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AALNC

AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS

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The Journal of Legal Nurse Consulting

Purpose

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

Manuscript Submission

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

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

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Medical Literature as Evidence and Expert Witness: Considerations for the Legal Nurse Consultant

Kara L. DiCecco, MSN RN LNCC

KEY WORDS
Medical Literature, Evidence, Expert Witness

The sobriquet of legal assistant is misapplied when defining registered nurses (RNs) who have achieved competency in the basic principles of kinematics, physics, organic chemistry, and statistical analysis in order to obtain professional licensure. The skill and expertise in reviewing and understanding medical literature is borne out of advanced education and hard-won clinical experience. This invaluable knowledge not only makes them the obvious choice to invite to the judiciary tournament but makes them key players. In the first of this two-part series on medical literature, the role of the scientific writing in the hands of the court and expert witness is examined – how it is used and its evolutionary importance to the legal nurse consultant in litigation. Part one will provide the foundation for part two, which will review the basics of reading and critiquing the research study. Published research studies, scholarly and professional journals, authoritative texts and learned treatises are all part of an expansive province of scientific literature. For the purposes of this article, the terms "medical" and "scientific" literature are interchangeably understood to include the peer-reviewed end products of medical, nursing and allied health research. A glossary of terms can be found at the end of the article.

When properly presented by the expert witness, medical literature serves to educate the judge and jury on information too complex or technical for the average understanding. Trial attorneys may use it to enhance or impeach the credibility of the expert witness. In pre-litigation, it finds and fills a role in facilitating settlement negotiations. In discovery, knowing what written material the testifying expert will rely on provides a clear advantage. Even if the expert witness stops short of committing in writing to a medical text as authoritative, a well-respected textbook specific to the expert's field will dictate a script of questions for deposition. At trial, however, the majority of expert witnesses will eventually align with a specific scientific methodology in order to qualify as an expert in the eyes of the court. In the right hands, medical literature is stealth weaponry.

The Evolution of Expert Testimony and Scientific Literature

In the early 1900s, the court endorsed experts if they demonstrated a measurable worth as a commodity to the public. Simply stated, if the expert was able to generate his livelihood in the chosen vocation, he was deemed qualified to testify (Waters, 2006). After *Frye v. United States* (1923), experts whose scientific methods had been affirmed by the scientific community at large (in contrast to experience-based opinion) were likewise ordained as acceptable to the court (Waters, 2006).

In *Daubert* (1993), the Supreme Court again altered the landscape by focusing their attention on the literal intent of Federal Rule of Evidence 702. No longer could an expert base his opinion solely on his prominence or the popular notion of peers. In the affected jurisdictions, whatever learned support the expert brought to court post-*Daubert* became subject to a new litmus test. It now required something more definitive: a four phase criteria designed to guide federal judges in filtering out unfounded science and faulty expert opinion (Table 1).

Table 1: The Daubert Four Factor Analysis

***Daubert's* Four-Factor Analysis:** The United States Supreme Court decision changed the standard for admissibility of expert testimony. Establishing the trial court judge as "gatekeeper" in determining the reliability of the expert's opinion based on scientific fact (methodology) that is:

1) Testable (falsifiable)

2) Subject to peer-review and publication

3) Has a known or potential rate of error*

4) Is generally accepted by the scientific community

*The *Daubert* analysis is sometimes listed as five criteria depending on the writer. This illustrates the inherent difficulty in law understanding science. In the Supreme Court decision (1993), the court addressed both the known or potential rate of error and the existence of controls in one paragraph which some authors interpret to mean a fifth analytical step. As the scientific method dictates, you could not have a quantifiable (known or potential) rate of error without existing controls (or for that matter evaluate its falsifiability with any accuracy) the "fifth step" is actually subsumed into the four-step analysis.

Playing by the Rules

Daubert (1993) and *Frye* (1923) do not stand alone as the only considerations for the admission of the expert's literature. In fact, the Supreme Court urged federal judges to apply the *Daubert* analysis as a flexible guide and not as a rigid set of rules. Medical literature as the basis for the expert's opinion is patrolled on all sides by the rules of evidence. The standards

for admissibility of expert witness testimony vary with the state and federal rules of procedure and evidence (Table 2).

While the *Daubert* holding pilots the federal courts, individual states are not necessarily under the same constraints. Only the U.S. Constitution and each state's unique constitution defines the parameters of legal interpretation. Even those states that have adopted the Federal Rules of Evidence are free to interpret the Court's intention (Larson, 2003; Peterson, 2004). Many states remain faithfully wed to *Frye's* "general acceptance" standard. Critics of *Frye* charge, however, novel scientific methods are expatriate because they lack the official sanction of the scientific community.

Still other states have created a hybrid of evidentiary rules for the acceptance of expert testimony (Figure 1). Florida, which aligns with the *Frye* ruling for admittance of expert testimony, additionally recognizes the "Pure Opinion Doctrine". The Florida 4th District Appellate Court decision in *Holy Cross Hospital, Inc. v. Marrone* (2001), attempted to clarify the distinction of testimony subject to Frye and that which qualified under the doctrine. The "Pure Opinion Doctrine" allows the expert witness to circumvent reliance on scientific literature instead basing expert view solely on clinical experience (Kodsi, 2006). The controlling principles of law, similar to medicine, only truly exist in shades of gray.

Table 2: Federal Rules of Evidence

F.R.E. 401: Definition of Relevant Evidence
"Relevant evidence" means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.

F.R.E. 403: Exclusion of Relevant Evidence on Grounds of Prejudice, Confusion or Waste of Time (The Balancing Test)
Although, relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues or misleading the jury, or by considerations of undue delay, waste of time or needless presentation of cumulative evidence.

F.R.E. 702: Testimony by Experts
If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case. *(Amended, effective Dec. 10, 2001.)*

F.R.E. 703: Bases of Opinion Testimony by Experts
The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to him at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Upon objection, facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect. *(Amended, effective Dec. 10, 2001.)*

F.R.E. 705: Disclosure of the Facts or Data Underlying Expert Opinion
(a) Disclosure of facts or data underlying expert opinion. The expert may testify in terms of opinion or inference and give reason therefor without first testifying to the underlying facts or data, unless the court requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination.

(b) Objection. An adverse party may object to the testimony of an expert on the ground that the expert does not have sufficient basis for expressing an opinion. The adverse party may, before the witness gives an opinion, be allowed to conduct a voir dire examination directed to the underlying facts or data on which the opinion is based. *(Amended, effective Dec. 10, 2001.)*

F.R.E. 706: Court-Appointed Experts
(a) Appointment. The court may on its own motion or on the motion of any party enter an order to show cause why expert witnesses should not be appointed, and may request the parties to submit nominations. The court may appoint any expert witnesses agreed upon by the parties, and may appoint expert witnesses of its own selection. An expert witness shall not be appointed by the court unless the witness consents to act. A witness so appointed shall be informed of the witness' duties by the court in writing, a copy of which shall be filed with the clerk, or at a conference in which the parties shall have opportunity to participate. A witness so appointed shall advise the parties of the witness' findings, in any; the witness' deposition may be taken by any party; and the witness may be called to testify by the court or any party. The witness shall be subject to cross-examination by each party, including a party calling the witness.

(b) Compensation. Expert witnesses so appointed are entitled to a reasonable compensation in whatever sum the court may allow. The compensation thus is fixed an payable from funds which may be provided by law in criminal cases and civil actions and proceedings involving just compensation under the Fifth Amendment. In other civil actions and proceedings the compensation shall be paid by the parties in such proportion and at such time as the court directs, and thereafter charged in like manner as other costs.

(c) Disclosure of Appointment. In the exercise of its discretion, the court may authorize disclosure to the jury of the fact that the court appointed the expert witness.

(d) Parties' Experts of Own Selection. Nothing in this rule limits the parties in calling the expert witnesses of their own selection. *(Added, effective Nov. 10, 1999)*

F.R.E. 803 (18): Exception to Hearsay
Learned treatises. To the extent called to the attention of an expert witness upon cross-examination, or relied upon by him in direct examination, statements contained in published treatises, periodicals or pamphlets on a subject of history, medicine or other science or art, established as reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence but may not be received as exhibits.

Exception to Hearsay

It is clear to see why medical literature would be subject to objection. More likely than not, the author is unavailable for oath or for the jury to evaluate his credibility. The interpretation of the author's intent is subject to explanation by a third party. Selective use of only favorable literature to each side's position denies the jury a more global understanding of the science. Within certain provisions, under the F.R.E. 803(18) medical literature is recognized as an exception to the hearsay rule with the burden of establishing reliability on

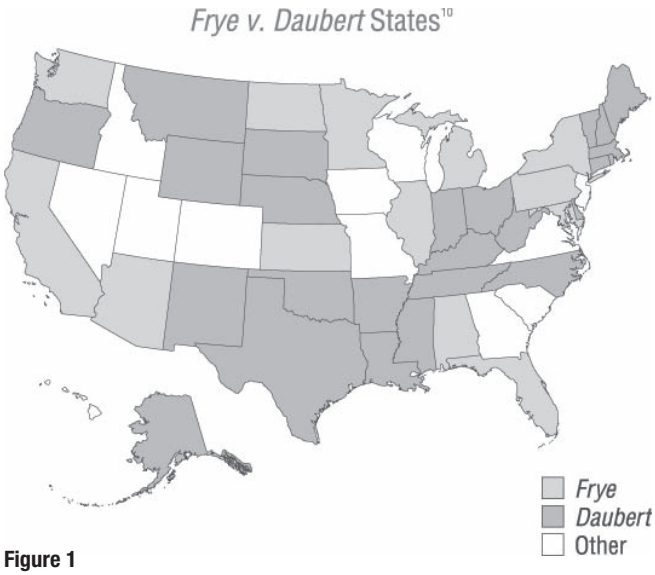

Figure 1

Reprinted with permission from The Changing Role of Judges in the Admissibility of Expert Evidence by Nicole L. Waters, Ph.D. (2006) National Center for State Courts, Civil Action, 5(1).

the party offering the item. Table 3 provides an example how a medical treatise may be used in cross-examination. Medical literature may also be introduced if established by judicial notice (F.R.E. 201).

The Unexcelled Schematics of *Mica* and *Homo Sapiens*

When John Steinbeck paraphrased Scottish poet Robert Burns in his 1937 novella *Of Mice and Men*, he wrote, "The best laid plans of mice and men often go awry." Despite Steinbeck's death predating the 1993 Supreme Court's *Daubert v. Merrell Dow Pharmaceuticals, Inc.* decision, his observation strikes center shot at the core of the high court's arguably quixotic decree. Admirable in its objective but unrealistic in its demands, *Daubert* clearly illustrates the dichotomous view our society holds of our jury system. As a society, we publicly promote our faith in the jury's ability to render a fair and impartial decision – but only after we censor what they are allowed to hear (Shuman and Sales, 1998).

Table 3: Cross-examination with Medical Literature
1) Only a treatise referred to by a witness on direct examination may be used for cross-examination.
2) Treatises generally referred by the expert witness on direct examination may be used for cross-examination.
3) A treatise recognized as authoritative on direct exam (but not relied upon) may be used for cross-examination.
4) Any treatise recognized as authoritative (whether or not the expert relied on it) may be used for cross-examination.
Source: 31 Am. Jur. Proof of Facts 2d 443

Through preview and debarment of medical testimony and scientific writings, the judge screens exactly who will present and what limited information they will convey to the triers of fact. Eventually the jury is called upon to determine what weight should be afforded the scientific evidence that is put before them. Much like a jigsaw puzzle with key pieces missing the jury must guess at what the incomplete picture represents. From a nursing perspective it is interesting to note that juries serve with less disclosure than the law requires for informed medical consent.

