prevention, and personal responsibility. Leaders who want to work to improve health care in this country should be promoted, as well as those who are open to trying new ideas and thinking outside the box. As Mary Ann Shea, JD RN, so succinctly said in the closing address at the 2008 AALNC National Education Conference, "Analyze the data to get to the truth. Feel it with your heart" and vote. The right to vote is an honor, and making an *informed* choice is a duty.

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**Kathleen M. McInnis, MS RN**, has 22 years of nursing experience in pediatrics, school nursing, maternal-child, and community health nursing. She earned her master's degree from the University of Colorado Health Sciences Center in 1995 in Community Health. She owned and operated Healthy Start Breastfeeding Support as a lactation nurse for three years and has taught prenatal breastfeeding classes for ten years, as well as other community-based classes in her home town of Durango, Colorado. She has been a member of AALNC since 2006, has worked as an independent LNC off and on for the last ten years, and currently operates Professional Legal Nurse Consulting, working for plaintiff and defense personal injury cases. She became interested in health policy issues and has offered research support regarding health policy to State Representative Ellen Roberts (R)-Colorado over the last two years. She can be reached at **katmci@frontier.net**.

# LNCExchange: A Networking and Educational Forum for LNCs

*Claudia P. Egan, BS RN; Cheryl McCracken, RN LNCC; and Elizabeth K. Zorn, RN BSN LNCC*

**What is LNCExchange?** LNCExchange is a non-fee based professional networking forum on Yahoo Groups, primarily for legal nurse consultants (LNCs) and other professionals in the health care field who work on medical-legal cases. It can be accessed at **www.LNCExchange.com**.

**What is the mission of LNCExchange?** The essence of legal nurse consulting is analyzing medical issues in the context of the applicable legal standards. Our mission is to advance the profession of legal nurse consulting within the legal community through meaningful networking between LNCs, attorneys, and health care providers who engage in the review of medical-legal and forensic matters.

Our goal is that the shared information will be educational and helpful, challenging LNCs to learn about and share the many facets of legal nurse consulting. Our group also provides LNCs the opportunity to network with attorneys and other professionals who interface with LNCs. LNCs with all levels of experience, including nurses just interested in learning about LNC work, are welcome to join our group.

**Why did you start LNCExchange?** All three moderators – Claudia P. Egan, BS RN; Cheryl McCracken, RN LNCC; and Elizabeth K. Zorn, RN BSN LNCC – had participated on one or more non-fee-based LNC listservs for a number of years prior to starting LNCExchange. Based upon our collective experiences, we identified a need for a focused, well-moderated group in which members are free to offer differences of opinions, as long as this is done in a thoughtful and respectful way. We also identified a critical need for the more seasoned LNCs to educate those just getting started about the realities of our profession and the skills that are needed to be successful.

**What is the educational, clinical, and legal nurse consulting experience of the three co-moderators?** We have each practiced in the LNC field for more than 15 years. We represent the three most common practice settings for LNCs: independent practice, in-house defense firm, and in-house plaintiff firm.

**What are the requirements for membership approval?** Prospective members must convey their professional interest in being part of our group. They must also provide their complete contact information, which is verified by one of the moderators. This is to preserve the integrity of our group by screening out spammers or anyone who does not have a legitimate reason for being part of our forum.

**What are the demographics of your membership?** We started with 50 members in February 2006. As of our 2-year anniversary, we had grown to more than 1,200 members. To the best of our knowledge, we have members from every state, including Alaska and Hawaii. The vast majority of our members are "behind the scenes" LNCs and/or nurse experts. This includes advanced practice nurses such as nurse practitioners, Certified Registered Nurse Anesthetists, and nurse midwives. We also have RNs with advanced training and credentials in specialty practice areas such as infusion therapy, wound care, and pain management. Finally, we have a number of physicians, attorneys, physician assistants, and even a nurse chiropractor.

**In what ways does LNCExchange serve as an educational forum?** Collectively, the members of our group have a wealth of clinical experience and knowledge about medical legal cases. The experienced LNCs and attorneys share their knowledge and experience related to analyzing medical legal cases, legal standards and strategy, tips for getting started as an LNC, and the skills that are needed to be successful. Many of the new LNCs are clinically active or have very recent clinical experience. Thus, they (and the physicians and advanced practice nurses) are able to answer clinical questions, including those that relate to the applicable standard of care in medical malpractice cases. We have tried to create an atmosphere in which differing points of view and perspectives are welcomed so that members can make informed choices about their practice and medical legal cases.

