

*The Journal of*  
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Volume 19 ▲ Number 1 ▲ Winter 2008

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The Journal of

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# LEGAL NURSE CONSULTING

Volume 19 ▲ Number 1 ▲ Winter 2008

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**Asbestos Medicine from a Defense Perspective ..... 3**

*Jane Barone, BS RN LNCC*

This article discusses asbestos medicine and how the legal nurse consultant (LNC) can assist counsel in evaluating these cases. LNCs can evaluate these cases from a defense as well as the plaintiff perspective. The focus of article is how to present defense issues. The LNC involved in reviewing asbestos-related litigation for the defense needs to be aware of other potential medical conditions with similar symptoms, in order to point out other medical issues to decrease the damages or determine the value of the case. LNCs should be familiar with the diagnosis, treatment, and theories of liability to assist the attorney in these cases.

**The Battle of the Experts: The Aftermath and Peer Review of Expert Testimony ..... X**

*Kara L. DiCecco, MSN RN LNCC*

What does society have today that operates largely undetected yet wields significant power? The following article is an analysis of the quiescent movement toward peer review of expert medical testimony. Traditional judicial restraints and evidentiary requirements often markedly limit the information presented to the jury. The vehicle with the potential to serve as a tool to further bar information from reaching the jury also prompts further investigation into the opposing views of this proposed action. This article does not purport to provide a full analysis of the legal debate, only to offer insight on the complexities of promoting ethical medical expert testimony.

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# A Little Perspective



Perspective is one of my favorite words. It allows us to notice things we might otherwise overlook. Perspective allows us to see what the other person sees and to appreciate another's view. The gift to appreciate great art comes from the observer's ability to view the piece from the artist's perspective, to briefly experience the emotion behind the work. Taking a moment to sit on the floor with a child helps you to perceive the world from their view and to remember the hurdles they encounter and surmount every day. Standing at the Grand Canyon's edge provides a breathtaking perspective of nature's mystery and power. Appreciating another's perspective provides an inroad into understanding diverse views and approaches.

In this issue, Jane Barone has generously authored *Asbestos Litigation from a Defense Perspective* to help readers view the medical-legal issues from a defense vantage point. By sharing her insight, she helps the reader understand the complexities of issues from this unique perspective. It doesn't matter whether the LNC works mainly in defense or plaintiff; the reader benefits from Jane's experience and expertise.

In *Peer Review of Expert Testimony*, I hoped to achieve three perspectives: defense, plaintiff, and society in general. The medical-legal field is certainly no stranger to controversial issues, and this topic is closely aligned with that observation. With the state of flux the legal field is experiencing, as an LNC, I invite you to familiarize yourself with the concepts of jury reformation, state health courts, and peer review of expert testimony. The implications for peer review of expert testimony on nursing is obvious, and the effect on the traditional jury system is even more profound. The article invites the question "Where does the nursing profession stand on the issue?"

We are also fortunate to have a unique and in-depth piece by authors Patricia Fedorka and Judith Sullivan. In *Practicing Within the Obstetrical Nursing Standard of Care*, they have provided the fact patterns of two obstetrical cases with attention to the nursing and legal duty of the obstetrical nurse. These authors have graciously shared their expertise to give the reader a detailed analysis of the applicable standards of care in reviewing these cases. There is much the reader will learn from this comprehensive article.

Janet Eads has provided the LNC's perspective in *Settlement Negotiations and the LNC Role*. If you are new to the field of LNC or have had limited experience with the attorney in this area, Janet has answered some fundamental questions to help the reader understand the process and desired outcomes.

This issue's *References and Resources* provides you with the online resources for the Medical Licensing Boards in the 50 states and Washington, D.C.

As you can imagine, this journal is not possible without the contributions of the authors and the hard work of the editorial board members. We are also fortunate to have Mindy Cohen as Board Liaison from National who has already brought phenomenal ideas and input. We will continue to work hard to bring our membership timely topics and welcome your suggestions.

Sincerely

*KARA DiCECCO, MSN, RN, LNCC*

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

# Asbestos Medicine From A Defense Perspective

Angela Pinto Ross, Esq.

KEY WORDS  
Asbestos

*This article discusses asbestos medicine and how the legal nurse consultant (LNC) can assist counsel in evaluating these cases. LNCs can evaluate these cases from a defense as well as the plaintiff perspective. The focus of article is how to present defense issues. The LNC involved in reviewing asbestos-related litigation for the defense needs to be aware of other potential medical conditions with similar symptoms, in order to point out other medical issues to decrease the damages or determine the value of the case. LNCs should be familiar with the diagnosis, treatment, and theories of liability to assist the attorney in these cases.*

In order to better understand the role of the legal nurse consultant (LNC) in asbestos-related litigation, it is first useful to know the history of asbestos use, the structure and types of asbestos, and the implications of long-term exposure and use. Asbestos was first used commercially in the late nineteenth century and has since been used in many different products including bricks, pipe coverings, brake linings, ceiling tiles, floor tiles, and fire retardant clothes.

The prevalence of its use, and the subsequent health problems that have been associated with it, has led to many asbestos-related cases. Plaintiffs in asbestos litigation come from various occupations. Frequent complainants include miners of asbestos, shipyard workers, brake lining workers, power plant workers, pipefitters, insulators, and boilermakers (Department of Health and Human Services, 2007).

## Analyzing Asbestos

Because asbestos is a hydrated magnesium silicate mineral, asbestos fibers break when crushed. These fibers have high tensile strength and are heat resistant. There are two main types of asbestos fibers are serpentine and amphibole. The serpentine fibers are curled or curved and are mainly chrysotile. The amphibole fibers are straight, needle-like fibers and consist of crocidolite, amosite, tremolite actinolite, and anthophyllite. Needle-like and smaller than a human hair, these fibers are more damaging (Department of Health and Human Services, 2007).

Special precautions are taken when removing asbestos, including special clothing and respirators to avoid breathing in the fibers because asbestos causes disease only when it is friable. The inhalation of the tiny fibers causes inflammation and fibrosis of the pleural lining of the lungs and parenchyma of the lungs (Guidotti, Miller, et al., 2003).

The LNC reviewing the case should make note of the plaintiffs' occupations and possible exposures that are documented in the medical records. This is significant because different occupations have different levels of exposure to asbestos and are exposed to different types of asbestos. Figure 1 shows the Medical Outline, an instrument that is useful for summarizing asbestos cases.

Figure 1

<u>MEDICAL OUTLINE</u>			
ATTORNEY WORK PRODUCT CONFIDENTIAL AND PRIVILEGED			
PREPARED: PREPARED BY: CASE: COURT: DOCKET NO.: OUR FILE NO.: DATE OF BIRTH: DATE OF DEATH:			
EVALUATION			
A. <u>MEDICAL RECORDS REVIEWED</u>			
<u>SOURCE</u>		<u>DATES</u>	
B. <u>PULMONARY HISTORY</u>			
<u>DATES</u>	<u>DIAGNOSIS</u>	<u>DOCTOR</u>	
C. <u>SMOKING HISTORY</u>			
<u>DATES</u>	<u>AMOUNT OF PACKS PER DAY</u>	<u>TYPE</u>	<u>SOURCE</u>
D. <u>OTHER MEDICAL CONDITIONS</u>			
<u>DATES</u>	<u>DIAGNOSIS</u>	<u>DOCTORS</u>	
E. <u>RETIREMENT/DISABILITY</u>			
F. <u>MISSING RECORDS</u>			

## Non-Malignant Pleural Abnormalities Associated with Asbestos

Asbestos-related pleural changes consist of pleural plaques (or pleural fibrosis), pleural thickening, and non-malignant pleural effusion. The latency period between exposure and development of asbestos-related pleural disease can span 15 to 25 years (Guidotti, Miller, et al., 2003). These changes, which are signs of asbestos exposure, can be seen on chest x-rays and computerized tomography (CT) scans. Computerized tomography readings are more sensitive in the detection of these changes because CT scans can distinguish pleural thickening from fat pads. Over time pleural plaques become calcified.

These asbestos-related pleural changes rarely cause any discomfort, although restriction may appear on pulmonary function tests. The majority of people with non-malignant pleural abnormalities do not develop malignancies, but they do have a lifetime risk of developing a malignancy (Guidotti, Miller, et al., 2003).

LNCs should make note of the plaintiff's height and weight. LNCs should be aware that there are several other causes of pleural changes. They include hemithorax, connective tissue disease, tuberculosis, chest surgery, drugs given for migraines, effusions, infections, and body fat. These types of changes tend to be unilateral (Guidotti, Miller, et al., 2003). When reviewing the medical records, the LNC should note any of the above-mentioned factors in order to determine whether the pleural changes are as a result of asbestos exposure or other issues.

## Asbestosis

Asbestosis is parenchymal fibrosis caused by inhaling asbestos fibers. Asbestosis only becomes evident after a latency period of 20 years or more. The severity of asbestosis, as discovered through x-ray, is determined by duration and intensity of exposure. The reduction of exposure to asbestos has reduced the severity of the disease (Guidotti, Miller, et al., 2003). If the asbestos exposure is noted in the medical record, LNCs should document this, so as to bring this to the attention of the defense attorneys.

Asbestosis can be diagnosed by a biopsy of the affected lung tissue. Fibrosis is graded from Grade I (mild) to Grade III (most severe). The grades of asbestosis correlate with the asbestos bodies and fiber counts in the lungs. Asbestosis is more advanced in smokers, presumably because of reduced clearance for asbestos fibers in the lungs and a higher frequency of irregular opacities on chest x-ray (Guidotti, Miller, et al., 2003).

Asbestosis may appear with or without pleural thickening. Fibrosis may remain the same or progress over time. The rapid progression of disease leans toward idiopathic fibrosis, as opposed to asbestosis (Guidotti, Miller, et al., 2003). The LNC should make note of all chest x-rays and CT scans, noting any progression or lack of disease. This will give the attorney the useful information as to whether or not disease exists.

Symptoms of asbestosis include dyspnea on exertion and a non-productive cough. Physical finding may include basilar rales and, in advanced cases, clubbing of the affected person's fingers. In order to make a diagnosis of asbestosis, the occupational exposure must be present. Generally, prolonged exposure of 10 to 20 years or short intense exposures (these exposures are rare today) are seen in asbestosis cases (Guidotti, Miller, et al., 2003).

In reviewing medical records, the LNC should note the above physical findings to help clarify the diagnosis for the defense attorney. In addition, documenting any references to exposure will assist the attorney in identifying whether or not his client is responsible for the exposure.

The severity of asbestosis is dose-dependent. There may be 15 years or more when the disease is latent. Restriction on pulmonary function tests is a classic sign of asbestosis. Mixed restriction and obstruction may also be found during the pulmonary function tests, and diffusion capacity may be reduced. The radiographic presentation on PA chest films is bilateral small primarily irregular parenchymal opacities in the lower lobes (Guidotti, Miller, et al., 2003).

Over time, the perfusion of these opacities may spread to the middle and upper lobes. Mixed irregular and rounded opacities are sometimes present. High resolution computed tomography (HRCT) is more sensitive than standard chest x-rays at detecting parenchymal fibrosis (Guidotti et al, 2003).

The International Labour Organization (ILO) was developed in the 1950s for grading the severity of pneumoconiosis. Films are read by "B-reader," which compares the patient's film to a standardized set of x-rays and designates a perfusion. The B reader will describe opacities as 0/0, 0/1, 1/0, 1/1, etc. up to 3/3 to denote severity. Per guidelines of the American Thoracic Society, readings above 1/0 are considered to be consistent with asbestosis (Guidotti, Miller, et al., 2003).

As Schiffman, (2006) cautions, there are many other causes of fibrosis that need to be ruled out, including drug reactions and infections, sarcoidosis, silicosis and other dusts, idiopathic fibrosis, connective tissue diseases, and exposure to iodizing radiation. The LNC needs to be aware of these potential causes and should be careful to note any of these findings.

Restriction is noted as reduced total lung volume and forced vital capacity (FVC). McCarthy (2006) also notes causes other than asbestosis for restricting total lung volume and FVC that LNCs should consider, such as obesity, cardiomegaly, ascites, pregnancy, pleural effusion, pleural tumors, kyphoscoliosis, neuromuscular disease, diaphragm weakness or paralysis, space occupying lesions, lung resection, congestive heart failure, and inadequate inspiration or expiration.

