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▲ A Prison Death: The Nurse Investigator's Role in an Administrative Agency

▲ Nutrition in Bariatric Surgery

▲ Bloodless Care

▲ Legal Issues of E-Health

▲ Nixing Computer Phobia: How to Acquire and Develop Basic Technological Skills

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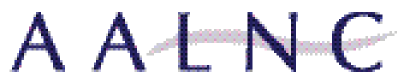

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The Journal of Legal Nurse Consulting

Purpose

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

Manuscript Submission

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

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LEGAL NURSE CONSULTING

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In January 2001, the Board of Nurse Examiners for the State of Texas launched an investigation into the death of a young prison inmate following receipt of a complaint against the nurse responsible for his care. This case illustrates how nurse investigators employed with state boards of nursing and legal nurse consultants (LNCs) employed in the civil arena similarly depend on strong analytical skills to accomplish their work. The procedures and body of law described herein are not specific to all states or all boards of nursing, but rather are an example of the work of one state agency in Texas, based on Texas law.

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As the number of bariatric surgical procedures increases, the number of lawsuits also increases, making risk management an important component of any surgical program. The complexity of bariatric surgery and the life-long changes necessary for successful weight loss require that surgical candidates be well-informed regarding the risks, benefits, and need for long-term compliance. A well-structured interdisciplinary approach will help ensure that candidates understand the surgery and recovery process, the risks and consequences of the surgery, and the long-term adaptations required. Unless the entire health care staff recognizes the risks, symptoms, and treatment of nutrient deficiencies, nutritional status is poised to become the basis of litigation more frequently as the number of patients undergoing bariatric surgery increases.

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The influx of computer technology in today's health care environment has placed a heavy burden on management to control a variety of impending computer-generated problems. Who will have access, what will be computerized, security issues, Internet access, e-mails, and how one addresses confidentially head a long list of areas that need focused planning and compliance. The issue of how to control the use of e-mail in the work environment becomes as challenging as the use of Internet resources for health information sending and retrieving (e-health) itself. Whether an organization adapts a strict policy on the personal use of e-mail during business hours depends on how this practice is used or abused by its employees. This paper will explore important inclusions in a policy governing the use of e-mail in the work environment.

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Wintertime

The holidays are over, and it is a new year. We have feasted, exchanged (and returned) gifts, packed away the decorations, and made New Year's resolutions. Perhaps you made a resolution to write an article for a future issue of the *Journal*.

On the subject of resolutions, it is sheer coincidence that the article on weight loss through bariatric surgery appears in this issue following the holidays! Janet McKee and Susan Tassinari explain how the procedure has evolved over the decades but is still associated with serious risks and complications, necessitating the multidisciplinary teamwork in the care of the surgical candidates.

Jeanne Jaconson's article describes the role of state Boards of Nursing to ensure safe care for consumers, including prison inmates. This unfortunate situation only supports why nurses should use the nursing process to competently and completely assess their patients and intervene accordingly. The positive outcome in this scenario is the prevention of additional injuries or deaths.

The prison death article verified that the nurse, as the only full-time medical officer, clearly had a duty to the inmate. Arlene Klepatsky's Point of Law column continues with the legal-ethical concerns of duty. Most nurses probably infer that duty is a given point when caring for patients. Arlene cites historic cases in which duty was not an element and implications for health care providers.

A new column on technology appropriately debuts in this first 2006 issue. There was no question who to tap for the premier article. Rosie Oldham, a previous AALNC national president, is a pioneer in the use of LNC technology. Rosie graciously passed the assignment on to two of her business associates, Deborah Gorombei and Lori Plate. They have authored the article on nixing computer phobia to develop technical skills. We encourage other legal nurse consultants to submit articles on the use of computer technology in their practices or in the courtroom to continue this column.

Computers – how did we ever live without them? They are ubiquitous in both the workforce and private use. Yet, with any technology, there are the accompanying problems. Laura Conklin's article explores the legal concerns in sending and receiving information electronically and the organizational policies to maintain security and confidentiality.

Thanks to Margo Conklin, Kathryn Jeffries, and the Executive Board of the Greater Baltimore Area Chapter for their Question and Answer column differentiating a legal nurse consultant and a nurse paralegal. We welcome other chapters to volunteer for this column. Larger chapters or states with several chapters (such as California, Texas, or Florida) might consider joining forces to rotate the quarterly responsibility.

Kara DiCecco has critiqued a book written by a physician-attorney about back pain litigation. This text could be a resource for case managers, life care planners, and legal nurse consultants for cases involving personal injury and workmen's compensation.

Here's the Winter 2006 issue for your reading enjoyment in these shorter days and longer nights when you might be curled up under a warm blanket or in front of a fireplace.

Holly Hillman

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

A Prison Death Case Study: The Nurse Investigator's Role in an Administrative Agency

Jeanne Jacobson, BSN RN LNCC

KEY WORDS
Correctional Environment, Negligence, Nursing Practice Act, Prison Death

In January 2001, the Board of Nurse Examiners for the State of Texas launched an investigation into the death of a young prison inmate following receipt of a complaint against the nurse responsible for his care. This case illustrates how nurse investigators employed with state boards of nursing and legal nurse consultants (LNCs) employed in the civil arena similarly depend on strong analytical skills to accomplish their work. The procedures and body of law described herein are not specific to all states or all boards of nursing, but rather are an example of the work of one state agency in Texas, based on Texas law. Information about the complaint and investigatory process of other state boards of nursing can be accessed on their individual Web sites, easily obtained through the National Council of State Boards of Nursing Web site at ***www.ncsbn.org***.

The mission of the state boards of nursing is to protect and promote the welfare of state residents by ensuring that each person holding a nursing license is competent to practice safely. One way in which boards regulate the practice of nursing is by investigating complaints about licensed nurses who have potentially violated the Nursing Practice Act (NPA), also called the Nurse Practice Act, and, when warranted, taking disciplinary action. To accomplish this enforcement work, nurse investigators identify key issues and make appropriate recommendations to the board.

The Texas Board of Nurse Examiners (BNE) received a complaint alleging that a healthy 18-year-old man had died of multiple organ failure while serving a sentence at a minimal-security facility. The young inmate ("BA"), having no prior criminal convictions, had been sentenced to the prison "boot camp" following a drunk driving conviction. A registered nurse ("Nurse KR") was responsible for the medical care of the inmates at this facility. For several weeks before his death, BA allegedly self-reported to Nurse KR that he had a sore throat, loss of appetite, shortness of breath, and was coughing up blood (hemoptysis). Nurse KR was accused of failure to both adequately assess BA and to intervene appropriately in his care.

After an initial investigation, the BNE determined that Nurse KR represented an "imminent and continuing threat to public welfare" and used its authority to immediately suspend her license (Texas Occupations Code §301.455). The Board simultaneously initiated proceedings for a probable cause hearing before an administrative law judge (ALJ), held within 14 days of the suspension. The BNE was able to prove, to the satisfaction of the ALJ, that Nurse KR had failed to appropriately assess and intervene in the care of BA by failing to communicate and collaborate with physicians, transfer BA to a hospital in a timely manner, adequately document his care, administer medications, and follow facility protocols and standing orders regarding medical situations. Following the hearing, the BNE's suspension of Nurse KR's license was upheld by the ALJ. On May 23, 2001, Nurse KR surrendered her license to practice nursing in Texas (Board of Nurse Examiners, Agreed Order, May 23, 2001).

This prison death was also criminally investigated by the Texas Rangers, an elite branch of the Texas Department of Public Safety with statewide jurisdiction. The Ranger investigation resulted in a rare criminal conviction of negligent homicide for substandard nursing care. The prison boot camp was subsequently and permanently closed. A variety of agencies may be involved in investigating prison deaths in other states.

Opening a Case: Scrutiny of the Complaint

The NPA, found in the Texas state administrative codes, is the statutory authority for the BNE's enforcement process. The board's assessment of a complaint against a licensed nurse leads to a determination of whether the nurse has violated the Texas NPA by (1) exhibiting unprofessional conduct, (2) failing to care adequately, (3) failing to conform to a minimum standard of acceptable professional nursing practice, or (4) unnecessarily exposing a patient or other person to the risk of harm (TOCA §301.452 (b)(10) and (13)).

Complaints about nurses typically include issues of diversion and/or intemperate use of narcotics, sexual misconduct, fraud, theft, falsification of records, and abuse of patients. The greatest number of complaints that require investigation under the NPA in Texas, however, regard the practice errors of failing to assess, intervene, and/or document the care of patients (Jacobson, 2001).

Complaints can be submitted by any consumer or member of the public in Texas. Following receipt of a complaint, the state board will evaluate the information provided to determine whether to pursue an investigation. Specifically, complaints are reviewed to establish jurisdiction and determine whether issues identified in the complaint, if proven, would constitute a violation of the NPA. The BNE will likely move forward with all potential violations under their charge of protecting the public.

The complaint against Nurse KR alleged that she had potentially demonstrated unprofessional conduct through her care of BA. The BNE investigator provided written notice to Nurse KR, the respondent, that a complaint was received about her nursing practice. The precise and accurate drafting of all allegations was critical at the opening of this investigation, as in all investigations, to pinpoint the evidence needed to prove the allegations. The burden of proof is on the party bringing the allegations, in this case the BNE. If notice is not given in a timely manner, if information including date or place of potential violations is not accurate, or if the allegations—as written—are not substantiated by the evidence, the allegations may be dismissed in court. The respondent is given an opportunity to submit a rebuttal and show that she was in compliance with the NPA and board rules. Nurse KR retained an attorney and denied any wrongdoing in her response to the BNE.

The Question of Duty

In this case, the first critical question that the BNE investigator needed to address was whether Nurse KR owed a duty to BA. This phase of the investigation consisted of interviewing boot camp employees, including the director, probation officers, and Nurse KR. An on-site visit helped to clarify the boot camp's medical system and Nurse KR's daily routine. Investigation revealed that Nurse KR was the full-time medical officer for the facility, responsible for the daily medical care of all inmates. Nurse KR was on call 24 hours per day, 7 days per week, except during vacations. The facility's physician spent only 6 hours per week at the boot camp, leaving Nurse KR as the facility's medical "gatekeeper." The non-medical staff apparently consulted her and deferred to her judgment on medical issues. Facility policy required that inmates requesting medical attention fill out a Request for Medical Attention form and place it in a locked box, to which only Nurse KR had access. Because it was Nurse KR's responsibility to review the requests and take action accordingly, Nurse KR's duty to BA was firmly established.

Proceeding with Discovery

In all cases, the assigned BNE investigator identifies the necessary documents to be obtained through discovery and then reviews all pertinent evidence gathered (medical records, witness statements, and employment records) to determine whether enough evidence exists to close the case or pursue action against the nurse's license. In the case of Nurse KR, the evidence documents included the prison boot camp medical policies and protocols, BA's medical records, and medication administration records obtained under affidavit through the subpoena power of the BNE. Because of the expedited nature of this case, no depositions were conducted, but witnesses were interviewed and statements taken.

