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The Expert Witness

AALNC

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The Journal of Legal Nurse Consulting

Purpose

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

Manuscript Submission

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

Manuscript Review Process

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

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Features

Departments

The Hot Seat

Expert witnessing is known as being in "the hot seat" and is appropriately named, given the scrutiny witnesses endure. Not everyone has their fortitude, but, thankfully, they step forward and the majority with utmost integrity. They are our leaders, our teachers, and our models. It is a grave moral responsibility, however, because experts in our society are automatically bestowed a certain prominence. We are seduced by their knowledge and notoriety. We rely on them to explain concepts too complex for the average juror. We grant them celebrity status. We readily defer to their opinions in matters of science, unwittingly counting on their objectivity. We hesitate to question their judgment. Experts in trial do tell a story but the law will police for manipulation of emotion skirting the ethical edge.

As an LNC, you must critically analyze and think through for yourself what you are presented as truth, no matter who says it. Hone the skills of critical analysis that you developed as a nurse. You'll need them even more in the law with all its characters. I recently attended a presentation of a powerful story that was clearly embellished for effect. It was emotionally riveting and visual stirring, but it was riddled with fabrications. Unfortunately, any first-year law student caught up in the idealism of the moment might have missed these distortions, but as LNCs you cannot afford this luxury. You have a duty to not only look at the composition of the picture; you must study the materials used, the message sent, and the motivation of the artist. Closely examine the frame and the person holding it. If someone holds something out as fact that escapes logic, question it. If someone tells you that what someone else was thinking, ask yourself how this is possible. This is classic hearsay and inadmissible in court. The court has a sworn duty to protect the jury from a distortion of the truth based on hearsay. Pursuant to Federal Rule of Evidence 705, experts must provide the court with the basis for their opinion. This includes producing the data, facts, and records on which they rely. The presentation I attended had no such documentation. Given the authority we extend to our experts in court, we must provide the checks and balances of accountability. To ensure the fairness in their influence, the honest expert will have no objection; on the contrary they will welcome it.

The Nurse Expert Witness: Changes in the Wind is the contribution of Marguerite Barbacci, Mindy Cohen, and Linda Rosen. This informative article takes a look at the ever-evolving role specific to the testifying nurse expert witness. *New Challenges for the LNC in the Insurance Industry*, offered by Kathy Ferrell, provides an interesting review of the roles an LNC may fill in the insurance industry. Our Better Business column, *The Expert's CV: A Tool You Can Use*, and the References and Resources, *Locating the Expert Witness*, are presented to provide the practicing LNC with a systematic analysis of the CV for evaluating the proffered expert and a sampling of resources for locating the specialized expert witness.

The Journal has two contributions from the 2008 AALNC National Educational Conference in Tampa. First, *The Role of the Legal Nurse Consultant in Correctional Health Care Litigation* by Joseph Paris offers an insider's perspective and wisdom regarding the specific procedures and issues an expert witness might expect when working in the correctional setting. The second offering, a special excerpt of Patricia Fedorka's *The Expert Witness: A Critical Role in Successful Litigation*, discusses key concepts and characteristics necessary to the nurse expert witness.

I would like to welcome the addition of two AALNC Chapters' recurring columns. The Kentucky Chapter has offered their assistance in providing the Questions & Answers forum in upcoming issues. This issue features *Effective Preparation of the Expert Witness for Deposition*, offering expansive coverage to effective preparation and is extremely informative. Authors Rose Clifford, K.C. Wagner, and Donna Hunter-Adkins bring their recognized expertise to the reader. The South Carolina Chapter has taken on the Working World column. *Don't Let Shock Take You by Surprise* is our clinical offering for this issue from Sarah Kaminski. It is both well-reasoned and instructive.

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Past, Present, and Future: The Evolution of the Nurse Expert Witness

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KEY WORDS
Expert Witness

Nurses have been serving as expert witnesses in medically related litigation for more than 30 years, especially related to identifying whether or not nursing care was rendered within acceptable standards of care. The role of the testifying nurse has evolved along with the growth of the legal nurse consulting specialty itself. This article will explore the history of expert witness testimony, describe the evolution of the nurse expert, and discuss current trends in nurse expert witness testimony.

The use of experts in legal proceedings dates back to the 14th century, when persons possessing special knowledge or experience were required to assist the court in deciding facts of cases at bar. Individuals with particular knowledge of a craft or trade were impaneled as a special jury to assist the court in understanding unique issues in their area of expertise that the court needed to understand before formulating a conclusion. A German tribunal is reportedly the first to permit the admission of testimony by medical experts. The early courts, however, did not delineate the degree of special knowledge or experience required of experts; it sufficed that they could aid the court in reaching a reasonable and intelligent conclusion in the case (Danner, 2003).

A court expert did not achieve the status of a "witness" until the 16th century, when legislation was enacted to provide for compulsory attendance and testimony. The principal purpose of expert witness testimony was to provide the court with opinions or inferences derived from the expert's skill, experience, or training in the subject matter at hand (Danner, 2003).

In the United States, the benefits of expert testimony in court proceedings were first recognized in the early 1900s in cases dealing with criminal insanity. Massachusetts and Colorado were the first states to rely on disinterested but qualified experts in the study of mental illness to determine the sanity of the accused. Other states were encouraged by the National Crime Commission to follow those states and adopt what the Commission called "a sensible system" for making determinations in that area (Danner, 2003).

The Expert Witness

As defined in Black's Law Dictionary, an expert is "a person who, through education or experience, has developed skill or knowledge in a particular subject so that he or she may form an opinion that will assist the fact finder" (Garner, 2004). Expert testimony is necessary when the decisions to be made by a judge or jury are dependent on understanding facts and scientific information that is more than the "common knowledge" a lay person would possess (Guido, 2001; Danner, 2003). Testimony provided by expert witnesses in court proceedings falls under the category of evidence.

Frye v. United States (1923) is considered the benchmark case in establishing the rule of "general acceptance" as related to the introduction of scientific evidence. In brief, *Frye v. United States* asserts that if an expert's conclusions are "generally accepted" in the scientific community, the expert's testimony is admissible as evidence to be submitted to the court. "When the question involved…requires special experience or special knowledge, then the opinion of the expert skilled in the particular science, art or trade to which the question relates is admissible in evidence" (*Frye v. United States*, 1923). The general acceptance standard remained in place until the Federal Rules of Evidence were established in 1975 (Oldknow, 2001).

The Federal Rules of Evidence, adopted by the US Supreme Court in 1975, govern the introduction of evidence in civil and criminal proceedings in Federal Courts. While the Federal Rules do not apply to State court proceedings, many states have modeled their evidence rules on the Federal specifications. Article VII of the Federal Rules of Evidence governs opinions and expert testimony. Rule 702 applies to testimony that may be offered by an expert witness. "If scientific, technical or other specialized knowledge will assist the trier of fact (Judge/jury) to understand the evidence or determine a fact at 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" (Federal Rules of Evidence amended Apr. 17, 2000, eff. Dec. 1, 2000).