The diagnosis of asbestosis can also be made based on pathological findings. Fibers that are coated by proteinaceous concretion are called asbestos bodies. Iron staining is done to see asbestos bodies that can be identified in lung tissue and bronchoalveolar lavage specimens. Asbestos fibers can be viewed via electron microscopy, while asbestos bodies can be seen under light microscopy. Pathological diagnosis is defined

as the presence of peribronchiolar fibrosis and interstitial fibrosis and more than one asbestos body in a section of lung parenchyma (Guidotti, Miller, et al., 2003).

Asbestosis cannot be cured. Very severe cases can lead to death; however, this is very rare. Treatment is symptomatic with bronchodilators, steroids, and oxygen. Smoking cessation is the general recommendation.

## Lung Cancer

Lung cancers can be caused by asbestos. The defense's position, although considered to be controversial by the plaintiff, is that lung cancer is not caused by asbestos unless asbestosis is also present. Additionally, it has been this writer's experience of over 10 years of reviewing these cases that the vast majority of plaintiffs with asbestosis currently smoke or smoked in the past. Lung cancer can be attributed to smoking in the absence of asbestosis. The LNC should carefully document the plaintiff's smoking history and that of his or her family. See Figure 1 as a sample of an outline to be used for these cases.

Smoking and asbestos have a synergistic effect and increase the risk of lung cancer. Browne (2001) determined that the synergistic effect is 3- to 4-fold, concluding that epidemiological studies clearly support this theory. In 1999, Weiss concluded that lung cancer is only elevated in humans exposed to asbestos when it is associated with asbestosis. Gustavsson (2002) showed there is a dose:response relationship between asbestos exposure and the occurrence of lung cancer.

## Mesothelioma

Mesothelioma is a rare form of cancer that affects the pleura or peritoneum. The incidence in women is two cases per million, and the incidence in men is 10 to 30 cases per million population (Dee, 2005). Causes of mesothelioma include asbestos, radiation exposure, erionite (an environmental mineral), and familial cases. The latency period for malignant mesothelioma is 35 to 40 years. Dee (2005) points out that there is no association between smoking and mesothelioma.

There are three types of mesotheliomas: epithelial, sarcomatoid, and mixed type. There is a 35- to 40-year latency period between exposure and development of mesothelioma; however, once it develops, this fatal tumor generally causes death within 18 months (Dee, 2005). Diagnosis can be made on CT scan, but the diagnosis is confirmed pathologically. Treatment is palliative and includes a pleurectomy, decortication or extrapleural pneumonectomy, or thoracoscopy with pleurodesis, radiation, and chemotherapies. Generally, however, no treatment is given (Pistolesi and Rusthovven, 2004).

Mesothelioma is diagnosed based on pathologic histology, and immunohistochemical staining is used to differentiate mesotheliomas from other cancers. Some of the stains include carcinoembryonic antigen and CD15 (Leu M1) – which are generally negative – and cytokeratin 5, cytoderatin 6, and calretinin – which are positive. Electron microscopy may be

used in difficult cases to distinguish the difference between mesothelioma, adenocarcinoma, and other tumors (Pistolesi and Rusthovven, 2004).

In a case where the exposure is chrysotile, the chrysotile defense may be used. This states that if the inhaled asbestos fiber was chrysotile, it probably was not related to asbestos fiber, as crocidolite is the only fiber that causes mesothelioma. Weill, Hughes, and Churg (2004) conducted epidemiological studies that supported this conclusion that chrysotile fibers were not responsible for the mesothelioma. In addition, Hodgson and Darnton (2000) similarly concluded that it was highly improbable that chrysotile caused malignant mesothelioma, while amphiboles may cause malignant mesothelioma.

Fiber burden analyses are done on pathology tissue to determine the type of fiber to which the patient was exposed. Guidotti, et al., (2003) found that they could identify the mineral type by using energy-dispersive x-ray analysis. LNCs are valuable to the defense counsel in finding alternative sources of the cause of mesothelioma.

## LNC Evaluation for the Defense

As part of their invaluable participation in these cases, LNCs review the medical records and prepare chronologies in asbestos-related litigation. LNCs can look for any evidence of asbestosis or pleural thickening found on independent x-ray reports. If the plaintiff's expert is the only physician making this finding, it may mitigate liability. LNCs can also investigate confounding reasons for fibrosis, pleural changes, and restriction, pointing out other medical issues to decrease the damages. They can describe the damages in summary form to determine the value of the case.

The plaintiff's smoking history is crucial, as the vast majority of these plaintiffs smoke or are ex-smokers. This is important to the causation issue in lung cancer cases and in chronic obstructive pulmonary cases, where smoking may be responsible for shortness of breath.

In summary, LNCs are valuable to the defense attorney by documenting the amount of pain and suffering involved in a case, so as to place an appropriate value on the case. LNCs should be familiar with the diagnosis, treatment, and theories of liability to assist the attorney in these cases.

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# The Battle of the Experts: The Aftermath and Peer Review of Expert Testimony

Kara L. DiCecco, MSN RN LNCC

## KEY WORDS

Expert Testimony, Peer Review

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*The topic is covert operations, a military strategy used to disarm your opponent. The ploy is to remain largely unseen until the last possible moment, when you reveal your tactical position. If the sci-fi world of the 1960s had the fantasy "Star Trek" with the cloaking device, and the late 1980s had the B-2 Spirit Bomber (stealth fighter) with its diminished zone of detection and reduced infrared footprint, what does society have today that operates largely undetected yet wields significant power? What follows is an analysis of the quiescent movement toward peer review of expert medical testimony. Traditional judicial restraints and evidentiary requirements often markedly limit the information presented to the jury. What has the potential to serve as a tool to further bar information from reaching the jury prompts further investigation into the opposing views of this proposed action. This article does not purport to provide a full analysis of the legal debate, only to offer insight on the complexities of promoting ethical medical expert testimony.*

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Is there solid rationale that justifies a medical organization preauthorizing, censoring, or reviewing a member's intended or post-litigation expert testimony? Should fellowship in a professional society be contingent upon acceptance of this conditional provision? Are the interests of the Court, parties to the legal issue, and, ultimately, society served by instituting such policies? Is the unethical witness so pervasive as to cause economic devastation to insurance carriers and proliferating miscarriages of justice? Is it time for a reformation of the legal system in favor of medical oversight? As can be expected, the literature on the appropriateness of peer review of expert medical testimony is highly polarized.

By role definition, the legal nurse consultant (LNC) is in a better position than the layperson to be exposed to evolving case law, landmark decisions and periodical publications from both medicine and law. Working in the medical-legal arena, the LNC possesses a distinct advantage with regard to access of information that may significantly impact the future of medical expert testimony in our courts. Considering that the layperson is most representative of the jury composite, any political direction that serves to limit, alter, or eliminate their traditional role of the jury as triers-of-fact warrants further scrutiny.

For the purposes of reviewing what information the interested public might readily find via the Internet, an online inquiry was conducted using the search engines Google, Yahoo, and Ask. The keywords "ethical testimony," "expert witness," "peer review," "medical societies," "medical negligence," "professional organizations," and "medical expert" were used alone and in alternate string searches. Resource retrieval was limited to the domains of .gov and .edu, and equal consideration given to .com and .org as related to organized legal and medical websites. Links to Portable Document Format (PDF) and other file extensions were reviewed only if the originating source could be tracked. Two topic-related articles were retrieved through subscription pay

access services (JAMA and Elsevier). Further literature and case law was retrieved through the proprietary databases of Pub Med and Findlaw. The foundation of this article is a synthesis of the information retrieved.

## Duty Established and Breached

The Health and Ethics Policy of the American Medical Association (AMA) House of Delegates on Expert Witness Testimony states, "Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses" (2004). According to AMA's Code of Medical Ethics on Medical Testimony (2004), "In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice." Other professional medical societies and organizations have similar policies (see Table 1). Duty aside, whether or not physicians have a duty to serve the public interest by providing expert medical opinion in court is not at the core of this debate. The central issue is who exactly is qualified to fill this position and who rightfully stands guard to assure the veracity of the testimony given.

The movement of peer review is largely based on the premise there is a proliferation of unchecked, fraudulent expert medical testimony in negligence cases (Satiani, 2006; Daly 2007). When retrieving literature on the subject, there is no shortage of accusations of "junk science," "hired guns," and "frivolous lawsuits" from the medical and defense perspectives (American Cardiology College Foundation [ACCF]/American Heart Association [AHA], 2004; McHenry, Biffel, Chapman and Spain, 2004; Rollins, 2004; Satiani, 2006). Authors observe that, in many cases, expert witnesses act as "opinions for hire" and predictably base their testimony on isolated findings, unscientific data or clearly biased testimony (Welner and Delfs, 2002; Rollins, 2004).



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**Table 1. Sample of Position Statements/Affirmations of Medical Societies/Professional Organizations.**

<p>American Medical Association (AMA)  <a href="http://www.ama-assn.org/ama1/pub/upload/mm/395/peerreview.doc">www.ama-assn.org/ama1/pub/upload/mm/395/peerreview.doc</a>            AMA statement on Medical Peer Review  <a href="http://www.ama-assn.org/ama/pub/category/2512.html">www.ama-assn.org/ama/pub/category/2512.html</a>            AMA Principles of Medical Ethics  <a href="http://www.ama-assn.org/ama/pub/category/2509.html">www.ama-assn.org/ama/pub/category/2509.html</a>            Reporting ethical violations  <a href="http://www.ama-assn.org/">www.ama-assn.org/</a> &gt; AMA Agenda in top toolbar &gt; Be Informed &gt; Policy Finder &gt; Accept (if in agreement with terms) &gt; Code of Medical Ethics &gt; E-9.00 Opinions on Professional Rights and Responsibilities &gt; E-9.07 Medical Testimony  <a href="http://www.ama-assn.org">www.ama-assn.org</a> &gt; AMA Agenda &gt; Be Informed &gt; Policy Finder &gt; Health and Ethics Policies of the AMA House of Delegates &gt; H-265.000 Legal Medicine  <i>and</i> Policy Finder &gt; Directives of the AMA House of Delegates &gt; D-265.000 Legal Medicine (for future action)            AMA view of National Practitioner Data Bank  <a href="http://www.ama-assn.org/ama/pub/category/4543.html">www.ama-assn.org/ama/pub/category/4543.html</a></p>
<p>American Association of Orthopaedic Surgeons (AAOS)  <a href="http://www3.aaos.org/member/expwit/statement.cfm">www3.aaos.org/member/expwit/statement.cfm</a>            Expert Witness Affirmation Statement of the AAOS  <a href="http://www3.aaos.org/member/expwit/request.cfm">www3.aaos.org/member/expwit/request.cfm</a>            Link for requests of signed affirmation statements  <a href="http://www3.aaos.org/member/profcomp/profcomp.cfm">www3.aaos.org/member/profcomp/profcomp.cfm</a>            Link to information regarding the AAOS' "Expert Witness Program"</p>
<p>American Association of Neurosurgeons (AANS)  <a href="http://www.aans.org/Library/Article.aspx?ArticleId=21843">www.aans.org/Library/Article.aspx?ArticleId=21843</a>            AANS' Rules for Medical Legal Expert Opinion Services  <a href="http://www.aans.org/about/membership/Rulesfor_LegalExpertOpinionServices.pdf">www.aans.org/about/membership/Rulesfor_LegalExpertOpinionServices.pdf</a></p>
<p>American College of Emergency Physicians (ACEP)  <a href="http://www3.acep.org/practres.aspx?id=29446">www3.acep.org/practres.aspx?id=29446</a>            Expert Witness Guidelines  <a href="http://www3.acep.org/practres.aspx?id=32142&amp;list=1&amp;fid=2282">www3.acep.org/practres.aspx?id=32142&amp;list=1&amp;fid=2282</a>            Link to Medical Legal Standard of Care Review. Members can request a review of expert testimony they feel is questionable, whether or not they are a party to the action. The names and identifiers are blinded to the reviewers.</p>
<p>American Academy of Pediatrics (AAP)  <a href="http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/5/974">http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/5/974</a>            Link to Policy of AAP for Expert Witness Testimony in Medical Malpractice Litigation</p>
<p>American College of Obstetricians and Gynecologists (ACOG)  <a href="http://www.acog.org/from_home/publications/ethics/co374.pdf">www.acog.org/from_home/publications/ethics/co374.pdf</a>            Link to ACOG Committee Opinion on Expert Testimony</p>
<p>American Academy of Psychiatry &amp; The Law (AAPL)  <a href="http://www.aapl.org/ethics.htm">www.aapl.org/ethics.htm</a> &gt; Publications            Link to The Law Ethical Guidelines for the Practice of Forensic Psychiatry</p>
<p>American Psychological Association (APA)  <a href="http://www.apa.org/ethics/homepage.html">www.apa.org/ethics/homepage.html</a>            Link to American Psychological Association Ethics Code</p>

## Causation

Proponents of reform point to a dearth of unsubstantiated claims of negligence that weave their way into the litigation process as the catalyst to inflated insurance premiums. What escapes capture, however, are truly unbiased accountings of the actual number of payouts, as well as the impact cited by both plaintiff and defense postures. Research into the facts and numbers can be easily traced back to the posting site.