Evidence showed that BA submitted two written requests to Nurse KR for care. In his first request, he described his symptoms as flu-like, with a painful cough and difficulty breathing. In his second request, he described hemoptysis and a painful sore throat. At this point, Nurse KR called the part-time staff physician, who ordered a prescription for penicillin V (Pen-Vee-K®). Nurse KR's physical assessment of BA included listening to breath sounds, which she documented as bilaterally clear. She encouraged BA to increase fluids and use non-prescription medications for his elevated temperature and congestion, and to return in 3 days if not improved. BA was required to appear at pill call 3 times each day during the waiting period to receive Tylenol® and a decongestant.

Nurse KR encountered BA around the facility in the normal course of activities during this 3-day medication period. On the day following her physical assessment of him, witnesses saw BA approach Nurse KR, stating again that he did not feel well. They described his breathing as "raspy." Witnesses heard Nurse KR state that BA was "okay" and "probably faking it." She told witnesses that she would believe BA's claim of hemoptysis only if witnessed by boot camp staff. Nurse KR did not place BA on medical profile, a procedure whereby the nurse creates a list of appropriate physical limitations due to an inmate's medical problems. BA, therefore, was required to engage in daily physical exercise and activities during the 3-day medication period before he was allowed to return to see Nurse KR.

Two days after her initial assessment, guards reported that BA had coughed up blood on a towel. Nurse KR arrived several hours later to perform a physical assessment; by that time, BA was unable to take deep breaths while she listened to his lungs. Nurse KR concluded that BA was "just being difficult" but decided to transfer him to the nearest hospital.

BA's status on arrival at the hospital provided a clear picture of the severity of his condition: he was in respiratory distress and his air exchange was poor. He was immediately intubated. His condition was diagnosed as leukopenia and renal insufficiency. Approximately 32 hours after he was admitted to the hospital, BA died from methicillin resistant staphylococcus aureus (MRSA) pneumonia, adult respiratory distress syndrome (ARDS), septic shock, and multiple organ failure. The medical records from the hospital, including emergency room records and intensive care records obtained during discovery, were important evidence in the case.

After the Investigation: The Settlement Process

The administrative remedy for cases where violations of the Texas NPA are proven include fines, disciplinary sanctions, and re-education requirements designed to protect the public. The majority of cases investigated by the BNE found to have merit (e.g., a violation of the NPA has occurred) are settled informally. Any informal settlement conference is confidential, and the information discussed may not be used in a subsequent civil matter; however, the outcome specifying the imposed disciplinary action (formalized in a document called an Agreed or Consent Order) is public information, and includes Findings of Fact (brief statements summarizing the facts of the case) and Conclusions of Law (the legal citations for the board's authority and the violations proven).

Only a small percentage of cases will proceed to hearings before an ALJ, a formal process open to the public. The ALJ hears evidence presented by BNE staff, the respondent, and her counsel, and then returns a recommendation regarding the license of the respondent. The board ultimately maintains the final authority to approve, amend, or reject any Proposal for Decision (proposed order) issued by an ALJ; however, a respondent may also appeal the ALJ or board's final recommendation.

Expert witnesses were obtained in this instance to provide the ALJ with guidance on how Nurse KR violated the NPA and breached the standard of care, and on how BA's illness progressed. Following an independent review of the evidence, a registered nurse with critical care nursing experience testified to Nurse KR's failures in her nursing care. This expert opined that Nurse KR did not perform as a reasonably prudent nurse would have in the same or similar circumstances, concluding that Nurse KR failed in her initial physical assessment of BA by neglecting to record his blood pressure, respiratory rate, or pulse rate. The assessment that Nurse KR made at that time (clear bilateral lung sounds) had to be inaccurate because of the symptoms he was experiencing. She should have heard rales in the lungs. An expert physician, board-certified in internal medicine and with 23 years of experience, also independently reviewed the evidence and testified to the progression of BA's illness. Because hemoptysis is a sign of advanced infection, Nurse KR should have transferred BA to the care of a physician the first time it was reported by staff. An x-ray would have confirmed pneumonia and allowed BA to be treated with the appropriate broad-spectrum antibiotic. Nurse KR's requirement that she see objective proof of the blood was inappropriate. The expert physician testified that BA's condition would likely have been curable if not allowed to progress to sepsis. During testimony, the expert witnesses substantiated the allegations against Nurse KR.

The ALJ determined that evidence indicated that Nurse KR would continue to carry on this substandard nursing practice if employed elsewhere as a registered nurse. The judge believed that the evidence substantiated the allegations and, therefore, justified the disciplinary action Nurse KR received. Nurse KR's failure to conduct proper patient assessments, and then make sound clinical judgments in her role as the sole gatekeeper for BA's medical care, likely caused his death. The board, therefore, acted appropriately in emergently suspending Nurse KR's license to immediately protect the public from her "care" (Texas BNE v. KR, Probable Cause Order, March 2, 2001).

The Work of a Nurse Investigator: Using LNC Analytical Skills in Development of a Case

As illustrated in this case study, the investigatory process used in this administrative agency is comparable to the process used by legal nurse consultants (LNCs) in civil case development. When the nursing board initially reviews a complaint, it analyzes the provided information, as does an LNC who evaluates a civil case for merit. An investigator then develops an investigatory plan designed to move the case forward. The critical analysis focuses on whether a nurse's actions constitute a violation of the NPA. The investigator sufficiently familiar with the NPA is able to readily identify any potential violations, should the allegations be substantiated. A nurse's actions are reviewed on the basis of information available to the nurse at the time of the incident and under the same set of circumstances as described in the complaint.

Discovery and Case Preparation

In this administrative process, the intermediate phase of an investigation (discovery, analysis of evidence, and development of a case review to determine whether the complaint is substantiated) is critical. The investigator searches for mitigating circumstances that could be equated to comparative negligence in a civil case. For example, if a nurse has made a medication error, did the system—such as the practice of storing similar medications together—contribute to the error? Was the respondent nurse the only contributor to the error? Investigators identify and prioritize pertinent issues, and ignore non-relevant ones. Whereas skilled LNCs in independent practice go beyond a record summary to provide the most useful and pertinent work product for attorney clients, it is also necessary for investigators to provide the same detailed level of scrutiny in case reviews for the board and their legal staff. During an investigation, additional issues may be identified that constitute violations of the NPA; it is the investigator's responsibility to bring these forward, even if not identified in the complaint.

As the investigation progresses, investigators identify pertinent issues in the case, identify and obtain evidence, interview witnesses, write legal documents including subpoenas, analyze medical records, research literature if necessary, prepare reports, meet deadlines, locate and work with expert witnesses, collaborate and communicate with attorneys, and provide support during litigation. While the four key elements—(1) duty, (2) breach of duty, (3) damages, and (4) proximate cause applied by LNCs when reviewing civil professional negligence cases for merit—also apply to the investigatory process, the administrative environment defines some differences.

In the civil arena, the LNC analyzes a case for negligence. In nursing licensure cases, this analysis is more specifically defined as identification of potential violations of the statutes regarding the NPA. The standard of care, however, with specifics as to the setting and time the alleged violation occurred, is also considered. It must be remembered that the mission of the board always supersedes the interest of the individual, any interest group, or the nursing profession; therefore, while other nurses employed with the Texas prison system may have maintained that Nurse KR functioned according to the culture of the prison system, the board applied the NPA, with which all nurses in all settings must comply, and found her conduct deficient.

Damages and Proximate Cause in the Administrative Case

Violations of the Texas NPA are not limited to acts that actually harm patients, but also include acts or failures to act in a way that brings a risk of harm to patients or clients. In other words—unlike civil cases—proof of injury, as the result of the negligent nursing care provided, need not be established. In Texas, for instance, any unnecessary or likely exposure of a patient or other person by the registered nurse to the risk of harm constitutes a violation of the NPA (TOCA §301.452 (b)(13)). Evidence of actual harm, however, may raise the level of seriousness of the violation from a minor incident to unprofessional conduct. The board may consider harm versus potential harm in deciding what disciplinary actions to impose. In the case study cited here, the death of a previously healthy young man constitutes obvious damages.

The measures of foreseeability and causation, in fact, are illustrated by the ALJ's Proposal for Decision in the case of BA. "But for" Nurse KR's negligent acts, the death of BA likely would not have occurred. Progression of untreated or improperly treated pneumonia into septic shock and even death was a reasonably forseeable end to his illness.

The Final Phase: Disposition of the Case

The final phase of development in a BNE case is a recommendation regarding the disposition of the case. The investigator's recommendation is considered in conjunction with precedent set by the board. The case will either be closed with no action, or disciplinary action will be proposed. If the case should proceed to either an informal or formal hearing, the investigator must feel confident that all issues have been clarified. As in the civil arena, unclear issues are always difficult to prove in court. Identifying critical evidence and meeting deadlines for document submission to the court will reduce the possibility of dismissal for procedural errors. Organizing documents, preparing exhibit lists, and communicating with witnesses are tasks that investigators tackle in the regular course of their work.

The Administrative Setting

Administrative law encompasses laws and legal principles governing the administration and regulation of federal and state governmental agencies. Agencies, such as the BNE, are delegated power by the state legislature to act as agents for the executive. Generally, administrative agencies are created to protect a public interest rather than to remedy private rights. The LNC who works as an investigator within an administrative agency such as a state board of nursing soon discovers that she is able to apply her knowledge, experience, and analytical skills to a variety of challenging cases, while becoming proficient in the administrative process. Thorough investigations of complaints about nursing practice lead to appropriate disposition of cases and fulfillment of the state board's mission to protect the people. LNCs may play a valuable investigatory role in the numerous state agencies that provide health care and oversee public health matters.

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Jeanne Jacobson, BSN RN LNCC, is currently employed with The Medical Resource Network, Inc. in Portland, Oregon. She received her LNCC designation in November 2004. She was previously employed with the Board of Nurse Examiners for the State of Texas for more than 4 years as an Investigator III and Senior Investigator. The cited case in this article was investigated under Executive Director Katherine A. Thomas, MN RN, and Director of Enforcement Anthony Diggs, MSCJ, and taken to hearing by James W. Johnson, General Counsel for the Board of Nurse Examiners. Jacobson believes that her experience with the Board was invaluable to her work as an LNCC. She is a member of the American Association of Legal Nurse Consultants and the Greater Portland Chapter of AALNC. Editorial input by Karen Fox, BSN RN LNCC CPHRM, Peg Woodward, JD BSN RN LNCC, and Judith Calman, MN RN, of The Medical Resource Network, Inc.

Nutrition in Bariatric Surgery: The Role of Nursing in Reducing Liability

Janet S. McKee, MS RD LD/N & Susan Tassinari, MS RD LD/N

KEY WORDS
Bariatric Surgery, Liability

As the number of bariatric surgical procedures increases, the number of lawsuits also increases, making risk management an important component of any surgical program. The complexity of bariatric surgery and the life-long changes necessary for successful weight loss require that surgical candidates be well-informed regarding the risks, benefits, and need for long-term compliance. A well-structured interdisciplinary approach will help ensure that candidates understand the surgery and recovery process, the risks and consequences of the surgery, and the long-term adaptations required. Unless the entire health care staff recognizes the risks, symptoms, and treatment of nutrient deficiencies, nutritional status is poised to become the basis of litigation more frequently as the number of patients undergoing bariatric surgery increases.