Despite the court's reliance on judicial scrutiny of medical literature and persistent search for medically sound testimony, problems with the current system for acceptance are numerous. With rare exception, the judge lacks the educational background needed to understand the intricacies of experimental design and therefore relies upon the proffered witness to explain the correctness of his opinion (Cecil, 2005; Peterson, 2004). In a sense, the judge relies on the applicant for the job to determine if he should be hired for the position; it is a poor "potential hire" who does anything but laud his or her own abilities and methodology. While Federal Rule of Evidence 706 permits the court on its own accord to appoint an independent witness to ensure impartiality, several authors note that this privilege is rarely and often reluctantly invoked (Cecil, 2005; Frankel, 2001; Ries and Jarrell, 2002; Tydings and Rosenberg, 2000).

In the true spirit of advocacy, counsel on both sides are charged with presenting their case in the best possible light. The abundance of medical literature available makes the selective use of only favorably biased materials commonplace (Davis, 2000; Frankel, 2001; Gould, 1993). Even divergent opinions do not necessarily promote equally alternative approaches in medicine. Further inquiry reveals judges tend to evaluate the methodology presented as a single finding instead of viewing them in the global perspective of what is known on the topic (Jasanoff, 2005; Raloff, 2005).

"Pantyhose" Science

The quest for "one-size-fits-all" science and absolute proof continues to fall short of the law's expectations. The inherent difficulty in identifying acceptable expert testimony revolves around published science and its methodological underwriter. Unfortunately, the scientific method does not translate well to a layman's understanding.

The intrinsic imperfection of the scientific method is the lack of a singular formula to demarcate "good science" from "bad" (Davis, 2000; Jasanoff, 2005). *Daubert's* objective to provide greater assurance of evenly distributed justice is blocked by two stalwart facts. The law misunderstands the nature of scientific inquiry, remaining reluctant to accept that predictable outcomes are not the result of an unfailing systematically applied process (Gould, 1993; Haack, 2005). Promising results and provisional conclusions stand only as long as it takes fellow researchers to overturn them. Similar to conducting a trial sans verdict, *Daubert* charges the judge to evaluate the way the research was carried out but not to evaluate the accuracy of conclusions drawn.

The empirical method has its foundation in the process of trial-and-error and novel approaches. Ironically, the very

nature of accepting the null hypothesis involves disproving the cause and effect relationship held so sacred in law. In the absence of formal education on scientific process, how do judges attain the necessary understanding to unmask faulty design and skewed statistics? How does the federal judiciary and its state contemporaries achieve the necessary knowledge to make just and right decisions? Without a system in place to aid in understanding, judges are left to make a highly subjective determination. Understanding the process requires more than an occasional participant, the student must learn the science.

What Nature Provides

In any ecosystem, the presence of checks and balances maintains order and prevents a shift of extremes. Immediately following the landmark decision in *Daubert* (1993), the scientific community voiced concern over judicial decisions based on scientific principles taken out of context. Included in their predictions were tectonic shifts toward increased pretrial challenges with burdensome financial impact to litigants, exclusion of scientifically valid expert testimony, misapplication of the intended purpose, and faulty reliance on only published, human studies (Raloff, 2005). Several initiatives to assist the courts were born out of the *Daubert* holding, but the effort to educate the judiciary is still evolving.

Table 4: Online Resources/References

The National Center for State Courts (NCSC): An exceptional resource. It promotes its function as "helping courts anticipate change and better serve the public." It provides leading and reliable information in the form of research, standards, technology and more. *http://www.ncsconline.org*
Daubert on the Web: This site is maintained by Peter Nordberg and is independent of the firm where his practice focuses on federal civil litigation. A graduate of Harvard College and the University of Pennsylvania Law School, he has provided a one-of-a-kind resource for information related to the ever-evolving evidentiary issues in Daubert. To be well versed on the issues, you owe to yourself to visit this site. *http://www.daubertontheweb.com*
Daubert Tracker: Updated daily, this is an invaluable source of information related to evidentiary gate-keeping standards. It boasts the country's largest repository of 'Daubert' documents. The service provides for an annual subscription fee or in the alternative, a flat fee for 2 hour and _ hour sessions. For free, you can view the first 10% of any Daubert related brief to determine if it is of interest to your research. *http://www.dauberttracker.com*
The Federal Judiciary Center: The education and research agency for the federal courts was created by Congress in 1967. Its purpose is to promote improvements in judicial administration. It contains publications, videos, educational materials and more. *http://www.fjc.gov/*

The Project on Scientific Knowledge and Public Policy (SKAPP): The mission of SKAPP is to study and examine how scientific knowledge is used and often misunderstood in government decision-making and legal proceedings. It provides a collection of case studies, conversations with scientists and scholarly papers. It openly provides its funding disclosure on its website. *http://www.defendingscience.org*
The Rand Institute for Civil Justice: An independent research program within the RAND Corporation. Not far from the parent goals of the RAND Corporation, its mission is to collect objective, empirical based, and analytical research to provide to the government and public/private sectors with the trends and outcomes of law in an effort achieve solutions to the problems inherent to public policy. Its online research studies provide a wealth of information. *http://www.rand.org/icj/*
American Association for the Advancement of Science (AAAS)/ Demonstration Project: Originally designed as a demonstration project to assist federal district court judges in locating qualified scientific and technical experts to serve as independent experts, the Court Appointed Scientific Expert (CASE) program now assists federal and states judges, administrative law judges and arbitrators in locating experts. Its is an interesting resource and study of how F.R.E. 706 has been used. *http://www.aaas.org/spp/case/case.htm*
Stanford School of Medicine's Center for Psychiatry and the Law: Although limited in its scope, this site contains case law (under resources) that explores how Daubert applies to the less traditionally quantifiable sciences. Due to ethical concerns in conducting traditional experimental research in a potentially vulnerable population, it is with a flexible criteria that acceptance of expert testimony must be qualified. *http://www.psychlaw.stanford.edu*
Cornell Law School/Legal Information Institute: Widely recognized as one of the most comprehensive and reliable sites for legal information on the web. Search for constitutions, codes, opinions and jurisdictional specifics. *http://www.law.cornell.edu*
State Court's Home Page: Many decisions and opinions at multiple levels of jurisdiction can be found on individual state's web page and can be downloaded for free. To access the a state's web page: *http://www.courts.state.(2digitpostalcode).us*

One of the earliest initiatives was the committee-based, 5-year demonstration project known as the CASE (Court Appointed Scientific Experts) program started in November of 1995 by the American Association for the Advancement of Science (AAAS). Its objective was education and assistance to the federal judiciary on scientific principles and provision of qualified experts. Although now extending to states levels, administrative law, and arbitrators, the project has met with mixed success. Critics charge that it hobbles the true intent of client advocacy and there is no assurance of impartiality based on potential for judicial bias while proponents argue the retention of scientifically qualified objective expert opinion through a unprejudiced third party will circumvent the use of "hired guns" (Frankel, 2001; Johnson, Krafka, and Cecil, 2000; Raloff 2005). Table 4 provides a listing of other online resources for organizations and initiatives monitoring the climate of the judiciary's progress toward scientific literacy. Table 6 provides a listing of various case law addressing expert testimony and scientific literature.

Table 5: A Selection of Case Law on Scientific Literature and Expert Opinion
***Frye v. United States,* 293 F. 1013 (D.C. Cir. 1923)** Set forth the "general acceptance" standard for the admissibility of scientific evidence.
***Daubert v. Merrill Dow Pharmaceuticals, Inc.,* 509 U.S. 579 (1993)** (a.k.a., Daubert III)* There are, in fact, a total of four *Daubert* decisions; 1) After moving the case to Federal Court on diversity grounds, the District Court granted the respondent's motion for summary judgment; 2) The United States Court of Appeals for the Ninth Circuit affirmed; 3) The United States Supreme Court rendered the landmark decision which vacated the judgment of the Court of Appeals and; 4) The remanded case returned to the Ninth Circuit for further proceedings. *To the purist, these are Daubert I-IV. The Supreme Court decisions in Daubert, Joiner and Kuhmo are collectively referred to as the "Daubert Trilogy".
General Electric Co. v. Joiner, 78 F. 3d 524 (1997) The issue on appeal was whether the proffered testimony of the expert (relating the plaintiff's small cell lung carcinoma as causally connected to his exposure of toxic PCB by-products and cigarette smoking) was scientifically sound. The District Court's exclusion of the plaintiff's expert testimony, led the Supreme Court to address the abuse of discretion standard in determining whether to admit or exclude scientific evidence.
Kuhmo Tire Co. v. Carmichael, 526. U.S. 137 (1999) Addressed the issue of whether or non-scientific expert testimony was subject to the same evaluation as scientific testimony. The Supreme Court ruled that it was, however, was careful to emphasize the findings in *Daubert* were meant to provide latitude and flexibility in their application.
Crowhorn v. Boyle, 793 A.2d 422 (2002) Example of the Superior Court of Delaware decision exercising the "gatekeeper" role when ruling on the admissibility of scientific evidence.
Austin v. American Association of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001) Speaks to "peer-review" of expert testimony by professional medical societies/organizations and their right to self-police. Two specific issues brought by the plaintiff-appellant: 1) Austin contended he had been suspended in "revenge" for testifying against the defendant doctor and, 2) he had sustained a significant economic loss to his income from being blacklisted by the professional association.
Holy Cross Hospital, Inc. v. Marrone, 816 So.2d. 1113 (Fla. 4th DCA 2001) Florida maintains *Frye* as the standard for admissibility of expert testimony but also entertains a "Pure Opinion Doctrine" (which is not subject to the *Frye* test in the allowance of expert medical testimony.) This case was brought on appeal to the District Court of Appeal of Florida, Fourth District to clarify the challenge of admissibility of the expert's testimony (as related to the expert's testimony on cancer staging.)
Mason v. Rizzi, 843 A.2d. 695 (2004) Superior Court of Delaware case that found for the plaintiff and disallowed the biomechanical engineer's testimony related to causation. The defendant appealed to the Supreme Court of Delaware to address the admissibility of biomechanical engineer testimony and causation.

Evaluate, Estimate, Eradicate, Elucidate

The legal nurse consultant (LNC) commands a role in evaluating the expert's curriculum vitae for articles and publications relevant to the issue before the court. Retrieving and critically analyzing the potential strengths and weaknesses of the opposing expert's scientific position falls squarely within the purview of the LNC. The LNC

objectively reviews the research design and methodology. Not all literature is of the same complexity, and the LNC is duty-bound to identify for the attorney where advanced expertise is needed in methodological or statistical analysis. The LNC then anticipates and estimates the adversary's strategy and literature, finding supporting and opposing scientific views through thorough investigative research.

The LNC studies to discover the fault lines in the opposing expert's position and eradicates falsely elevated claims of credibility backed only by unfounded science. In the final step of elucidation, the LNC uses his or her nursing background and knowledge of health care to effectively explain to the client the scientific method and research design. Alerting the attorney-client to the advantages or disadvantages of the expert's position on either side provides an immeasurable and a distinctive gain. The long-held maxim, "If you can't attack the science, attack the scientist" will yield to the right empirical knowledge and assistance and direct the focus to the material issue.