In the case of reporting fault with the current legal system, outrageous payouts, escalating premiums, or violations of testimony, the origins often trace back to special interest groups vested in tort reform (Selected Malpractice Claim Data, n.d.; Luria and Agliano, 1997; Reigning in the Plaintiff's Bar, 2004; Medical Crisis, 2007). In the case of reporting moderate to static malpractice premiums, conservative awards for victimized litigants, or failures of peer review, the investigative road leads to potential opposition of tort-reform, such as plaintiff's firms and watchdog groups (Medical Statistics, n.d.; Quick Facts on Medical Malpractice Issues, n.d.; Health Care Providers Win Most Cases, n.d.; Medical Malpractice Award Trends, 2003; Zegart, 2004).

The characteristics of massive tort litigation and the nuances of the causal attribution in epidemiology are significantly different in structure and outcome from the individual malpractice claim. The stark diversity of statistics promoted as representative of medical malpractice payouts likely means that the public is witness to statistical sleight of hand on both sides of the debate.

The impact of jury awards should be analyzed and reported in their respective contexts. Not every claim should proceed just because it technically can avail itself of the legal process. Maloccurrence (unfavorable outcome) and malpractice is not the same thing. Honest mistakes happen to even the most caring physicians. Not all states are experiencing a medical malpractice crisis secondary to inflated jury awards, and but some states are in serious jeopardy and losing qualified physicians due to this phenomenon (Hellinger and Encinosa, 2003). Accurate reporting of geographic profiles for escalating malpractice premiums cannot be arbitrarily dismissed.

## Damages

Among the damages assessed from a plaintiff's perspective is the inability to find qualified expert physicians willing to testify, no matter how negligent the breach in the standard of care. Undeniably, qualified witnesses will be dissuaded by potential retaliatory efforts of the defendant physician(s), the likelihood being ostracized from professional societies, and the prospect of difficulties intrinsic to a peer review system (Cohen, 2004). The peer review process has its detractors for a reason. In the two well-established realms of peer review – publishing and hospital peer review committees – accounts of abuse of power, failure to disclose conflicts of interest, incorrect conclusions, and unethical competitive practices have been reported (Chalifoux, 2002; Waite, 2003; Chu, 2005; Altman, 2006; Freedman, 2006).

Conversely, proponents of the peer review process of medical testimony see retrospective review as one approach to

quell experienced testimony believed to intentionally deceive and manipulate the jury that ultimately leads to outrageous awards. From the defense perspective, unfounded and unsubstantiated claims of negligence take on a more convincing appearance and are more compelling when presented by a polished, professional expert witness (Ellman, 2003). The idea that testimony will be subject to thorough examination, probing, and possible sanctions may serve to stifle those witnesses eager to participate in the litigation process (Foucar, 2005).

## Plaintiff's Opening Arguments

In many jurisdictions, an Affidavit (or Certificate) of Merit is required to attest to the legitimacy of negligence claims and to weed out non-meritorious claims. Despite the view generated by the media in many high-profile cases, the average juror does not mindlessly bend to the will of the legal counsel in trial. Overwhelmingly, juries take their duty seriously. The average juror is a contributing member of society who is asked to disrupt his or her life for an initially unspecified period of time and, along with a group of strangers, to render a decision that will significantly affect the life of their fellow citizen – not an enviable position.

Although arguably imperfect, safeguards are built into the legal system to lessen the likelihood of an unjust verdict (Foucar, 2005). The process of voir dire (F.R.C.P. 47(a)) seeks to eliminate any personal bias that might preclude a fair trial. Juries are not elected positions, and their careers do not depend upon the decision they render, which leaves them free of political pressure. Jurors take an oath to accept the Court's guidance on interpreting the law and to listen to medical testimony of complex principles that requires remediation to explain the underlying medical issues. Yet there remains a basic distrust of the jury system.

Just to present to the jury, the medical expert has already had to pass through the judge's crucible of reliability (Frye, 1929; Daubert, 1993). If there is any doubt as to the credentials, knowledge base, or qualifications of the proffered expert, it is incumbent upon the legal counsel on either side to call it to the Court's attention. For example, either counsel may file a Motion (Federal Rules of Civil Procedure [F.R.C.P.] 7 (b) (1)) to bar the expert's testimony if it is based on unsound scientific material pursuant, or conduct voir dire of the expert prior to testifying pursuant to F.R.E. 705(b) (see Table 2).

**Table 2. Sampling of Case Law Involving Peer-Review of Expert Testimony.**

*This table is not meant to provide an exhaustive list of applicable case law, only to provide the reader with some introductory case law on the topic.*

[www.findlaw.com/11stategov/il/index.html](http://www.findlaw.com/11stategov/il/index.html)

Choose Courts > U.S. Court of Appeals 7th Circuit (from findlaw) > enter docket number 004028 in search box

*Donald C. Austin v. American Association of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001), cert. denied, 534 U.S. 1078 (2002)*

The case above is based on an appeal of disciplinary action.

*Austin v American Association of Neurological Surgeons, 120 F Supp 2d 1151 (ND Ill 2000)*

[www.aoc.state.nc.us/www/public/coa/opinions/2006/050891-1.htm](http://www.aoc.state.nc.us/www/public/coa/opinions/2006/050891-1.htm)

*In re Lustgarten, 177 N.C. App. 663 (05-891) (2006)*

The case above is based on an appeal of disciplinary action. The original case prompted one of the defendant doctors to file disciplinary complaint against Lustgarten.

***Hardin v. Carolina Neurological Services, No. 97 CVS 503, N.C., Wake County Super. Ct. (1998)***

*In re Lustgarten, No. 02 CVS 12218 (N.C., Wake County Super. Ct. Apr. 21, 2003)*

[www.aoc.state.nc.us/www/public/coa/opinions/2001/991439-1.htm](http://www.aoc.state.nc.us/www/public/coa/opinions/2001/991439-1.htm)

*Burgess v. Busby, 142 N.C. App. 393 (99-1439) (2001)*

Linda Burgess, Joy Clement, Bonnie Eddleman, Meta Fisher, Terry Kesler, Tommy Knox, Gene Moore and Mark Sides, v. Merle Rudy Busby. Case where plaintiff's brought claim against former defendant in a medical negligence claim. Although defendant doctor was exonerated (a fellow physician was found liable), and def. doctor issued a letter containing the names and addresses of the jurors, under the heading "Jurors who have sued doctors" and posted in mailboxes at a regional medical center.

*Fullerton v. Florida Medical Association, No. 37 2004, CA 0001249 (Fla., Leon County Cir. Ct. filed May 27, 2004)*

San Francisco internist, John Fullerton brought suite against the FMA and three complainant malpractice-defendant physicians for libel, witness intimidation, and racketeering.

*Trull v. Long, 621 S. 2d 1278, 1279-81 (Ala. 1993)*

Case discussing Omertà (code of silence) among physicians.

*Ubinas-Brache v. Dallas County Medical Society, 68 S.W.3d 31 (Tex. App. 5th District, 2001)*

After a series of complaints that resulted in a disciplinary action expelling Dr. Ubinas-Brache from the Dallas County Medical Society (DCMS), the case has resulted in a series of legal battles, which include the AMA supporting the expulsion and a jury trial finding in favor of Ubinas. The Court of Appeals reversed this decision based on a missing but essential element (malice) of Ubinas' claim. The issue of the medical societies' fee petition (for attorney fees) was awarded Nov. 16, 2006 to the DCMS and supporters, which Ubinas appealed.

[www.tsc.state.tn.us/OPINIONS/TSC/PDF/973/mcdaniik.pdf](http://www.tsc.state.tn.us/OPINIONS/TSC/PDF/973/mcdaniik.pdf)

*Kenneth McDaniel v. CSX Transportation, Inc., 955 S.W.2d 257 (Tenn. 1997)*

Tennessee Supreme Court decision setting forth the factors of admissibility of scientific expert opinions in Tennessee. Essentially added a 5th step to Daubert's four factors. The 5th step: "Was the expert's research conducted independently of litigation?" A "McDaniel hearing" would be the legal standard to weigh admission of scientific expert testimony in "The Alliance Protocol". Tennessee has its own trilogy with the addition of decisions rendered in *State v. Stevens, 78 S.W.3d 817 (Tenn. 2002)* and *Charles Brown v. Crown Equipment Corp., 181 S.W.3d 268 (Tenn. 2005)*.

See Table 4: Additional Online Resources

If no such motion is filed or voir dire conducted and the presiding judge deems the expert qualified, counsel should challenge the expert witness' credibility and basis for opinion through cross-examination disclosing the faulty logic (F.R.E. 607). It then becomes the duty of the jury to weigh and evaluate the credibility of both positions. The medical profession's quest for perfection in the judicial system is unrealistic and seemingly impossible to meet. Juries will occasionally make mistakes; so do health care professionals. The appeal process exists for a true miscarriage of justice and errors of law.

## Defense' Opening Arguments

In 1998, the AMA adopted the position that giving expert medical testimony constitutes the practice of medicine and is therefore subject to peer review (Reardon, 1998). The thrust of this decision made current licensure a requirement for serving as an expert witness and sanctions for false, biased, or unscientific testimony a reality (American Academy of Pediatrics [AAP], 1994; ACEP, 1997).

Expert testimony is required because the courts have long recognized that the specialized scientific knowledge base of the physician exceeds the understanding of the average juror (F.R.E. 702). The physician must therefore act as teacher and guide with regard to complex medical terminology and procedures, and must possess a solid background in the designated specialty about which the physician is asked to testify (American College of Emergency Physicians [ACEP] 1997; American Association of Neurological Surgeons [AANS], 2006; American College of Obstetricians and Gynecologists [ACOG], 2007). It is the physician's duty to instruct the jury on equally acceptable treatments and procedures and to identify any personal opinions or theory that vary significantly from generally accepted specialty practice (AMA, 2004; AANS, 2006). The expert witness is not an advocate for either side (Council on Ethical and Judicial Affairs Report, 2004). Zealotry should be viewed with absolute skepticism. The expert witness is there to educate not advocate.

## The Witnesses

A physician's testimony may carry profound weight with the jury. With that influence comes a tremendous responsibility toward ethical behavior. Debate about the appropriateness of professional organizations self-policing takes on a special significance when viewed in light of the deference that our courts pay to the physician's opinion.

Several cases dominate the online literature available regarding peer review of expert testimony (see Table 3). Following a 6-month suspension by the American Association of Neurological Surgeons, Donald Austin brought suit against the Association, claiming he was suspended in retaliation for his expert medical testimony against another Association member. He further asserted that he had experienced significant economic loss as a result of the suspension. The final adjudication of *Austin v. AANS* (2001) spawned a vitriolic denunciation by the 7th Circuit Court of Appeals. The 7th Circuit's decision held that Austin's claims of retaliation and economic devastation were without merit.

In *Re Gary James Lustgarten* (2006), the North Carolina Court of Appeals reversed a decision finding Lustgarten had testified in bad faith in a medical negligence trial and further remanded the case to the trial court to dismiss the disciplinary proceedings by the North Carolina Medical Board against Lustgarten. Lustgarten had testified against



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two neurosurgeons in a medical malpractice claim that involved a young man's post-operative complication and subsequent death.

In a third case, *Burgess v. Busby* (2001), the jury brought suit against a defendant doctor for inappropriate post-trial activities. Although Busby had been absolved of negligence, his fellow physician was found negligent and the jury awarded \$150,000.00 to the plaintiffs. This resulted in Busby placing a letter in the physicians' internal mailboxes at Rowan Regional Medical Center that contained the names and addresses of the individual jury members under the heading "Jurors who have found a doctor guilty." Two other categories, "People who have sued doctors" (listing the plaintiffs) and "Others of whom I am leery" (plaintiff's witnesses), were also contained in the letter. The jury, in turn, filled suit against the doctor for taking this action. The original dismissal of the lawsuit was remanded to the trial court for further proceedings on intentional infliction of emotional distress, common law obstruction of justice, and punitive damages.