Gastrointestinal surgery to control obesity is commonly referred to as "bariatric" surgery. The term bariatric is derived from the root words *baro*, which means "pertaining to heaviness," and *iatric*, which means "relating to medicine or physicians" (Anderson, Anderson, and Glanze, 1994). The concept of using surgery to control obesity was conceived after patients who underwent resection of portions of the stomach or small intestine for other reasons were noted to lose weight (O'Connell, 2004). The earliest known weight loss surgery was the intestinal bypass, which was first performed in the 1950s. The intestinal bypass produced weight loss through malabsorption but led to a loss of essential nutrients and sometimes fatal side effects and is no longer performed (National Institute of Diabetes and Digestive and Kidney Diseases, 2004).

In 2004, the number of bariatric surgeries performed was approximately 141,000, representing an increase of 123% over 2002 (Brand, 2004). According to the American Society for Bariatric Surgery, approximately 170,000 surgeries are expected to be performed in 2005 (personal telephone conversation, March 23, 2005). As the number of bariatric surgical procedures increases, the number of lawsuits is also increasing, making risk management an important component of any surgical program. The complexity of bariatric surgery and the life-long changes necessary for successful weight loss require that surgical candidates be well-informed regarding the risks, benefits, and need for long-term compliance. Surgical candidates require pre-screening for appropriateness, pre- and post-operative education on the physical and nutritional aspects of the surgery, and long-term follow-up to address problems, concerns, and compliance issues. A well-structured interdisciplinary approach will help ensure that surgical candidates understand the surgery and recovery process, the risks and consequences of the surgery, and the long-term adaptations required.

The role of nutrition is central to bariatric surgery, based on the very nature of the surgical process and its goal of rapid weight loss. Bariatric surgery success is defined as a loss of 50% of excess body weight (Mattison and Jensen, 2004). Weight loss after surgery is reported to be approximately 60% of excess weight during the first 2 years, remaining stable after time (Kim, Tarnoff, and Shikora, 2003). Some studies have shown sustained weight loss up to 14 years after surgery (Pories et al, 1995; Scopinaro et al, 1998); however, even when the surgery is successful, the surgical process and subsequent dietary restriction also produce nutrient deficiencies with long-term effects. Nutrient deficiencies following bariatric surgery may lead to anemia, osteoporosis, metabolic bone disease (National Institute of Diabetes and Digestive and Kidney Diseases, 2004), and severe protein-calorie malnutrition (Faintuch et al, 2004). Table I provides the criteria for each of these conditions.

Table I: Criteria for Diagnosis.

Condition	Criteria
Osteoporosis	Bone mineral density >2.5 standard deviations below the young adult mean*[1]
Anemia	Men: Hemoglobin <13.5 g/dL Women: Hemoglobin <12.5 g/dL[2]
Protein depletion	Mild: Albumin 2.8-3.5 g/dL Moderate: Albumin 2.1-2.7 g/dL Severe: Albumin <2.1 g/dL[3]

**Osteopenia, a risk factor for osteoporosis, is defined as a bone mineral density between 1 and 2.5 standard deviations below the young adult mean as calculated by a bone density (DXA) scan where the normal young adult score is greater than –1.0.*
[1]International Osteoporosis Foundation (2005).
[2]Conrad, M. (2005).
[3]Niedert, K.C. (2001).

More serious complications can result from deficiencies of thiamin and fat-soluble vitamins, including Wernicke's encephalopathy (Bozbora et al, 2000; Chaves, Faintuch, Kahwage, and Alencar, 2002; Sola et al, 2003), beriberi (Towbin et al, 2004), and night blindness (Hatizifoitis, Dolan, Newbury, and Fielding, 2003). Unless the entire health

care staff recognizes the risks, symptoms, and treatment of nutrient deficiencies, nutritional status is poised to become the basis of litigation more frequently as the number of patients undergoing bariatric surgery increases.

The nursing staff is an integral part of the multidisciplinary team, assisting in patient selection, providing the hands-on care of the patient, and educating the patient regarding the surgical process and post-operative dietary restrictions. It is critical for the nursing staff to understand the immediate and projected nutritional consequences of surgery, in order to monitor the patient for diet tolerance and nutrient deficiency symptoms, encourage dietary compliance, and reinforce the long-term dietary restrictions. In an interdisciplinary, well-organized bariatric surgery program, the dietitian maintains a key role in assisting the nursing staff to recognize nutritional complications and provide appropriate interventions.

Initial Screening

Careful patient selection is critical to long-term success in bariatric surgery patients. Between 32% and 57% of bariatric surgery candidates have some type of eating disorder, which may lead to weight loss failure, even when the actual surgery is technically successful (Hsu, Betancourt, and Sullivan, 1996; Kim et al, 2003; Vander Wal, 2003). Non-compliance with diet restrictions can also result in weight loss failure and multiple negative outcomes, such as dehydration and protein-calorie malnutrition. The National Institutes of Health (NIH) issued a Consensus Statement on the importance of a multidisciplinary team, including nutrition experts, throughout every step of the surgical process to ensure a successful result (NIH, 1991).

Poor communication and mismanaged expectations are among the chief forces causing the rapidly increasing number of lawsuits among bariatric surgery patients. Studies show that 40% to 60% of medical malpractice lawsuits allege improper informed consent (Aon Alliance, 2005). Collaboration of the multidisciplinary team members will help to identify potential nutritional issues, while defining actual client expectations and commitment to the proposed surgery. A team approach to identifying inappropriate surgical candidates is essential in reducing the risk of weight loss failure and subsequent litigation.

The nursing assessment should include basic questions structured to help pinpoint problem areas, such as current eating patterns, usual body weight, current body weight, number of weight loss attempts, and history of underlying eating disorders. Table 2 lists questions that should be included in a screening tool.

Table 2: Initial Nutrition Screening.

1. Current height and weight
2. Usual height and weight
3. Goal weight
4. Why weight loss is desired
5. Highest weight and date
6. Lowest weight and date
7. History of binge eating, anorexia, or bulimia
8. Frequency and type of exercise routine
9. Weight loss programs attempted in the past
10. Reasons weight loss programs were not successful
11. Eating habits: frequency of snacking and eating out
12. Types of food eaten: fried foods, sweets, alcohol, milk products, meats
13. Dieting problems: portion control, snacking, emotional eating, binge eating, high calorie foods

Pre-Operative

During the pre-admission process, all candidates should receive a documented nursing screen that identifies patients at nutritional risk (such as pre-bariatric surgical candidates) and referral to the dietitian. The dietitian will conduct a thorough baseline assessment of the patient's current nutritional status, evaluating anthropometric, biochemical, clinical, and diet history data prior to surgery to identify any potential problems such as depleted protein stores, anemia, and other nutrient deficiencies. The dietitian will also evaluate the patient's current eating habits and institute pre-surgical dietary and behavioral changes, in an effort to assess the patient's ability to comply with long-term restrictions.

Nursing staff should carefully review the dietitian's assessment, in order to understand any potential problem areas. The nursing staff involved with the patient pre-operatively should also reinforce the dietary and behavioral changes developed by the dietitian, and provide information about the surgical procedure, recovery, and short-term post-operative dietary restrictions.

The nursing staff and the dietitian should coordinate education efforts, to ensure that all areas of concern are addressed and that all team members reinforce the most important areas. There are currently no standardized nutritional guidelines for bariatric surgery; the education provided should follow the policies and procedures of the facility where the surgery will be performed. At a minimum, educational materials should stress the need for life-long alterations in eating patterns, possible post-operative complications (such as emesis, dumping syndrome, and dehydration), and the need for life-long vitamin and mineral supplementation.

The dietitian is responsible for educating the patient regarding short- and long-term post-operative dietary changes. The nursing staff should become familiar with the nutrition materials used by the dietitian, in order to reinforce these diet changes and to answer questions. In order to reduce negative outcomes and liability risks, it is essential that the education

provided by all team members is consistent. A patient who receives conflicting information on the post-operative diet and long-term dietary restrictions will undoubtedly become confused and may present as non-compliant. Whether nursing staff or the dietitian provides nutrition information, the education provided should be documented, including the scope of education and the materials provided, patient comprehension, and intent to comply.

Peri-Operative

The dietitian will re-educate the patient about the surgical changes to the gastrointestinal tract, the capacity of the post-surgical stomach, and how the diet will be progressed during the peri-operative stage. Nursing staff should review the nutritional education materials to assist the patient in dietary compliance. All education and reinforcement should be documented, including dietary non-compliance and attempts to re-educate the patient.

The dietitian and nursing staff must work together to monitor dietary tolerance and readiness for diet progression. Although diet progression may vary from facility to facility, patients are generally allowed sugar-free clear liquids at the rate of 1 ounce per hour on the first post-operative day. If the patient tolerates the clear liquids with no emesis or diarrhea, patients are advanced to a clear liquid diet. Patients remain on liquids for the first post-operative week and then advance to a pureed diet over the next 1 to 2 weeks (Smith, 2001).

Intensive education and monitoring by the dietitian and the nursing staff are essential to increase the patient's likelihood of tolerating the diet and to address and/or prevent complications. Complications in diet toleration may occur if the diet is progressed too rapidly, the patient is non-compliant, or a gastrointestinal leak develops. Nursing staff should immediately notify the physician and the dietitian if the patient experiences difficulties tolerating the diet. Once the physician has evaluated the patient and ruled out anatomical causes for intolerance, the dietitian can make recommendations for adjusting the diet to assist with tolerance.

The dietitian will also recommend supplementation of vitamins, minerals, protein, and fluids to meet the patient's needs. The dietitian should provide suggested meal patterns to the patient upon discharge, including general guidelines for eating and foods to be emphasized (Marcason, 2004). Potential nutrient deficiencies and complications will be reviewed again to help the patient identify the signs and symptoms that require medical intervention.

The information provided post-operatively is a review of the information provided prior to surgery. Although there are no standardized nutritional guidelines, there is general consensus on diet progression, maintenance, and the need for vitamin and mineral supplementation. Many hospital Web sites provide general guidelines for the post-bariatric diet, such as **www.stvincents.org/healthservices/bariatrics and www.csmc.edu/2447.html**. The American Society for Bariatric Surgery (**www.asbs.org/html/patients/rationale.html**) also provides diet information.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that facilities provide education about nutrition interventions and modified diets (JCAHO, 2002). Because dietary compliance is essential to the short- and long-term success of bariatric surgical patients, all patients—including those in free-standing surgical units—should receive consistent, comprehensive education from all members of the health care team through written protocols, policies, and educational materials that meet JCAHO standards. To reduce the risk of liability, all members of the health care team can ensure that the patient receives and understands the education required by the facility protocol by documenting each instance of education and the patient's subsequent comprehension. Using a standard form helps guarantee that all areas of education are completed, but should not take the place of careful documentation. Nursing staff should review each patient's chart, prior to discharge, to certify that all education has been provided and documented.