Rule 702 was amended in response to the 1993 US Supreme Court decision, *Daubert v. Merrell Dow Pharmaceuticals, Inc.* In Daubert, the Supreme Court charged trial judges with the additional responsibility of "gatekeeper." In this role, the trial judge evaluates the methodology, reliability and relevance of opinions presented by scientific experts. If the trial judge opines that scientific testimony is not supported by accepted scientific methodology, the judge can exclude the unreliable "scientific" expert testimony and prevent it from being admitted as evidence (Daubert, 1993; Oldknow, 2001; Croke, 2002).

Subsequent to the Daubert decision, additional cases have been decided by the United States Supreme Court, which add clarity to the definition of a scientific expert. The 1997 Supreme Court decision in *General Electric Company v. Joiner* established that an expert's conclusions entered into evidence must match the data upon which the expert relied to formulate the opinion. In *Kuhmo Tire Co. v. Carmichael* (1999), the Court further defined the gatekeeper function as applicable to *all* expert testimony, not just testimony based in science. An amendment to Rule 702 affirmed the trial court's role of gatekeeper and provides standards for assessing the reliability and helpfulness of proffered expert testimony. Consistent with *Kumho*, amended Rule 702 provides that all types of expert testimony present questions of admissibility for the trial court in deciding the reliability of evidence. The trial judge decides if the expert's credentials and qualifications establish that the proposed testimony is based on sound scientific principles, not unsupported speculation, and the expert is qualified through knowledge, training, skill, experience or education (Oldknow, 2001; Croke, 2002).

Standards of Care

Analysis and testimony of the expert should reflect knowledge of the acceptable standard of care contemporaneous to the incident giving rise to the claim. Standards of care may be viewed as the level or degree of quality considered adequate by a given profession (Guido, 2001).

Created by the duty undertaken, standards of care describe the minimal requirements that define an acceptable level of care (Guido, 2001). Standards of care are used as the basis for proving a breach of duty (Iyer, 2007). The legally recognized standard of care is not flawless care, the "best care ever," or the type of care a nurse expert would provide. In nursing, the standard of care is typically defined as the care provided by a reasonably competent nurse practicing in the same or similar circumstances.

The standard of nursing care is defined by case law, statutes, nurse practice acts, facility policies, and nursing professional organizations. An expert testifying to the standard of nursing care must be able to describe reasonable, competent nursing care as compared to actions that would be considered substandard nursing care under the same or similar circumstances. Once the standard of care is articulated, the causal relationship between the failure to exercise the standard of care and the physical injury must be conveyed (Brent, 1997; Guido, 2001; Danner, 2003).

Evolution of the Nurse Expert Witness Role

Historically, nurses have testified in court as fact witnesses. A fact witness offers testimony regarding information and observations directly known or observed. The fact witness recounts events that transpired to the judge and jury. The fact witness can testify *only* to the facts of an issue and may not draw conclusions or form an opinion (Bogart, 1995; Guido, 2001).

Acceptance of nurses serving as expert witnesses by the courts was much slower to evolve. Case law is replete with references upholding the policy of the only qualified person to render opinion evidence against a health care provider is a member of the same profession. It is well-established that only a physician is qualified to render expert testimony as to the standard of care for physicians. Likewise, other professions recognize that members of their profession are the professionals best qualified to testify to the standard of care. For example, a podiatrist is the only professional competent to testify to the podiatric medicine standard of care (Botehlo, 1984). Similar court decisions exist relative to physical therapists, chiropractors and audiologists (Butler, 2004).

For decades, the courts accepted that physicians had the necessary expertise to explain and testify to the standards of nursing care. Essentially, physicians were allowed to serve as "nursing's voice" by testifying to the role and accountability of professional nurses (Guido, 2001; Murphy, 2005). In *Goff v Doctor's Hospital*, (1958), a California court allowed a physician to testify about what nurses should have done, stating, "Surely a qualified doctor would know what was standard procedure of nurses to follow" (Murphy, 2005).

In 1972, the Pennsylvania Supreme Court recognized that a physician might not be the best expert on nursing standards, but it still allowed physicians testimony to be admitted into evidence, because "all areas of medical expertise are within the knowledge of medical doctors" (*Taylor*, 1972). In *Paris v Kreitz* (1985), the court held that "physicians are clearly acceptable experts with regards to nurses" (Butler, 2004).

The 1980s saw the advent of court cases that began to lay the groundwork for the courts to recognize that the professional most appropriate to define the nursing standard of care was a nurse. In *Maloney v Wake Hospital Systems* (1980), the court held that "the role of the nurse is critical to providing a high standard of health care in modern medicine. Her expertise is different from, but no less exalted, than that of the physician." A Georgia court, holding that a nurse's knowledge of infection control related to venipunctures was on par with a physician's, permitted a nurse to testify that a defendant physician had violated the standard when drawing blood (*Avet v McCormack*, 1980). In *Young v Board of Hospital Directors, Lee County, FL* (1984), the court held that a psychiatrist was not familiar with the day-to-day practices of psychiatric nursing and therefore was not qualified to testify about the nurses' duty or practice (Cushing, 1985; Guido, 2001).

The routine practice of physician experts testifying to nursing standards has been questioned in the legal press. Armstrong (1987) wrote, "The status of nursing has changed, however; and not only do physicians no longer have the special knowledge required to testify in all cases of nursing malpractice, but their use as experts may create problems that could be avoided by using nurses as experts in most nursing malpractice cases. The inquiry should focus on whether the

physician was familiar with the customary practice of nurses regarding the procedure in question. Courts should not assume knowledge because nursing and medicine are two distinct disciplines, albeit with some overlapping functions" (Butler, 2004).

It is not surprising to any nurse that the lay public often has an inaccurate and, at times, completely erroneous understanding of the nursing profession. Given this, when the practice or competency of a nurse's actions are brought before the legal system, lay judges, juries, attorneys, or administrative law judges must make decisions as if they understood nursing practice. To make these decisions, they cannot rely on their own knowledge; they must be assisted by documentary and testimonial evidence. More often than not, the assistance of a nurse expert witness is required (Murphy, 2005).

Nursing is a profession with associated educational qualifications, licensing requirements, and a code of ethics. One of the distinctions of a profession is that it establishes its own standards of care. Most, but not all, nursing malpractice cases require testimony by a nursing expert witness to establish the standard of care (Iyer, 2007).