**Table 3. F.R.E. Expert Testimony and Selection of Laws Affecting Peer Review.**

*This list is not exhaustive. It is meant only to provide introductory information to the reader on laws affecting the expert witness testimony and the peer-review process.*

**Rule 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 upon 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.

**Rule 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 the expert 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. 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.

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### Rule 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, if 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 reasonable compensation in whatever sum the court may allow. The compensation thus fixed is 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 expert witnesses of their own selection.

### Title IV of Public Law 99-660. The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98

#### U.S.C. Title 42 The Public Health and Welfare Chapter 117

Encouraging Good Faith Professional Review Activities

[www.npdb-hipdb.hrsa.gov/legislation/title4.html](http://www.npdb-hipdb.hrsa.gov/legislation/title4.html)

### Individual States' Medical Practice Act

(See References and Resources column)

### U.S. Constitution Amendment I (Freedom of Speech) and Amendment XIV (Due Process)

As case law in this area expands, precedents in criminal law (perjury), contract law (breach of contract) and Federal False Claims Act Whistleblower Statutes (anti-retaliation) may develop.

## Plaintiff's Closing Arguments

The rules of evidence exist to protect the jury from confusing, misleading, or emotionally overwhelming material (F.R.E. 403). The remedy for exposing unfounded testimony is not to blame the legal system or to empower total self-regulation of professional medical organizations. The law provides for the inherent imperfect nature of medicine by providing defensible positions. States have significant power to govern themselves, and many jurisdictions recognize that a physician may use his best judgment with unfavorable results (Boumil, Elias, and Moes, 1995). The law may also recognize that a respectable minority may choose an alternate path of treatment, or that there are two equally acceptable schools of thought (Boumil et al, 1995). If the jury feels that the defendant was not negligent, they are given recourse in the jury charge (F.R.C.P. 51(b)).

As a society, we can agree that patients should be protected from substandard medical care and that legitimate claims of

medical negligence should be allowed in the trial courts. In the 1970s, the Courts moved to a national standard of care and away from the locality rule of the 1880s because injured plaintiffs were being denied access to the expert testimony that plaintiffs must have to present their claims (Lewis, Gohagan, and Merenstein, 2007). Closed communities of referral-based practices prevented local physicians from testifying on the plaintiff's behalf. To balance the scales, the Courts allowed witnesses to look outside these communities for experts (Lewis et al, 2007). A return to the locality rule and legislation to require in state licensure for expert witnesses as part of the peer review movement by many medical societies would again deny legitimate claims due process.

## Defense's Closing Arguments

In the true spirit of the law, there should be a concerted effort to arrive at the truth. Political activism toward change is a way to assure that only legitimate claims enter the legal process. Other than listening to medical experts testify, what scientific understanding of medicine does the judiciary have? Law school curriculum does not provide for an education equivalent to a medical degree.

Judges are experts at law, not medicine. Their experience and exposure to the litigated medical issues may well be limited to the trials they have been randomly assigned to hear. Federal Judges have immediate access to the *Reference Manual on Scientific Evidence*, Second Edition (2000) to help them understand the complexities of matters litigated pertaining to epidemiology, statistics, multiple regression, engineering practices and methods, DNA evidence, toxicology, and survey research, to name a few, but obviously the science is much more complicated than one voluminous text. If physicians deliver dishonest or fraudulent medical testimony, they discredit physicians as a group and endanger the public's trust in physicians (CEJA Rep., 2004). Who better to evaluate the quality of a physician's testimony than a physician of similar training and education?

## The Verdict

Much of the drive toward peer review of expert testimony is based on the tort reform and the numbers projected to runaway juries and sky-rocketing insurance premiums. Understanding this helps to illustrate the importance of accuracy in reporting negligent acts and accurate settlements.

Under The Health Care Quality Improvement Act, 45 Code of Federal Regulations (C.F.R.) § 60.7, any entity that makes a payment under an insurance policy or self-insurance program on behalf of a health care provider in settlement of a judgment in a medical malpractice claim has the duty to report occurrences to the NPDB. Belief in the number of medical malpractice payouts by insurance carriers is one of the platforms on which the need for peer-review is built. The payouts are judged largely by data collected from the statistics provided by the National Practitioner Data Bank (NPDB), and the accuracy of these numbers is of paramount importance.

Unfortunately, the occurrence of potential under-reporting to the NPDB is a widely documented problem (Baldwin, Hart, Oshel, Fordyce, Cohen, and Rosenblatt, 1999; OIG Report, 2005). The problem of under-reporting is potentially two-fold: 1) failure to report and 2) lack of follow-up and enforcement for those failing to report from within the governmental agencies themselves (GAO report, 2000; Waters, Parsons, Warnecke, Almagor, and Budetti, 2003; Adams, 2005; Pear, 2005; Jablow, 2006). There is more malpractice and incompetence occurring than reported, and accurate reporting has the potential to cause a further detrimental impact in the form of an increased malpractice premiums and payouts. The foundation for building a platform needs to be solid.

## Grounds for Appeal

When attorneys are ill, they seek the advice of physicians. When physicians are sued, they seek the advice of an attorney. The adversarial nature of the physician/attorney relationship does little to promote society's well-being. One attempt to find common ground is being tested in Chattanooga, Tennessee. Spearheaded by W. Neil Thomas, III, a Hamilton County Circuit Court Judge, the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association

began a joint effort in 2005 to implement the "Alliance Pilot Program" to promote sound and accepted medical expertise in trial ("Judge Thomas," 2005). The program reviews the intended medical opinion before trial by the assigned judge. Where indicated, an independent medical expert may be appointed to evaluate the validity of the scientific opinion (on both sides). Following the evaluation, the independent medical expert testifies whether the opinions satisfy the necessary factors and survive challenge at a McDaniel Hearing (similar to a Daubert hearing). Objective tracking of the program's outcomes may yield insight into the feasibility of this joint venture in other areas.

Unfortunately, achieving understanding between the two professions is not likely to happen soon. Illustrating the divergent positions of medicine and law is the ACEP's current Medical Legal Review option for members (see Table 4). Members are encouraged to forward deposition transcripts, medical records, and other documentation to a 12-member committee of physicians from the ACEP membership for cases they find representative of "egregious testimony" and not reflective of a breach in the standard of care. The reviewers are blind to parties, and a panel reviews the documents.

Once reviewed, the panel posts the results of the combined effort for members to review. Unfortunately, the conclusions and judgments rendered on the adherence to the standard of care and expert witness' opinion are frequently made in the absence of information such as the plaintiff's medical records. The absence of all essential documents in determining a health care provider's negligence or the accuracy of an expert witness' opinion would be impossible to evaluate from a legal perspective. A similar system in practice through the ACOG Grievance Committee or Florida's Hillsborough County Medical Association "Board of Censors" may provide foreshadowing of the future of the peer-review system of expert witness testimony (Luria and Agliano, 1997; Walker, 2005).

A particularly troubling issue is the connection between physician suicide and the legal process (Andrews, 2005; Leone, 2005). An understandably emotionally charged example that may have found solid camaraderie among medical professionals is that of Philip Ticktin, M.D., a highly respected, extremely well-liked emergency room physician. The details of Dr. Ticktin's experience with the legal system tells of a caring provider unjustly accused of medical negligence embroiled in an unfounded legal claim and slow tortuous litigation process. The disturbing conclusion of Dr. Ticktin's story is his suicide and his written wish that his death shed light on an unjust legal process (Sessions, n.d.). The trigger for this tragic loss was the overwhelming stress, frustration, and discouragement that Dr. Ticktin experienced in his prolonged legal battle, but as any qualified physician must readily concede, what took Dr. Ticktin's life was the underlying, uncontrolled depression.

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**Table 4. Additional Online Resources for Topic Related Material on Expert Testimony.**

*This is not an all-inclusive listing of online resources nor is this an endorsement of any services or information. As with all online resources, the reader is cautioned to independently evaluate the website for credibility.*

**www.mcandl.com/**

Home page for McCullough, Campbell & Lane, LLP. Listing for States' criteria regarding expert witness testimony. Choose MCL Publications > Summary of Medical Malpractice Law > Index of States > Scroll to Expert Witness in desired state

**www.citizen.org/publications/release.cfm?ID=7234**

Listing of State's Disciplinary Ranking for Physician Sanctions (2002)

**www.npdb-hipdb.hrsa.gov/**

The National Practitioner Data Bank

**www.idex.com**

Promoted as The Collaborative Network for Expert Witness Research. As promoted on the Google listing, IDEX expert witness research assists defense attorneys and insurance companies in locating expert testimony, expert transcripts, expert disciplinary actions. A part of the AAOS Professional Compliance Program and Expert Witness Clearinghouse Project, AAOS members voluntarily submit depositions to the AAOS who in turn forward the information to this "independent" company. Through an agreement with IDEX, AAOS fellows named as defendants in medical liability litigation may obtain information on "defense" expert witnesses.

**www2.aaos.org/aaos/archives/aaos\_rep/nov2006/Expert.asp**

**www.trialsmith.com/TS/**

Openly promoted as online databank exclusively for plaintiff lawyers.

**www.chattanooga.com/articles/article\_74807.asp**

*The Alliance Protocol* is a collaborative effort, pilot program between the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association to create a system of independent medical witness. The program has been endorsed by the AMA.

**www.ccemt.org**

Coalition and Center for Ethical Medical Testimony (CCEMT). Co-founders A. Bernard Ackerman, M.D and Louise Andrew, MD, FACEP, JD.

*Author's Note: Search for this Web site has led to site currently under construction, intermittently indexed through the waybackmachine.org and redirection to www.CCEMT.net, some static pages are available at: <http://ccemt.affiniscape.com/displayindustrynews.cfm?industrytopicnbr=437>*

**www.cpwb.org/**

The Center for Professional Well-Being. Founded in 1979, promoted as offering solutions toward physician satisfaction, resiliency and effectiveness. Offers services in Litigation Stress Management among other services

## The LNC's Role in Mediating Fairness

The call to action is to determine honest differences of opinion from fabrication. An essential tool of law is the discovery process. Nothing replaces focused attention to the details of the discovery process, or thorough investigation and follow-through in the pre-trial stage. Screening cases for medical/nursing negligence provides the LNC the opportunity to illuminate both the strengths and weaknesses of the case and provides a front-line position in assisting the attorney in evaluating unfortunate outcomes from true malpractice.

In retaining experts, thorough examination of the experts credentials and prior testimony via established deposition banks will help ensure objectiveness. These should be actively sought and reviewed if there is any question as to the veracity of the proffered witness. The expert's publications on both sides should be retrieved and reviewed.

The LNC also should investigate the aftermath of the scientific literature relied on. While remaining within the confines of literature reflecting the state of knowledge at the time of the alleged negligence, letters to the editor and commentary questioning the flaws in recently published data are often found in the subsequent journal. The LNC's role is to provide the attorney-client with objective and exhaustive research of the matter under review.

The exposed jugular vein of peer review by medical societies may well be the movement's collegiality with tort reform. An issue that might otherwise find merit with an audience of informed consumers may do well to divorce itself from this arrangement. The thinking person is left trying to balance legitimate review against personal agendas. This allegiance may provide momentum among physicians but does not add any measure of credibility from a consumer's perspective. An undercurrent of medical paternalism in questioning the jury's intellect at the disciplinary proceedings against expert witnesses only serves to undermine the nobility of the medical profession. According to the AMA Principles of Medical Ethics (1992), physicians are obligated to speak up when obvious negligence is at issue.

Whether or not the defendant health care provider feels the claim is warranted is not a stand-alone issue. Rallying against perceived injustices will do little to unearth the truth and ensure justice. Defendant physicians will need to work with their counsel and become available members of the trial team (Dodge and Fitzer, 2006; Anderson, 2005). The noblest motivation for peer review of expert testimony does not lie at either extreme of the political opinion. Its value is found closer to ethical epicenter of assuring patients safe, quality health care. The medical, nursing, and legal professions all have a duty in honoring this directive.

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# Practicing Within the Obstetric Nursing Standard of Care

Patricia D. Fedorka, PhD RNC, & Judith Sullivan, BSN RN

Obstetrics is one of the most highly litigated areas of medicine. Inpatient obstetric care (labor and delivery) results in more than 50% of all the obstetrical claims (White, Pichert, Bledsoe, Irwin, & Entman, 2005). Although nurses are not often named as individual defendants at the onset of a medical malpractice case, hospitals usually are. Once that occurs, all employees of the hospital, including the nursing personnel, will be scrutinized by a nursing expert to determine the nurses' adherence to national nursing standards in the care they provided to the patient. In a Sentinel Event Alert in July of 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) stated that most perinatal deaths and injuries are caused by an organization's culture and the miscommunication among caregivers (JCAHO, 2004).