Summary

LNCs are called to assist the legal community in illuminating a greater understanding of the research process and its inherent structure. Even when the LNC is not in the position of directly educating the fact-finder as an expert witness, helping the attorney understand the skeletal framework of research design and results will sharpen the attorney's eye for critique and enhance the attorney's knowledge of scientific principles.

The LNC's background in scientific principles and methodology provides the skills to initially weigh the research investigator's approach and conclusions, which are inseparably linked in critical analysis. The LNC's ability to translate complex medical terminology and procedures into communication-friendly explanations for the attorney-client will benefit both the judge and jury. In the quest for a just ruling, the attorney, the judiciary, and the permutation of scientific theory all need an objective liaison.

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Glossary of Terms
Academia: Associated with the cultural community of higher education and peer-reviewed research.
Abstract: A brief statement summarizing the important points of a research study or article. A starting point for medial legal research.
Authoritative Text: A text to which a professional discipline would turn to for reliable answers. Defying exact description at times due to an expert witness' reluctance to be "locked into" a definitive source for opinion, an example of an authoritative text is the core text/curricula used in medical or nursing schools. The expert, however, must still lay the groundwork in testimony for its acceptance by the court by acknowledging its value to the profession.
Bibliography: A list of books, periodical articles, web sites, or other material used when researching a particular topic found at the conclusion of the research article. Online sources are sometimes referred to as "webliographies".
Citation: The unique information needed to a specific book, article or information source. Usually contains the name of the title, author, publishing source, date of publication, issue or volume number, pages or other identifying information.

Commercial Marketplace Test: Predating the Supreme Court's Frye ruling, the court's measure used to determine if proposed expert witness demonstrated the qualifications to testify on the matter at issue in trial.

Doctoral Dissertations (sometimes known as "thesis"): In academia, a document that present's the author's research/findings and is submitted/defended to substantiate candidature for professional qualification and credentials.

Hearsay: Facts or testimony known only by a witness from a "second hand" source. The witness does not have direct knowledge of the issue, only what they have been told by the intermediate source. Since the source of information is not present to evaluate their credibility, the information is generally inadmissible. Exception to hearsay is addressed in F.R.E. 803-807.

"Hired Gun": Slang term used to describe an expert witness would is thought to base his opinion solely on the side most favorable to the hiring attorney and not scientific principles or facts. An opinion that can be "bought".

Journal (Trade or Professional): A collection of articles and other material, such as reports or proceedings, issued by an organization, an institute, or society.

Judicial Notice: The court's acceptance, for purposes of convenience and without requiring a party's proof, of a well-known and indisputable fact. (See F.R.E. 201).

Junk Science: Loosely defined to describe any study or report that reaches sweeping conclusions despite the weaknesses/limitations in the method for collection and analytical data. Often used in conjunction with special interest litigation to cast doubt on research studies attempting to show a cause-and-effect relationship.

Learned Treatise: Reference or text generally accepted by a profession as a reliable source for information specific to a discipline or practice. An expert witness in trial would need to recognize the source as authoritative or similar in some aspect for the court to admit it as limited evidence although it would generally not be admitted as an exhibit for the jury to review. The reasoning here is sound. You would not want the jury thumbing through a textbook picking out conflicting material without a greater understanding of the whole.

Methodology: The intrinsic components of a scientific method's design. Includes the instruments, strategies and hypotheses that give process to the study.

Motion *in Limine*: (Latin: "at the threshold"). As it relates to the admission of expert testimony, a pre-trial motion that seeks to limit or bar an expert's testimony. The basis for the motion may be the Federal Rules of Evidence (for instance, F.R.E. 403, Exclusion of relevant evidence on grounds of prejudice, confusion or waste of time) or Federal Rules of Civil Procedure (for instance, failure to produce expert reports in compliance with the discovery rules).

Peer-reviewed Research (also know as "refereeing" in academia): A process of subjecting an author's scholarly work or ideas to the scrutiny of others who are experts in the field. It is used for screening submitted manuscripts or for review in awarding funding/grant recipients.

Periodical: Any magazine, journal or newspaper that is published on a continuing basis or at regular intervals.

Periodical Index (or Indices): A list of citations for articles published on various topics, which is arranged alphabetically and grouped by subject or author.

Scientific Method: The process of the formal and systematic study of natural or experimental phenomena.

Scholarly Journal: Usually published four to six times per year. The target audience is researchers and experts. Articles are subject to peer-review. Generally includes citations and or footnotes and a list of references.

Symposium: Associated with an academic conference. Often the forum for presentation for scholarly papers, current research, state-of-the-art knowledge or development in a particular professional field. The information is often presented symposium paper.

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The Legal Nurse Consultant as a Board of Nursing Expert Witness

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KEY WORDS
Board of Nursing, Expert Witness

*Each state's Board of Nursing is an administrative agency whose mission is to protect consumers through the licensing of registered nurses and through the enforcement of the Nursing Practice Act. Each state's Board of Nursing is responsible for investigations and discipline of registered nurse licensees for violation of the Nursing Practice Act. The primary purpose of the enforcement program is to protect the public from incompetent, negligent, unsafe, dishonest, or impaired RNs. For the purposes of this article, the focus is the California Board of Registered Nursing. Further information regarding other states' Board of Nursing official titles, scopes of regulation, and enforcement policies can be found at the National Council of State Boards of Nursing Web site (**www.ncsbn.org/index/htm**).*

The legal nurse consultant (LNC) is well equipped to assist Boards of Registered Nursing (BRN) in the enforcement of the Nursing Practice Act (NPA). According to the American Association of Legal Nurse Consultants (AALNC), the LNC is a licensed registered nurse (RN) who performs a critical analysis of clinical and administrative nursing practice, health care facts and issues, and their outcomes for the legal profession, health care professions, consumers of health care and legal services, and others as appropriate with a strong educational and experiential foundation, the LNC is qualified to assess adherence to standards and guidelines of health care practice as it applies to the nursing and health care professions (AALNC 2005).

The Process

The BRN can receive complaints about a RN from many sources including a patient or family member, an employer, a nursing colleague, or another member of the health care team. The role of the LNC as a reviewer for the BRN is extremely important. The LNC will first identify whether the nurse in question deviated from the standard of practice of nursing or if he/she committed unprofessional conduct. Secondly, the LNC will serve as an expert witness on behalf of the BRN at any hearing that may result from the LNC's assessment and subsequent expert opinions.

In California, within 10 days after receipt of receiving a complaint, the BRN sends a written notification of receipt to the complainant. Complaints containing allegations of the greatest consequences such as gross negligence/incompetence or patient abuse are given priority attention. The complaint is then investigated by the Department of Consumer Affairs Division of Investigation (DCADI). The DCADI often does a preliminary investigation and then sends the case on to a consulting RN for further review. If no violation can be substantiated, the case is closed and the complainant is notified. Investigations that do provide evidence that the accused nurse has violated the NPA and that the violation warrants formal disciplinary action are resolved by informal or formal proceedings. Cases involving unlicensed or criminal activity are referred to the local district attorney for prosecution (CA BRN, Title 16, Chapter 14).

As an expert witness, the LNC will be provided with the relevant nursing and medical records, as well as other pertinent information such as interviews conducted during the investigation. The expert witness will then be asked to render a professional opinion of the care provided by the accused RN to the patient or patients involved. If disciplinary action or criminal action is taken, the LNC expert witness may be called to testify at the Administrative Law Hearing.

It is extremely important that the LNC expert witness identifies any conflict of interest prior to accepting a case review assignment from the BRN to assure that there is no prior knowledge of the accused RN or a current employment relationship with the accused RN's employer. If the LNC expert witness accepts the case but then upon the review discovers that he/she cannot be completely objective in the rendering of opinions, the BRN representative who sent the materials should be contacted immediately so the case can be reassigned.

As a BRN expert witness, the LNC will not be asked to determine what discipline should be imposed upon the accused RN. The written opinion must be based solely on the information provided by the DCADI; however, the LNC should also refer to nursing texts and other authoritative reference materials that help to define accepted standards of practice. As with any expert witness, the final opinions should be based upon the accused RN's adherence to or deviation from the standards of care and what another reasonably prudent nurse with the same education, training, and experience would have done in the same situation.

Types of violations that RNs are accused of include standard of care issues, substantial relationship criteria issues, sexual misconduct, drug and alcohol violations, and criminal behavior such as dependent adult or elder abuse. Regardless of the violation at hand, the BRN expert witness will be asked to render an opinion as to the degree of professional misconduct

that occurred. The degree of professional misconduct will fall into one of three categories:

1. Gross Negligence: An ***extreme*** departure from the standard of practice.
2. Negligence: A departure from the standard of practice.
3. Incompetence: A lack of knowledge or ability in discharging professional nursing obligations.

When reviewing a case that involves standard of care issues, it is imperative to consider what are known in California as the Standards of Competent Performance. These Standards of Competent Performance state that a RN shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological, and physical sciences to applying the nursing process as follows:

1. Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team;
2. Formulates a care plan, in collaboration with the client, to ensure comfort, hygiene, and protection, and for disease prevention and restorative measures;
3. Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family, and teaches the client and family how to care for the client's health needs;
4. Delegates tasks to subordinates based on the legal scopes of practice of the subordinates, and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates;
5. Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed; and
6. Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided (CA Code of Regulations, Title 16, Chapter 14).

Often the LNC as a potential BRN expert witness does not want to be the one to find fault or negligence in a fellow colleague. The American Nurses Association Code for Nurses includes eleven requirements for nursing professionals to uphold. The third requirement states, "The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person" (ANA, 2005). As a RN with a bound duty to act as a patent advocate and especially if holding oneself out as a LNC, it is therefore the LNC's professional duty to provide case reviews for our state's Board of Nursing. On the same note, as a Board of Nursing expert witness, the LNC may be the one to discover that the subject nurse did indeed conduct him/herself appropriately and that the accusations being investigated are false.

Case Examples

The following two cases are examples of BRN reviews. Not only do Boards of Nursing protect the public, but the Boards of Nursing can also rule in favor of nurses.

Case #1: The BRN received an allegation that RN-Maria was suspected of fiduciary abuse of an elderly patient, Ms. Kate. The allegation stated that RN-Maria withheld funds from a check she cashed for her patient. The initial relationship between this RN and the patient is one whereby this RN was providing home health nursing services to the patient as a paid employee of Acme Home Health Services under a physician's order. The LNC expert witness reviewed the complete home health records in regard to Ms. Kate and the statements made to the BRN Investigator by RN-Maria, Ms. Kate, and Ms. Kate's daughter.

On January 31, 2002, the patient began to receive skilled nursing services through Acme under a physician's order. The plan of treatment included RN visits two times per week to perform nursing assessments, blood glucose monitoring, and medication management. RN-Maria made eleven of the twelve skilled nursing visits as ordered by the physician between the dates of January 31, 2002 and March 21, 2002. Medicare was appropriately billed by Acme for each visit.

According to the numerous interviews that were documented, including those of the police department, the California Department of Health Services (CDHS) investigator, the Acme supervisors, and the BRN investigator, some of the facts were consistent from both the accused RN and the patient. For example, the amount of money in question was consistent. However, there were differences of opinions on the actual events, how they occurred, and what consisted of the verbal contract or lack thereof.