**In what ways does LNCExchange serve as a networking forum?** Through the exchanges that occur in our forum, members are able to learn about and network with other LNCs in their own geographical areas, as well as across the country, for assistance with their cases and practices. Members can also post and respond to needs for clinical nursing and medical experts, for attorneys who specialize in medical legal litigation, and also for LNC job opportunities. Networking occurs daily via public posts to the listserv. In addition, a tremendous amount of private networking goes on between members who connect through our group.

**What are some of the common topics or "threads" that are discussed on LNCExchange?** The most common discussion topics include standard of care issues involving a particular clinical scenario in medical malpractice cases, tips for researching the peer reviewed medical literature, clinical guidelines for evidence of the applicable standard of care, and evaluation of causation issues; and tips for getting started in the LNC profession, including educational and mentoring options, as well as marketing tips for the independent LNCs.

**What are some of the more controversial topics that are discussed on LNCExchange?** The most controversial topic relates to the various for-profit course-based LNC "certifications"

awarded to nurses after merely taking a course, even though the students may have never even worked on an actual medical legal case. It is our personal opinion that this is primarily a marketing ploy by for-profit courses that, unfortunately, dilutes the meaning of certification within the LNC profession. Given that certification is not necessary to practice as an LNC, the moderators believe that, to the extent that LNCs or attorneys believe that certification is important, it should be experienced-based as with other nursing certifications. Another relatively controversial topic relates to LNCs marketing themselves directly to the public (for example, to screen a potential medical malpractice case for merit without the involvement of the attorney's legal knowledge), which is inadvisable in that it could be construed as the unauthorized practice of law and could forever preclude a plaintiff from bringing action if the statute of limitations expires on the LNCs' watch.

**What are the various options that members have for receiving the "posts" generated by the listserv?** Members have three options for reviewing messages posted to the group. The first is "individual e-mails" in which the member receives an e-mail containing each message sent to the listserv. LNCExchange averages about 25 messages per day (or about 750 messages per month). Some members who choose this option set up a separate e-mail account just for listserv posts. The second option is a "daily digest" in which the member receives one e-mail per day with a trailer of all the posts of the day. There is also a "no e-mail" or "special notices" option in which members do not get any e-mails (except for a rare special notice from the moderators if they so choose), but rather visit our Web page to view messages, all of which are archived and can be searched for particular topics. We currently have in excess of 15,000 archived messages.

**What other resources and benefits does LNCExchange provide for its members?** LNCExchange's home page has a "files" section in which the moderators and members can upload documents for use by LNCs in their practice. This includes information on LNC education and training (including a chart with many of the LNC course options nationwide), setting up an independent LNC practice, marketing tips, screening and investigating medical malpractice cases, identifying and researching the background of potential experts, and sample work products such as timelines, chronologies and case analysis. It also contains subfolders in which LNCs and medical legal experts can upload their CVs.

We also have a "links" section that contains the URLs for numerous Web sites of interest to LNCs, including those related to business resources, medical literature, clinical guidelines, abbreviations and acronyms, demonstrative evidence, educational opportunities, mentoring programs, job opportunities for LNCs, and local AALNC chapters.

**What is involved "behind the scenes" in maintaining and moderating the listserv?** Collectively, the moderators spend about 25 to 35 hours per week attending to listserv matters and interacting with members. This includes reviewing and responding to inquiries sent to the whole group, contacting members privately who don't comply with our guidelines, making educational contributions to the group, responding to private communications from members, speaking with members by telephone, screening and approving new members and selected messages, problem-solving with members when they have technical computer problems, and obtaining feedback from members who unsubscribe from the group. General moderating responsibilities are rotated on a monthly basis to ensure that at least one moderator is monitoring group activity each day.

**What are some of the more important guidelines that members must abide by when posing questions and answers on LNCExchange?** All new members receive a list of "member guidelines" that we feel are imperative to maintain a substantive highly functioning professional group. Abiding by these guidelines is a requirement for remaining in our group. Our goal is to foster an environment rich with contacts and information and to maintain a warm and inviting atmosphere in which members are free to express their views.