The informed, educated legal nurse consultant (LNC) can assess and evaluate the particular areas identified as potentially high risk in the labor and delivery process. The following case studies review two different medical malpractice cases and reflect some of the most common areas for litigation in labor and delivery. The case studies present the salient demographics, patient issues, interventions undertaken by the registered nurse, and the outcomes of the cases. The article concludes with a glossary to familiarize readers with terms common in obstetrics.

## Legal Case Study #1

### Background Demographics

In 2004, Mrs. P. was a 31-year-old, gravida 2, para 0 (this was Mrs. P.'s second pregnancy with no past deliveries). Her expected date of delivery was June 1, 2004. Her lab work was all within normal limits: O positive, Rubella immune, Hepatitis B negative, VDRL non reactive, and Group Beta Strep negative. Mrs. P.'s pre-pregnant weight was 215 pounds and she gained 27 pounds during the pregnancy. Her first prenatal visit was on October 30, 2003, for a total of 14 prenatal visits. There was no significant medical or obstetrical history.

Ms. P. was admitted on June 7, 2004, to a community hospital in a Mid-Atlantic state. Her vital signs were: blood pressure 131/91, temperature 99.4, heart rate 98, and respirations 20. She was having mild contractions every 3 minutes, lasting 45 - 50 seconds, considered a normal labor pattern. She was 3 centimeters dilated, -2 station, and 90% effaced.

External electronic monitoring was initiated at 18:54. According to the labor nurse's documentation, the fetal heart rate was in the 150s, with average variability and no

late decelerations (all within normal ranges). However, the plaintiff experts testified that the staff nurse had incorrectly interpreted the fetal heart rate (FHR). In their opinion, the FHR exhibited decreased-to-absent long-term variability and late decelerations with more than 50% of the contractions starting at 19:05. Long-term absent variability and recurring late decelerations are signs of a nonreassuring fetal heart rate tracing, which should have resulted in nursing interventions and physician notification.

At approximately 23:25, the nurse did a vaginal exam and applied scalp stimulation with no response in the FHR. Because scalp stimulation should produce acceleration in the FHR, the absence of such acceleration is considered a non-reassuring sign. At 01:00, the FHR had a deep variable deceleration into the 60s for over a minute. Although severe variable deceleration of decrease in FHR to the 60s lasting for at least 60 seconds is also considered nonreassuring, neither of the two incidences resulted in physician notification or nursing interventions for a non-reassuring FHR pattern such as 10 liters of oxygen by tight face mask, position changes, and an increase in the IV fluid.

At 20:53, the tocodynamometer was no longer picking up contractions for the remainder of the labor until the patient was taken to the OR at 03:25 the next morning. Standards of care dictate that if a reading cannot be maintained with external monitoring, internal monitoring should be instituted. Without the ability to assess contractions, vital information is missing from the fetal assessment picture.

At 01:45, the physician was present and performed artificial rupture of membranes for thick meconium, which is usually an indication that the fetus had experienced repeated hypoxia in utero. The attempt to insert an intrauterine pressure catheter (IUPC) was unsuccessful. (Standards of care dictate that if the IUPC is unable to be inserted, the nurse has the duty to attempt to hand-hold the tocodynamometer to assess contractions.) An Internal Scalp Electrode (IFM) was applied to assess the FHR. Beat-to-beat variability was present with periods of both decreased to average long-term variability, which is considered reassuring. The patient began to have repetitive variable decelerations to the FHR of the 50s for over a minute.

By 02:55, the variables were prolonged (more than 2 minutes long), and frequent overshoots with loss of long-term variability showed a pattern becoming more seriously compromised and ominous. The patient was 6 centimeters dilated, and the head remained high, an indication that the patient was not going to deliver in the near future. The

physician came onto the unit and examined the patient. After viewing the fetal monitoring strip, a decision was made to perform a cesarean section (but not considered an emergency). The patient was ordered a dose of Terbutaline, a medication that stops contractions. At 0325, Mrs. P was taken to the OR via bed and positioned on her left side. The scalp electrode was removed immediately upon entry to the OR, and no further assessment of the FHR was carried out (more than 35 minutes).

A 7-pound, 2-ounce female infant was delivered at 04:09 (74 minutes from decision time to do a cesarean section) with one loose nuchal cord. A pediatrician was at the delivery. According to the American College of Obstetrics and Gynecologists (2002), "...consensus has been that hospitals should have the capability of beginning a cesarean delivery within 30 minutes of the decision to operate" (p. 147). The infant was born limp, with no spontaneous respirations and a heart rate of less than 100. She was suctioned with a bulb syringe twice and suctioned with a catheter twice. She received oxygen via facemask and was bagged for 1-2 minutes. She was assigned the Apgar scores of 5 and 8, at 1 and 5 minutes, respectively. (A score of 8 to 10 indicates an infant in good condition, 4-7 indicates the need for stimulation, and lower than 4 indicates the need for resuscitation). The Apgar scores were later disputed as being artificially inflated.

The infant was initially given to the father to hold until the mother was returned to her post partum room. The first infant assessment was done by the Nurse B. at 04:30, at which time she documented "slight flaring and grunting" (flaring of the nostrils and grunting are usually indications of respiratory distress); however, no follow-up was done. No temperature or glucose assessments were carried. (It is important to frequently assess newborns for hypothermia due to their inability to regulate their temperatures which can lead to depletion in their limited glucose stores and contribute to respiratory distress). After this brief assessment, according to deposition testimony, the infant was returned to the mother and father to hold.

The second assessment was done in the nursery at 08:45 by Nurse B., who documented "slight grunting with stress." At 08:50, "head scrubbed for first bath" was documented, although the infant's temperature was 96.8 (the normal range is 97.7 to 99.3). According to AWHONN (2001), "The first bath should be delayed until after the newborn's temperature has stabilized and remains within normal limits for at least 2 to 4 hours to minimize the risk for hypothermia" (p. 6). The nurse's note states, "Infant noted to begin to grunt audibly and became dusky" (which are additional signs of respiratory distress). "Taken to infant warmer. When settled, infant skin color returned to pink without oxygen. Taken to room and

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placed in isolette. Temperature was 95.6, skin probe applied, warm blanket applied. 09:00 Rechecked temperature 95.8. Skin pink, respirations easy. 09:15 Infant found to be cyanotic and apneic. Stimulated with free flow. HR 130. Infant taken to NB nursery for glucose testing and cultures per Dr. M.”

Seizure activity was noted in the baby, 6-8 hours after delivery. The infant was transferred to a tertiary care center with a neonatal intensive care unit. During the hospitalization, the infant was diagnosed with hypoxic ischemic encephalopathy and treated for seizures and respiratory distress syndrome. The child, at present, suffers from devastating neurological impairments and will need 24-hour care for the rest of her life.

### Departures from Accepted Standards

The following represent departures from accepted standards of nursing practice:

1. *Failure of the nurse to competently assess/interpret the FHR tracing and recognize a non-reassuring/decompensating fetal heart rate tracing:* The nurse did not recognize recurrent late decelerations. She never documented or reported them. (The physician documented late decelerations in his progress notes). The nurse continually documented average variability when variability was decreased or absent. The nurse inaccurately documented variable decelerations as “20 seconds in duration,” when in reality they were more than 140 seconds. In deposition testimony, the nurse stated that she never was concerned about the tracing to a degree that she felt she needed to call the physician or to discuss any concerns about the strip with the physician when he was present.

According to the Association of Women’s Health Obstetrical and Neonatal Nursing (2003), the appropriate use of electronic fetal monitoring includes interpreting and evaluating the electronic fetal monitoring tracing. Nurses must have the knowledge and expertise to evaluate fetal heart rate and contraction patterns correctly to be able to differentiate between reassuring and non-reassuring patterns in order to institute appropriate interventions. According to both the American Nurses Association (2003) and the Association of Women’s Health, Obstetric and Neonatal Nurses (2003), the nurse has a duty to be competent in her area of expertise, which includes, for a labor and delivery nurse, the accurate interpretation of electronic fetal monitoring (EFM).

2. *Failure of the nurse to competently and adequately assess, interpret, and document fetal status with the use of EFM:* The nurse occasionally attempted to manually assess contractions, but very intermittently. The toco was not registering contraction for periods approximately 7 hours, which made it impossible to determine the timing of decelerations. During deposition and trial testimony, the father of the baby stated that the labor and delivery nurse encouraged him to hold the contraction monitor on his wife. The nurse testified, in her deposition, that

she did not have any entries that “said anything about the relationship of the uterine contractions when they occurred related to the fetal heart rate.” She stated, “she could not determine if some decelerations were late decelerations (non-reassuring) since the contractions were not printing out on the strip, yet she stated she was comfortable with her assessment.”

AWHONN (2003) addressed the necessity of using continuous monitoring with high-risk patients. This patient was considered high-risk due to periods of a non-reassuring FHR and thick meconium fluid. Also, according to the hospital’s policy on “Electronic Fetal Monitoring,” uterine activity must be monitored in correlation with fetal heart rate. This hospital policy was not followed.

A second hospital’s policy on “Meconium Stained Amniotic Fluid” stated that continuous fetal monitoring should be provided. This hospital policy was also not followed.

3. *Failure of the nurse to intervene and implement standard nursing interventions:* At no time were any nursing interventions carried out, despite severe variable decelerations, late decelerations, and decreased/absent variability. During the non-reassuring fetal heart rate pattern, the nurse should have implemented extrauterine resuscitative measures, which included increasing IV rate, position changes, and administration of oxygen at 8-10l liters by facemask (AWHONN, 2003).
4. *Failure of the nurse to follow national and hospital standards regarding frequency of fetal heart rate and contraction assessment:* According to AWHONN (2003), fetal heart rate should be monitored every 15 minutes in a high-risk labor patient in the active stage of labor. The defendant’s hospital policy on “Identification of High Risk Pregnancies” stipulates that the patient’s fetus should have been assessed and evaluated every 15 minutes in the active stage of labor. Despite national and hospital policies, the nurse assessed and documented only every 30 minutes
5. *Failure of the nurse to recognize a high-risk infant and monitor and treat appropriately in the post-partum period (low Apgars, meconium stained fluid, need for resuscitation with bag and mask, signs of respiratory distress including flaring and grunting, and hypothermia):* The American Academy of Pediatrics and the American Heart Association (2000) speak to the necessity of frequent infant assessments based on a variety of risk factors. The nurse did not perform frequent infant assessments. (No assessment was done from 04:30 to 08:45.) Washing the infant’s head at 08:45, with grunting and flaring and an abnormal temperature was against the defendant hospital’s policy, due to low temperature and signs of respiratory distress. Although the infant had become dusky, it was returned

to the parents. The nurse also neglected to notify the physician of the infant's compromised status.

6. *Failure of the nurse to follow pediatrician's standing orders:* The steps, in place per standing orders, were not followed: An infant should be placed in isolette with humidity for 2 hours following delivery for Dr. X.'s C-section babies. If the infant's temperature is 97 degrees or lower, the infant will be placed in radiant warmer, wrapped in a warmed blanket, until the temperature reaches 98 degrees. Temperature should be rechecked in an hour, and if it remains below 97 degrees, the nurse should place the infant in an isolette and notify the physician. Bathe the infant only when the temperature is stable at 97 degrees or higher. Get 2-hour blood sugars on all babies symptomatic of hypoglycemia. If cyanosis or respiratory distress present, start oxygen at 40% per head box and notify the physician.

### Discovery Process and Outcome

Following a lengthy discovery, the case was unable to be settled before the trial process. The defendant parties consisted of the hospital, which represented the nurses, and the physicians who had independent counsel. The case went to trial. Due to the number of expert witnesses for the defense and the plaintiff, the trial lasted for more than 3 weeks.

Nursing experts for the defense (hospital nurses) testified that the care given by nurses at the delivering hospital was according to nursing standards and was not a factor in the baby's poor outcome. Plaintiff testimony by nursing experts stated that the care given by the nurses at the delivering hospital was not according to standards, and therefore was negligent. The witnesses stated that the aforementioned negligence contributed to the neurological injury sustained by the infant during the intrapartum period and by lack of timely and appropriate care in the immediate neonatal period.

After hearing the testimony presented by the defense and plaintiffs, the jury awarded the family \$17 million, the largest award in the state at that time.

## Legal Case Study #2

### Background Demographics

Mrs. S. was a 34-year-old G3P2 (third pregnancy, two previous deliveries) at 28 weeks of gestation (37-40 weeks is full term) under the obstetrical care of Dr. W. She was taken by private automobile to the emergency department (ED) of Titusville Hospital on December 8, 1994, following a one-car motor vehicle accident. Mrs. S. was the restrained driver when the car hit a tree, triggering the airbag to inflate.