The case of *Flanagan v. Labe* (1997) illustrates the reality that, while the profession of nursing has assumed greater responsibilities over the years, recognition of those responsibilities does not correlate with greater recognition of nurses' autonomy (Smith, 1998). In *Flanagan v. Labe*, the Supreme Court of Pennsylvania upheld a lower court's decision to exclude the testimony of a registered nurse as the plaintiff's causation expert. At trial, the registered nurse expert testified that substandard nursing care lead to the patient developing subcutaneous emphysema. The court declared the nurses' testimony inadmissible because it would have "consisted of [a] medical diagnosis of [the] patient's condition," inconsistent with the Pennsylvania Nurse Practice Act (*Flanagan v. Labe* 1997, at 183).

In 2003, The American Association of Nurse Attorneys (TAANA) submitted an amicus (friend of the Court) brief to the Illinois Supreme Court in the case of *Sullivan v. Edward Hospital*. The brief was drafted by members of TAANA's Litigation Section, citing to multiple authorities, including not only of Illinois. The brief argued that only nurses have the responsibility and authority to define the scope and practice of nursing, and, therefore, only a nurse is qualified to offer expert opinion as to nursing standard of care. On February 5, 2004, the Illinois Supreme Court issued a decision which extensively cited the TAANA brief and ruled that only a nurse is qualified to offer opinion evidence as to the nursing standard of care (*Sullivan v. Edward Hospital*, 2004). The American Association of Legal Nurse Consultants (AALNC) promoted this theme in the AALNC Position Statement on Providing Expert Nursing Testimony, holding that "the only expert competent to testify on clinical and administrative nursing issues is a licensed registered nurse" (AALNC, 2006).

Trends for the Testifying Nurse

While nurses have testified on nursing standard of care issues and as fact witnesses, these traditional testifying roles have expanded in more recent times. With the evolution of legal nurse consulting practice, opportunities for nurses bridging the medical and legal professions have expanded to roles beyond providing expert testimony. Many legal nurses work in-house or independently to assist attorneys to understand the medical issues in their cases; legal nurses work in the criminal justice system, in hospital-based risk management, as insurance industry-based case managers, or as life care planners. The value of this work has, in turn, led to expanded issues on which the nurse is qualified to testify, such as liability, causation, damages, pain and suffering, criminal issues, and forensics.

Today, not only are nurses testifying on standard of care in malpractice cases, but nurses working in the insurance industry are testifying as liability experts for the plaintiff and defense in insurance bad faith cases. Insurance industry nurses have knowledge regarding insurance regulations, contract language, claims payment policies, and insurance bill auditing. Armed with this knowledge, the insurance nurse is well equipped to testify for the plaintiff or defense on such bad faith issues as delayed payments of claims, misrepresentation of policy provisions related to coverage of certain services, and not attempting to settle claims fairly or promptly when liability has been established (Ferrell, 2008).

For example, in the case of *Dykes et al. v Central United Life Insurance Company et al.* (2006), the plaintiff purchased a supplemental cancer policy from Central United Life Insurance Company. The insurance company presented her with a policy that promised to pay benefits for the treatment of cancer based on "actual charges" submitted by her doctors. The plaintiff unfortunately developed cancer some years after purchasing the policy. Instead of paying the actual charges as submitted by her doctors, the insurance company paid the bills at a lesser amount. The plaintiff attorney utilized a nurse expert to analyze the policy and testify on his client's behalf in her suit against the insurance company. The jury found in favor of the plaintiff and awarded her compensatory and punitive damages totaling over $300,000.

In the area of causation, typically the domain of physicians, case law is being established to allow the testimony of nurse expert witnesses. In the case of *Freed v. Geisinger Medical Center*, 910 A.2d 68 (2006), the Pennsylvania Superior Court held that the proposed nursing expert was qualified to testify that breaches in the standard of care provided to a paraplegic patient led to the development and worsening of pressure ulcers. In this decision, the nursing expert was allowed to testify as to causation when, previously, such testimony was believed to be within the purview of the physician witness.

Relevant Experience and Expertise

As the nursing profession becomes more specialized, the nurse serving in an expert capacity should be experienced

in the specialty of the alleged nursing negligence. While some issues requiring expert nurse testimony deal with basic nursing care, more often than not, testimony on highly specialized nursing issues demands an expert with the ability to address the specialized issues based on clinical experience with specialty certification an added benefit.

Expertise is appropriately established on the basis of 1) knowledge of the area involved; and 2) recent experience. While the testimony of a nurse expert who is not employed or working in the same specialty as the issues at hand may be accepted by the court, the weight of the testimony may not be accorded the same acceptance as a witness who has current experience or more education. It is a well-recognized fact that juries often look closely at a witness' qualifications.

The best nurse expert witness is one who is actively practicing clinical nursing, has testifying experience, and testifies for both plaintiffs and defense. The expert who limits testimony for one side or the other can readily come under fire as a "hired gun," whereas a witness who testifies for all members of the bar can be recognized for their objectivity.

Fact Witnesses

Historically, nurse fact witnesses testified in medical negligence cases in which they were not a named party but were peripherally involved in the patient's care. While this role definition remains true today, a fact witness may also assume the role of instructor to the court. The fact witness is responsible for reviewing, researching, and summarizing the medical issues germane to a particular case. Events in the medical records are summarized and presented to the judge and jury in terms easily understood by laypersons. The fact witness does not discuss the standard of care, detail deviations of care, or offer theories of causation. A fact witness describes the intricacies of nursing and medicine in a format that the triers of fact can appreciate. A fact witness can be retained by an attorney or appointed by the court (Turner, 1995; Bogart, 1995; Guido, 2001).

Today, fact witness testimony by nurses is offered in at least two additional significant aspects of litigation. First, the nurse is often called upon to attend independent medical examinations of plaintiffs. As such, the attending nurse acts as the eyes/ears of the attorney and may be called, if necessary, to rebut testimony of the examining physician as it relates to his/her observations and/or alleged examination.

Non-economic damages are arguably the most challenging for attorneys to convey and perhaps the most difficult for the judge and jury to evaluate. A new and expanded role for the nurse fact witness is to summarize and testify to the issue of pain and suffering experienced by the plaintiffs involved in litigation. The essence of the pain and suffering expert is to explain the nature of the injuries, course of treatment, and the impact of the injuries and their treatment on the plaintiff. Rule 1006 of the Federal Rules of Evidence permits testimony summarizing information in the medical records. In many cases, the plaintiff is often the best person to describe the pain and suffering experienced at the hand of the defendant. Utilizing a nurse to discuss pain and suffering does not preclude the testimony of the plaintiff, but it can augment the information provided in the plaintiff's own words. Often, the patient lacks the medical knowledge to explain medical information to the jury. In cases of extended hospitalizations, the plaintiff may not have a clear recollection of events that transpired or may have sustained injuries that prevent the plaintiff communicating with the jury. According to Iyer (2007), "Nurses' holistic picture of patient care makes them uniquely qualified to testify about the patients' experiences in the role of an expert." Damages testimony is also offered by nurses related to economic considerations.