Post-Operative

Bariatric surgery patients require long-term follow-up by the health care team to prevent or address complications, including protracted vomiting, dumping syndrome, diarrhea, malnutrition, dehydration, and protein, vitamin, and mineral deficiencies. The most common mineral deficiency is iron (Skroubis et al, 2002). Serum iron levels have been shown to decline as long as 6 to 8 years following surgery, with the decline related not to caloric intake but to eating behaviors (Avinoah, Ovnat, and Charuzi, 1992). Vitamin B_{12} is the most common vitamin deficiency (Skroubis et al, 2002). Research indicates that 30% of gastric bypass patients cannot maintain normal plasma B_{12} levels through oral vitamin B_{12} supplementation, resulting in the need for routine B_{12} injections (Provenzale et al, 1992). Life-long supplementation with iron, B_{12}, folate, calcium, and a multivitamin with minerals is required to prevent nutritional deficiencies and complications. In addition, post-surgical patients require approximately 60g to 80g of protein daily to avoid hypoalbuminemia.

Once again, the collaborative effort of all team members will benefit patients and their families. The dietitian provides education regarding the need for supplementation, both pre- and peri-operatively. Nursing staff reinforces the requirement of a life-long regimen of multivitamins with minerals and other supplements (American Society for Bariatric Surgery, 2001). The nursing staff should also provide and document education and reinforcement of the dietary restrictions, as well as the need for supplementation during the inpatient and discharge process.

On an outpatient basis, the patient will be seen most often by the bariatric physician and nursing staff following surgery, until released to a primary care physician. Both the bariatric nursing staff and the primary care nursing staff should provide continued reinforcement and counseling to

ensure that the patient understands the nutrient requirements and how to meet them. Ongoing monitoring of diet tolerance and compliance, vitamin and mineral supplementation, and laboratory values is essential after discharge from the hospital for a long-term successful result. Patients with abnormal nutrition lab results—including iron, blood urea nitrogen (BUN), electrolytes, and albumin—should be referred immediately to the dietitian for a thorough assessment of the patient's diet, intake, and tolerance.

Nausea, vomiting, abdominal pain, and constipation are common post-operative complaints. Vomiting should be evaluated by a physician to rule out anatomic causes (Provenzale et al, 1992). Once other causes are ruled out, nursing staff should review the general eating guidelines to assess the patient's compliance. Table 3 outlines the general eating guidelines that should be reviewed with the patient. Patients who are experiencing difficulty in following the dietary guidelines should be referred to a dietitian for further counseling.

Table 3: General Guidelines for Bariatric Patients.

1. Eat for 20 minutes or more to avoid bolus eating and allow for satiety.
2. Chew food well and consume in small volumes. Cease eating when the sensation of restriction occurs.
3. Ingest liquids at least 30 minutes before or after meals. Do not drink liquids with meals.
4. Eat proteins before fats and carbohydrates and consume at least 60 grams of protein daily.

Marcason, 2004.

A written referral to the dietitian should be considered for all patients experiencing diet intolerance or nutrient deficiencies, once the more serious causes are ruled out. Nursing should document any education or interventions provided on an outpatient basis. A referral to the dietitian should be documented and a letter requested from the dietitian documenting the education and counseling provided.

Failure to provide adequate education, treatment, and referral can lead to dietary non-compliance and intolerance. Prolonged intolerance to diet can result in dehydration, nutrient deficiencies, and protein malnutrition, and can lead to serious complications or even death. Documenting education, treatment, and interventions can reduce the risk of litigation that can result if a patient suffers a serious negative outcome.

Considerations for Skilled Nursing Facilities and Acute Care Centers

As the number of bariatric surgeries performed increases, skilled nursing facilities will likely begin to experience the admission of post-bariatric surgery patients, both for short-term recovery and as long-term residents with a remote history of bariatric surgery (Muir and Haney, 2004). The potential for post-operative bariatric patients in skilled nursing facilities presents new challenges for the long-term care health team. The likelihood of nutritional complications will be great, due to the risks of malnutrition, dehydration, nutrient deficiencies, pressure ulcers, and diet intolerance in post-bariatric patients, especially in those patients with recent surgery.

Nursing home regulations require a comprehensive assessment by the dietitian and an individualized care plan for the resident developed by the interdisciplinary health care team. The plan may stipulate a special diet, smaller portion sizes, different meal timing, and supplementation for each post-bariatric surgery resident. The nursing staff should be familiar with the needs of post-bariatric surgical patients in general, as well as the individualized plan developed specifically for each patient, in order to ensure that each resident's specific needs are met.

Hospitals and skilled nursing homes must develop a post-operative bariatric diet for patients who have recently had surgery, based on post-operative bariatric diet principles. For long-term post-operative residents, an individualized diet will be required. Special low-volume, high-protein supplements that are low in carbohydrates and calories may be required. Nursing in-services and written education materials should be provided to familiarize the nursing staff with the general eating guidelines and the diets and supplements in use.

Summary

The nursing staff plays an essential role at each stage of the bariatric surgery process, as well as in the long-term follow-up of surgical patients. Nursing staff will need to understand the nutritional aspects, risks, and treatments to assist patients in tolerating their diet, and to prevent nutrient deficiencies and other complications. Education and consultation by the dietitian can assist nursing in understanding the importance of nutrition in bariatric surgery. Careful and comprehensive documentation of dietary requirements, education, and monitoring will help reduce the likelihood of nutritional complications and litigation.

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Legal Issues of E-Health

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The influx of computer technology in today's health care environment has placed a heavy burden on management to control a variety of impending computer-generated problems. Who will have access, what will be computerized, security issues, Internet access, e-mails, and how one addresses confidentially head a long list of areas that need focused planning and compliance. The issue of how to control the use of electronic mail (e-mail) in the work environment becomes as challenging as the use of Internet resources for health information sending and retrieving (e-health) itself. Whether an organization adapts a strict policy on the personal use of e-mail during business hours depends on how this practice is used or abused by its employees. This article will explore important inclusions in a policy governing the use of e-mail in the work environment.

Today's health care environment has changed over the years with the influx of computer science in the health setting. Health care delivery systems have grown dependent on the use of computer technology in the workplace. Consumers can access health information and test results directly from the provider's office or participate in counselling sessions with a therapist. Employees are able to access a staggering amount of information on a variety of topics via the Internet. Communication through an e-mail environment has increased the ability to send and receive responses to a myriad of interactions. Regulating the employee use of non-work related e-mail provides a challenge for management that must be addressed.

Know the Current Climate

The key to success in developing a policy for the use of e-mail in the organization is to become aware of the current use. This can be accomplished through a qualitative and quantitative analysis of current e-mail utilization and practices. A qualitative survey distributed by management to all e-mail users will help to define peak times for use, who utilizes e-mail the most and why. Such a survey should include questions addressing the amount of e-mail sent on a given day, the size of attached files, and a general inquiry into types of e-mail sent and received in a typical day. This information will help to identify potential problems with confidentiality and security. The assurance of anonymity helps ensure the validity of results by eliminating employee concerns of having the data anaylzed by management.

A combination of the following techniques can be employed to gather data through a quantitative review: measure gross levels of e-mail traffic according to time of day, and review incoming and outgoing destinations. One company found that 75% of the traffic was tied to non-business use (Safsten, 2002). If large files are being sent or received, this has the potential of clogging the system. In addition, the danger of receiving damaging viruses into the company's network is possible even with sophisticated firewall protection. It is important to have senior management involved in this process because upper management is not always aware of the amount or source of e-mail, how it affects the organization, and who are the biggest users. In order for a policy to be effective, it must have input and buy-in from senior management.

Unsolicited E-mails

There are many hidden dangers and the potential for litigation in unsolicited e-mails. Do members of a health care organization volunteer medical or health advice in response to e-mail inquiries? This practice has the potential for a myriad of legal problems, depending on what is asked and who is giving the advice. Does the advice follow current clinical guidelines, or is it the employee's personal opinion? An established policy needs to address who will be responsible to reply to unsolicited e-mails and what type of subject matter may be safely addressed, what will be referred and to whom (Sing, Salzman, and Sing, 2001). Depending on the organization's mission, unsolicited e-mails may be welcomed in light of giving advice to improve health practices and increase the organization's referral base. This will only have a positive effect, however, if the respondent is knowledgeable and cautious as to the advice rendered via e-mail. Guidelines must be in place to address this sensitive area.

Personal Use of E-mails

This is one of the most difficult areas to address because it is so difficult to control. E-mail has become the medium of choice in communicating personal and business information. However, some messages can be demeaning or abusive with little thought to the potential of becoming possibly incriminating statements. Supervisors and employees in general need to be informed on how to avoid language that can infer defamation, harassment, and discrimination. Such verbiage may lead to litigation if misinterpreted by the reader. Designing and enforcing a policy that specifically forbids the sending of e-mail that contains ethnic slurs, racial epithets, or anything that can be interpreted as harassment, disparagement of others based on religion, national origin, gender, sexual orientation, age, disability, or political beliefs will diminish the chances of litigation (Johnson, 2005).

The organization must maintain the right to monitor use of the Internet by all employees. Employees who are allowed to use business time for personal use of the Internet should be made aware that abuse of this privilege will have

consequences for excessive use. Even personal e-mail can have a negative effect on the organization, as the recipient knows the individual sending the message is at work. Keeping emotions in check becomes important because a face-to-face encounter and body language is missing in the exchange (Kropf, 2004). As long as the guidelines are clear, employees will view the Internet as a mutual asset and not something to be used for personal gain.

Security and Confidentiality

Designing a way to secure electronic information in an organization is crucial to survival in today's computer climate. E-mail messages that fall into the wrong hands have the potential of causing embarrassment, or worse, leaking sensitive information to competing organizations. Even deleted e-mail messages can be retrieved from the hard drive by anyone who has the technical knowledge to retrieve them. In today's legal climate, "private email" is a misnomer as the company is the owner of the email's content.

One way to protect e-mail messages is to use encryption or e-filters. Names and other identifiable information should be encoded or encrypted to prevent unauthorized access (Leibs, 2005). Only someone with a decryption key will be able to open the message. Another means of protection is to set time limits on when e-mail messages will be destroyed. This will prevent messages from being accessed after deletion by anyone (Lesavich, 2001). Both methods require sophisticated software that may not be in the budget plans. Retrievable e-mails may be a source of litigation for any organization if they can be traced to employees who use them for illegal practices. How this will be addressed and enforced needs to be explicit in the policy. Web sites should require user identification or password code for access. Signing off when a transaction is completed will prevent unauthorized use. Passwords or other identification codes should not be shared with anyone. Other methods to prevent a security breach are mandatory periodic changes of passwords and prohibiting writing down passwords near workstations.

Writing the Policy

The Internet and the use of e-mail has become a powerful tool in health care delivery. Unfortunately, it can also be a great distraction for employees who browse non-work related sites. Control of use and abuse rests in the hands of management. Employees need to understand their limitations for use and consequences for abuse, best defined in the form of a policy addressing major concerns. Employees need to know that the organization has the right to monitor e-mail and Internet use and will exercise that right. Anything that is part of the organization's intellectual properties cannot be shared without permission (Net Policies and Procedures, 1999).