We encourage members to offer tips, suggestions, and options for others to consider so that members can make informed choices. We also recognize that reasonable minds can differ, and thus we welcome debate and differing points of view. To this end, members are required to communicate in a kind and thoughtful way, selecting language that is respectful when disagreeing with another point of view. While fortunately rare, "flaming," insults, and foul language are not acceptable. Any material that, within the judgment of the moderators, is harassing, defaming, offensive, abusive, or indecent is not allowed. In order to keep the group focused, posts must be relevant to medical-legal issues.

We encourage members to compose a concise, informative message, including a subject heading accurately reflecting the main point of the message. This allows members to quickly delete messages they are not interested in reading. We ask that members sign every post with a full signature. We feel this makes it more likely other members will respond to their request.

**What should not be posted on LNCExchange?** We discourage members from posting detailed case information without the express permission of the managing attorney, as this is in violation of attorney-client privilege and the principles of confidentiality. We do not permit "off-topic" posts, such as jokes, information about charitable causes, holiday greetings, and religious or political discussions. Copyrighted material cannot be posted without permission from the author. We do not permit discussion of specific hourly rates for LNCs, as this could be construed as a violation of Federal anti-trust laws. We also encourage members to network privately when exchanging the names and contact information of potential experts.

**Do you allow members to advertise their LNC products or services?** Members who offer LNC products or services are permitted to post about their product or service no more than twice per year. This supports members offering and those in need of these services without inundating the group with unsolicited advertisements. We do not allow non-LNC members to join with the sole purpose of marketing a product or service to our members.

**What has the feedback been from members about the value of LNCExchange?** Since its inception in February 2006, we have received very positive and regular feedback from many members about the value of the group. The new LNCs describe it as a "lifeline" and essential to the development of their practice. We commonly hear that most of what they have learned about LNC work is through the information and networking provided in our group. Feedback from experienced LNCs is also very positive as it relates to the exchange of information about clinical issues, expert identification, practice issues, and sharing of Web resources.

**What does the future hold for LNCExchange?** We expect that LNCExchange will continue to be an important source of education and networking among its members. We anticipate that the group will continue to grow at a steady pace and that additional educational resources will be added to our files and links sections. The success of LNCExchange is largely attributed to the willingness of many members to participate, network, and share their thoughts, resources, and experiences in this field. Professionals interested in joining our group can go to **www.LNCExchange.com**.

As co-moderators for LNCExchange, we support AALNC's mission and goals, recognizing that it is the premier professional organization for LNCs, fostering growth and professional standing for LNCs within the nursing and legal professions.

**Claudia P. Egan, BS RN**, received her Bachelor's degree from New York University in 1981. She worked as a registered nurse in hospital settings such as ICU, NICU, High Risk Labor and Delivery, and Infectious Disease Research until 1990, when she became employed by the plaintiff law firm Faraci, Lange, Johns & Schwarz as a LNC specializing in medical malpractice, personal injury, and toxic torts. In 1995, Egan formed a medical-legal consulting business working with attorneys who specialize in medical malpractice, personal injury, and criminal law. In December 2000, she formed Alpha CHECKPOINT of Rochester, Inc., as an extension of her forensic expertise, offering forensic testing needs (drug and alcohol testing, DNA paternity testing, infidelity testing, etc.) to employers, attorneys, and the public. She is a member of the Rochester Legal Nurses Network (RLNN), American Association of Legal Nurse Consultants (AALNC), International Association of Forensic Nurses (IAFN), American College of Forensic Examiners International (ACFE) – Fellow Status, and Monroe County Bar Association. She can be reached at **egan@alphacheckpoint.com**.

**Cheryl McCracken, RN LNCC**, graduated from the Jewish Hospital School of Nursing in 1982. She was employed at University Hospital in Cincinnati, a Level III Trauma Center, from 1982 to 1993. Her practice at University Hospital included the Burns Special Care Unit, the Emergency Department, and the Critical Care Float Pool. From 1993-1995, she was employed full-time as an in-house LNC at Jacobson, Maynard, Tuschman & Kalur, a large firm that specialized in medical malpractice defense. From 1995-1998, McCracken was employed as a Community Health Nurse providing medical surgical care and home infusion therapy. In 1998, she accepted her current position as full-time in-house LNC at Frost Brown Todd LLC. Her caseload includes predominantly medical malpractice cases, but she also consults on personal injury, product liability, and insurance defense matters. Cheryl is a member of the American Association of Legal Nurse Consultants (AALNC) and obtained her LNCC in 2002. She was inducted into Sigma Theta Tau International Honor Society of Nursing in April 2008. She is currently enrolled at Xavier University in Cincinnati, where she is working toward her MSN and teaches sophomore-level BSN students nursing therapeutics in the clinical and lab settings. She can be reached at **cmcracken@fbtlaw.com**.