Ms. Kate stated that RN-Maria was her home health nurse for the confirmed period of time and that, in February 2002, she became bedbound due to illness. Ms. Kate needed cash in order to pay for some home repairs, so she asked RN-Maria to cash a check for her. Ms. Kate wrote a personal check to RN-Maria for $5,000. When RN-Maria returned from cashing the check, she told Ms. Kate she needed to borrow $1,500, which she would repay. She then gave Ms. Kate $3,500. Ms. Kate stated she was scared to death and didn't want to fight with RN-Maria. Ms. Kate denied ever having requested RN-Maria to provide private duty care to her outside of the hours that Acme was contracted. Ms. Kate's daughter denied having been contacted by RN-Maria for approval to provide private duty nursing to her mother for additional payment. There was no formal contract entered into by RN-Maria and Ms. Kate for either private duty services to be rendered or for a personal loan. Ms. Kate had

no recollection of RN-Maria ever actually making any visits to her home outside of the expected skilled nursing visits arranged by Acme.

RN-Maria agreed that she made visits to Ms. Kate as an employee of Acme for the confirmed period of time. Aside from her visits to the patient as an Acme employee, she also visited Ms. Kate as an "independent caregiver" but kept no record or documentation of the time spent in this private capacity. RN-Maria reported that Ms. Kate asked her to provide the private duty services and that she checked around first to be sure that it was all right to provide private duty services to an Acme patient and that "some people" told her she was allowed to do this outside of normal Acme business hours. RN-Maria also reported asking Ms. Kate's daughter if this private duty arrangement would be all right and that the daughter did not care how her mother spent her money. RN-Maria stated that she cashed Ms. Kate's $5,000 check and that she not only gave her the money but had the patient sign a receipt to document the event (there was no such receipt submitted as evidence during any of the investigations). After Ms. Kate received the $5,000, RN-Maria stated that the patient turned around and offered to give her back $1,500 as payment for caregiver services that were to begin on March 1, 2002. RN-Maria stated that she made a few 15-minute visits in early March, during which she encouraged Ms. Kate to eat and checked her blood sugar. RN-Maria reportedly called Ms. Kate a couple of times per day to check on her. At some time later, Ms. Kate called and asked for her money back and then reported RN-Maria to her physician as having stolen the money.

It appears that, at some point after the police, employer, and CDHS investigations began, RN-Maria delivered $1,000 to Ms. Kate in the form of a money order and reportedly chose to keep $500 as payment for private caregiver services that she felt she had rendered. Later, prior to a criminal prosecution hearing, RN-Maria mailed a cashier's check in the amount of $500 to Ms. Kate.

The evidence presented during several investigations led the LNC expert witness to the opinion that RN-Maria coerced Ms. Kate into either giving her or loaning her $1,500, with no formal agreement to render private duty services or to repay the money. RN-Maria deviated from what the ordinarily responsible and prudent RN would have done when she:

- handled a patient's funds while working as an employee for a home health agency. This was not within her scope of practice as an Acme employee.
- entered into an informal agreement to provide private duty services outside of her employment with Acme, and if she did so, without any type of written agreement with the patient as to what services would be rendered and at what rate of pay would be compensated. Ms. Kate denied that this informal agreement ever occurred.
- borrowed money from a patient, regardless of intent to pay it back or not.

The CDHS had done its own investigation, substantiated the allegation, and turned over the case to the District Attorney's (DA) office for criminal charges. The criminal prosecution was of one count of Penal Code Section 368(e), which stated that:

Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or a dependent adult, to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor.

This count was dismissed in the interest of justice and because RN-Maria repaid the $1,500.00 she received from the patient.

It was the reviewer's final opinion that RN-Maria violated the Substantial Relationship Criteria as defined by the California Code of Regulations Section 1444, including subsection (c): theft, dishonesty, fraud, and deceit, as follows:

A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare.

Case #2: The BRN received a complaint alleging that, on August 1, 2003, RN-Alison "assaulted" a terminally ill patient, Mr. Jones, under her care. The complaint was made by Mr. Jones' adult son, following Mr. Jones' death. The assault allegedly occurred when RN-Alison placed a pain medication patch on the patient after he objected to the use of the patch. Additionally, it was alleged that the pain patch was used to keep the patient excessively sedated.

The LNC expert witness reviewed Mr. Jones' complete home health hospice records, as well as formal statements made during the BRN investigation by several of Mr. Jones' family members, RN-Allison, and some of her hospice colleagues who had also been to Mr. Jones' home during his hospice program admission.

Mr. Jones was admitted into the Hospice Program on July 11, 2003, on the following medications: MS Contin, Roxanol, and medicinal marijuana. Several different nurses made home health hospice nursing visits several times per week. On July 18, 2003, the physician prescribed an increase in the MS Contin and the Roxanol, and added Lorazepam. On July 22, 2003, the hospice nurse noted that Mr. Jones was inconsistent with his mediset and use of pain medications, and she obtained an order for a Fentanyl patch. On July 28, 2003 RN-Sue made a visit and noted that the Mr. Jones had not yet began the use of his Fentanyl patch due to being fearful. However, RN-Sue could not pinpoint the source

of the patient's fear, documenting that the patient would continue to use MS Contin until he was ready to use the Fentanyl patch.

On August 1, 2003, RN-Alison made her only visit to Mr. Jones. This weekend visit was requested by the patient and made by RN-Alison who was on-call. RN-Alison documented that Mr. Jones was experiencing pain that was an 8 to 9 out of 10, yet he was able to ambulate. RN-Alison observed that Mr. Jones seemed "spacey" and had difficulty following the conversation or answering questions. RN-Alison applied a 25 microgram Fentanyl patch per the physician's order, and the patient took two MS Contin during her visit as well. RN-Alison had concerns with Mr. Jones' safety and reported her concerns to her supervisor.

On the August 2, 2003, visit, RN-Joy documented that Mr. Jones' pain was in his stomach and liver area, and the Fentanyl patch relieved severe pain. The Fentanyl patch was continued along with oral Roxanol for breakthrough pain. Mr. Jones continued to deteriorate from his terminal illness and had to be subsequently treated for a urinary tract infection. The hospice team documented their daily attempts to get the family more involved or to hire caregivers due to increasing safety issues. The hospice team documented many dysfunctional family dynamics and eventually made an Adult Protective Services referral. The ongoing problems continued throughout August 2003 and included many documented events of noncompliance with the hospice care plan by Mr. Jones and his family. The patient was noted to continue the use of the Fentanyl patch and several breakthrough narcotics without any adverse effects. On August 27, 2003, the hospice agency discharged Mr. Jones from service due to noncompliance with the hospice care plan.

The LNC expert witness concluded that RN-Alison had only the one direct patient contact with Mr. Jones on August 1, 2003. There was no indication that the patient refused the patch or verbalized any wish on that date to not use this pain medication. There was no evidence of excessive sedation resulting from the administration of the medication. RN-Alison's behavior and conduct met the standard of care expected of a competent RN. As a result of the LNC expert witness' opinion that RN-Alison had met the standard of care, the investigation file was closed; no formal charges were ever filed against this nurse.

Conclusion

The Boards of Nursing appreciate a LNC's availability to review cases and to act as expert witnesses, recognizing that LNCs play a vital role in their investigations of alleged professional misconduct and that the objective performance LNCs provide will reflect well on the nursing community. For more information on becoming as an expert witness in this capacity, contact your state's Board of Nursing and request an application.

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Neonatal Resuscitation: The 2006 Standards for Evidenced-Based Clinical Practice

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KEY WORDS
Neonatal Resuscitation, Standards of Practice

The guidelines for neonatal resuscitation were revised by the American Heart Association (AHA) and the American Academy of Pediatrics in 2006. Historically, the guidelines have been revised approximately every 6 years since their inception in 1987. The revisions are formulated in response to clinical research and evidenced based practice. This article will summarize the program changes, discuss the science behind the revisions, and, most importantly, delineate the implications for all medical facilities that provide neonatal resuscitation. The current algorithm for neonatal resuscitation will be reviewed. Lastly, implications for legal nurse consultants involved in the review or litigation of cases involving delivery room management will be highlighted.

The first few minutes of a neonate's life are critical as the transition from intrauterine to extrauterine life ensues. Fortunately, the vast majority of neonates complete this transition without incident, experiencing a benign hospital course and a successful discharge to home. Approximately 10% of neonates, however, require some form of resuscitation in the delivery room setting. Even smaller percentages, approximately 1%, require resuscitation beyond bag and mask ventilation (American Heart Association [AHA]/ American Academy of Pediatrics [AAP], 2006). This subset is compromised of neonates with varied medical problems such as prematurity, the presence of a major birth defect, meconium aspiration, infection, or intrauterine compromise.

The Neonatal Resuscitation Program (NRP), a joint venture between the AHA and the AAP, has provided the neonatal community with guidelines governing neonatal resuscitation for more than 20 years. The principles of initial stabilization, establishment of effective ventilation, and circulation with appropriate pharmacologic and volume support form the cornerstone of the NRP. The guidelines are periodically updated, with the most recent changes published in 2006. These modifications in management will impact all facilities providing neonatal resuscitation.

Science and Evidenced-Based Guidelines Process

A multi-year process ultimately culminates in the revisions to the NRP guidelines. The road to the 2006 revisions spanned 8 years and began in 1998, when the NRP Steering Committee of the AAP and the Pediatric Subcommittee started reviewing the scientific data that encompassed hundreds of articles regarding resuscitation. Specifically, the committee examined the quality of evidence that existed for all aspects of resuscitation. After review of these articles, the Evidence Evaluation Conference met in late 1999 to debate the first set of proposed guidelines and the level of evidence supporting changes in practice. In February 2000, content experts met again to further finalize the recommendations and prepare final statements for the Emergency Cardiovascular Care Committee. This resulted in the publication of the *Guidelines 2000, Emergency Cardiovascular Care and Resuscitation: International Consensus on Science.*

In December 2003, an international meeting of 35 neonatologists convened to critically analyze the new scientific data and move forward with final recommendations. After 6 years of exceedingly thorough research and analysis, the AHA Guidelines were published in *Circulation* in December 2006. The pediatric/neonatal portions of the guidelines were also reprinted in *Pediatrics* in May 2006. The *Textbook of Neonatal Resuscitation, 5th Edition* is available through the AAP.