Whether the policy is strict or liberal will depend on the organization and its ability to monitor and enforce the policy. Employees need guidelines such as what sites cannot be accessed, what personal e-mails can be sent, and what will be blocked in order to protect the network from potential viruses and worms. Downloading of attachments from Web sites or personal e-mails can potentially cause harm to the system in spite of firewalls and virus protection software. The display or transmission of sexually explicit images or cartoons from e-mails or messages that contain ethnic slurs, racial epithets, or anything that can be interpreted as harassment, disparagement of others based on religion, national origin, gender, sexual orientation, age, disability, or political beliefs should be strictly forbidden. Another important aspect is to consider who will see the monitor screen, such as office visitors or patients.

Once the policy is written and presented to the staff, the monitoring for compliance is essential for success. Management needs to identify how this will be done and who will be responsible for enforcing the policy. Consequences for misuse should be clear, understood by the employees, and may range from a disciplinary notice to termination. It becomes important to have input from those designated to enforce the policy, in early stages of development, to determine feasibility of enforcement. To ensure compliance, or at the very least knowledge of the policy, employees can be asked to sign a statement agreeing to abide by stated guidelines. Consistency in application of the policy will assure compliance to established guidelines.

Conclusion

It is clear that computers and the Internet have become an integral part of doing business in health care. Employees have become accustomed to retrieving information at a rapid rate and from a variety of sources. Sending and receiving e-mail has become an essential part of doing business in organizations. Compliance related responsibilities cannot be overlooked (Kelvin, 2004). The absence of a policy addressing e-mail messaging and use of the Internet, in general, can cause great harm to the organization's network. Employees need to be aware of the fact that the organization has the right to monitor use of telecommunication in the workplace and will do so. A policy that defines use and consequences of abuse will emphasize the shared responsibility of computerization. Consistent enforcement of the policy is essential to its success.

In today's technology-driven society, every business must be ready to comply with demands for e-records requested during litigation discovery procedings. E-litigation, as it is often called, can be very costly for companies with poor retrieval abilities. Companies must be able to identify, categorize, and access all types of records sent via e-mail in the course of doing business (Mitchell, 2005). Companies must implement a reasonable record retention and destruction policy that addresses paper and e-mail records. Disaster recovery of sensitive records requires enforcement policies reflecting an "in good faith" approach to prevent desctruction of documents potentially harmful to an organization. The liability is increased when the e-mail data requested is destroyed preventing retrieval during discovery attempts. In the event of litigation, companies have the right to protect

documents that are privileged or trade secrets, and need to work with opposing counsel should any of those documents be inadvertently disclosed (Ross, 2005).

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Point of Law

Duty: A Historical Perspective

Arlene D. Klepatsky, Esq RN

"Duty" is a concept that we frequently encounter in our daily lives. As members of society, we have legal and ethical duties. As spouses, parents, drivers, and property owners we have legal and ethical duties. As registered nurses, legal nurse consultants (LNCs), and nurse attorneys, we have legal and ethical duties. This list could go on and on. This column will focus on legal duties. The definition of duty as it applies to negligence cases will be explored. Some of the key historic cases that have shaped the law of duty will be presented. In addition, the processes of determining when a duty exists and what conduct will satisfy the duty will be discussed.

Most LNCs have consulted on a negligence case in the course of their practices. Both malpractice cases and personal injury cases (such as cases involving injuries due to motor vehicle accidents, falls, animal bites) involve negligence claims. A negligence claim is successful only when the plaintiff proves each of the four legally-required elements of negligence, which are duty, breach of duty, causation, and harm (also referred to as damages). If the plaintiff fails to prove each and every one of the four elements, the plaintiff will lose the case.

The first element to be considered in the analysis of a negligence claim is "duty." In a legal dispute in which duty is at issue, the decision regarding whether or not a duty exists and what conduct it requires is determined by the court, meaning that it is determined by the judge as opposed to the jury. Even in a jury trial, it is for the court to decide whether or not the plaintiff has presented enough evidence to satisfy the burden of proof on the element of duty. In contrast, the jury decides whether or not the burden of proof has been satisfied on the other three elements of negligence: the breach of duty, causation, and harm.

Duty Defined

Black's Law Dictionary defines duty as a "legal obligation that is owed or due to another and that needs to be satisfied; an obligation for which somebody else has a corresponding right" (Garner, 2004). William Prosser, one of the great legal scholars in the law of torts, which includes negligence claims, has written:

> There is a duty if the court says there is a duty; the law, like the Constitution, is what we make it. Duty is just a word with which we state our conclusion that there is or is not to be liability; it necessarily begs the essential question… (Prosser, 1953).

Evidence of the Standard of Care

The judge decides the issue(s) regarding the element of duty in a negligence claim. The following list includes some evidence that may assist the judge in making a decision on the standard of care, or scope of duty, in a malpractice case. The LNC may be instrumental in alerting the attorney to the existence the items of evidence listed below. It is assumed that the attorney has knowledge of the first three items on the list.

- **Statutes:** In modern American jurisprudence, the common law rules have often been changed by the enactment of federal and state statutes. Statutes mandate certain conduct. An example of a statute as evidence of the standard of care is provided by the child abuse reporting statutes. These statutes clearly state what a health care provider must do when child abuse is suspected. The court will apply this statute in deciding the standard of care should a negligence case arise for failure to report. Violation of some statutes is considered to be "negligence per se".
- **Agency Regulations:** Federal and state administrative agencies that promulgate rules and regulations also may affect the standard of care. Agency rules and regulations also mandate certain conduct. They could affect a judge's decision on duty.
- **Case Law:** Applicable case law may provide a precedent that will be followed by a judge when circumstances of the case at issue are similar.
- **Accreditation Standards:** JCAHO (Joint Commission on Accreditation of Health Care Organizations) accreditation standards have been recognized as some evidence of the standard of care.
- **Facility Documents:** The following documents, some required by agency regulations and JCAHO, may be important to the court in making a final determination of duty in a given case:
    - Policies & Procedures
    - Medical Staff Bylaws and Medical Department Rules & Regulations
    - Job Descriptions
    - Other (Some health care facilities may have documents not listed above.)
- **Contracts:** These include such contracts as those between a nursing registry and the health care facility and those between an emergency physician's group and the health care facility.
- **Professional organization guidelines:** These include publications of guidelines by professional organizations such as those published by ACOG (American College of Obstetrics and Gynecology).
- **Manufacturer's instructions:** Manufacturers' instructions are important when medical equipment or a medication is involved in an injury. Manufacturers' instructions may be obtained from the manufacturer of the product. With respect to medications, the PDR (Physician's Desk Reference) is a compilation of the manufacturers' instructions of the pharmaceutical companies.
- **Medical Literature:** These include medical and nursing text books as well as peer-reviewed medical and nursing journal articles.
- **Expert testimony:** Expert witnesses may provide testimonial evidence relevant to duty and the standard of care. This evidence will also be considered by the judge in deciding the issues of duty.

The Restatement (Third) Torts, a well-recognized distillation of tort law, provides that:

> An actor is subject to liability for negligent conduct that is a legal cause of physical harm. . . [However,] even if the defendant's negligent conduct is the legal cause of the plaintiff's physical harm, the defendant is not liable for that harm if the court determines that the defendant owes no duty to the plaintiff. Findings of no duty are unusual, and are based on judicial recognition of special problems of principle or policy that justify the withholding of liability (*Restatement [Third] Torts*, n.d.).

In a nationally recognized case, *Tarasoff v. Regents of the University of California*, the judge explained that public policy considerations must be taken into consideration by the judge in finding whether or not a duty exists in a particular set of circumstances. "[Duty] is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection" (*Tarasoff v. Regents of University of California*, 1976).

Judges have formulated tests to determine whether or not a duty should be found in a new set of circumstances. A famous federal judge, Lerned Hand, formulated such a test. The factors that were considered by Judge Hand in deciding whether or not a duty existed were: the likelihood that the harm will occur, the gravity of harm should it occur, and the cost of preventing the harm (*United States v. Carroll Towing*, 1947). This test has evolved since 1947. The late Chief Justice Rose Bird set out an expanded version of Judge Hand's test in 1985. In writing the opinion for a unanimous California Supreme Court, she said, "Whether such a duty exists is a question of law to be determined on a case-by-case basis [Citations]. In considering whether one owes another a duty of care, several factors must be weighed, including:

> [T]he foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost, and prevalence of insurance for the risk involved (*Isaacs v. Huntington Memorial Hospital*, 1985).

An example of a case in which a court found that no duty existed and, therefore, no liability for negligence, is the famous case of *Palsgraf v. Long Island Railroad Company* (1928). For a discussion of Palsgraf as the seminal case on duty, see **lawschoolhelp.com** at **http://www.west.net/~smith/duty.htm**. For the full text of the Palsgraf case, see **http://www.courts.state.ny.us/history/cases/palsgraf_lirr.htm**.

Helen Palsgraf was waiting on the platform of the Long Island Railroad Station to board a train when another train began to leave the station. A man carrying a package ran to catch the leaving train and jumped aboard. It seemed that he was about fall, so a conductor on the train grabbed him, and a conductor on the platform pushed him from behind. The package, which contained fireworks, dropped onto the rails and exploded. There was nothing about the package that gave notice that it contained fireworks since it was covered with newspaper. The shock from the explosion knocked down some scales at the other end of the platform where Mrs. Palsgraf was waiting. The falling scales injured Mrs. Palsgraf. She sued the Long Island Railroad for negligence.

Chief Justice Cardozo, who wrote the *Palsgraf* opinion, ruled that the railroad did not owe a duty to Mrs. Palsgraf with respect to the actions of the conductors in helping the man who was boarding the train. Chief Justice Cardozo wrote:

> Relatively to her it was not negligence at all. Nothing in the situation gave notice that the falling package had in it the potency of peril to persons thus removed. Negligence is not actionable unless it involves the invasion of a legally protected interest, the violation of a right. "Proof of negligence in the air, so to speak, will not do" (*Palsgraf v. Long Island Railroad Company*, 1928).

Since there was nothing about the package to alert the conductors that it posed a foreseeable risk of harm to Mrs. Palsgraf at the other end of the platform, the railroad did not owe a duty to Mrs. Palsgraf under the circumstances. Since there was no duty owed to Mrs. Palsgraf by the railroad, she did not have a claim of actionable negligence against the railroad for the injuries she suffered. It is interesting to consider whether the court's opinion would be different today, considering that the railroad would be a common carrier in a post-911 environment.

In making a determination on the element of duty, the court first decides whether or not a duty exists, given a particular set of circumstances. If the court finds that a duty does exist, the court then must decide the scope of the duty (i.e., the conduct required to satisfy the duty). The term "standard of care" is occasionally used interchangeably with the term "scope of duty." An interesting example of a case in which the court decided the scope of duty is the historic case of the *The T. J. Hooper*. T. J. Hooper was the name of a tug boat that was the subject of the litigation. In this case, two tug boats were towing barges that were carrying cargo. During a gale, the barges sank and the cargo was lost. The owners of the cargo sued the barge owners for their losses. The barge owners, in turn, sued the tug boat company. The company argued that since no other tug boat owners in the area used weather radios, that the standard of care in the industry did not require use of weather radios. This is occasionally referred to by nurses as the community standard. The court acknowledged that the general practice of an industry is usually the standard of care, but not always. The court said:

> A whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests however persuasive its usage. Courts must in the end

say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission (*The T. J. Hooper*, 1932).