**Elizabeth K. Zorn, RN BSN LNCC**, attended Vassar College and the University of Rochester (BSN 1976). After graduation, she worked in the Pediatric Intensive Care Unit at the University of Rochester Medical Center and then as nursing manager in the hospital's high-risk obstetrical unit. From 1985 to 1995, she worked as a LNC at Nixon, Hargrave, Devans & Doyle, where she provided assistance in the defense of medical malpractice and other personal injury cases. Since 1995, she has worked at Faraci Lange, a plaintiff law firm in Rochester, New York, specializing in medical malpractice, products liability, toxic tort, and other personal injury matters. Zorn is a member of the American Association of Legal Nurse Consultants (AALNC), Rochester Legal Nurses Network (RLNN), and the Monroe County Bar Association. She is author of the chapter "Legal Nurse Consultant Practice Within a Law Firm" in AALNC's *Legal Nurse Consulting Principles and Practice*, 2nd ed (2003), two chapters in AALNC's new *Legal Nurse Consulting Online Course* (2006) and chair of AALNC's Awareness Committee (2008). She can be reached at **elzorn@faraci.com**.

# Medical Guidelines and Reviewing Medical Records

*Perry Hookman, MD FACP FACG*

## Q: What should the LNC know about medical guidelines when reviewing medical records?

## A: "Guidelines" may be extensively quoted by medical experts on both sides, both the plaintiff and defendant. What you may not hear from most medical experts is that many of the clinical guidelines are non-evidenced-based. But worse yet, some guidelines may be biased.

Guidelines – or more properly Clinical Practice Guidelines (CPGs) – are systematically developed statements that aim to help physicians and patients reach the best health care decisions. According to Field et al. (1990), good guidelines have many attributes, including validity, reliability, reproducibility, clinical applicability and flexibility, clarity, development through a multidisciplinary process, scheduled reviews, and documentation.

Guideline development involves many steps:

1. A topic must be identified and refined. A guideline panel is then convened. This panel should consider all reasonable management strategies for dealing with the problem. Medical specialty societies are the most common sponsors.
2. The next step is to perform a systematic review to identify and appraise the available evidence.
3. A critical appraisal of this evidence must be then translated into a guideline.
4. The guideline must then be disseminated to the relevant audience and implemented.
5. Finally, the impact of the guideline should be prospectively assessed using meaningful and measurable outcomes.

The nation's Institute of Medicine defined CPGs as "systematically developed statements to assist the practitioner and patient decisions about appropriate healthcare for specific circumstances." Kohn et al. (2000) state that CPGs are essentially consensus statements created by various entities and experts, both public and private, to outline what may be appropriate treatment for a specific medical condition, group of symptoms, or an approach at disease prevention. According to Moses (2008), "contemporary development of CPGs involves the use of evidenced based medicine (EBM) that proposes the model under which medical decisions and practice are based on the best available evidence."

Unfortunately, the quality of guidelines varies considerably. The development of CPGs and the EBM approach is a science that continues to evolve. Guidelines rely on both evidence and opinion. They are neither infallible nor a substitute for clinical judgment. They do, however, go beyond systematic reviews to recommend what should and should not be done in specific clinical circumstances. Some are widely respected by physicians. They have helped to standardize care, diminish local variation, and improve health outcomes.

**Q. Can the LNC depend upon CPGs to support medical opinions of the medical experts?**

A. Yes, as long as the LNC is aware that CPGs have problems, especially EBM-developed CPGs. Many are of low quality because of:

- Peer-reviewed literature can be incomplete dealing with a particular guideline;
- Most guidelines are developed for the "textbook patient," which is not of the real world; and
- Many guidelines are often developed without knowing their acceptability to physician, patient, or health care system. Thus there is low compliance with published guidelines (Kane et al., 2006). Most guidelines should be graded as to quality and accuracy.