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Upon presentation at 12:37, Mrs. S. was examined by Dr. L., the physician covering the ED. It was determined that she suffered a concussion with "trauma to the abdomen, jaw, neck, back and knees." The ED nurse noticed that the fetal heart rate (FHR) was 132 beats per minute by auscultation and that the "patient reports baby less active." After Obstetricians Drs. W. and F., and Internist Dr. T. discussed her condition, it was decided to transfer her at 13:30 to the OB Department for "monitoring."

Blood tests drawn in the ED at approximately 13:00 showed hemoglobin of 9.9 and a hematocrit of 32.5. The patient's hemoglobin and hematocrit had been 10.8 and 32.5 in August 1993. Her blood type was A positive.

At 13:33, Mrs. S. was admitted to the labor and delivery floor, with a blood pressure reading of 98/56 and pulse of 84. The telephone orders that were given to the labor room nurse by Dr. W. at 13:40 included continuous fetal monitoring, bedrest, prenatal vitamin daily, urinalysis with micro, and Tylenol II by mouth every 6 hours as needed.

At 13:45, Internist Dr. T. examined Mrs. S. at Dr. L.'s request. At that time, Mrs. S. was complaining of right side rib cage and abdominal pain. Dr. T.'s assessment was that Mrs. S. had a slight concussion, cervical strain, and possible lower rib fracture. He ordered a repeat complete blood count. At 14:00, she continued to complain of right jaw and rib pain, as well as lower abdominal and low back pain.

At 14:25, Mrs. S. was given two Tylenol tablets. She complained again about right side pain. Up until 14:30, no contractions had been noted. At this point in time, however, uterine irritability was noted and the fetus was noted to have variable decelerations. At 15:00, Mrs. S. complained of low pelvic pressure and right side and low back pain. The nurse noted that the Tylenol had been ineffective. No contractions were noted on the monitor, and the FHR was noted to be in the "150s increasing 160s with long-term variability +".

At 15:40, the results of the blood count drawn at 15:13 showed hemoglobin of 8 and a hematocrit of 22.8. Dr. T. was notified of these results, but he gave no orders at that time. At 17:00, the FHTs were recording "intermittently," with the FHTs 150s increasing to 80s "with "occasional variable decelerations and no contradictions."

Variable decelerations continued to be documented in most of the nursing notes. At 18:40, uterine irritability was noted long with positive long-term variability. At 20:30, the nursing notes indicate that contractions were occurring every 1-1.5 minutes with "sharp" variable decelerations.

Dr. F. was called. At 19:15, he ordered Darvocet II every 4 hours as needed for pain. At 20:40, he ordered Brethine 0.25 mg to be given subcutaneously. At 20:40, Brethine was given; however, the contractions continued. Mrs. S.'s complaint of cramping and left side tenderness was noted.

At 21:00, approximately 7.5 hours after admission to the labor room, Dr. W. was present in the patient's room. 10 minutes later, the IV was "open wide." Dr. W. also ordered an ultrasound of the pelvis "in A.M. first thing please," as well as a CBC also in the morning. At

21:50, Dr. W. examined Mrs. S.'s cervix and noted it to be closed and thick, with "no evidence of blood on glove." Her assessment of Mrs. S. at that time was that she had uterine irritability and generalized soreness. Dr. W. ordered a K-pad, analgesia, and continuous fetal monitoring, in addition to the pelvic ultrasound.

At 23:14, the results of the third hemoglobin and hematocrit of 8 and 22.8 were phoned to

Dr. W. No new orders were received. At 01:00 on December 9, 1994, the nurse documented "much tenderness of the abdomen." T 0130 "guarding" is noted. At 01:40, Dr. W. was notified of contractions, and, on her orders, Brethine was given at 01:45. At 02:30, Dr. W. was notified of an increase in the fetal heart rate, poor variability, and sharp decelerations. No orders were given.

At 03:45, Mrs. S.'s "cramps were more consistent" and were documented by the nurses as every 1.5 to 2 minutes. Darvocet was given. At 06:15, Mrs. S. reported that the pain in her side was less than it had been. At 06:35, her hemoglobin and hematocrit were reported to be 7.3 and 21, respectively.

At 07:30, the nursing documentation indicated that the fetal heart rate was 140s-150s with good variability and variable decelerations. Dr. W. was notified at 07:45, and she instructed the nurse to do a vaginal exam. The cervix was 1 cm and thick.

Dr. W.'s next visit was at 08:40. Mrs. S. was taken off the monitor and transported to the radiology department by wheelchair at 08:50. At 10:15, Mrs. S. returned to the labor room by gurney, bathed herself, and then was placed back on the monitor. Dr. W.'s next untimed note indicated that the results of the ultrasound showed "a partial separation of the placenta." She also commented at that time that "there are no signs of fetal distress." Dr. W.'s next note, also untimed, stated that the fetal heart rate pattern "appears to be sinusoidal." She obtained a consult from a Perinatologist, who suggested giving Mrs. S. two units of packed cells and transferring her to Magee Women's Hospital. The 10:15 nursing note also describes a sinusoidal fetal pattern "at times."

At 12:10, Mrs. S. was transferred to a tertiary care center and was administered oxygen. At 13:05, the first unit of packed red blood cells was started. The fetal heart rate was in the 160s, with decreased variability and "sinusoidal at times." Mrs. S. was taken to the operating room for a cesarean section at 14:10. From that time forward, there was no electronic fetal monitor recording of the fetus.

Baby boy S. was born at 14:55 and had Apgar scores of 1, 2, and 3 at 1, 5, and 10 minutes, respectively (a score of 8 to 10 indicates an infant in good condition, 4-7 indicates the need for stimulation, and fewer than 4 indicates the need for resuscitation). After a full resuscitation that included chest compressions, the infant was treated in the neonatal intensive care unit for more than 3 months. At discharge, the baby was diagnosed with hypoxic ischemic encephalopathy and suffers from profound neurologic defects including cerebral palsy and mental retardation.

## Departures from Accepted Standards

The fetal monitoring tracing was concerning at the time of admission to the labor and delivery area, as evidenced by a lack of variability and the presence of variable decelerations. The baseline fetal heart rate was in the 150 beat-per-minute (bpm) range. At approximately 14:10 on December 8, 1994, there was evidence of a sinusoidal heart rate pattern with decreasing variability and variable decelerations, a pattern that is smooth, uniform, within the normal heart rate range, and without periods of normal FHR reactivity. (This pattern is considered non-reassuring and is often seen in the presence of a fetal bleeding or anemia.)

At 14:39, a more pronounced sinusoidal tracing occurred and continued periodically throughout the remainder of the tracing. At 15:05, the baseline FHR has risen to the 160 bpm range, indicating a rise in baseline rate. The presence of decreased variability and a sinusoidal pattern with variable decelerations may indicate fetal hypoxia.

By 22:00, the baseline continued to rise and reached the 170 bpm range by 22:20. By 22:50, the variable decelerations become more prolonged and the variability became absent. The FHR tracing continued, as described above, into the early morning hours of December 9, 1994. Beginning at approximately 08:20, a persistently sinusoidal tracing was evident and continued until monitoring was stopped when Mrs. S. was taken to the operating room.

The significance of these findings indicates that, at the time of admission to the labor and delivery area, the FHR tracing was nonreassuring and concerning. By 14:39, it was clear that a sinusoidal pattern was developing, which can be the direct result of fetal anemia. The anemia can be the result of several etiologies, with placental abruption perhaps being the most common. By 22:50, it was clear that the FHR pattern was ominous, without any evidence of improvement for the duration of the tracing.

Failures of the standards of practice contributed to the injuries suffered by Baby boy S. The nursing care did not meet the standard of practice as evidenced by the following:

1. Failure to have Mrs. S. examined in person by an Obstetrician. This should have done as soon as Mrs. S.'s condition was deemed stable by the ED Physician, Dr. L., but certainly by 13:50 when it was clear that the FHR tracing was concerning.
2. Failure to monitor for fetal well-being on admission to the emergency department. A fetal monitor should have been brought to the emergency room immediately following Mrs. S.'s admission to the hospital.
3. Failure to recognize the ominous FHR pattern by 22:50 and arranging for Obstetrician presence after Mrs. S.'s transfer to the labor room.
4. Failure to institute fetal "resuscitation" by altering the maternal position, administering oxygen, and administering IV fluid hydration. Oxygen was not administered for more than 23 hours.
5. Failure to follow physician orders to monitor continuously.
6. Failure to recognize the signs and symptoms of possible abruption in a woman who has had direct abdominal trauma.
7. Failure to recognize the presence of uterine irritability by 19:50 on December 8, 1994, and obtaining Obstetrician presence to evaluate both maternal and fetal status.
8. Failure to recognize the significance of the subjective finding of decreased fetal movement as reported by Mrs. S. upon admission, as well the objective finding of decreased fetal extremity movement during the ultrasound examination.
9. Failure to recognize severe maternal anemia that was an early sign of maternal hemorrhage.
10. Failure to recognize that Brethine administration is contraindicated in women suspected of having an abruption.
11. Failure of the second nurse, assuming care for Mrs. S. at 07:00 on December 9, 1994, to evaluate the entire FHR tracing and note the ominous nature of the tracing and to obtain immediate Obstetrician presence.

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12. Failure to recognize that the need for narcotic control of pain mandates physician assessment of maternal condition prior to administration.
13. Failure to notify a supervisor that a woman who has had direct trauma to her abdomen was at risk of preterm labor and/or abruption and/or delivery.
14. Failure to follow hospital protocols that call for the notification of and consultation with the pediatrician for transport considerations to a tertiary hospital with a level 3 NICU if it is suspected that a woman may be delivering at less than 35 weeks gestation.
15. Failure to accompany an unstable obstetric patient when transported to radiology.
16. Failure to utilize an appropriate method for transporting Mrs. S. to radiology.
17. Failure to institute the chain of command when it was apparent that no Obstetrician was in the hospital 1) to evaluate Mrs. S. within the first hour of her admission to the labor and delivery area, 2) when narcotics were necessary to treat maternal pain, and 3) when no action was taken by the Obstetrician to evaluate fetal well being when the tracing became ominous as 2250.

## Outcome

[Creative: Please save space for ~200 words]

## Conclusion

Nurses must be cognizant that their actions will be assessed as to whether they met the nursing standard of care by a variety of measures. These include the State Nurse Practice Act, national professional organizations' publications, specialty professional organizations guidelines (AWHONN) and (ACOG), in-service training manuals and information, and hospital policies and protocols. The American Nurses Association (2003) clearly states that the nurse assumes responsibility and accountability for his/her nursing judgements and actions.

As professionals with our own licenses and duties, we are held responsible for providing competent, safe patient care. Failure to follow standards of care may not only result

in untoward outcomes for patients but may result in costly and time-consuming litigation.

## Glossary of Key Terms

Fetal heart rate definitions from the National Institute of Child Health and Human Development Research Planning Workshop, 1997:

**Acceleration:** a visually apparent *abrupt* increase (defined as onset of acceleration to peak in < than 30 seconds) in fetal heart rate above the baseline. The increase is calculated from the most recently determined portion of the baseline. The acme is equal to or greater than  $\geq 15$  beats per minute (bpm) above the baseline, and the acceleration lasts  $\geq 15$  seconds and < than 2 minutes from the onset to return to baseline. (Accelerations are considered to be a sign of fetal well-being).

**Amniotic fluid index (AFI):** the amount of amniotic fluid measured by ultrasonography in centimeters. AFI is expressed as the sum of the measurements of the deepest amniotic fluid pockets in all four abdominal quadrants. An amniotic fluid value of 5 or less serves as a red flag that requires some type of further assessment or management decision.

**Apgar Scoring:** the newborn is assigned an Apgar score at 1 and 5 minutes of life. The Apgar score is a quantitative description of the infant's response to the extrauterine environment and to resuscitation, but because scoring is not performed until one minute of life, it is not used to determine the need for resuscitation. When the newborn's Apgar score at 5 minutes is less than 7, scoring should be continued every 5 minutes for up to 20 minutes.