The "Duty to Rescue" Cases

An interesting type of recurring case in common law, also referred to as case law, is the "duty to rescue" case. In these cases, most courts have found that there is no general duty of a stranger to rescue a person in peril. This remains the law in most states today. The examples given by the courts often include that of a stranger who sees a young child on a railroad track with the train approaching. The question is whether or not there is a [legal] duty owed by the stranger to rescue the child. In other words, would the stranger be liable for negligence for failing to attempt to rescue the child? As horrendous and outrageous as it sounds, the courts did not recognize a duty of a stranger to rescue a person, or even a child, in peril.

Most states today do not recognize a general duty to rescue a person in peril in the absence of other facts. Only a handful of states, including Vermont, Minnesota, Massachusetts, Rhode Island, and Wisconsin, recognize a duty in some circumstances to take affirmative action when another person is in peril, even if it is just calling 911. LNCs should check their own state's statutes to determine the law on the duty to rescue in their jurisdiction.

Exceptions to the General Rule

The courts have, however, carved out exceptions to the general rule that there is no duty to rescue. When a special relationship exists, such as between spouses, between parent and child, and between health care provider and patient, there is a duty to rescue or to provide assistance. Historically, courts have recognized that there is a duty of care owed by a nurse to the nurse's patient based on the nurse – patient relationship. In fact, the nurse – patient relationship has been used by the courts as an example of when a duty to rescue clearly exists.

Another exception to the rule that there is no general duty to rescue is in a situation in which a person's conduct has caused the peril to the person in need of aid. *The Restatement (Second) Torts* states that:

> If an actor knows or has reason to know that by his conduct, whether tortious or innocent, he has caused such bodily harm to another as to make him helpless and in danger of further harm, the actor is under a duty to exercise reasonable care to prevent such further harm (*Restatement [Second] Torts*, 1997).

Even when there is no duty to render aid to an injured person in the first instance, once a person begins to render aid, courts have found that a duty of care is created and liability for negligence can be found for conduct falling below the standard of care. However, when aid is rendered in emergency situations, the Good Samaritan statutes may apply. These statutes provide some level of immunity from a negligence claim when rendering aid in an emergency situation when no prior duty exists to do so.

Duty Based on Health Care Provider – Patient Relationship

In case law, the formation of a health care provider-patient relationship is the basis for a finding that the health care provider owes a duty to the patient. The issue that occasionally arises in these cases is whether or not a physician-patient or a nurse- patient relationship has been formed by a particular set of circumstances. In such cases, the circumstances in a particular jurisdiction that cause the formation of a health care provider-patient relationship must be determined. For example, the California Board of Registered Nursing (BRN), a state administrative agency, has drafted an advisory statement on abandonment of patients. This document sets out the conduct that the BRN deems as forming a nurse-patient relationship. The BRN advisory statement provides:

> A nurse-patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse. Failure to notify the employing agency that the nurse will not appear to work an assigned shift is not considered patient abandonment by the BRN, nor is refusal to accept an assignment considered patient abandonment. Once the nurse has accepted responsibility for nursing care of a patient, severing of the nurse-patient relationship without reasonable notice may lead to discipline of a nurse's license (California Board of Registered Nursing, 1998).

Malpractice cases occasionally contain issues regarding whether or not a physician-patient relationship has been formed. Some of the issues that arise include the following: Is the physician-patient relationship formed when a new patient makes an appointment? Does the physician have to see the new patient in order for the relationship to be formed? Does an on-call rule in medical staff bylaws, in and of itself, cause the formation of the relationship when a particular physician is on-call but has not yet seen the patient? Do requirements of a statute such as the Emergency Medical Treatment and Active Labor Act (EMTALA) create a physician-patient relationship? Does a post by a physician providing advice to a list member on a listserv create a physician-patient relationship? Answering these questions is beyond the scope of this column. These issues need to be researched in order to determine the applicable law related to the formation of such professional relationships in a particular jurisdiction.

Duties to Third Parties

Duty clearly arises when a health care provider-patient relationship is formed. Courts have also decided that duties flow beyond the health care provider-patient relationship to third parties that may be affected by a health care provider's conduct. The seminal case for this doctrine is the Tarasoff v. Regents of University of California (1976) case.

In the *Tarasoff* case, a psychotherapist at a university clinic was informed by his patient that he was planning to kill Tatiana Tarasoff. The psychotherapist failed to warn Ms. Tarasoff or her parents of the threat of harm by his patient. The patient did, in fact, kill Ms. Tarasoff. In a negligence suit against the university, the university argued that the psychotherapist owed no duty to Ms. Tarasoff, as she was not the psychotherapist's patient. The California Supreme court stated:

> We shall explain that defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances (*Tarasoff v. Regents of University of California*, 1976).

Tarasoff makes it clear that courts will extended a duty of care beyond the health care provider – patient relationship to third parties in certain circumstances. Though this is a California case, many states follow *Tarasoff*. There are other cases in which a physician's duty has extended to a third party. For example, courts have found that a physician has a duty to warn a third party when there is a foreseeable risk of harm due to a contagious disease of the physician's patient.

Evolution of the Law of Duty

As technology advances, the concept of duty will necessarily evolve as well. Courts today are dealing with such issues as those created by advances in genetic research. For example, courts must determine whether or not a duty of care is owed to third parties to warn them of genetic conditions that they may be at risk of suffering or passing on to offspring. How far will the duty be extended? Will it extend to future generations, yet unborn? It is up to the judges in our courts to make such decisions based on the evidence presented to them at trial in conjunction with the balancing of the policy factors as discussed above.

Conclusion

When a dispute arises on the issue of duty, it is the judge who decides whether or not a duty exists and, if so, the standard of care that must be satisfied. The law of duty will continue to evolve as technology advances. The LNC may play a part in this evolution. The LNC may be instrumental in locating evidence that will ultimately assist the judge in making decisions on issues involving the element of duty.

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"Medical-Legal Aspects of the Spine" by Marjorie Eskay-Auerbach, MD JD

Kara DiCecco, MSN RN LNCC

"Medical-Legal Aspects of the Spine" by Marjorie Eskay-Auerbach, MD, JD

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www.lawyersandjudge.com

To casually observe that writing a reference book for understanding the medical-legal dimensions of litigating back pain is a formidable task does little to communicate the inherent difficulties in covering such a controversial topic. Despite this, Marjorie Eskay-Auerbach, M.D., J.D. has tackled the project head-on in "Medical-Legal Aspects of the Spine" from Lawyers and Judges Publishing Company, Inc. (2005). Based on the title, the reader might expect a guide to presenting information on back injury to the triers of fact, or anticipate a compendium of tips and hints for navigating the rules of evidence regarding the admissibility of medical literature. While both the title and the author's educational background give credence to the book's subject matter, the actual content is less the above and more of a primer on the dimensions of back pain. In nine chapters the author impressively covers a wide terrain from chapter one, an introduction to the incidence of back pain to chapter nine, concluding on surgical treatment options.

The poorly understood dynamics of spine pain creates a wide spectrum of opinions and treatments with little consensus on a universal understanding for the origin or relief of back pain. For every reference cited or study conducted the reader could easily locate articles published to refute the findings. The author nicely illustrates this fact when she cites the article promoting the long held belief that the finding of (at least 3) Waddell's signs by the physician on physical exam is evidence of malingering[1]. To the author's credit, she also cites the article Waddell later published on the controversy that his original article is frequently misinterpreted and is often misquoted[2]. Evidentiary literature involving back pain is unyielding in its need for critical analysis.

Chapters one and two cover basic medical models for back pain and the various healthcare providers involved in the treatment of spine pain, respectively. The caveat here, however, is reader beware. In chapter one and others, several blanket statements and statistical conclusions may serve more as opinions (based on the author's experience) than established fact in the absence of supporting references. The medical profession has traditionally viewed the validity of back pain from a limited western perspective. The reader is encouraged to tread cautiously around the subjective trap of assumption and hold out for firmer footing where the author provides reliable sources that can be researched.

Chapter two introduces the various disciplines involved in caring for the patient with back pain. While the author defines the role and educational background of each discipline, arguably she has presented the higher-end educational requirements for some. For example, as it reads, the physical therapist must achieve several years of "post-graduate" (Master's degree) education. As with most healthcare professions, there are levels of educational preparation and attainment, and licensed physical therapists (as well as registered nurses and occupational therapists to name a few) do not necessarily have to be Masters prepared to practice. This fundamental observation of educational background is key when determining exactly who to depose and what weight the Court may afford the witness's opinion. Playing devil's advocate, the author may have intended to relate the educational requirement is several years post-graduation (High School) which could be easily remedied in subsequent printings of the text.

The true wealth of this book lies in the remaining seven chapters. As an orthopedic surgeon, Dr. Eskay-Auerbach is clearly at ease with the subject matter. These chapters address the pathophysiology and anatomy of the spine (chapter 3), the physical examinations (chapter 4) and diagnostics (chapter 5) requested by the physician, as well as listing the various treatment and surgical options available to the patient. These chapters are well written and relate key concepts in a tangible way. Forgoing the temptation to use terminology-riddled prose, the author explains the process of the physical examination by the physician and what the findings indicate in a straightforward manner that lends itself to jury friendly explanations. Dr. Eskay-Auerbach covers the breadth of treatment options available to the patient, including procedures relatively new on the horizon of evidence-based medicine. She

[1] Waddell, G., McCullough, J.A. , Kummel, E. & Venner, R.M. (1980). Non-organic physical signs in low-back pain. *Spine*, 5*(20)*, pp. 117-125.

[2] Main, C.J. & Waddell, G. (1998). Behavioral responses to examination: A reappraisal of the interpretation of "nonorganic signs". Spine, 23(21), pp. 2367-2371.

rightly divides common conditions of the cervical (chapter 6) and lumbar (chapter 7) spine into isolate chapters since they possess unique attributes and considerations in litigation. By separating chapters into non-surgical (chapter 8) and surgical options (chapter 9), she allows the reader to focus on the evolution of and rationale for strategies involved in the treatment of back pain.

The diagrams of the mechanics of anatomy are basic black and white representations which are at times very helpful while at other times do little to clarify and illustrate the author's point. This is neither the fault of the author or artist, but an observation that some concepts are too complex to translate into one-dimensional, black and white plates. While the dermatomes and their functional distribution are provided to the reader in table format, this concept may be easier to understand when mapped out on an illustration of the human body allowing the reader to adequately visualize the affected areas.