**Q. Where should the LNC research guidelines?**

A. The medical literature is awash with guidelines (Fried et al, 2007). More than 2,000 guidelines are currently represented in the National Guideline Clearinghouse

(**www.guideline.gov**). But the LNC should know where those guidelines came from, as well as the quality of what the expert is quoting to allegedly support the expert's medical opinion. Among the guideline efforts in the United States that are generally considered successful are those of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the National Academies, as well as the treatment guidelines for sexually transmitted diseases issued by the Centers for Disease Control and Prevention. Efforts outside the United States include those of the World Health Organization and the National Institute for Clinical Excellence (NICE), in the United Kingdom.

But what is most important about what you see and hear as "evidence" and supporting medical expert opinions are not just "guidelines" but those guidelines backed by evidence in the peer reviewed medical literature that is valid and accurate. Medical organizations that create guidelines face difficult challenges and guidance is needed (Steinbrook, 2007).

According to Hookman (2007), if guidelines are to be truly evidence-based, all recommendations of those guidelines should be supported by up-to-date systematic reviews. Guidelines are classified by the U.S. Preventive Services Task Force in decreasing grade order from I, II-1, II-2, II-3, and III. In addition, the levels of evidence upon which these guidelines are based are classified in decreasing levels of quality from A, B, C, and D. Every medical expert or LCN who uses guidelines and clinical studies to support a medical opinion will be asked by the questioning attorneys: What is the grade of the recommendations? What is the grade of the evidence? If the attorney does not elicit and bring out the quality of these guidelines to the jury, he is either not doing his job well or covering something up. If the medical expert on either plaintiff or defense side does not do this, he either does not know what he should know or is obfuscating.

Guidelines have also been questioned when pharmaceutical and medical-device companies with a financial stake in the outcome provide substantial funding for their development and implementation. At present, the financial ties between guidelines panels and industry are extensive. A survey of 685 disclosure statements by authors of guidelines concerning medications found that 35% declared a potential financial conflict of interest. Taylor and Giles (2005) found in that researchers and physicians who write the rules on prescribing drugs have extensive financial connections with the pharmaceutical industry. Public-health experts say that the results of the Taylor and Giles survey, which is the largest of its kind, suggest that drug companies are distorting decisions about how their products are being prescribed.

In the United States, the NIH Consensus Development Program (**www.consensus.nih.gov**), which was started in 1977, sponsors evidence-based assessments of important medical issues. Each assessment includes a systematic literature review, prepared through the Agency for Healthcare Research and Quality (AHRQ), a public conference that features research presentations, and a consensus statement that is disseminated widely. The public conferences use a system of jurors and witnesses. Panel members can have neither financial nor other potential conflicts, and panels are independent of both the NIH and the Department of Health and Human Services. The consensus statements reflect the conclusions of the panels, not those of the institutes. The conference speakers, by contrast, may have industry ties, but if they do, those ties are disclosed. Despite its rigor, however, the process has limitations: it takes about 18 months from conception to completion, each assessment costs about $500,000, and only three or four conferences are held each year.

**Q. So what should the LNC do when presented with CPGs?**

A. Each LNC should remember the following:

- CPGs are intended only to assist the physician in decisions about appropriate health care for specific clinical circumstances-not to be the definitive plan of treatment for every case.
- The EBM approach to establishing CPGs increases objectivity in their development but does not imply that CPG recommendations are absolute and without problems.
- Physician compliance with CPGs in general is still low.
- CPGs should be used selectively. They do not apply to every patient. Each patient is unique so it is necessary to factor in the patient's competing medical problems and medications, general health and well-being, and values.
- Always consider the source of a CPG to determine its potential bias favoring the drug companies who profit by approach to the companies drug, or the insurance company who profits by delaying or entirely withholding certain procedures.

**Q. What should the LNC look for in the medical records?**

A. Although physicians may decide whether or not to follow a CPG, and to what degree, the doctor not adhering to the published CPG must indicate his knowledge of the CPG in the medical records. The LNC must adequately review each document in the patient's record to see if the reasons for not following the CPG are documented. The doctor should clearly state the limitation of that particular CPG for his individual patient's treatment based on the available research as it applies to his patient in that particular circumstance.