Life Care Planners

The life care plan identifies the costs associated with future medical care required by the plaintiff for any life altering occurrence – illness, injury, or disability – as a result of injuries sustained in a personal injury, workers compensation, or medical malpractice incident. While life care planning has been in existence since the 1980s, nursing involvement in this specialty has grown to the point of having its own professional association, The American Association of Nurse Life Care Planners, which offers its own certification program. "Nurses are uniquely qualified to prepare life care plans. They have the

medical training and experience to understand the needs of the injured person and to anticipate those needs and services which have not yet been addressed by health care providers. In addition, nurses traditionally have played a pivotal role in rehabilitation medicine as facilitators of the management of disabled patients. Nurses are well experienced in organizing plans of care and coordinating the recommendations of team members" (Iyer, 2003).

The nurse life care planner develops a comprehensive plan for future medical expenses based on an analysis of the patient's physical and medical needs. Each life care plan is individualized and annotated with the medical records for needed services. When the life care plan is submitted to the court, the jury should have a clear picture of the impact of an injury on the patient and family. The nurse life care planner is often called to testify to the accuracy of the document prepared and to justify the rationale for each item presented in the care plan. The life care planner is considered a testifying expert; the care planner will be asked to testify to the methodology used to prepare the care plan and to justify the treatments, services and costs included in the care plan. Preparation for cross-examination of the care plan details is part of the expert witness role (Iyer, 2007).

Forensic Nurses

Forensic nursing is a relatively new field that combines the health care profession with the judicial system. Forensic nursing encompasses a wide variety of subspecialties, including sexual assault nurse examiners, child abuse nurse investigators, nurse death investigators, and court-appointed advocates on behalf of victims of domestic violence and elder abuse or neglect. Forensic nursing was officially recognized as a nursing specialty by the American Nurses Association in 1995. In April 2002, the International Association of Forensic Nurses (IAFN) gave its first international certifying examination for nurses trained in the treatment of victims of sexual assault. The 71 nurses who passed the exam earned the international designation SANE-A (Sexual Assault Nurse Examiner – Adult and Adolescent). Five states also have their own certifying examination for Sexual Assault Nurse Examiners: Kentucky, Maryland, New Jersey, South Carolina, and Texas.

In the past, court testimony by forensic nurses has been limited by the belief that physical examination, diagnosis of the cause of injuries, and documenting "medical findings" are the practice of medicine. In recent years, the courts have upheld expert testimony given by forensic nurses in numerous Appellate decisions, recognizing the increasing ability of nurses with specialized education and training to provide scientific credibility in criminal prosecution of crimes against children and adults (Yorker, 2003). Forensic nurses now testify in court as both fact and expert witnesses. In *Griffen v State* (2000), the court held that a registered nurse was qualified to testify as an expert witness in a rape prosecution based on her training, experience, and duties as a sexual assault nurse examiner at a rape crisis center.

In the 2004 decision of *State v Bragg* (2004), the court held that a pediatric nurse practitioner was qualified to give expert testimony in a sexual abuse case when describing findings of a child's physical assessment as being consistent with sexual abuse. The nurse expert had 40 years of experience working with pediatric patients and had worked with physically and sexually abused children for 23 years. The nurse's training and experience was the basis for the court qualifying the nurse as an expert witness as it related to matters beyond the knowledge or experience possessed by laypersons.

Conclusion

Nursing is firmly established as a distinct profession apart from medicine within the health care field. With the publication of *Legal Nurse Consulting: Scope and Standards of Practice* (AALNC, 2006), legal nursing became recognized as a nursing specialty practice by the ANA. The role of the nurse expert witness is acknowledged as a specialized practice role within the field of legal nurse consulting. The credibility and value of nursing practice within the legal arena continues to broaden and deepen as opportunities for non-traditional nursing roles increase. Attorneys recognize the value of retaining nursing experts not only for their nursing malpractice cases, but also for an ever-increasing variety of litigation matters involving illness or injury.

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New Opportunities for the Legal Nurse Consultant in the Insurance Industry

Kathy G. Ferrell, BS RN LNCC

KEY WORDS
Expert Witness, Insurance

The United States Census Bureau reported that 249.5 million American had health insurance in 2006 (DeNavas, 2007). Working within the health insurance industry provides the legal nurse consultant (LNC) an opportunity to use her clinical knowledge and skills as well as acquire a new set of skills. Experience in the insurance industry helps train the LNC to work in a variety of roles – including case manager, utilization reviewer, medical policy coordinator, and medical bill auditor – as well as prepares the LNC to serve as an expert witness with both plaintiff and defense firms on cases involving health insurance.

Accident and health insurance policies provide the policyholder with medical benefits in the event of illness or injury as provided for in the individual contract. Most insurance companies usually offer group policies and individual policies. Group policies are offered to companies with larger numbers of employees. Such employers often design their insurance policies that are offered to all their employees. Group policies may differ in services and procedures covered, in the amount of deductibles, maximum coverage, and types of illnesses or injuries covered.

An insurance company usually drafts a standard benefit plan which it offers to individuals in the open market on a "take it or leave it" basis. The individual purchasing this insurance often has no bargaining power on the costs or benefits offered and may not understand the terminology used by the insurance company (Hubler, 2007). The legal nurse consultant (LNC) must learn to interpret contract language and benefits allowed under each type of policy.

The cost of health care continues to rise faster than many consumer costs, and the cost of health insurance subsequently continues to rise. Cost containment measures such as pre-authorization and others have been implemented to promote cost-effective management of health insurance premiums. Providing cost-effective management of premium dollars requires that the LNC understand the health care delivery system, standards of care, clinical pathways, and how charges and contracts are structured.

Many private health insurance companies employ nurses to serve in various roles. They usually require previous clinical nursing experience of 3-5 years, a current nursing license for the state where the insurance company is located, and often a bachelor's degree in nursing. Such nurses use their clinical backgrounds for understanding and analysis of complex medical information.