Given the difficulties intrinsic to writing on such a controversial subject matter, Dr. Eskay-Auerbach has provided a reference tool that could be repeatedly utilized to enhance the reader's understanding of the complexities of back pain litigation. While it would be a disservice to the reader to say this book could be held out as a star authoritative text on the subject matter (which the author does not portend), this reference would easily serve as a primer of essential information for the legal nurse consultant or novice attorney preparing to depose a medical expert in back pain. A book that clearly and decisively explains the varied procedures, disciplines and terminology involved in spinal litigation will always be in high demand for our profession. Whether practicing from the plaintiff or defense perspective, undeniably back pain is frequent component of the litigation process and "Medical-Legal Aspects of the Spine" is a good place to start.

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Q: Nurse Paralegal/Legal Nurse Consultant: Similar Work Product. What is the Controversy?

Margo Conklin, MSN BSN RN LNCC & Kathryn Jeffries, BS BSN RN

A: This question has been bandied about the legal profession for the past 10 years. In order to even begin to answer this question, we must first break it into individual parts, or sub questions.

Q: What is a Paralegal?

A: According to the National Association of Legal Assistants (NALA), paralegals are a group of individuals who through formal education, training and experience, assist attorneys in the delivery of legal services. They have knowledge and expertise of the legal system and procedural law within their specific scope of practice. Paralegals perform work that is legal in nature under the supervision of attorneys.

Q: What is a Nurse Paralegal?

A: The American Bar Association (ABA) defines the paralegal as an individual, qualified by education, training, or experience who is employed or retained by a lawyer, law office, or other entity, and who performs specifically delegated substantive legal work for which an attorney is responsible. A Nurse Paralegal is a paralegal with nursing experience.

Q: What is a Legal Nurse Consultant?

A: The American Association of Legal Nurse Consultants (AALNC) Mission Statement identifies a legal nurse consultant (LNC) as a registered nurse (RN) who consults on healthcare issues within the legal arena.

Q: What is the primary difference between a Nurse Paralegal and a Legal Nurse Consultant?

A: A legal nurse consultant practices under the umbrella of consulting as a specialty practice of the nursing profession. The LNC is consulted by members of the legal profession for expertise in nursing and health care (AALNC Position Statement on the Role of the LNC as Distinct from the Role of the Paralegal and Legal Assistant).

A nurse paralegal practices under the auspices of the legal profession. Although the nurse paralegal is also consulted by the legal profession for expertise in nursing and healthcare, the nurse-paralegal is not necessarily a currently licensed registered nurse.

Q: What are the different types of educational programs for a Nurse Paralegal?

A: The individual who wants to be a nurse paralegal has the option of a degree or certificate program. The number of credits and course requirements will vary from institution to institution depending upon which program the student chooses.

Most colleges that offer nurse paralegal programs require that the nurse has experience as a licensed RN and that the license is current. The specific amount of years of experience depends on the educational institution.

This author evaluated one college which offered two programs for the Registered Nurse: *Nurse Paralegal* with a Bachelor of Science (B.S.) in Paralegal Studies, and *Paralegal Studies for the Registered Nurse* with a Certificate awarded upon completion. Admission criteria for both programs include current licensure in the college's state and documentation of a minimum of 2000 hours as a practicing RN. The curriculum for the certificate program includes seven (7) courses for a total of 24 credit hours. The curriculum for the Nurse-Paralegal program varies depending on the educational requirements of the individual needed to obtain a B.S.

Q: What sort of courses can a student expect to take in a nurse-paralegal program?

A: *General Law* will introduce the student to the legal arena, with emphasis on the judicial process at the federal and state levels. Terminology is also an important component of the course. *Legal Research* and *Legal Writing* are two (2) courses that are invaluable to anyone considering a career in the legal field. *Legal Research* introduces the student to the intricacies of a law library and various methods to research similar case issues which set a precedent. *Legal Writing* focuses not only on the appropriate format for legal citations, but also includes instruction in writing reports, summaries, and letters. All of which will be expected of the nurse-paralegal.

Torts is a course that focuses on the elements of negligence. Statsky (1994) defines a tort as "… a civil wrong that has caused harm to person or property for which the courts will provide a remedy." The tort of negligence is basis for a medical malpractice claim. An understanding of negligence allows the nurse-paralegal to look at a medical record from a different perspective. Was the care in question truly negligent, or was it poor? Was the negligent care the proximate cause of the client's damages? These are just a few of the many questions

that need to be asked when assessing a case for potential negligence.

Civil Litigation and *Technical Litigation Support* are courses that will go step by step through the entire litigation process. Through these courses the nurse-paralegal will learn how the unique nursing experience can assist an attorney at trial.

It is wise to fully evaluate the school's curriculum so that there is no doubt the legal courses taken are applicable to the medical, nursing and/or healthcare arena. The paralegal courses covering real estate law are probably not of interest, whereas the course of business law might be of interest, particularly to one who is interested in being independent. Criminal law might be of interest to those interested in forensics.

Q: What are the different types of educational programs for a LNC?

A: The LNC's basic nursing education, whether it be Diploma, Associate, or Bachelor Degree are all acceptable for the practice as a legal nurse consultant. Registered nurses with an active license have a range of educational possibilities, including but not limited to, home/self-study programs, formal programs providing continuing education units (CEU's) or a Certificate, and degree programs offered by colleges and universities. Since subject matter may vary, AALNC's *Legal Nurse Consulting: Principles and Practice* is recognized as the standard curriculum.

This author evaluated one college which offered a legal nurse consulting course for its seniors. This particular course is taught by a local Nurse-Attorney who maintains an active nursing license and proves to be an invaluable asset to the course. This is a seven-credit course that includes a nine-week internship. Students may "intern" at elder law clinics, law firms and with the State Board of Nursing. Internships have led to permanent employment for several students. *Legal Nurse Consulting: Principles and Practice* (Bogart et al., 1998) is the text book used for this course. Assignments include analyzing medical records from an actual case and writing chronologies.

Q: What type of jobs can each of these individuals expect to obtain?

A: With the educational background of the nurse-paralegal (paralegal degree or certificate) the attorney is looking for an individual to assist with all aspects of the litigation process: medical and legal. The nurse paralegal is seen as a peer among other paralegals in the office and is often expected to participate with drafting legal documents. The nurse paralegal will often find time divided between the medical aspect of the case and the legal aspect of the case. The activities of the nurse paralegal are usually defined by the attorney and the 'walls within he/she works'. In addition to working with a law firm, the nurse paralegal may also find employment with insurance companies, hospitals, and/or government agencies.

The LNC engages in activities which focus on the medical, nursing, and other healthcare issues in the situation. The LNC may work in-house, but is more likely to work independent from a law firm; specifically working with the litigation team of a law firm on a particular healthcare issue. It is not expected that the LNC would participate with the drafting of legal documents although some LNCs may find themselves assisting in this area. Through conversation with the attorney, the LNC may request the attainment of additional medical documentation, provide insight into questions to ask parties in the case, and review legal documents for their medical accuracies.

Case Study

Legal Nurse Consultant, Jane Doe, has been contacted by Attorney Brown to assist with a medical/legal matter. Attorney Brown represents the plaintiff (John Black) in the case and filed the Complaint with the court prior to retaining the services of LNC Jane Doe.

Nurse Paralegal, Mary Weather, works in-house for defense attorney Blue Boy who represents the interests of Dr. Error. Attorney Blue Boy has asked Nurse Paralegal Weather to assist him with his defense of Dr. Error.

Plaintiff Attorney Brown mailed Ms. Doe a copy of the medical records with the following instructions: Organize and review the medical records, identify potential health care witnesses to depose, begin drafting a chronology. Attorney Brown also asks Ms. Doe for any medical research relative to the case issues.

Defense Attorney Boy received a copy of the Complaint from the Court alleging negligence against Dr. Error. A copy of relevant medical records was also provided by the plaintiff with the Complaint. Both the Complaint and the medical records were given to Ms. Weather for her review. Having worked with Attorney Boy for the past year, Ms. Weather was familiar with the litigation process. Ms. Weather first reviewed the Complaint and compared the factual allegations with documentation in the medical records; noting any discrepancies. Ms. Weather organized the medical records provided and began drafting a list of Mr. Black's health care providers and identifying additional medical records and documents needed. She also started a medical chronology. Ms. Weather knew her list of health care providers would be important throughout the discovery process, particularly during her review of plaintiff's answers to interrogatories.

Ms. Doe completed her initial review and draft chronology and followed up with a telephone consultation with Plaintiff Attorney Brown. Attorney Brown next asked Ms. Doe to assist with the location and retention of two causation physician experts. He also advised her that he would be taking Dr. Error's deposition in two weeks and wanted her to draft questions relating to Dr. Error's care of Mr. Black during his last hospitalization.

Defense Attorney Boy next received a Plaintiff's Answers to Defendant Error's First Set of Interrogatories, a copy of which he gave to Ms. Weather. Ms. Weather reviewed plaintiff's answers and proceeded with the following: Identification of additional

health care providers' records needed and drafting Subpoena Duces Tecum for the production of these records, drafting additional questions for Attorney Boy to pose to plaintiff for the production of radiology films, and telephone conversations with Dr. Error's office staff to obtain factual information and a complete set of Dr. Error's medical bills recorded for Mr. Black.

Summary

This case study is just a brief example of various roles and responsibilities the LNC and Nurse Paralegal have during the litigation process in an attempt to demonstrate the intertwining of the medical/legal aspects. The Nurse Paralegal is expected to have the necessary education and skills to perform paralegal responsibilities to assist with the litigation process. While the LNC may have 'paralegal skills' developed through years of experience as an LNC, her nursing skills, not her paralegal skills, are why she is sought out by the attorney.

Experienced RNs are invaluable in the legal arena and bring many intangible qualities to the paralegal field. There is networking, problem-solving, meeting deadlines, and the ubiquitous stressful situation, just to name a few. Nurses are the experts in maintaining and evaluating information in a medical record.

No matter which educational path an experienced nurse takes, the blend of the nursing and legal profession is rewarding. The challenge of objectively reviewing medical documents and translating them into information that fits a legal framework is rewarding. It is amazing how a nurse can read something in a record and have it trigger a long forgotten memory of a patient or clinical scenario that brings a different understanding to the situation at hand. The opportunity to use years of "watching" patients and talking interns into doing things the "right" way for something other than getting through the shift without incident, can be a great deal of fun.

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This article was authored by **Margo Conklin**, MSN BSN RN LNCC, and **Kathryn Jeffries**, BSN RN, with development and editorial assistance from the Executive Board of the Greater Baltimore Area Chapter of the American Association of Legal Nurse Consultants.

Nixing Computer Phobia: How to Acquire and Develop Basic Technological Skills

Deborah Gorombei, MS BSN RN LNCC & Lori Plate, RN LNCC

Many software programs are available to support litigation processes. Word processing programs, case management and trial presentation software have become standard in today's litigation environment. Knowing how to operate the software and related technology can make a difference in how efficiently you work, how quickly you can form an opinion about a case, and how effectively you can present your ideas in an alternative dispute resolution or trial setting. The following information may not be new, but hopefully will give you a better understanding of some of the available options. The only way to develop your skills is to make a commitment to overcome any fear of technology you may have. A brief section on document loss prevention is included that will hopefully decrease your anxiety while increasing your confidence so you can try new software functions without fearing that you may lose your files.