Apgar Scoring System			
	0	1	2
<b>Heart Rate</b>	Absent	Slow (<100 beats/min)	Normal (>100 beats/min)
<b>Respirations</b>	Absent	Irregular, slow	Regular, strong cry
<b>Muscle Tone</b>	Limp	Some flexion	Active motion
<b>Reflex Irritability</b>	No response	Grimace	Cough, sneezes or cry
<b>Skin Color</b>	Blue or pale	Body, pink extremities blue	Body and extremities pink

**Baseline fetal heart rate:** the approximate mean FHR rounded to increments of 5 bpm during a 10-minute segment, excluding

1. Periodic or episodic changes;
2. Periods of marked fetal heart rate variability and
3. Segments of the baseline that differ by > 25 bpm

**Bradycardia:** baseline fetal heart rate below 110 beats per minute for longer than 10 minutes.

**Cervical Dilation:** the process by which the cervical os and cervical canal widen from less than 1cm to approximately 10cm, allowing for the birth of the fetus.

**Deceleration:** a transitory decrease in the fetal heart rate from the baseline rate.

**Early deceleration:** a visually apparent gradual decrease (defined as onset of deceleration to nadir of 30 seconds) and return to baseline fetal heart rate associated with a uterine contraction. The decrease is calculated from the most recently determined portion of the baseline. It is coincident in time with the nadir of the deceleration occurring simultaneously to the peak of the contraction. In most cases, the onset, nadir, and recovery of the deceleration are coincident with beginning, peak, and ending of the contraction, respectively.

**Effacement:** the taking up (or drawing up) of the internal os and the cervical canal into the uterine side wells. The cervix changes progressively from a long, thick structure to a tissue-thin structure. Effacement is usually described in percentages from 0% to 100%.

**Electronic fetal monitoring:** an auditory and visual assessment of uterine activity and the fetal heart rate with data generated by electronic technology. Generated data includes a digital and graphic display and a permanent record on the paper of laser disk.

**Hypoxemia:** low levels of oxygen in the blood.

**Nonreassuring fetal heart rate pattern:** a fetal heart rate pattern that may reflect an unfavorable physiologic fetal response to the fetomaternal environment. A descriptive term.

**Overshoot:** exaggerated compensatory increase in the fetal heart rate after a variable deceleration, usually at least 10-20 bpm with no variability, no abruptness, and returns to the baseline gradually. Nonreassuring when repetitive and without baseline variability. Also referred to as rebound overshoot.

**Prolonged deceleration:** a visually apparent decrease in fetal heart rate below the baseline. The decrease is calculated from the most recently determined portion of the baseline. The decrease from the baseline is  $\geq 15$  bpm, lasting  $\geq 2$  minutes, but  $< 10$  minutes from onset to return to baseline. A prolonged deceleration of  $> 10$  minutes is a baseline change. Prolonged decelerations can be associated with stimuli, such as cord compression, uterine hypertonus, and response to medications. Prolonged decelerations are considered nonreassuring.

**Reassuring pattern:** a fetal heart rate pattern reflects a favorable physiologic response to the fetomaternal environment. A descriptive term.

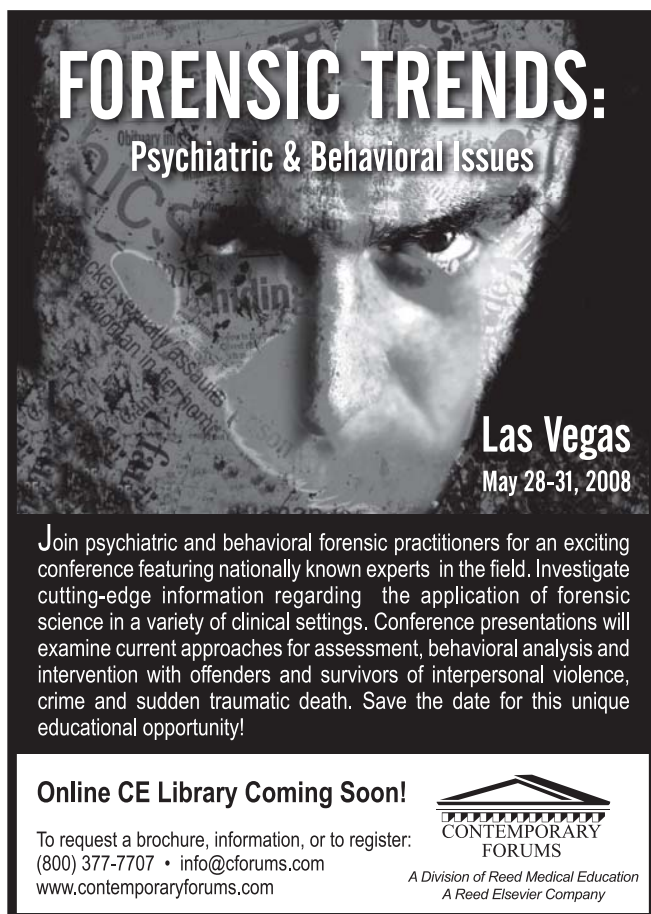
**Short term variability (STV):** changes in the fetal heart rate from one beat to the next. Measures the R-to-R intervals of subsequent fetal cardiac cycles (QRS). Presence reflects fetal reserve. Measured only by direct spiral electrode.

**Scalp Stimulation test (SST):** a test used during labor to assess fetal well-being by pressing a fingertip on the fetal scalp. A fetus not under excessive stress will respond to the digital stimulation with heart rate accelerations.

**Sinusoidal pattern:** a persistent sine wave or recurrent undulating FHT [should this be fetal heart rate?] that is smooth (absent short term variability), uniform, usually within the normal heart rate range, and without periods of normal fetal heart rate reactivity. This pattern is considered non-reassuring and is often seen in the presence of a fetal bleeding or anemia.

**Spiral Electrode:** an internal monitoring device, applied directly to the fetal presenting part, that receives signals from the electrocardiac impulses of the fetal heart. Used to directly determine fetal heart rate and short-term variability based on changes in the R-to-R intervals in successive QRS complexes.

**Station:** the relationship of the presenting part to an imaginary line drawn between the ischial spines of the maternal pelvis. If the presenting part is higher than the ischial spines, a negative number is assigned, noting centimeters above zero station. Station -5 is at the inlet, and station +4 is at the outlet. During labor, the presenting part should move progressively from the negative stations to the midpelvis at zero station and into the positive stations.



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**Tachycardia:** baseline fetal heart rate above 160 beats per minute for longer than 10 minutes.

**Tocodynamometer(tocotransducer):** an external monitoring device that detects changes in uterine shape through the abdomen. Provides information about relative frequency and duration of contractions. Strength of contractions must be manually palpated.

**Variable deceleration:** an abrupt decrease in the fetal heart rate from the baseline rate most commonly in response to compression of the umbilical cord. Deceleration is irregular in shape, timing, and depth. May be associated with contractions (periodic) or not associated with contractions (nonperiodic).

**Variability (baseline variability):** variations or fluctuations or the fetal heart rate during a steady state (in the absence of contractions, decelerations, and accelerations). Changes are due to sympathetic and parasympathetic innervation. Generally used to describe beat-to-beat changes (STV) and oscillatory changes (LTV). Monitoring method determines which type of variability can be reliably described.

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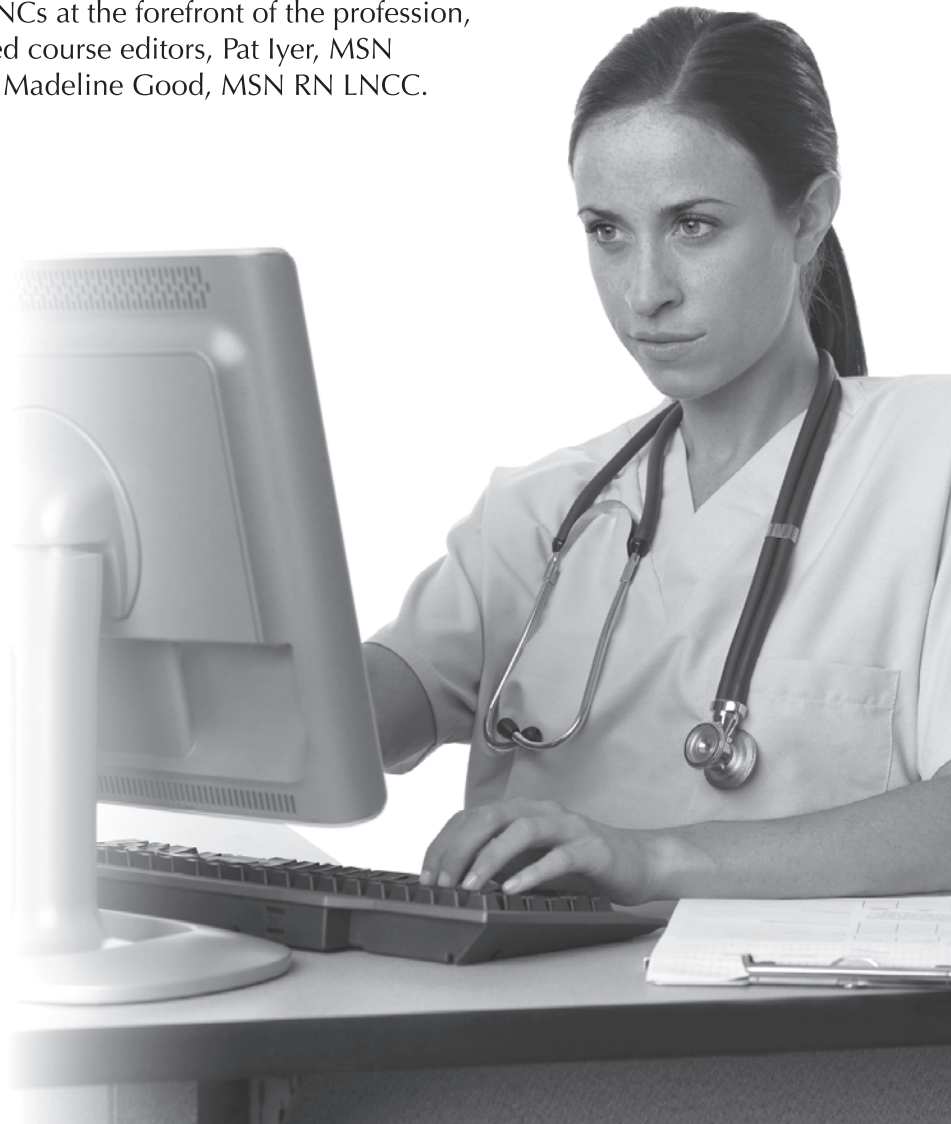
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or call 877/402-2562.



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AMERICAN ASSOCIATION OF  
LEGAL NURSE CONSULTANTS

# References & Resources

## Medical Boards and License Verifications

*Kara DiCecco, MSN RN LNCC*

The following table provides a listing of the Medical Boards/Licensing Verifications for physicians in the individual United States and District of Columbia. As always, the researcher is reminded to consult other authoritative legal resources for current law and regulations pertaining to licensure in contrast to relying solely on this information.