Role of Case Manager

In a health insurance company, the LNC may serve as a case manager (CM). The Case Management Society of America (CMSA) defines a case manager as:

> *"A healthcare professional who is responsible for coordinating the care delivered to an assigned group of patients based on diagnosis or need. Other responsibilities include patient/family education, advocacy, delays management, and outcomes monitoring and management. Case managers work with people to get the healthcare and other community services they need, when they need them, and for the best value" (2002).*

The CM is instrumental in using health care dollars wisely and promoting quality outcomes. In the role as CM, the LNC uses the nursing process to identify patient (policyholder) needs, plan and arrange service delivery, and monitor service provisions and outcomes. In order to maximize health care dollars allotted for case management, the LNC must perform pre- and post-loss medical record review to identify pre-existing conditions that may impact baseline performance of the patient. (Iyer, 2003)

An example would be an individual who has suffered a stroke. After acute hospitalization for stabilization, the health care team determines that the patient is an excellent candidate for rehabilitation. The CM determines the benefits and any dollar limits provided by the patient's insurance contract. According to the policy benefits, she arranges for inpatient rehabilitation or outpatient physical therapy (PT), occupational therapy (OT), and other services. She negotiates the best prices for items such as wheelchairs, walkers, bedside commodes, or other durable medical equipment to be used when the patient is discharged home. Through the recovery phase of stroke injury, the CM monitors the quality of care provided to the patient and the progress toward meeting rehabilitation goals.

The CM also serves as a patient advocate in communicating patient needs to the health care providers and ensuring insurance payments. The LNC serving as a CM is experienced in coordination of care among multiple specialties. The LNC is prepared to hold critical discussions of medical issues with the treating provider to ensure the right treatment is given thereby optimizing recovery. (Banja, 2007)

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The CM uses her knowledge of standards of care when identifying and communicating patient needs to health care providers. CMSA has defined standards of care as:

> *"Statements that delineate care that is expected to be provided to all clients. They include predefined outcomes of care clients can expect from providers and are accepted within the community of professionals, based upon the best scientific knowledge, current outcome data, and clinical expertise" (2002).*

Although not required, insurance companies look with favor upon LNC case managers who obtain certification in case management.

Role of Utilization Review

LNCs are also employed in the insurance industry to perform pre-payment, concurrent, or post payment utilization reviews (UR). Most health insurance companies perform UR of certain services or procedures as another way to control costs and ensure appropriate spending of benefit dollars. The services that require UR are determined by the individual insurance company and may even differ among individual policies offered by the same company.

Some group employers who offer group policies require pre-authorization (prior authorization) of selected services or procedures to ensure medical necessity and that premium dollars are utilized efficiently. Requests for prior authorization are initiated by phone or fax from the provider or, in some cases, the patient or member. In some instances, the provider will be asked to forward copies of the member's medical records to evaluate medical necessity. The LNC must communicate clearly with the provider, analyze the information, and apply decision criteria to determine the outcome of the request. If the patient's medical information meets criteria, the physician and patient are notified in advance that the insurance company will pay for the procedure as per the patient's policy provisions.

UR can also be performed while the patient is hospitalized or in a skilled nursing facility (concurrent review) to ensure medical necessity for appropriate length of hospital stay, setting and services, and to identify and facilitate discharge planning. Length of stay (days of inpatient hospitalization) is assigned when the patient enters a hospital. If the patient needs to remain hospitalized longer due to complications or unexpected outcomes, the UR nurse reviews the hospital records each day to determine the medical necessity for each additional day. Criteria for appropriate length of stay may be determined by each insurance company, although most companies use national criteria such as Milliman and Robertson Health Care Management Guidelines, InterQual ISD criteria, or Medicare coverage of Skilled Nursing to maintain consistency among managed care organizations across the nation. The concurrent review nurse screens the medical plan of care at the earliest opportunity to determine discharge needs and/or placement. Those who would benefit from case management are also identified at this time.

Post-payment or retrospective UR occurs after the care or service has been provided but before claims are paid. Computer programs suspend claims when the company has seen a sudden increase in utilization. An example is the increase billing for nerve conduction services following the FDA 2006 501K marketing approval of a handheld device marketed especially to family practitioners. The UR nurse must order and review the medical records to determine the medical necessity and correct billing of the service before the insurance company will pay. The LNC in this role must be familiar with contract benefits, standards of care (such as those endorsed by specialty societies, published in peer reviewed literature, authoritative text, etc.), clinical pathways, appropriate coding for procedures and diagnoses, and usual and customary charges or fee schedule amounts in order to approve or deny payment.

If an unfavorable determination (denial) is rendered in any of the UR functions, the patient (member) and/or physician is given the opportunity to appeal. Because the UR nurse will likely be asked to defend her decision, clear and concise documentation of her rationale is critical in this role. The second level of appeal will be conducted by UR nurses (not the original decision maker) or physicians. Often the Medical Director of the insurance company conducts the second level appeal and will contact the treating or requesting physician for more information before rendering a decision. The third and final appeal is performed by a physician in the same specialty as the treating physician or a panel of physicians including a physician of the same specialty.

Role of Medical Policy Coordinator

Another interesting role within the insurance industry is medical policy coordinator, who creates new medical policies and periodically evaluates or revises existing policies. The LNC may be asked to investigate or research a new surgical procedure, such as a transplant surgery, for possible coverage by the insurance company.

The LNC as a medical policy coordinator has a demonstrated familiarity with some of the legal issues encountered in coverage of transplant surgeries and often works closely with the insurance company's legal counsel on such issues. Her investigation might include researching peer-reviewed literature, speaking with local and national transplant surgeons, contacting national organizations such as the National Institutes of Health (NIH), and locating national centers for excellence for transplant surgery. She shares her findings with the Medical Director, Medical Policy Committee, benefits coordinator, finance department, and others for a decision regarding coverage. The medical policy coordinator then drafts new medical policy clearly documenting under what circumstances the transplant surgery will be covered.

Role of Medical Bill Auditor

One of the most difficult roles for the LNC within the insurance industry is the hospital or provider bill auditor. The Health Care Financing Administration, which oversees Medicare, has estimated that the government loses 30 cents to every dollar from fraudulent practices in the medical community. Medical billing fraud is a contributing factor for the rising cost of health care and health care insurance premiums. The LNC as a bill auditor will likely find the most common areas of billing errors to be:

1. duplicate billing;
2. number of days in the hospital;
3. incorrect room charges;
4. operating room time;
5. up coding (shifting the cost for a lower cost service or a medication to one more costly);
6. keystroke error;
7. billing for canceled tests or services; and
8. billing for services never rendered by the physician.

For each type of facility (hospital, skilled nursing, rehabilitation, home health, etc.), there are different local and national regulations (such as those required by the Centers for Medicare & Medicaid Services) that must be understood and applied in the review of bills. The LNC must also be familiar with current procedural terminology and codes (CPT), which are updated and published annually by the American Medical Association for medical billing. She must also have knowledge and expertise in ICD-9 (International Classification of Disease) codes and diagnosis-related groups (DRG), which are indicated on each insurance bill to identify the patient's illness or injury. Appropriate use and identification of these codes are necessary to ensure appropriate payment. Insurance bills are truly written in code and not easily deciphered.