Current NRP Algorithm

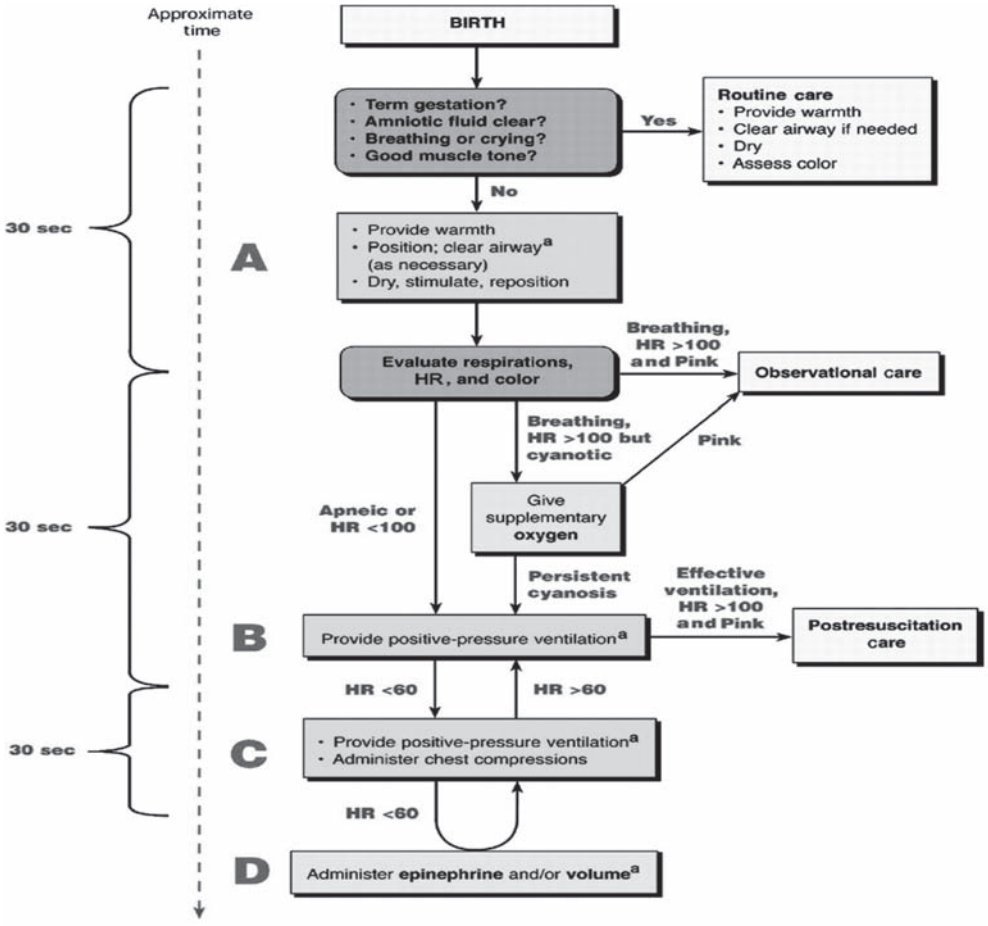
The schematic diagram in Figure 1 outlines the sequence of interventions for the clinician engaged in a neonatal resuscitation. Note that each step in the process is carefully outlined and scripted so that the clinician has appropriate clarity with the algorithm.

Summary of NRP Guideline Changes

Per the AHA/AAP (2006), the major modifications concern six different areas of resuscitation:

1. Oxygen Use during Neonatal Resuscitation: For neonates born at term, 100% oxygen should be used in the presence of cyanosis or when positive pressure ventilation (PPV) is required. Research suggests that resuscitation with less than 100% oxygen may be just as successful. If resuscitation is begun with less than 100%, oxygen concentration can be increased up to 100% if no appreciable improvement occurs within 90 seconds following birth. If supplemental oxygen is not available, room air can be utilized to deliver positive pressure ventilation.

For a premature neonate at less than 32 weeks gestation, an effort should be made to reduce excessive tissue oxygenation by using an oxygen blender and pulse oximeter during



American Heart Association, American Academy of Pediatrics, Pediatrics 2006;*117:e1029-e1038.*

Figure 1: Neonatal Flow Algorithm

resuscitation. PPV can be begun with an oxygen concentration between 21% and 100%. Adjustments in oxygenation should be undertaken to achieve saturation between 90% and 95%. A decrease in the oxygen concentration is warranted if oxygen saturations rise over 95%. If the heart rate does not rapidly increase to greater than 100 beats per minute, a ventilation problem may exist and should be corrected by the utilization of 100% oxygen.

2. Meconium Management: For the neonate that presents with meconium-stained amniotic fluid, the NRP no longer recommends that every meconium-stained neonate routinely receive intrapartum suctioning before delivery of the shoulders. Recommendations about post-delivery neonatal suctioning remain unchanged from previous guidelines.

3. Methods of Ventilation and Assessment: The latest recommendations for bag-and-mask ventilation include a call for the assistance of another caregiver when beginning PPV. After the ventilation is started at the appropriate rate and pressure, the assistant is asked to report heart rate and breath sounds as indicators for effective ventilation. Per the AHA/AAP (2006) guidelines, heart rate is assessed first, and if it is not improving, assessment of chest movement and breath sounds is indicated. Increasing heart rate is the primary sign of effective ventilation during resuscitation. Other signs are improving color, spontaneous breathing, and increasing muscle tone. After 30 seconds, these clinical indicators should be checked by the individual that is actually performing the bag and mask ventilation. For neonates who fail bag-and-mask ventilation or endotracheal intubations, the NRP indicates that the laryngeal airway has been shown to be an effective alternative for assisting ventilation of some newborns. In terms of confirming endotracheal tube (ET) placement following intubation, an increasing heart rate and carbon dioxide (CO_2) detection are the primary methods of verification.

The NRP offers guidelines regarding the use of devices for assisting ventilation. T-piece resuscitators or flow-controlled pressure limited mechanical devices are recognized as acceptable methods of administering PPV during resuscitation for the newly born and especially for the premature neonate. Even when assistive devices are available, self-inflating and flow-inflating bags utilized with correct clinical technique remain the cornerstone of achieving effective ventilation in most resuscitative efforts.

4. Administration of Epinephrine and Naloxone: For pharmacologic resuscitation, the recommended route for Epinephrine is the umbilical vein. The ET route dose, which is 10 times the intravenous (IV) dose, can be considered while intravenous access is being obtained. The high dose of Epinephrine should never be given intravenously. The recommended doses for Epinephrine are as follows:

- IV: 0.1 to 0.3 ml/kg of 1:10,000 solution drawn into a 1-ml syringe
- ET: 0.3 to 1.0 ml/kg of 1:10,000 solution drawn into a 3-ml or 5-ml syringe

Naloxone, a narcotic antagonist, is not recommended by the AHA/AAP (2006) during the primary stages of resuscitation. Both of the following conditions must be present per the NRP to consider the administration of Naloxone: 1) continued

respiratory depression after PPV has restored a normal heart rate and color; and 2) a history of maternal narcotic administration within the past 4 hours. The preferred route for Naloxone is intravenous. The intramuscular route is acceptable, but the onset of action will be delayed.

5. Thermoregulations Issues: In terms of temperature control, placing the trunk and lower extremities of a very low birth-weight neonate in a polyethylene bag may help maintain core body temperature in the delivery room by decreasing evaporative loss of heat. For the neonate who has experienced hypoxia and ischemia either in the intrauterine or extrauterine environment, hypothermia may reduce the extent of brain injury. Further clinical trials are needed, however, to quantify the benefit of sustained hypothermia as insufficient data currently exists. Given the current status, the 2006 NRP program recommends the achievement of normothermia, as hyperthermia may worsen the extent of brain injury following hypoxia and ischemia.

6. Resuscitation Decisions: The withholding or withdrawing of support is a team-oriented decision between the obstetricians, neonatologists, and parents when that difficult situation presents itself as a component of a neonatal resuscitation. The NRP discusses the withdrawal of support when functional survival is highly unlikely, e.g. after 10 minutes of continuous and adequate resuscitative efforts with no heart beat or respiratory effort. In addition, if the neonate has a condition with an uncertain prognosis and high morbidity, borderline survival, and extreme burden on the child, parental desires concerning the initiation of resuscitation should be supported. Resuscitation is indicated in conditions associated with a high rate of survival with acceptable morbidity: 1) Gestational age > 25 weeks (unless evidence of hypoxia or intrauterine infection exists); and 2) neonates with most congenital anomalies.

Implications for Hospitals

With the implementation of the 2006 guidelines, health care facilities must be cognizant of the need for certain types of equipment in addition to specific personnel training issues. For example, if a facility does not have an oxygen blender or pulse oximeter in the delivery room, the personnel in the facility should follow the previously reviewed protocol outlined for the preterm infant. Carbon dioxide detectors, while recommended, are not without shortcomings. Signs and symptoms of adequate air entry must be ascertained clinically by assessing chest wall movement and auscultation of breath sounds as an adjunct to the CO2 detector. As cited previously, increasing heart rate is the primary determinate of effective resuscitation.

The Neonatal Resuscitation Program (AHA/AAP, 2006) suggests that a refresher course be completed every 2 years. This consists of reviewing the material, completing a written evaluation, and participating in a skills scenario evaluation. With the recent update of the NRP, the format for the evaluation of the skills, the mega code, was revised to provide fair, consistent, and meaningful assessments. A standardized script is read to the student prior to the evaluation, which clearly states the expectations. The evaluation is then timed, and coaching during the skills evaluation is not allowed. The skills performance of the participant is objectively scored with a minimum passing score that is weighted on the following items:

1. Checks resuscitation bag, mask, and oxygen supply;
2. Indicates need for positive pressure ventilation;
3. Provides positive pressure ventilation correctly;
4. Takes corrective action when heart rate is not rising and chest is not moving; and
5. Demonstrates correct compression technique (AHA/AAP, 2006).

These five skills must be demonstrated correctly to pass the skills portion of the program. The health care facility is responsible for the evaluation and ongoing assessment of the competence of the skills required for neonatal resuscitation. While the nurse may perform the necessary skills in a simulated classroom environment, the ability to perform in an actual clinical setting must be evaluated and determined by the health care facility. Since neonatal resuscitation involves cognitive, behavioral, and psychomotor skills and the opportunity to practice these skills in a real-time clinical situation may be limited, health care facilities are urged to provide mock codes and simulation labs to practice the needed skill set including appropriate documentation. This can be accomplished during the orientation period for a new hospital employee or upon periodic review via the senior clinical nurse, clinical nurse specialist, neonatal nurse practitioner, or education coordinator.

The health care facility is responsible for providing a mechanism for documentation of the events of the resuscitative effort during the transition from intrauterine to extra uterine life. The NRP Instructor Manual provides three samples of documentation forms that can be used as a template or utilized with a computer documentation system. In addition, per the Instructor Manual, a NRP Instructor cannot be held responsible for how a former student performs in a clinical setting. The health care facility is responsible for utilizing the most current NRP materials and providing timely communication about changes to those who participate in neonatal resuscitation. Effective January 2007, all NRP instructors are required to employ the 2006 guidelines (AHA/AAP, 2006).

Implications for the LNC

Inadequate or inappropriate resuscitation can lead to long-term sequelae in the neonate that may not manifest for weeks or years. If the LNC is asked to review a case involving neonatal resuscitation, the resuscitation process of the neonate cannot be examined independent of the maternal history. Maternal factors such as fetal distress, preterm labor, chorioamnionitis, thick meconium staining, abnormal fetal presentation, multiple gestation, or maternal substance abuse may weigh heavily as to the clinical risk that can be anticipated

prior to delivery. In any event, the guidelines for neonatal resuscitation apply to all deliveries, and it is essential that the LNC evaluate a case involving a questionable resuscitation with the NRP algorithm as a basis. Specifically, the LNC will want to seek answers to these questions:

1. Were appropriate personnel in place at the time of delivery?
2. Was the neonate supported from a thermoregulatory standpoint? Cold stress can lead to increased respiratory distress and metabolic acidosis.
3. Was ventilation established either by positive pressure or bag valve mask if the neonate was apneic or failed to show improvement in heart rate or color despite the delivery of supplemental oxygen?
4. If necessary, was endotracheal intubation completed in a timely manner? Was accurate tube placement quickly verified?
5. If necessary, were chest compressions initiated and discontinued when clinically appropriate?
6. In the case of pharmacologic intervention or volume expansion, were doses reflective of the neonate's weight and given via the appropriate routes?
7. Documentation in a neonatal resuscitation may be contemporaneous as a designated "recorder" may not be present for delivery room resuscitation. Careful review of the sequence of events and comparison to the NRP algorithm is necessary. Absent documentation over several minutes for a neonate presenting with severe birth depression in the delivery room can be significant. The LNC should review the complete delivery room note as well as the Neonatal Intensive Care Unit (NICU) admission note for additional data regarding the resuscitation.
8. Was the neonate closely monitored post-resuscitation, particularly in terms of glucose homeostasis? The presence of hypoglycemia has been demonstrated to lead to adverse neurological outcome.