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**Perry Hookman, MD**, in active practice, is Board Certified in both Gastroenterology and Internal Medicine. He has authored/coauthored more than 50 publications in peer-reviewed medical literature on topics in Internal Medicine and Gastroenterology. He is the author of the new book *Medical Malpractice Expert Witnessing: Introductory Guide for Physicians & Medical Professionals* (available at **www.hookman.com**). He received his training in Internal Medicine and in Gastroenterology at The Johns Hopkins Hospital in Baltimore, Maryland. He currently holds a Medical School faculty appointment and is on the teaching medical staff of a large community hospital. He has served on the Editorial Board of several medical journals. Hookman has been elected to fellowship in the American Gastroenterology Association, the highest level of membership. He is also a Fellow of the American College Of Physicians, the American College Of Gastroenterology, the American College Physician Executives, and The American Society of Gastrointestinal Endoscopy. Among his awards are Knighthood from the Archbishop of the Greek Orthodox Church of North and South America, the Physician of the Year Medal "for Community Leadership and Devoted Humanitarian Efforts," and the Annual Award of Merit from the United Jewish Federation "for outstanding achievement and service." He can be reached at **hookman@hookman.com**.

# Institutions and Organizations Analyzing Health Care and Public Policy Issues

*Kathleen M. McInnis, MS RN*

The following table provides a listing of both private and public agencies researching and developing public policy in health care. This list provides only a sample of organizations and institutions and, as always, the researcher is cautioned to conduct their own independent research and investigation of the sources offered.

| | |
|---|---|
| **www.brookings.edu** | The Brookings Institute is a private, non-profit organization devoted to independent research and innovative policy solutions. A majority of the Board of Trustees are economic advisors and analysts. |
| **www.CanadianMedicine.blogspot.com** | Promoted as news and views from the editors of the National Review of Medicine. Interesting articles and thoughts from North of our border. |
| **www.cato.org** | The Cato Institute was founded in 1977 by Edward H. Crane. It is a non-profit public policy research foundation headquartered in Washington, D.C. The Institute is named for Cato's letters, a series of libertarian pamphlets that helped lay the philosophical foundation for the American Revolution |
| **www.commonwealthfund.org** | The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good. |
| **www.fightchronicdisease.org** | The mission of the Partnership to Fight Chronic Disease (PFCD) is to educate the public about chronic disease and potential solutions for individuals and communities; mobilize Americans to call for change in how governments, employers, and health institutions approach chronic disease; and challenge policymakers on the health policy changes that are necessary to effectively fight chronic disease. |
| **www.health08.org (Kaiser Family Foundation)** | A leader in health policy and communications, the Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the U.S., with a growing role in global health. |
| **www.heritage.org** | Founded in 1973, The Heritage Foundation is a research and educational institute - a think tank - whose mission is to formulate and promote conservative public policies based on the principles of free enterprise, limited government, individual freedom, traditional American values, and a strong national defense. |
| **www.nashp.org** | The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. |
| **www.nationalreviewofmedicine.com (Canadian site)** | The National Review of Medicine scours the world to offer Canadian physicians an overview of the hottest and most relevant medical issues presented in a pithy, punchy style that informs and entertains.<br>Established in 2004 by Parkhurst Publishing Ltd. |
| **www.nhpf.org** | Created in 1971 by senior-level congressional staff and executive agency decision makers to address their information needs and provide a safe harbor for open and frank conversations, the Forum has remained true to its original goals and also evolved to meet new challenges. NHPF is a nonpartisan organization that does not advocate particular policy positions. The Forum maintains a "no press" rule to foster candor and allow for the honest exchange of ideas and viewpoints. |
| **www.thenationshealth.org** | Each month, The Nation's Health delivers the latest public health news, findings and information to about 28,000 readers. The Nation's Health focuses on the news that public health professionals need to know, whether it's happening in their state legislatures, the nation's capital or on a global scale. |
| **www.urban.org** | In the mid-1960s, President Johnson saw the need for independent nonpartisan analysis of the problems facing America's cities and their residents. The President created a blue-ribbon commission of civic leaders who recommended chartering a center to do that work. In 1968, the Urban Institute became that center. |

Book Review

# Medical Malpractice Expert Witnessing: Introductory Guide for Physicians and Medical Professionals

*By Perry Hookman, MD*
*Publisher: Potomac Press*
*ISBN: 978-1-4200-5895-6*
*$239.95, available at www.hookman.com*

*Reviewed by Kara L. DiCecco, MSN RN LNCC*

While there is no formula approach to expert witnessing, acceptable practice should be founded in part on legal standing and in part on a moral compass. The expert should provide a well-formulated opinion, based on sound scientific principles, that is unequivocal when presenting to the trier-of-fact. Expert opinion calls for an allegiance to the truth regardless of the outcome and despite the competitive pressure of opposing forces. That is the aim of the expert opinion in the true spirit of the law. In practice, however, it often misses the mark. If there were a core text for orientation to the experience of expert witnessing, this book might find the mark.