(Author's Note: ICD-9 was developed by HCFA (now CMS) in the 1980s and is still used today, although it is revised yearly. Everyone agreed to its use because everyone wanted to be eligible for federal money. ICD-10 was developed in 1990 by the World Health Organization (WHO). It is used in some countries, by many epidemiologists, and by some at CDC. There is no money incentive or penalty for using ICD-10 and, therefore, because of the immense expense in changing over the systems, no one is expecting to change to ICD-10 in the near future. CMS is trying to save money by not paying for certain hospital-acquired complications and has no money to overall their payment systems at this time. This author's information states that insurance companies will not overhaul their computer systems to ICD-10 unless the government makes them do it.)

As part of insurance bill audits, the patient's medical records must be carefully reviewed to determine that illnesses or injuries listed on the bill are supported by documentation. Having the wrong diagnosis information on a bill may result in incorrect payment or incorrect denial of payment. The LNC as a billed auditor is skilled in reviewing the medical records and corresponding bills efficiently and in great detail.

Facility bills require itemization and are often very lengthy and complex. The LNC must be able to identify billing irregularities, such as double billing for the same service under different procedure codes, or billing for services that are not documented in the medical record. The auditor also looks for inconsistencies, such as a bill for a service not usually associated with the patient's illness.

Likewise, bills for physician services must be compared to the medical record for accuracy. Documentation in the physician medical record must support both the complexity of the office service billed and the medical necessity of the complexity of a service. Certainly a provider can provide a complete review of all body systems, examine all body systems, order a series of diagnostic tests, and provide detailed counseling, but was it all medically necessary when the patient's visit was prompted by a cough and sore throat?

All of this specialized knowledge and experience is valuable to the LNC who moves into independent practice or a practice within a law firm. Such an LNC will be in a unique position to identify incorrect and possibly fraudulent provider billing practices, incorrect application of contract language to provider bills resulting in incorrect payments by the insurance company, and evidence of bad faith practices by an insurance company.

Bad Faith Insurance

Insurance is governed in each state by state regulations. The language of an insurance contract defines the obligations of the policyholder and the insurance company. Litigation often occurs because one party failed to fulfill the terms of the contract; in these cases, wording of the contract often determines the outcome. The public has no input into the terms of coverage or wording used by the insurance company in writing a policy. Most individuals believe that health insurance is a necessity and, therefore, typically sign the contract without understanding the terms or coverages.

To compensate for this lack of understanding, the courts have adopted a rule of construction. Stated simply, the courts have ruled that language in health insurance policies has been constructed in favor of the insurance company. To balance this inequity, the courts usually rule in favor of the policyholder when litigation arises over ambiguous language or coverage (Ponder v. Blue Cross of Southern California, 1988).

Parties to all contracts must adhere to a covenant of good faith and fair dealing. In general, bad faith insurance practices are those that demonstrate a company's unreasonable withholding of coverage benefits. Some examples of bad faith include:

- Misrepresenting fact or policy provisions related to coverage of certain services;
- Refusing to pay claims without conducting a reasonable investigation or review of the available information (i.e., not requesting a copy of the patient's medical record);
- Failing to pay a claim within a reasonable timeframe;
- Not attempting to settle claims promptly or fairly when liability has been established;

- Offering to settle a claim at an unreasonably low dollar amount and forcing the insured to bring suit in order to receive a reasonable settlement amount;
- Failing to provide an explanation for the reason a claim was denied and offering an explanation of appeal rights; and
- Making claims payment unduly burdensome by asking the insured to provide the same medical information repeatedly or in different formats.

The LNC as Expert Witness

Previous experience in the insurance industry helps prepare the LNC to work with plaintiff and defense firms on cases involving health insurance. One case in which this author served as expert witness for the plaintiff was Dykes et. al. v. Central United Life Insurance Company, et. al., No.2:06-CV-02264-IJP (N.D. AL filed Oct.25, 2006). In this case, the patient bought a cancer policy and paid monthly premiums, not knowing whether she would ever need this additional insurance. At the time the policy was sold to her, the policy and the salesman stated that, in the event of cancer, all services related to removal of the cancer and/or radiation or chemotherapy treatments would be covered and actual charges would be paid to her. The term "actual charges" was not defined in the policy, but had been explained to the policyholder to mean that whatever amounts the provider billed, that amount would be paid directly to her. The definition of "actual charges" as used in the insurance industry was "the amount of money a doctor or supplier charges for a certain medical service or supply" (Centers for Medicare & Medicaid Services, 2002).

Unfortunately, Dykes developed cancer and began submitting claims for payment for surgery to remove the cancer, and subsequent radiation and chemotherapy treatments. Instead of paying the amount billed by the provider ("actual charge") as stated in the policy, the defendant insurance company paid the patient a different and lesser amount. That amount was equal to what her primary insurance company (such as Blue Cross and Blue Shield or Medicare) allowed as payment.

Just prior to Dykes' request of payment for her cancer treatments, the insurance company sent a letter to all their cancer policy holders explaining that cancer treatments had become very expensive and that the defendant insurance company had adopted a definition of "actual charge" to mean the amount paid to the physician by an insurance company or Medicare. The term "actual charge" now had a different meaning than the one used when the policy was sold. The insurance policy itself did not give a definition for actual charges or an explanation on how payments would be calculated.

When the patient received her first cancer benefit payment, she believed that she had not received the benefit (payment) promised to her by the terms of her contract. She was unable to persuade the defendant insurance company to pay her the amount she was owed; therefore, she sought help from an attorney during a time when she was fighting a losing battle with cancer.

This author was contacted by the attorney to review the contract language in the cancer policy and compare the payments received with the bills from the health care providers. A bill audit was performed to determine the damages (incorrect payment) to the insured (patient). These findings were prepared and reported to the attorney in the format requested. The attorney determined that the case was meritorious, and the case was filed in the Northern District Federal Court of Alabama. The suit stated that Central United failed to perform according to the terms of the contract (bad faith). At issue was the wording of the contract agreement and the resultant payment for covered services.

An affidavit was prepared outlining this author's education, experience, and training that qualified her as a testifying expert in this case. Preparation for deposition by the defense attorney required that this author become thoroughly familiar with the medical records, procedure (CPT) and disease (ICD-9 codes), provider bills, payments from the insurance company, and damages (the difference in what was billed and what was paid). In addition, it required further

Table 1 – Definition of "Actual Charge."

Insurance Industry Definition ACTUAL CHARGE	Central United Definition ACTUAL CHARGE
Centers for Medicare & Medicaid Services: The amount of money a doctor or supplier charges for a certain medical service or supply.	The amount actually paid by or on behalf of the Covered Person and acceptable by the provider for the services provided.
The Managed Health Care Dictionary: Physician's actual fee for service at the time the insurance claim is submitted to the insurance company, government payer, or HMO	
Dictionary of Health Care Management: The amount a hospital, physician, or other practitioner or institution actually bills a patient for a particular medical service or procedure.	
Concise Dictionary of Modern Medicine: The actual amount charged by a physician for medical services rendered	
Mosby's Dictionary of Medicine, Nursing & Health Professions: The amount actually charged or billed by a practitioner for a service. The actual charge usually is not the same as that paid for the service by an insurance plan.	

research of the term "actual charge" to support understanding and experience with this term.