Alabama	<a href="http://www.albme.org">www.albme.org</a>	Alabama Board of Medical Examiners
Alaska	<a href="http://www.dced.state.ak.us/occ/pmed.htm">www.dced.state.ak.us/occ/pmed.htm</a>	State Medical Board
Arizona	<a href="http://www.azmd.gov/">www.azmd.gov/</a>	Arizona Medical Board
Arkansas	<a href="http://www.armedicalboard.org/index.asp">www.armedicalboard.org/index.asp</a>	Arkansas State Medical Board
California	<a href="http://www.medbd.ca.gov/">www.medbd.ca.gov/</a>	Medical Board of California
Colorado	<a href="http://www.dora.state.co.us/Medical/">www.dora.state.co.us/Medical/</a>	Board of Medical Examiners
Connecticut	<a href="http://www.ct.gov/dph/site/default.asp">www.ct.gov/dph/site/default.asp</a>	Boards and Commissions > Connecticut Medical Examining Board
Delaware	<a href="http://www.dpr.delaware.gov/boards/medicalpractice/index.shtml">www.dpr.delaware.gov/boards/medicalpractice/index.shtml</a>	Board of Medical Practice
District of Columbia	<a href="http://hpla.doh.dc.gov/hpla/site/default.asp">http://hpla.doh.dc.gov/hpla/site/default.asp</a>	Health Professional Licensing Administration
Florida	<a href="http://www.doh.state.fl.us/mqa/medical/index.html">www.doh.state.fl.us/mqa/medical/index.html</a>	Florida Board of Medicine
Georgia	<a href="http://medicalboard.georgia.gov/02/csbme/home/0,2458,26729866,00.html">http://medicalboard.georgia.gov/02/csbme/home/0,2458,26729866,00.html</a>	Composite State Board of Medical Examiners
Hawaii	<a href="http://www.hawaii.gov/dcca/areas/pvl/boards/medical/">www.hawaii.gov/dcca/areas/pvl/boards/medical/</a>	Department of Commerce and Consumer Affairs Licensing Area
Idaho	<a href="http://www.bom.state.id.us/">www.bom.state.id.us/</a>	Idaho Board of Medicine
Illinois	<a href="http://www.idfpr.com/dpr/WHO/med.asp">www.idfpr.com/dpr/WHO/med.asp</a>	Division of Professional Regulation
Indiana	<a href="http://www.in.gov/pla/bandc/mlbi/">www.in.gov/pla/bandc/mlbi/</a>	Medical Licensing Board of Indiana
Iowa	<a href="http://www.docboard.org/ia/ia_home.htm">www.docboard.org/ia/ia_home.htm</a>	Iowa Board of Medicine
Kansas	<a href="http://www.ksbha.org/">www.ksbha.org/</a>	Kansas State Board of Healing Arts
Kentucky	<a href="http://kbml.ky.gov/default.htm">http://kbml.ky.gov/default.htm</a>	Kentucky Board of Medical Licensure
Louisiana	<a href="http://www.lsbme.louisiana.gov/">www.lsbme.louisiana.gov/</a>	Louisiana State Board of Medical Examiners
Maine	<a href="http://www.docboard.org/me/me_home.htm">www.docboard.org/me/me_home.htm</a>	Board of Licensure in Medicine
Maryland	<a href="http://www.mbp.state.md.us/">www.mbp.state.md.us/</a>	Board of Physicians
Massachusetts	<a href="http://www.massmedboard.org/">www.massmedboard.org/</a>	Board of Registration in Medicine
Michigan	<a href="http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27541---,00.html">www.michigan.gov/mdch/0,1607,7-132-27417_27529_27541---,00.html</a>	Michigan's home page > Dept. of Health and Human Services > List of Agencies (right-hand menu) > Community Health > Medical (left-hand menu) Department of Community Health
Minnesota	<a href="http://www.state.mn.us/portal/mn/jsp/home.do?agency=BMP">www.state.mn.us/portal/mn/jsp/home.do?agency=BMP</a>	Minnesota Board of Medical Practice
Mississippi	<a href="http://www.msbml.state.ms.us/">www.msbml.state.ms.us/</a>	Mississippi Board of Medical Licensure
Missouri	<a href="http://www.pr.mo.gov/healingarts.asp">www.pr.mo.gov/healingarts.asp</a>	Missouri Division of Professional Regulation
Montana	<a href="http://mt.gov/dli/bsd/license/bsd_boards/med_board/board_page.asp">http://mt.gov/dli/bsd/license/bsd_boards/med_board/board_page.asp</a>	Board of Medical Examiners <a href="http://www.dphhs.mt.gov/azindex.shtml">www.dphhs.mt.gov/azindex.shtml</a> > Professional Licensing
Nebraska	<a href="http://www.dhhs.ne.gov/crl/medical/medsur/medindex.htm">www.dhhs.ne.gov/crl/medical/medsur/medindex.htm</a>	Nebraska Department of Health and Human Services: Medicine & Surgery
Nevada	<a href="http://www.medboard.nv.gov/">www.medboard.nv.gov/</a>	State of Nevada Board of Medical Examiners
New Hampshire	<a href="http://www.nh.gov/medicine/">www.nh.gov/medicine/</a>	New Hampshire State Board of Medical Examiners
New Jersey	<a href="http://www.state.nj.us/lps/ca/bme/index.html">www.state.nj.us/lps/ca/bme/index.html</a>	Division of Consumer Affairs: State Board of Medical Examiners
New Mexico	<a href="http://www.nmmb.state.nm.us/">www.nmmb.state.nm.us/</a>	New Mexico Medical Board

New York	<a href="http://www.op.nysed.gov/">www.op.nysed.gov/</a>	Office of the Professions <a href="http://www.op.nysed.gov/bdcomp.htm">www.op.nysed.gov/bdcomp.htm</a> > Medicine <a href="http://www.op.nysed.gov/med.htm">www.op.nysed.gov/med.htm</a>
North Carolina	<a href="http://www.ncmedboard.org/">www.ncmedboard.org/</a>	North Carolina Medical Board
North Dakota	<a href="http://www.ndbomex.com/">www.ndbomex.com/</a>	North Dakota State Board of Medical Examiners
Ohio	<a href="http://med.ohio.gov/">http://med.ohio.gov/</a>	State Medical Board of Ohio
Oklahoma	<a href="http://www.okmedicalboard.org/">www.okmedicalboard.org/</a>	Oklahoma Medical Board of Licensure & Supervision
Oregon	<a href="http://egov.oregon.gov/BME/">http://egov.oregon.gov/BME/</a>	Board of Medical Examiners
Pennsylvania	<a href="http://www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&amp;q=432799">www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&amp;q=432799</a>	State Board of Medicine <a href="http://www.dos.state.pa.us/dos/site/default.asp">www.dos.state.pa.us/dos/site/default.asp</a> > "Becoming a Licensed Professional > Medicine
Rhode Island	<a href="http://www.health.ri.gov/hsr/bmld/index.php">www.health.ri.gov/hsr/bmld/index.php</a>	Board of Medical Licensure and Discipline
South Carolina	<a href="http://www.llr.state.sc.us/pol/medical/">www.llr.state.sc.us/pol/medical/</a>	South Carolina Board of Medical Examiners
South Dakota	<a href="http://doh.sd.gov/boards/medicine/">http://doh.sd.gov/boards/medicine/</a>	South Dakota Board of Medical & Osteopathic Examiners
Tennessee	<a href="http://health.state.tn.us/licensing.htm">http://health.state.tn.us/licensing.htm</a>	Department of Health (choose For Healthcare Professionals)
Texas	<a href="http://www.tmb.state.tx.us/">www.tmb.state.tx.us/</a>	Texas Medical Board
Utah	<a href="http://www.dopl.utah.gov/">www.dopl.utah.gov/</a>	Utah Division of Occupational & Professional Licensing
Vermont	<a href="http://healthvermont.gov/hc/med_board/profiles.aspx">http://healthvermont.gov/hc/med_board/profiles.aspx</a>	Department of Health: Board of Medical Practice
Virginia	<a href="http://www.dhp.state.va.us/medicine/">www.dhp.state.va.us/medicine/</a>	Virginia Board of Medicine
Washington	<a href="https://fortress.wa.gov/doh/hpqa1/hps5/Medical/default.htm">https://fortress.wa.gov/doh/hpqa1/hps5/Medical/default.htm</a>	Medical Quality Assurance Commission
West Virginia	<a href="http://www.wvdhhr.org/wvbom/">www.wvdhhr.org/wvbom/</a>	West Virginia Board of Medicine
Wisconsin	<a href="http://drl.wi.gov/prof/doct/def.htm">http://drl.wi.gov/prof/doct/def.htm</a>	State of Wisconsin Department of Regulation & Licensing
Wyoming	<a href="http://wyomedboard.state.wy.us/">http://wyomedboard.state.wy.us/</a>	State of Wyoming Board of Medicine



# Settlement Negotiations and the LNC's Role

Janet M. Eads, BSN RN

**Q: What are settlement negotiations? When and why do they occur, what do they involve, how should they be conducted, and how can the LNC assist in their resolution?**

**A: A settlement negotiation is a bargaining process among two or more parties, using a give and take approach while attempting to arrive at a mutual agreement or settlement.**

Every one of us engages in some type of negotiation in our daily lives – with our spouses, children, co-workers, or employers. Settlement negotiations are usually found in the legal arena in the areas of business transactions, labor/management, criminal matters, and civil disputes. For our purposes, legal nurse consultants (LNCs) deal more frequently with civil disputes such as personal injury, product liability, or medical malpractice issues, and can be a valuable asset moving cases to resolution.

An LNC can become involved in the process of settlement negotiations as an independent consultant or as an employee of a law firm, insurance company, or third party administrator. In my experience, the LNC's role in this process usually occurs on the side of the defense, while the claimant, i.e. the plaintiff, can be the individual representing himself or the person may be represented by an attorney. Please be aware, however, that it is a requirement in some states to have an adjuster's license in order to negotiate claims.

Statistics reveal that settlement negotiations succeed in 90% to 95% of all claims, which means that only 5% to 10% proceed to trial. One may ask, "Why negotiate a settlement?" Negotiations are advantageous in clearing already overcrowded court dockets, eliminating the costs of trial and its preparation, avoiding the additional stress of participating in the litigation process, and recognizing the reality that either side could have non-credible witnesses and lose in trial.

### Stages of Settlement

Settlement negotiations can occur anytime in the litigation process – before, during, or after trial, as well as before or after appeal. The stages in negotiations include positioning, argumentation, crisis, and either resolution or continuation to trial:

1. Positioning begins with each side presenting and discussing in generalities the merits of the case. The

claimant usually demands a settlement amount that is higher than he or she anticipates receiving, or requests an amount considered fair to all involved parties. In most instances, each side's position is on either end of the spectrum.

2. Both sides then argue their case, and, ideally, both parties make concessions to settle the claim in order to close the gap on these distances. While exchanging information, both parties see the strengths and the weaknesses of each side materialize.
3. When a deadline to settle a claim approaches, a crisis can emerge. The respective negotiators must decide if they can make any further concessions or present any other alternatives to reach a settlement.
4. If the parties agree to a settlement, a decision needs to be made regarding the details of the agreement. If a settlement cannot be reached, however, the claim can escalate into suit and proceed to trial.

Cases must be thoroughly investigated and reviewed before beginning the negotiation process. The absence or presence of liability must also be determined; however, a claim should not be settled before the plaintiff is fully aware of the extent of his or her injuries. One should only proceed with this process if the claimant's condition has stabilized or the individual's treatment for the alleged injury has been completed. This is especially important because, once a claim is settled, the plaintiff cannot claim that his or her injury is more severe and request further compensation.

The LNC involved in the settlement negotiation must have thorough understanding of claim handling, as well as knowledge of the laws regulating it. Negotiations should involve a good faith effort to settle the claim fairly. There is also a need to be cognizant of negligence or any other statutory laws in the jurisdiction in which the claim occurred.

The consultant must complete a comprehensive analysis of the claimant's condition and damages.

The plaintiff, with or without an attorney, must present his or her theory of liability and supporting arguments clearly so that effective negotiations can take place. In order to accomplish this, reserves for a claim are set by assessing a monetary value, which assists the individual on the side of the defense in negotiating the claim to arrive at a settlement range. Strategy should be planned to include low-end, middle, and high-end settlement offers. A reserve is an estimation of how much it will cost to settle the claim. Included in this amount are expenses such as actual and/or projected medical costs, pain and suffering, and loss of income. Claim reserves are usually set by the experience of the person handling or adjusting the claim, as well as by reviewing the previous outcomes of similar cases.

Ideally, negotiations should be conducted in a friendly and positive manner. There should be areas of agreement regarding the claim, but parties can also "agree to disagree" on certain aspects of the case. All parties involved, from both plaintiff and defense, should listen to the others' ideas, summarize their opponents' comments, and ask questions regarding the details and facts supporting their positions.

## Conclusion

In conclusion, the plaintiff typically prepares its case, presents its stance, and requests a monetary settlement. The defense then makes its initial offer. The negotiation process

continues until either an agreement or an impasse is reached. If a settlement is agreed upon, it is confirmed in writing, and a settlement release is obtained. If negotiations reach a stalemate, alternative dispute resolution (ADR), which includes mediation or arbitration, is another possibility.

The LNC is able to defend the strengths of the case but is also aware of the weaknesses as well. The LNC's involvement in settlement negotiations provides a considerable advantage as a result of his or her nursing background and knowledge base. The nurse's clinical experience results in a better understanding than a non-medical employee of the claimant's medical condition. When settlement demands and accompanying bills are presented for consideration in claim reimbursement, clinical knowledge also plays an important role in realizing what charges are relevant to the claim in question and which expenses are unrelated.

**Janet M. Eads**, BSN RN, has been a member of AALNC since 1993, when the St. Louis Chapter was chartered. She has served on the Chapter Board in every position except Treasurer and was Secretary for two terms. Initially, she was an independent LNC but switched to an in-house position for a third party administrator in 2001, where she continues to be employed as a Professional Liability Nurse Consultant. She can be reached at either [janet.eads@sedgwickcms.com](mailto:janet.eads@sedgwickcms.com) or [janeads52@sbcglobal.net](mailto:janeads52@sbcglobal.net).

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## Submission Guidelines

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

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

### Manuscript format

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

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