In the introduction of *Medical Malpractice Expert Witnessing: Introductory Guide for Physicians and Medical Professionals*, the author shares his fervent belief in the need to dialogue with the medical profession about the practice of medical testimony in the courtroom setting. He identifies a need to provide guidance to those practitioners who may one day face the courtroom but are ill-prepared to understand the principles that underlie the legal practitioner's duty. The crucible through which they now pass, he argues, does little to foster a healthy relationship between the two professions. It is not an easy position to argue with. The first-hand observer in a deposition need only minutes to view how attorneys and physicians seem to jockey in juxtaposition as they nose toward the answer in a photo-finish race. It's a dance with both doing their best to lead, no one following, and, not surprisingly, each stepping on the other's toes.

In just one remarkable moment of gestalt, the author illuminates beautifully how the duplicity of meaning in key concepts may have led to the all-too-common distrust and suspicion of motive in each other's profession. Mutual disdain, he points out, may well be the end product of a long-standing confusion over the actual meaning of key words. The physician assumes that rendering his opinion must be in terms of absolute and is understandably reluctant to do so. The attorney does not fully appreciate the physician's hesitation as he searches for a commitment to "more likely than not." It is a matter of training and experience for both, but not from the same perspective. A simple clarification of the word "causation" from the legal perspective, with an acknowledgment toward the physician's definition of the word, might lead to common ground and the ability to move forward in a less adversarial light. It is undeniably a formidable task to bring attorneys and physicians to this commonality, but Hookman approaches the task with literary enthusiasm that compels the reader to view the mission as actually attainable.

Hookman correctly observes that both professions have much to learn from each other. In any conflict situation, clear communication is an integral part of resolution. Finding a common ground between physicians and attorneys may be established by paving the way with a basic understanding of what occurs, why it occurs, and what information you need when it occurs in the legal setting.

In 27 chapters, Hookman covers an impressive array of legal subjects. He reviews disciplinary law to strategies against medical negligence litigation. He addresses specialty practice concerns from a proactive approach while familiarizing the reader with the legal environment. He explores the purpose of alternative dispute resolution to the nuances of pretrial investigation of the defendant. He covers information from deposition purpose to preparation. He speaks to the issues of credibility of the witness by providing a chapter written by a trial judge. Focused on the testifying physician, the principles and insight that the author shares in this and subsequent chapters translate easily into areas of importance for any health care discipline. The author tackles the essentials of Daubert with concrete examples of case law and wrestles to the ground the issue of translating medicalese into English. Endearingly, the author provides lessons to the reader of his own testimony mistakes and provides pearls of wisdom from physician defendants and medical expert witnesses. He has also effectively gathered a sampling of the personal approaches of practicing attorneys from both sides of the debate, and the experiences of legal scholars and fellow authors. On a more esoteric level, he provides for the reader an explanation and insight into the processing of trial "themes."

This is a thinking person's text. The reader will appreciate the objective approach that the author takes in offering both sides of the coin in the supporting literature he presents. Where the author is offering a personal bias or opinion, he clearly alerts the reader that he is doing so. This is of paramount importance when you realize that the author has

digested a multitude of books on expert witnessing to provide the reader with a synopsis of their key elements. By offering the collective intelligence of multiple minds, the author introduces the reader to experiences and resources that might otherwise escape notice. Hookman also provides a solid reading list of clinical guidelines, legal opinions, and practical matters. These references are contained both within the pages of the text as well as on the additional CD provided.

Readers won't necessarily agree with everything in this text, nor should they. Investigation of the primary source is expected. By way of example, I personally viewed the attorney tactics outlined in Chapter 20 as more of a strategy that can be anticipated versus an actual abuse of the expert. I willingly concede, however, that, taken to the extreme, some tactics are indeed unprofessional. At most points, though, I am struck by the stark familiarity of what I read and the gracious gift of an insider's knowledge.

An interesting yet delightful subtlety in the author's writing style may go unnoticed by all but those with an interest in adult-learning principles. The author has taken the opportunity to translate and imprint on the mind of the reader important concepts by connecting them to engaging quotes, including clip art and sample documents to keep the visual learner involved. By the time you have finished the book, you also have obtained a fair working knowledge of frequently encountered Latin words and phrases, as he has taken the opportunity ("opportunitas") to provide translation for immediate application.