In deposition testimony, this author testified that the definition of "actual charge" was the amount billed by a physician or health care provider for a service and not the amounts paid to the provider by Medicare or any other insurer. Several dictionaries and other published literature supporting this definition were offered as exhibits during the deposition and subsequent testimony at trial (Table 1).

Following depositions, the attorneys were not able to arrive at a settlement; therefore, the case was scheduled for a jury trial in the U.S. District Court for the Northern District of Alabama. Testimony during the trial was used to educate the jury on how insurance companies determine coverage benefits on a bill, how provider bills (claims) are prepared, and how claims are processed and paid by insurance companies. In particular, this writer was asked to differentiate between what a provider charges for his service and what he is paid for a service.

On August 27, 2007, the Court entered a judgment in the case, which is being appealed to the United States Court of Appeals (*11th Circuit Appellant Court in Atlanta, GA*). The jury determined that the defendant insurance company had failed to perform its obligations to pay Ms. Dykes' cancer bills according to the terms of her policy. "Actual charges" was defined as the amount billed by a physician for a service. The defendant insurance company was ordered to pay compensatory and punitive damages in excess of $300,000 to the plaintiff.

Conclusion

The roles for LNCs within the insurance industry continue to expand. Job listings for LNC and case managers within the insurance industry are often found on the Internet, at job fairs, and even in the newspaper classified section. LNCs should not forget to include insurance companies in their marketing plans.

After obtaining experience in the insurance field, LNCs should present their specialized training and knowledge to plaintiff and defense attorneys. Only by promoting the uniqueness of legal nurse consulting to the legal profession can we contribute to bridging the gap between medicine and law.

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The Role of the Legal Nurse Consultant in Correctional Health Care Litigation

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KEY WORDS
Correctional Health Care, Expert Witness, Litigation

Traditionally, legal nurse consultants (LNCs) have practiced in a variety of areas including personal injury, product liability, medical malpractice, workers' compensation, and the like. It is only in the past few years that a number of LNCs have specialized in correctional health care litigation. This author has encountered these in increasing numbers, either working for law firms or practicing independently. The purpose of this article is to explore the role of LNCs in correctional health care litigation and, perhaps, inspire more LNCs to consider working in this developing field. Parts of this article were presented at the AALNC 2008 National Educational Conference.

In the past two decades, a new, distinct professional – the legal nurse consultant (LNC) – has emerged as an adjunct to attorneys and other professionals. LNCs offer support and perform research in health care litigation and other medical-legal matters. A primary role of the LNC is to evaluate, analyze, and render informed opinions on the delivery of health care and the resulting outcomes. Just as is the case in non-correctional medical litigation, attorneys involved in correctional medicine litigation need to save their strength for the Courtroom and have delegated a number of their former office functions to LNCs.

Correctional Medicine and its Legal Challenges

Correctional medicine presents multiple challenges. Practitioners entering prisons and jails are expected to deliver standard of care medicine in non-medical surroundings. Created for punishment, the correctional environment is antithetical to the ideals of patient advocacy, nurturing, and healing that are so dear to all physicians. In addition, correctional doctors must learn to deal with poor historians, incomplete records, and some very difficult patients. Due to the nature of correctional medicine, practitioners should expect to encounter difficult personalities, saddled with the sequelae of lack of prior care, prior risk-taking lifestyles, and their consequences. Inmates may use medical services to procure comfort items such as special clothes, bedding, soaps, creams, lotions, better housing, or job assignments by exaggerating trivial medical conditions or faking diseases. Despite these challenges, correctional medicine attracts large numbers of health professionals, engaged in the medical care of over two million prisoners.

A feature of correctional medicine is the ever-present threat of litigation. According to the Bureau of Justice Statistics' Sourcebook of Criminal Justice Statistics Online, a total of 24,073 civil rights or prison conditions suits were filed in US District Courts in 2003, the last year for which data is available (Bureau of Justice Statistics, n.d.). The better-managed correctional health care systems include risk management as a tool to ward off litigation and to improve medical care.

The Eighth Amendment of the United States Constitution was enacted to prohibit torture to prisoners. Over time, the Courts interpreted the Eighth Amendment to mean that deprivation of medical, dental, or mental health care also constituted "cruel and unusual punishment" and would include failure to relieve pain and failure to restore function (Rold, 2008). Because correctional medicine is practiced in a paramilitary environment, there are numerous areas where inmate medical care may be difficult to deliver. Perceived breaches of the standard of care are frequently the target of inmate-driven litigation against correctional medical and security staff. These concepts were reviewed by noted Plaintiff's Attorney William Rold (Rold, 2008). A summarization of 67 typical correctional medical suits was recently published (Paris, 2008).

The venue of a correctional case impacts the research to be performed by LNCs. In a simplified interpretation, federal court cases are filed by inmates or their representatives under the premise that a violation of the inmate's civil rights has occurred (Rold, 2008). For these, the legal standard of "deliberate indifference to a serious medical need" addresses whether the inmate had access to care, had access to a professional opinion, and received all the care that was ordered by the professionals. In contrast, state court filings generally deal with issues of malpractice (simple medical negligence).

Differences in medical opinion become important, and simply proving that the inmate had access to care would not be enough. Unfortunately, this simplified picture becomes complicated in many jurisdictions, and the case venue – federal or state court – does not preclude the introduction of civil rights or malpractice elements in the litigation. While these matters are for seasoned correctional attorneys to sort out, LNCs may become more effective in their role as they learn the nuances of correctional health care venues in different localities.

Sorting out the Parties

As with any litigation, a first step is to determine for which party the LNC is working. While this may obvious in many correctional cases, the question becomes complicated when there are multiple defendants. In corrections, the defendants may include physicians, midlevel providers, nurses, correctional officers or sheriff deputies, the various government agencies that hire any of these workers (such as cities, counties, states, or the federal government), and the companies or corporate entities that employ and manage correctional medical and non-medical staff.

A major consequence of the myriad of different parties involved is the possibility of encountering conflicting defenses that may pit certain defendants against others. In many cases, different groups of defendants are represented by different attorneys who may or may not agree on a common defense. A seasoned LNC may save expensive attorney time by performing this essential medical-legal research, a task that would be very difficult for a paralegal without a medical background.

Plaintiff vs. Defense Cases

LNCs may find themselves on the plaintiff or the defense side of a correctional health care case. There are major differences between these two. Many plaintiff attorneys take a shotgun approach, blame prison/jail conditions, blame both practitioners and custody for the alleged loss, and let the defense grapple with a long list of allegations involving medical staff, correctional (security) staff, or both.