LNCs are most commonly involved in the review of cases involving neonates who have suffered adverse outcomes several years after birth. This is often the situation as the full effects of a birth insult may not be known for some time, given the dynamics of pediatric growth and development. The LNC must be careful to apply the guidelines for resuscitation that existed at the time of the birth to determine if a violation in the Standard of Care (SOC) can be qualified.

On another note, the LNC must also be aware that a suboptimal neurological outcome in a neonate can be related to many factors not associated with the neonatal resuscitation sequence. In utero events prior to the onset of labor, underlying maternal disease processes, and the presence of complications during the NICU stay can be contributing factors to a poor outcome. These include clinical conditions such as intraventricular hemorrhage that may develop into hydrocephalus, necrotizing enterocolitis resulting in bowel loss, retinopathy of prematurity, meningitis or other severe infective process, chronic lung disease, and cor pulmonale.

Conclusion

The importance of appropriate neonatal resuscitation cannot be underestimated for the successful transition from intrauterine to extrauterine life. The algorithm provided by the NRP offers the medical community guidelines for care when a neonate does require resuscitation in the delivery room. For the LNC reviewing a case involving a neonate with a questionable resuscitation, reviewing the documentation of the care provided against the algorithm is paramount to determine if the case has merit.

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Medical Malpractice Tort Reform

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KEY WORDS
Malpractice, Tort Reform

Medical malpractice reform is a very complex subject, involving a number of controversial issues. Non-economic damage caps, federal and state involvement, physicians practicing "defensive medicine," and the continuing increase in health care costs and medical malpractice premiums surround this dilemma. With national medical costs rising 75% between 1991 and 2002 (Weiss, 2003), a national debate has ensued regarding the effectiveness of medical malpractice caps in curtailing rising health care costs and physician insurance premiums. There is a need for a set of solutions from all parties involved and affected by this reform.

Increasing medical malpractice insurance premiums have led some physicians – particularly those in the high-risk specialties of emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics/gynecology, and radiology – to change their specialty practice area. Other physicians have moved to a different state, leaving some geographic areas without necessary medical specialists, or have stopped practicing medicine altogether. Medical malpractice payout caps were deemed the answer to manage the "out-of-control" jury awards, believed to be a source of increasing insurance premiums.

Malpractice Caps: Intention vs. Outcome

Weiss Ratings, Inc., is a leading independent provider of assessments, safety ratings, and analyses on the performance of mutual funds, financial institutions, and insurance companies, and receives no compensation from the rated companies. In 2003, Weiss published a study on the effects of medical malpractice caps. This study noted that 19 states had imposed medical malpractice payout caps between 1975 and 1998. These caps were not standardized among the participating states and ranged from $250,000 to $1,000,000. The median payout for these states was $60,000 in 1991, and by 2002 increased substantially to $110,000 – an 83% increase. Most states did not have a corresponding increase in cap limits; however, five states adjusted their caps to coincide with inflation (Weiss, 2003).

Although the median payout of claims between 1991 and 2002 for the states that adopted caps was 15.7% lower than the remaining states without malpractice caps, the institution of malpractice caps has not prevented the rise in malpractice insurance premiums (Weiss, 2003). In fact, median annual premiums increased for states both with and without caps. The rate increase for physicians in states that had not instituted caps was approximately 36%, compared to the physicians in states with caps that paradoxically experienced rate increases of approximately 48%. Of particular note, the states without caps experienced a greater reduction in premiums as compared to the states with imposed caps (Weiss, 2003).

The impact on physicians has been documented in a study published in *The Journal of the American Medical Association* (JAMA) that reported that states with tort reforms had a 2.4% increase in the number of physicians, not in the total number of hours worked by physicians, compared to states with no caps. These results, however, must be interpreted with caution. If the overall total number of hours worked per physician decreased, this increase in physician number may not be reflective of the effects of reform (Kessler, Sage, and Becker, 2005).

Another study, released by JAMA at the same time, surveyed more than 800 Pennsylvania physicians in the high-liability specialties of emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics/gynecology, and radiology (Studdert, Mello, Sage, et al., 2005). The study reflected the increase in "defensive medicine" acts to protect physicians against malpractice lawsuits. Defensive actions may include ordering tests and procedures that could be deemed medically unnecessary – such as prescribing additional medication, admitting a patient, or referring a patient to another physician or hospital – that may significantly contribute to the rising costs of health care and subsequent higher premiums. The study also revealed that 93% of the physicians surveyed indicated that they practice defensive medicine, with 52% making unnecessary physician referrals as a safety precaution (Studdert, Mello, Sage, et al., 2005).

State and Federal Levels

State Level: State lawmakers continue to look at reform issues, including limits to non-economic damage awards, the allocation of plaintiff-attorney fees as a percentage of a damages award, expert witness standards, and the inadmissibility of apology statements by health care practitioners. Discussions are ongoing regarding insurance practices, possible state controlled limits on premiums, and reporting of payments.

Federal Level: Overwhelming opposition exists from both attorney firms and state lawmakers regarding involvement at the federal level. The National Conference on State Legislatures (NCSL) published the anticipated results of possible federal involvement:

> The proposed federal legislation, introduced in 2005 (and continuing in 2006), would dismantle state judicial authority and preempt all existing state laws governing medical malpractice lawsuits with the following:

- Limits on non-economic (pain and suffering) damages at $250,000;

- A 3-year statute of limitations to initiate lawsuits, or one year from discovery; statute of limitations for children until age 8;
- Limits on attorneys fees in settlement or judgment;
- Collateral source benefits may be introduced into evidence in court;
- Periodic payments ordered for future damages exceeding $50,000;
- Standard guidelines for awarding punitive damages and limitations on the amount awarded;
- Prohibitions on instructing a jury about any limitations to damage awards;
- Punitive damages may not be awarded against the manufacturer or distributor of a medical product approved by the Food and Drug Administration;
- A specific statement that the provisions would preempt all state laws not in conformance with the standards presented (NCSL, 2006, "Medical malpractice tort"; "2005-2006 Policies," Federal Activity section, para. 3).

The NCLS clearly opposes federal involvement with the following statement from their Web site:

> NCSL opposes federal efforts to preempt existing state laws or state constitutional provisions in the area of medical malpractice lawsuits, specifically federal legislation that would preempt state laws and/or constitutions in the following manner:
> - Preempt state laws governing the applicable statute of limitations in such cases;
> - Preempt state laws governing the awarding of damages by mandating a mandatory uniform amount of damages of any kind (compensatory, non-economic or punitive) at the federal level;
> - Preempting state laws governing the drafting of pleadings and introduction of evidence in such cases; and
> - Preempting state laws and/or constitutions governing the awarding of attorney's fees… (NCSL, 2006, "2005-2006 Policies," Medical section, para. 3).

Malpractice legislation will continue at the state level, with strong federal influences more apparent during an election year. States with legislation have a reduction in actual claims, but they have higher payments than states without legislation. Whether this is a positive measure of success is not clear. Counsel may be forced into careful scrutiny when accepting cases based on potential payment rather than merit alone. There may be cases that are meritorious, but the attorney may choose not to accept them if the potential awards would not offset the expenses. In general, this would not benefit the plaintiffs if they cannot find an attorney to take their case. Considering the current health care crisis, it is yet to be determined if the decrease in claims actually reflects improved care.

Tort Reform or Insurance Reform?

There are many conflicting reports and opinions regarding "tort" versus "insurance" reform. Caps were expected to have several cascading effects. Caps were intended to decrease the average amount paid out by the insurance company, so that insurers could gauge physician premium rates more accurately. Caps were expected to result in decreased premium payments for physicians. But have caps on non-economic damages met their expectations? According to the 2003 Weiss study, the states without caps have shown the greatest decrease in physician premiums. "In states with caps, the median annual premium increased by 48.2%, but surprisingly, in states without caps, the median annual premium increased at a slower clip-by 35.9%" (Weiss, 2003; p.3).

Conversely, the 2003 U.S. Department of Health and Human Services (DHHS) premium increase report from 2001-2002 stated, "The insurance crisis is acute in states that have not reformed their litigation systems. Over the last 2 years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%" (U.S. Department of Health and Human Services, 2003, para. 61). These differences in results between the Weiss study and the DHHS report necessitate a more in-depth examination before concluding the actual affects of caps.

Caps may also serve to deter attorneys from taking legitimate malpractice claims for disadvantaged patients who may have limited claims to lost wages or other uncapped damages. The $250,000 or $350,000 damage cap may not be realistic in a very complex case with many costs. Cases involving minors, retirees, or stay-at-home parents would be most affected due to the low loss-of-income component.

The property/casualty insurance industry, including medical malpractice insurance, is cyclical with hard and soft market periods. There is normally a pattern of an increase and decrease of premium rates. For many years, throughout the soft market of the 1990s, there had been an under-reserving as the insurance companies relied on investments (Weiss, 2003). Reserving is an amount of capital held back from investments in order to meet probable or possible demands. Under-reserving is an insurance practice that gives insurers a competitive edge in the marketplace because it frees up capital that would otherwise be set aside to pay claims. When interest rates are high, medical malpractice insurers do well because the time between a claim being filed and actually paid typically spans several years (Weiss, 2003).

The 2000s brought decreased interest rates, lower investment incomes, and the hard market, which weakened the financial structure of these companies. Despite the increased premium rates, there has been little improvement in the financial safety of the medical malpractice insurers.

This has resulted in the need to quickly increase premium rates with little incentive for a decrease, even with the non-economic damage caps in effect.

Physician-owned malpractice insurers began in the mid-1970s when many doctors were unable to obtain coverage. Since then, the number of physician-owned malpractice insurers has increased and currently insure more than 60% of doctors. Not surprisingly, however, these companies have suffered the same increases in claim costs as the commercial companies because the overriding cost element of litigation affects all insurers regardless of their form of ownership (U.S. Department of Human Services, 2003).

Monitoring tort reform and insurance reform can be time-consuming and necessitate continual reading of journals, Web sites, and reports. There are many ways to monitor the tort reform bills, including browsing the National Conference of State Legislatures Web site (**www.ncsl.org/standcomm/sclaw/medmalreform05.htm**). "Medical Malpractice Tort Reform 2005 State Introduced Legislation" features a table that itemizes the bill number, summary, and final actions by state.

Potential Solutions

Physician Responsibilities: Physicians are in the prime position to contribute to decreasing health care costs. They can decrease the amount of patient claims by instituting and monitoring safety practices. According to the American Medical Association (AMA), "In 2005, the American Medical Association (AMA) led passage of the Patient Safety law. In 2006, the AMA will continue to lead physicians' efforts to measurably improve patient safety and quality of care..." (AMA, 2006, para. 1,"Clinical Quality Improvement").