Hookman's common-sense approach to a multifaceted topic, in clear and concise writing, offers sound bites of practical information while providing an exceptional tool for any health care provider wishing to safely navigate the medical-legal waters of litigation, either by choice or reluctant participation. It is a survival guide.

*Medical Malpractice Expert Witnessing: Introductory Guide for Physicians and Medical Professionals* is a timely piece for medical and legal professionals alike. This text should find a place on the shelf of health care providers as well as legal professionals. It is for anyone involved in or affected by expert witness testimony. It is not only interesting and informative; it can make the rare claim to something more. Hookman's treatise is an invaluable primer for the beginner, a guide for the experienced, and reference book for all parties of the legal debate. Hopefully, Hookman's seminal work will foreshadow a collaborative understanding between the medical-legal professions.

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

*The Journal of Legal Nurse Consulting*
401 N. Michigan Ave
Chicago, IL 60611-4267
Phone: 877/402-2562
E-mail: JLNC@aalnc.org

# Submission Guidelines

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

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

**Manuscript format**
Manuscripts should not exceed 3,000 words in length. The title page should include the title of the manuscript and the authors' names, credentials, work affiliations and addresses, daytime phone numbers, fax numbers, and e-mail addresses. One author should be designated as the corresponding author. The title page, the tables and figures, and the reference list should each appear on a separate page. Pages, beginning with the title page, should be numbered consecutively.

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

**Style and reference guidelines**
*JLNC* follows the manuscript style and reference guidelines of the *Publication Manual of the American Psychological Association* (5th ed.). Legal citations must adhere to the guidelines published in *The Bluebook: A Uniform System of Citation* (15th ed.), Cambridge, MA: The Harvard Law Review Association.

**Reprint permission for copyrighted material**
When using figures or tables from another source, the author must obtain written permission from the original publisher and include that as part of the manuscript submission materials. The author is responsible for obtaining permission for the use of photographs of identifiable persons.

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

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

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# *The Journal of Legal Nurse Consulting*
# Topics Sought for Feature Articles

AALNC
AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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

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

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

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

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

**Medical Malpractice**
Medication Co-prescriptions: Responsibility in Adverse Reactions, Abuse
Medical-Legal Issues in Telemedicine/Teleradiology
Failure to Diagnosis Breast Cancer: Liability, False-Negative Mammograms
Dental Litigation: Temporomandibular Disorders
Missed Diagnosis of MI
Use of EKG and Cardiac Enzymes
Delayed Diagnosis/Treatment of Stroke, CVA: Heparin/TPA
Emergency Room Law
Paramedic Litigation
Legal Considerations in Pre-hospital Care
Anesthesia Complications/Standards
Plastic Surgery: Complications, Liability, Plastic Surgeon vs. Cosmetic Dermatologist
Avascular Necrosis: Complications, Liability, Malpractice, Legal Outcomes
Pap Smears: Malpractice in Gynecology
Imaging Liability: Radiologists
Alternative Therapy and Malpractice: "Accepted Practice" vs. "Reasonable Care"
Cruise Ship Medical Guidelines
Red Cross Issues and Liability

**Obstetrical Malpractice**
Nucleated Red Blood Cells: Timing of Brain Injury at Birth
Medical-Legal Aspects of Placental Pathology/ Examination
Vaginal Birth after Caesarean Birth: Standards
Contraception, Morning-After Pill
Infertility Practices
In-Utero Drug Exposure

**Personal Injury**
Carpal tunnel Litigation
Repetitive Stress Injuries

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

**Toxic Tort**
Carbon Dioxide Poisoning
Mercury poisoning
Lead Poisoning

**Miscellaneous**
School Disability Litigation, IEPs
School Nurse Standards
Autopsy Findings/Terminology
Pharmacy Responsibilities for Patient Education, Informed Consent
Legalization of Marijuana
Athletic Injuries: Medical-Legal and Malpractice Standards in Treatment
Evaluation of Hearing Loss
Ambulatory Care/Outpatient Care Settings
Latex Gloves/Sensitivities
Fraud: Medical Bill Review

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20th Anniversary

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AALNC
AMERICAN ASSOCIATION OF
LEGAL NURSE CONSULTANTS
401 N. Michigan Ave., Suite 2200
Chicago, IL 60611-4267

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