Computer technology is currently being taught at the elementary school level. If you are reading this and over 30 years old, you may not have had the opportunity to learn these skills in a classroom setting. We are likely to use specific programs and functions we are familiar with and refrain from using other, less familiar functions. Similarly, we refrain from learning unfamiliar software. A good place to start is a self assessment to determine what we know and do not know. H & H Publishing provides a web administered, self assessment tool called Technology and Internet Assessment [TIA] (H & H Publishing, 2003). For a nominal fee of $3.00 (at the time this article was written), you can take the assessment and receive immediate feedback. Microsoft® Corporation also offers an online test to assess software knowledge (Microsoft, 2005). After you determine areas for improvement, take goal directed steps to learn a new function each week. Make a commitment to yourself and do not give up.

Where to Get Training

Computer training is big business. Depending on your learning preference, financial commitment and schedule, a variety of educational options exist. Please refer to the end of this article for detailed references.

Phone a friend or family member: Asking a friend or family member may be a great option for learning how to extend your computer skills. Do not spend a lot of time trying to figure out a software function. Ask for help early. The longer you remain frustrated with a program, the less enjoyable learning will be. Frustrating experiences may limit your willingness to learn more about a program.

Ask your Information Technology person: Your IT person is often familiar with the software stored on office computers.

Newsletters: element K Journals provides both free tips and monthly publications on an extensive list of software titles.

Online Help: Several web pages offer tips in plain English to help with common functions and frequently occurring questions.

Online training: Online training and demonstrations can be helpful for those who do not have the time to attend a seminar or who may be visual learners.

Books: Software training manuals and journals are useful for those who learn best by reading. Software that is widely used by the general public often has abbreviated instructions that are laminated and easy to reference.

Software 'help' menu and technical support: Most software vendors offer a built in "help" option or telephone technical support. Some software comes with interactive training or free Webinars to help you get started.

Be sure you inquire about any technical support fees. These fees can be rolled into the software purchase or be charged on a per-call basis.

Formal courses: Universities, community colleges, YMCAs, and many corporations offer computer training classes. Check local resources or companies such as CompUSA and Fred Pryor seminars.

Other advice: No matter how tempting it may be to ask someone to perform a software function for you, take that opportunity and try to increase your skills one step at a time. Install your own software (with IT standing next to you) and ask questions until you really understand how to perform a software function. Try to learn one new function each week and ask the same of your co-workers. By the end of the week, you can show each other how to use a previously unfamiliar function. Teaching others what you have learned will help you retain what you have learned as well.

Learn how to connect your laptop to speakers, projectors, another computer or a VCR. Get familiar with the cable connections and begin to do it yourself. Practice makes perfect!

Preventing Loss of Work

Automatically Recovered Files

One of the most frequent calls for help is associated with the "lost file". Know where your files are stored and where your recovered files go when a disaster occurs and your computer shuts down.

Specifying a location for automatically recovered files using Microsoft Word

1. On the **Tools** menu, click **Options**,
2. Click the **File Locations** tab.
3. In the **File Location/File types** dialogue box, click **AutoRecover files**
4. Click **Modify**

If you want to store automatically recovered files in a different folder, locate and open that folder.

[Suggestion: Create a folder called 'Auto Recovery' and use the above steps to direct recovered documents to this folder. This way, when a crisis happens, you know where to go to get the latest version of your work].

Automatic Back up Copies

You can automatically create a back up copy each time you save a document. The back up copy saves information from the previously saved version of the document. In other words, if you accidentally save changes you did not intend to save, you can open the back up copy to reveal the version previous to the last save. This is also helpful in case you accidentally delete the original file. You will be able to delete the back up versions when you no longer need them.

1. On the **Tools** menu, click **Options**, and then click the **Save** tab.
2. Select the **Always create backup copy** check box.

Automatic Background Saves

Set the computer to perform automatic saves for you. Save and name your document soon after you begin entering information. Designate the file name and folder placement.

1. On the **Tools menu**, click **Options**, and then click the **Save tab**.
2. Check the box: **'allow automatic background saves'** (recommended).

[Note: if your computer 'crashes' before you save your document, it may be located in a TEMP file on your computer. This is also true if you open an attachment in an email and begin working on the attachment. If you click 'Save' instead of 'Save As,' your document may be directed to your TEMP folder. Also, some TEMP folders are 'hidden.' If you are unable to locate a file in these situations, it is best to ask for assistance].

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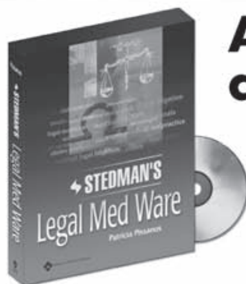

Stedman's Legal Med Ware

Patricia Pissanos

Any legal professional who deals with personal injury, medical malpractice, medical claims, and workman's compensation cases knows the importance of preparing an accurate, understandable chronology of medical events, and comparing them to the allegations of a case. It's a highly detailed, time-consuming process involving stacks of documents plus cutting and pasting into a word processing application. But now there's a better way!

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- ICD 9 codes
- User-friendly functionality
- And more!

A5D539ZZ cr 01/06

What customers are saying about Legal Med Ware:

"[The] drug dictionary as well as drug information can be put right into the document... [Without the program] you need to do that yourself."
—Betty Joos, MEd, BSN, RN, Informed Decisions, Inc., Co-author, Marketing for the Legal Nurse Consultant

"I used LMW quite a bit in the month I subscribed and found it to be very useful...LMW assisted me in completing a sample work product I'm proud of."
—Patricia Allred, Triad Legal Nurse Consulting, Liberty, N.C.

"I was recently appointed Chairperson of the LNC Section of The American Association of Nurse Attorneys. I will be recommending your software to the members of the LNC Section."
—Conswella M. Byrd, RN, JD, Esq., Director, CSUH Paralegal and Legal Nurse Consultant Programs

"Legal Med Ware has been a vital tool in my LNC practice due largely in part to of the variety of ancillary components available when developing a medical chronology. Whether you are starting out or looking for a fresh way to streamline your work product, you should look to Legal Med Ware. LNC's have been turning to this innovative, industry-specific software for years — so should you."
—Cindy Banes, RN, LNCC, President – LNC Resource, Ask-A-Legal-Nurse – LNC for over 17 years

STEDMAN'S

For details about multi-user licenses, visit stedmans.com and click Multi-User Software or call 1-800-326-1685

There are many ways software can make your work more efficient. Protecting yourself against lost data should increase your confidence in exploring new software functions. If you are interested in becoming a Technical Legal Nurse Consultant, exploring software potential and knowing how the software works is a big step in acquiring the necessary skills for this position.

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H & H Publishing Company, Inc. (2003). *Overview of TIA*. Retrieved September 28th, 2005 from http://www.hhpublishing.com/_assessments/TIA/index.html

Microsoft Corporation (2005). Find Training. Retrieved September 28th, 2005 from http://www.microsoft.com/learning/training/find/findcourse.mspx

element K Journals (see Web site below)

Web Sites of Interest

Computer Assessments:

http://www.hhpublishing.com/_assessments/TIA/index.html

http://www.microsoft.com/learning/training/find/findcourse.mspx

Online Tutorials:

http://www.learnthat.com/default.asp

http://www.edcomp.com/

http://www.pryor.com/index_Body.asp

Training/Seminars:

http://www.compusa.com/training/catalog/default.asp

http://www.pryor.com/index_Body.asp

Tips and Help:

http://www.questgems.com/comparch_menu.html

http://www.elementkjournals.com/

http://www.datadoctors.com/help/questions/ask_1.cfm

http://www.theofficeexperts.com/index.htm

http://www.willamette.edu/wits/resources/docs/software/msoffice/word-faq.htm

Deborah A. Gorombei, MS BSN RN LNCC, is the Vice President of Operations/COO for R & G Medical Consultants, Inc., contributing her clinical and administrative background in nursing and computer technology. She provides technical services, legal nurse consulting products, and serves as an expert witness in critical care and trauma cases. She received her BSN from Loyola University (Chicago) and her MS Degree in Critical Care Nursing – Clinical Nurse Specialist/Management Track from Purdue University. Her background in nursing includes work with the Arizona Department of Health Services (Bureau of Emergency Medical Services) as Injury Prevention Specialist, Trauma Coordinator for Maricopa Medical Center, Adult/Pediatric Flight Nurse, Director Clinical Development and Critical Care Services, Administrative Director and Chief Flight Nurse for University of Chicago Hospitals' Aeromedical Network [UCAN], and management positions in MI/CCU.

Lori Plate, AD RN LNCC joined R & G Medical Consultants, Inc., in August 2003 as a nurse reviewer and was recently promoted to Director of R & G Global Legal Solutions. She has 20+ years of nursing experience in Critical Care and Post Anesthesia Recovery, working both at the bedside and in management roles. She attended the University of Arizona, earned an AD in Applied Science from County College of Morris in New Jersey, and studied business management at Farleigh Dickinson University as well as nursing at The University of Phoenix. She has held specialty certification in both Critical Care and Post Anesthesia, and has served as a director for critical care and PACU units. In 2003, she received the Mayo Clinic Service Award and the prestigious Mae Berry Award for outstanding client service.

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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. Manuscripts should be addressed to Katie Fitzgerald, Managing Editor, Journal of Legal Nurse Consulting, 401 North Michigan Avenue, Chicago, IL 60611-4267; email: kfitzgerald@sba.com (email preferred), phone: 312/321-5177.

Manuscript format

Manuscripts should not exceed 12 pages (approximately 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

Submit one paper copy and one electronic copy (on a 3.5-in. disk) or via email kfitzgerald@sba.com. Microsoft Word is preferred. 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 the disk 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 (4th 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.

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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.

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Figures include line drawings, diagrams, and graphs. 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 glossy prints.

Manuscript Review Process

Manuscript submissions are peer reviewed by eminent professional legal nurse consultants with diverse professional backgrounds. First-time authors are encouraged to submit manuscripts. Manuscript assistance can be provided upon request to the editor. Acceptance will be based on the importance of the material for the audience and the quality of the material. Final decisions about publication will be made by the editor.

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Upon acceptance of the manuscript, the author will assign copyright to *JLNC*. Permission for reprints or reproduction must be obtained from AALNC.

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Please use the checklist below to be sure that your submission follows *JLNC* guidelines.

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_____ Permission for including or reproducing previously published information (e.g., tables and figures) is enclosed.

_____ Numbers and percentages have been checked against one another and the text for accuracy.

_____ Tables and figures reflect the information given in the text.

_____ The four paper copies are printed double-spaced on 8? x 11-in. paper, and manuscript has been copied onto a 3.5-in. disk.

_____ The manuscript does not exceed 12 pages in length.

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_____ The pages are numbered consecutively, beginning with the title page.

_____ Photographs are black-and-white glossy prints.

_____ One author has been designated as the corresponding author.

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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
Organ Donation/Transplant: Process, Standards, Liability Issues
Wrongful Birth
Drug Testing: Workplace, Athletes, Medical-Legal/Ethical Issues

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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

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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
Chiropractic Issues and Liability
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
Mold Litigation
Carbon Dioxide Poisoning
Mercury poisoning
Lead Poisoning

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