According to the DHHS report on Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care:

> The best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors and to correct them. Experts believe these quality improvement opportunities hold the promise not only of significant improvements in patient health outcomes, but also of reductions in medical costs by as much as 30%. It has been identified that health facility problems are often due to complex process or system issues rather than individual errors. These can best be addressed by collecting information from a broad range of physicians and hospitals, and encouraging them to collaborate to identify and fix problems. (U.S. Department of Human Services, 2003, para. 22).

Physicians are aware of defensive medicine practices, but these actions may be hindering an effective solution by significantly contributing to the already rising cost of health care and subsequently higher premiums. Unwarranted tests may be ordered and procedures performed to protect physicians from perceived liability issues. Improved monitoring of complex, high-risk procedures may also help the situation (Studdert et al., 2005).

Part of a solution may be increased physician self-policing efforts. "Policing," or sharing information across the states regarding high-risk physicians who have lost licenses in other states or have had multiple successful claims against them, may reduce repeated errors or malpractice generated by a few physicians. There may be a need for stricter oversight or a better reporting system of incidents. Decreasing the number of high-risk physicians in practice may affect the future medical malpractice premium rates.

Patients want to know what is happening to them. Increasing honest physician-patient communication may help to decrease the number of claims. Physicians who express concern, provide information, and offer an apology when needed can create an atmosphere where the patient feels cared for and participates as a partner in his or her own care. This approach may influence the patient's attitude toward a lawsuit.

Consumer Action: Consumers also bear the burden of increased medical premiums. Should they sign mandatory arbitration statements in order to be treated by a provider? Should they relinquish their rights to sue for non-economic damages when caps may not have proven to be as effective as predicted? Should consumers take more responsibility for their actions concerning their health care?

Other Solutions: Other suggestions for solutions include payment schedules for untoward outcomes, such as a workers' compensation system, limitations on lawyers' contingency fees, periodic installments for payment of damages, abolition of the legal concept of joint and several liability, early-offer system to give immediate rewards to avoid long and costly trials, mediation and arbitration, and hospitals and physicians requiring patients to agree to mandatory arbitration (Friedenberg, 2006).

Conclusion

Arizona is one state that does not have legislation on the amount of damages recoverable in a medical malpractice action. In fact, the Arizona Constitution prohibits the enactment of any law that may limit the amount an individual may recover for personal injury or death. Other states are following this lead. In July 2005, the Wisconsin Supreme Court struck down the state's caps on non-economic – often referred to as "pain and suffering" damages – maintaining that they bear no "rational" relationship to lowering malpractice insurance premiums. (NCSL, 2005, "Medical malpractice tort," "2005 State introduced legislation table," para. 49).

Health care, insurance, and legal systems all agree that additional analysis is required to better understand how these systems interrelate and impact society. There are many stakeholders, and the solutions are as complex as the issues. All interested parties need to take an active, dynamic role in

contributing to the solutions. Whether it is a need for tort reform or insurance reform, physician behavior changes and self-monitoring efforts, increased patient safety, consumer self-responsibility, or other possible solutions, all stakeholders need to work together. As a team, we need to find ways to decrease health care costs, increase health care availability, and allow the justice system to fairly compensate for legitimate health care mistakes, while filtering non-meritorious claims.

To review your state's Medical Malpractice Tort Reform, visit **http://204.131.235.67/standcomm/sclaw/medmalreform05.htm**.

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Basic Terminology in Negligence and Malpractice Cases

Karon Goldsmith

Legal nurse consultants (LNCs) who practice in the area of negligence and malpractice need to be familiar with the basic terminology and legal jargon that is commonplace within this area. While not all-encompassing and certainly not a primer on law, this column highlights some of the most common terms and phrases used in our daily professional practice.

Negligence

Negligence is defined as the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of others' rights.

In making a claim of damages based on allegation of another's negligence, the injured party (plaintiff) must prove the following four elements of negligence:

1. **Duty** – The party alleged to be negligent (defendant) had an established duty and responsibility to the injured party.
2. **Breach of Duty** – The defendant's action or omission was not what a reasonably prudent person would have done under similar circumstances.
3. **Causation** – The damages were caused ("proximately caused") by the negligence.
4. **Damages** – The plaintiff suffered damages or injuries from the action or failure to act by the defendant.

Comparative negligence occurs when a plaintiff's own negligence proportionally reduces the damages recoverable from a defendant. This type of negligence is often also termed "comparative fault."

Concurrent negligence involves the negligence of two or more parties acting independently but causing the same damage.

Contributory negligence is relevant when a plaintiff's own negligence played a part in causing the plaintiff's injury and that is significant enough (in a few jurisdictions) to bar the plaintiff from recovering damages. In most jurisdictions, this defense has been superseded by comparative negligence.

Joint negligence involves the negligence of two or more persons acting together to cause an accident. Cf. concurrent negligence.

Negligence per se is a type of negligence that has been established as a matter of law, so that breach of the duty is not a jury question or an issue that the jury needs to decide. Negligence per se usually arises from a statutory violation. Negligence per se is also termed legal negligence.

Professional negligence – See malpractice.

Malpractice

Malpractice is an instance of negligence or incompetence on the part of a professional. To succeed in a malpractice claim, a plaintiff must also prove proximate cause and damages. Malpractice is also termed professional negligence.

Medical malpractice occurs when a doctor fails to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under same or similar circumstances.

Cause

Cause is something that produces an effect or result, such as the cause of the accident.

"But-for" cause is a phrase used when an injury occurs, and in the absence of the "but-for" event, the injury could not have occurred. In many situations, this is also termed actual cause; cause in fact; factual cause or efficient cause. See proximate cause.

Intervening cause is an event that comes between the initial event in a sequence and the end result, thereby altering the natural course of events that might have connected a wrongful act to an injury. If the intervening cause is strong enough to relieve the wrongdoer of any liability, it becomes a superseding cause.

Proximate cause becomes important when the cause is legally sufficient to result in liability. Proximate cause can be an act or omission that is considered in law to result in a consequence, so that liability can be imposed on the actor. Proximate cause deals with the defendant's liability for unforeseeable or unusual occurrences or consequences following the defendant's act.

A quotation in Black's Law, quoting Prosser and Keeton on the Law of Torts, explains the concept of proximate cause: "'Proximate cause' – in itself an unfortunate term – is merely the limitation which the courts have placed upon the actor's responsibility for the consequences of the actor's conduct. In a philosophical sense, the consequences of an act go forward to eternity, and the causes of an event go back to the dawn

of human events, and beyond. But any attempt to impose responsibility upon such a basis would result in infinite liability for all wrongful acts, and would 'set society on edge and fill the courts with endless litigation'… As a practical matter, legal responsibility must be limited to those causes which are so closely connected with the result and of such significance that the law is justified in imposing liability. Some boundary must be set to liability for the consequences of any act, upon the basis of some social idea of justice or policy" (Garner, 1999; page 213).

The concept of proximate cause encompasses unforeseen medical complications that develop from the original injury. Proximate cause also encompasses the aggravation of the original injury caused by the administration of necessary medical care.

Superseding cause is an intervening act or force that the law considers sufficient to override the cause for which the original tortfeasor (violator of the law) was responsible, thereby exonerating that tortfeasor from liability.

Res ipsa loquitur: "The thing speaks for itself." The res ipsa loquitur doctrine provides that, in some circumstances, the mere fact of an accident's occurrence raises an inference of negligence so as to establish a prima facie case. The phrase "res ipsa loquitur" is a symbol for the rule that the fact of the occurrence of an injury, taken with the surrounding circumstances, may permit an inference or raise a presumption of negligence, or make out a plaintiff's prima facie case, and present a question of fact for defendant to meet with an explanation. It is merely a short way of saying that the circumstances attendant on the accident are of such a nature as to justify a jury, in light of common sense and past experience, to infer that the accident was probably the result of the defendant's negligence, in the absence of explanation or other evidence that the jury believes. The application of the principle nearly always presupposes that some part of the causal process is known, but what is lacking is evidence of its connection with the defendant's act or omission.

Before a plaintiff is entitled to submit his claim to the jury on the theory of res ipsa loquitur, he must establish three things with regard to the injury-producing event: (1.) The event must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2.) It must be caused by an agency or instrumentality within the exclusive control of the defendant; and (3.) It must not have been due to any voluntary action or contribution on the part of the plaintiff.

Damages

Damages are the dollars awarded in a lawsuit to compensate for the injuries suffered as a result of negligence or actions of the defendant. There are many different types of damages and are dependent upon the issues and circumstances of the lawsuit.

Special Damages are economic damages that actually were caused by the injury and include medical and hospital bills, ambulance charges, loss of wages, property repair or replacement costs, or loss of money due on a contract.

Non-Economic Damages are awarded for pain, suffering, future problems, and crippling effects of an injury, loss of ability to perform various acts, shortening of life expectancy, mental anguish, loss of companionship, and loss of consortium (love of spouse).

Punitive Damages combine punishment and the setting of public example. Punitive damages may be awarded when the defendant acted in a malicious, violent, oppressive, fraudulent, wanton, or grossly reckless way in causing the special/economic and non-economic damages to the plaintiff.

It is important to know the regulations, rules, and statutes that are applicable in the legal arena in which the case will be tried – i.e. federal, state, or local courts. For example, some states do not allow the jury to award damages for pain and suffering.

Daubert Standard: Federal Rule of Evidence 702

LNCs often function as expert witnesses and frequently locate and evaluate expert witnesses in negligence and malpractice cases. It behooves the LNC to be familiar with the Daubert Standard used by the courts in deciding to allow or disallow expert witness testimony.

The Daubert Standard is a legal precedent established in 1993 by the U.S. Supreme Court regarding the admissibility of expert witnesses' testimony. The Daubert motions filed are used to exclude: (1.) the presentation of unqualified evidence to the jury; and (2.) the testimony of an expert witness who has no such expertise or used questionable methods to obtain the information as the basis of their opinion. Expert witness opinions are provided when scientific, technical, or special knowledge is needed to help in understanding the evidence.

Expert testimony is allowed under Federal Rule 702 if the court determines that the information provided by the expert will assist the trier of fact in the case. In order to meet the requirements of the Daubert Standard, the testimony needs to be from a reliable body of scientific, technical, or specialized knowledge by an expert in his or her area of specialty.

In Daubert, the Supreme Court ordered federal trial judges to become the "gatekeepers" of scientific evidence. Trial judges now must evaluate proffered expert witnesses to determine whether their testimony is both "relevant" and "reliable" – a two-pronged test of admissibility. The Court offered "general observations" of whether proffered evidence was scientifically valid.

The **relevancy** prong of Daubert: The relevancy of testimony refers to whether or not the expert's evidence "fit" the facts of the case. For example, an accident reconstruction expert may be invited to tell the jury if it was raining on the night of an accident. However, the accident reconstruction expert would not be allowed to testify if the fact that it was raining was not relevant to the issue at hand in the trial.

The **reliability** prong of Daubert: The Supreme Court explained that in order for expert testimony to be considered reliable, the expert must have derived his or her conclusions from the scientifically valid principles.

Although trial judges have always had the authority to exclude inappropriate testimony, prior to Daubert, trial courts often preferred to let juries hear evidence proffered by both sides. Once certain evidence has been excluded by a Daubert motion because it fails to meet the relevancy and reliability standards, it will likely be challenged when introduced again in another trial. Even though a Daubert motion is not binding to other courts of law, if something was found not trustworthy, other judges may choose to follow that precedent.

The elements of the Daubert Standard need to be affirmed before LNCs or other expert witnesses will likely be allowed to testify. The better qualified any expert witness is with specialized knowledge in their field, the better the expert will be at meeting the challenges by attorneys.

Frye Test

The Frye Test evolved in 1923 and allows scientific evidence to be admitted when it is accepted by the scientific community. The Frye Test does not include the caveat that the testimony must assist the trier of fact. A good expert witness can translate the information accepted by the scientific community into testimony that is understandable and helpful to assist the trier of fact, which may be the judge or the jury.

Conclusion

Familiarity with basic terminology and phrases in negligence and malpractice cases can enhance the quality of services the LNC provides to attorneys. When LNCs are researching or evaluating expert witness testimony, it is imperative to be aware of the requirements and pre-established requisite standards relating to the expert's testimony in negligence and malpractice cases. It is important for the LNC to be aware of the expert witness's familiarity with the basic legal terminology and phrases described above.

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Informed Consent Disclosure Statutes By State/Jurisdiction

As with any area of law, the LNC must be vigilant for change. Individuals are independently responsible for how they use this information. The reader is cautioned to consult current case law, legislative reform and attorney guidance before relying solely on this information. Issues of incompetence and minors, guardianship, terminal illness, and abortion rights may have unique statutory laws per individual state with regard to informed consent.

Professional Community Standard = Physician Based Standard *Reasonable Prudent Patient Standard/Materiality = Patient Based Standard*
**Indicates some variation of physician or patient-based standard.*

State/Jurisdiction	Case Law/Statute (where provided)	Standard
Alabama	*Fain v. Smith,* 479 So. 2d 1150 (1985) Ala. Code § 6-5-484 (2002 Supp. 1990)	Professional Community Standard
Alaska	*Korman v. Mallin,* 858 P. 2d 1145 Alaska Stat. 09.55.556 (2002)	Reasonable Prudent Patient Standard (Materiality)
Arizona	*Gurr v. Willcutt,* 707 P. 2d 979 (Ariz. Ct. App. 1985) Ariz. Rev. Stat. §§ 12/561, 12-563 (2002)	Professional Community Standard
Arkansas	*Aronson v. Harriman,* 901 S.W. 2d 832 (1995) Ark. Code. Ann. 16-114-206 (2002)	Professional Community Standard
California	*Arato v. Avedon,* 858 P. 2d 598 (1993)	Reasonable Prudent Patient Standard (Materiality)
Colorado	*Gorab v. Zook,* 943 P. 2d 243 (1997) Colo. Rev. Stat. Ann. § 13-64-401 (2002)	Professional Community Standard* (but defendant has burden of proving standard was met)
Connecticut	*Gemme v. Goldberg,* 626 A. 2d 318 (Conn. App. Ct. 1993)	Reasonable Prudent Patient Standard (Materiality)
Delaware	*Robinson v. Mroz,* 443 A. 2d 1051 (De. Super. Ct. 1981) Delaware Code Ann. Title 18 §6852 (2002)	Professional Community Standard
Florida	*Ritz v. Florida Patient's Compensation Fund,* 436 So. 2d 987 (Fla. Dist. Ct. App. 1983) Fla. Stat. Ann. §766.103 (2002)	Professional Community Standard
Georgia	*Ketchup v. Howard,* 543 S.E. 2d 371 (Ga. Ct. App. 2000) Ga. Code Ann. §31-9-6.1 (2002)	Reasonable Prudent Patient Standard (Materiality)
Hawaii	*Carr v. Strode,* 904 P. 2d 489 (1995) Haw. Rev. Stat. §671-39 (2002)	Reasonable Prudent Patient Standard (Materiality)* (but state medical board is responsible to develop specific standards for disclosure)
Idaho	*Shabinaw v. Brown,* 963 P. 2d 1184 (1998) Idaho Code §39-4303 (2002)	Professional Community Standard
Illinois	*Ramos v. Pyati,* 534 N.E. 2d 472 (Ill. Appl Ct. 1989) Illinois Stat. Ann. Ch. 110, 2-622	Professional Community Standard
Indiana	*McGee v. Bonaventura,* 605 N.E. 2d 792 (Ind. Ct. App. 1993) Ind. Code Ann. §34-18-12-1 (2002)	Professional Community Standard
Iowa	*Bray v. Hill,* 517 N.W. 2d 223 (Iowa Ct. App. 1994) Iowa Code Ann. 147.137 (makes a written consent containing general information presumptively valid)	"Patient Rule" with 3 prong test for causation *Bray v. Hill* and other cases recognize a Patient Based Standard*
Kansas	*Stovall v. Harms,* 522 P. 2d 353 (1974) Kan. Stat. Ann. §65-6709 (2001)	Professional Community Standard* (applies reasonable patient/materiality standard as to abortion)
Kentucky	*Keel v. St. Elizabeth Medical Center,* 842 S.W. 2d 860 (1992) Ky. Rev. Stat. Ann. §304.40-320 (2002)	Professional Community Standard* (with "reasonable individual" overlay)
Louisiana	*Boudoin v. Crawford & Marshall, Ltd.,* 709 So. 2d 798 (La. Ct. App. 1998) La. Rev. Stat. Ann. §40; 1299.40 (2002) (makes a written consent containing general information presumptively valid)	Louisiana Medical Consent Law *Boudoin v. Crawford & Marshall, Ltd.* and other cases recognize a Patient Based Standard*
Maine	*Ouellette v. Mehalic,* 534 A. 2d 1331 (1988) Me. Rev. Stat. Ann. Title 24 §2905 (2002)	Professional Community Standard

Maryland	*Faya v. Almaraz,* 620 A. 2d 327, 334 (1993)	Reasonable Prudent Patient Standard (Materiality)
Massachusetts	*Feeley v. Baer,* 669 N.E. 2d 456 (Mass. App. Ct. 1996)	Reasonable Prudent Patient Standard (Materiality)
Michigan	*Marchlewicz v. Stanton,* 213 N.W. 2d 317 (Mich. Ct. App. 1973)	Professional Community Standard
Minnesota	*Kinikin v. Heupel,* 305 N.W. 2d 589 (Minn. 1981) *Cornfeldt v. Tongen,* 295 N.W. 2d 638 (Minn. 1980)	Professional Community Standard (See §145.4242 regarding abortion) (2003)
Mississippi	*Hudson v. Parvin,* 582 So. 2d 403 (1991)	Reasonable Prudent Patient Standard (Materiality)
Missouri	*Baltzell v. Baptist Med. Ctr.,* 718 S.W. 2d 140 (Mo. Ct. App. 1986)	Professional Community Standard
Montana	*Llera V. Wisner,* 557 P. 2n 805 (1976)	Professional Community Standard
Nebraska	*Eccleston v. Chait,* 492 N.W. 2d 860, 868 (1992) (physician based standard criticized but followed) Neb. Rev. Stat. § 44-2816 (2002)	Professional Community Standard
Nevada	*Smith v. Cotter,* 810 P. 2d 1204 (1991) Nev. Rev. Stat. §§41A.110, 449.710 (2002)	Professional Community Standard
New Hampshire	*Smith v. Cote,* 513 A. 2d 341 (1986) N.H. Rev. Stat. Ann. §507-E:2 (2002)	Professional Community Standard
New Jersey	*Acuna v. Turkish,* 808 A. 2d 149 (N.J. Super. Ct. Law Div. 2002)	Reasonable Prudent Patient Standard (Materiality)
New Mexico	*Henning v. Parsons,* 623 P. 2d 574 (N.M. Ct. App. 1980)	Reasonable Prudent Patient Standard (Materiality)
New York	*Karlin v. IVF America, Inc.,* 712 N.E. 2d 662 (1999) applying N.Y. Public Health Law §2805-d (2002)	Professional Community Standard
North Carolina	*Osburn v. Danek Medical, Inc.,* 520 S.E. 2d 88 (N.C. Ct. App. 1999) N.C. Gen. Stat. §90-21.13 (2002)	Professional Community Standard* (with a "reasonable person" overlay)
North Dakota	*Jaskoviak v. Gruver,* 638 N.W. 2d 1 (2002)	Reasonable Prudent Patient Standard (Materiality)
Ohio	*Bedel v. University of Cincinnati Hosp.,* 669 N.E. 2d 9 (Ohio Ct. App. 1995) Ohio Rev. Code Ann., §2317.54 (2001)	Reasonable Prudent Patient Standard (Materiality)
Oklahoma	*Spencer v. Seikel,* 742 P. 2d 1126, 1129 (1987)	Reasonable Prudent Patient Standard (Materiality)* (suggests a "subjective patient standard" might be applied)
Oregon	*Zacher v. Petty,* 826 P. 2d 619 (1992) Or. Rev. Stat. §667.097	Reasonable Prudent Patient Standard (Materiality)* Physician based standard applied with regard to use of "therapeutic privilege"
Pennsylvania	*Southard v. Temple Univ. Hosp.,* 781 A. 2d 101 (2001) 40 Pa. Cons. Stat. §1303.504 (2002)	Reasonable Prudent Patient Standard (Materiality)
Rhode Island	*Lauro v. Knowles,* 785 A. 2d 1140 (2001) R.I. Gen. Laws §9-19-32 (2002)	Reasonable Prudent Patient Standard (Materiality)
South Carolina	*Baxley v. Rosenblum,* 400 S.E. 2d 502 (S.C. Ct. App. 1991)	Professional Community Standard
South Dakota	*Wheeldon v. Madison,* 347 N.W. 2d 367 (1985)	Reasonable Prudent Patient Standard (Materiality)
Tennessee	*Ashe v. Radiation Oncology Assocs.,* 9 S.W. 3d 119 (1999) Tenn. Code. Ann. §29-26-118 (2002)	Professional Community Standard
Texas	*Rodgers v. Coleman,* No. 01-93-00372-CV., (Tex. App.1994) Tex. Rev. Civ. Stat. art. 4590i §6.02 (repealed 2003)	Texas Medical Disclosure Panel Reasonable Prudent Patient Standard (Materiality)*
Utah	*Nixdorf v. Hicken,* 612 P. 2d 348 (1980) Utah Code Ann. §78-14-5 (2002)	Reasonable Prudent Patient Standard (Materiality)
Vermont	*Perkins v. Windsor Hosp. Corp.,* 455 A. 2d 810 (1982) Vt. Stat. Ann. Title 12 §1909 (2002)	Professional Community Standard
Virginia	*Tashman v. Gibbs,* 556 S.E. 2d 772 (2002) Va. Code. Ann. §8.01-581.20 (2002)	Professional Community Standard
Washington	*Backlund v. University of Washington,* 975 p. 2d 950 (1999) Wash. Rev. Code Ann. §7.70.050 (2002)	Reasonable Prudent Patient Standard (Materiality)
West Virginia	*Adams v. El-Bash,* 338 S.E. 2d 381 (1985) W. Va. Stat. §55-7B-3	Reasonable Prudent Patient Standard (Materiality)
Wisconsin	*Johnson v. Kokemoor,* 545 N.W. 2d 495 (Wis. Ct. App. 1996) Wis. Stat. Ann. §448.30 (2001)	Reasonable Prudent Patient Standard (Materiality)
Wyoming	*Weber v. McCoy,* 950 P. 2d 548 (1997)	Professional Community Standard

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