Defense attorneys review all the areas cited by the plaintiff and plan a response to counteract each of these. LNCs need to get into the right mindset to be effective for plaintiff or defense attorneys. Unlike expert witnesses, who frequently need to prove lack of bias by showing that they had participated as a witness for either side in the past, independent LNCs are free to specialize on plaintiff or defense cases, or to do both. Certain attorneys who employ LNCs in correctional health care litigation may take exclusively plaintiff or exclusively defense cases.

Plaintiff: LNCs, whether in independent practice or when working for an attorney, are frequently involved in the decision to take or not to take plaintiff correctional cases. The LNC must ponder the elements necessary to establish a negligence claim, such as duty, breach, causation, or damages. In addition, the decision to proceed to litigation from the plaintiff's side is partially based on economic incentives. Plaintiff attorneys take only a fraction of the cases proposed to them. Meritorious plaintiff cases are more likely to be chosen. Plaintiff attorneys and their staff review and decline a number of less-than-meritorious cases. Because such review would be expensive at attorneys' hourly rates LNCs are frequently the key to the review and selection process for plaintiff cases.

Defense: Defense attorneys and their staff need to review all the areas claimed by the plaintiff and must methodically study which claims may be easily countered, which may be borderline defensible, and which may not be defensible and may have to be settled. Before case study may begin, complete and organized case documentation is a must. As with non-correctional medical litigation, LNCs are valuable allies for procuring and sorting electronic and paper health records, organizing the case documentation, and, preparing the case timeline. In addition to these specialized analytical skills, some LNCs have become very adept at utilizing available software for timeline preparation and document indexing.

Preparing Correctional Case Timelines

LNCs need to assimilate certain concepts unique to correctional health care. These are the management of sick call slips (inmate requests for health care) and the coordination of security records kept by correctional officers or sheriff's deputies with more conventional health records kept by doctors and nurses. Sick call slips are written by inmates, who write the date of request, which may be correctly or incorrectly stated or even left blank. For each sick call slip, there should be a written response with a nurse's signature and the date, and finally, a date and record of an actual clinical visit, the review of which may entail reading paper or electronic records.

The timeline being prepared needs to reflect all these dates and times, together with the degree of certainty or uncertainty assigned to each event. Security records kept by correctional officers in prisons and sheriffs' deputies in jails may be electronic or on paper, and detail when certain events took place, including medical catastrophes, seizures, psychotic breakdowns, or suicide attempts. Careful correlation and timing of these events is essential. The LNC may also request commissary records to ascertain whether the inmate patient did or did not comply with prescribed therapeutic diets.

LNC's Role in Expert Witness Selection

For either the plaintiff or the defense teams, careful study is required to 1) gauge the caliber of expert witnesses listed by the opposing counsel; and 2) secure the participation of equal or higher caliber expert witnesses for their side. Seasoned LNCs participate in both processes.

Types of correctional expert witnesses: There are three basic types of experts in correctional health care litigation: medical experts, purely correctional experts, and correctional-medical experts.

1. Medical experts (MD, DO, PA, NP, RN, LPN, etc) assess conformance to community standards of medical care and may not have correctional health care experience; many are Board Certified Specialists.
2. Purely correctional experts are usually ex-wardens, ex-correctional officers and the like. Their opinion is valuable regarding security-related issues.
3. Correctional-medical experts are a subset of medically trained persons with expertise in issues of access to care who have been exposed to the interaction of security and medical staff in prisons and jails.

Table 1. Sample Questions and Answers for Prepping the Expert
Q: "Doctor, how can you participate in the defense of a case falling below your high standards of care?"
A: "Given the specifics facts of this case, the prison (jail) providers did not, in my opinion, fall below the standard of care."
Q: "Doctor, your CV denotes that you believe in accreditation by the National Commission on Correctional Health Care. How can you participate in the defense of a non-accredited facility?"
A: "Institutional accreditation by the NCCHC (or ACA) is desirable but not mandatory to operate a prison or jail in the US."
Q: "Doctor, don't you agree that there were many omissions in this patient's care?"
A: "My case review did not show that there were many omissions in this patient's care."
Q: "Doctor, is this the way you would have treated this patient?"
A: "I am not discussing how I treat my patients, because the clinical circumstances of each case may be different. I believe the patient in question was treated in accordance with the standard of care."
Q: "Doctor, you have testified in XX number of correctional suits; would you agree that you now qualify as a hired gun?"
A: "I believe that there are only a small number of correctional health care experts. Therefore, they may be called frequently to render opinions in Court. I have an active correctional medicine practice. I do not consider myself a hired gun, and I participate only in cases I deem meritorious."
Q: "Doctor, what books or treatises in correctional health care are authoritative, in your opinion?"
A: "At this time the pace of medical progress is so fast that, by the time a book is printed, it is out of date. When facing an individual medical situation, I conduct an Internet search for recent literature and make a decision based on such search, plus my training and experience."
Q: "Doctor, what is your definition of deliberate indifference?"
A: "Deliberate indifference is a legal concept. I am not a lawyer. From my readings of the correctional-medical literature, I learned that there is a need to ensure that incarcerated persons have access to care, have access to a professional opinion, and have received all the care that was ordered by the professionals."
Q: "Doctor, is the standard of care in corrections different than that of the non-incarcerated population?"
A: "The standard of care is a legal concept. I can tell you that the expectations of health care are the same in and out of corrections, and that correctional and non correctional patients should be treated equally. For a given medical situation, physicians sometimes rely on guidelines published by a number of specialty societies. Often times, guidelines by different specialty societies for the same medical topic are somewhat different form one another."
Q: "Doctor, doesn't the National Commission on Correctional Health Care (or the American Correctional Association) publish clinical standards of care?"
A: "The standards for institutional accreditation of the National Commission on Correctional Health Care are widely respected. They cover multiple areas of jail/prison health care, such as access to care, visits to physicians, quality improvements, and so on. However, there is limited clinical content in these standards. The NCCHC has posted in its website certain guidelines for the performance of chronic care in corrections. These guidelines are voluntary and not specifically built into the standards for accreditation."

Who can be a correctional medical expert witness? LNCs looking for the ideal expert witness in a correctional case need to be aware of State and Federal qualification criteria. In same jurisdictions, these are aimed a preventing "professional expert witnesses" to evolve testifying into a career, i.e., deriving more income from testifying than from their profession. The LNC verifies that the proposed correctional medical expert witness possesses recognized expertise in the field, has worked until recently or is presently working in corrections, has a proven track record as a correctional practitioner or in correctional medical management, and has either never testified or has testified before for both sides.

Finding an expert witness: LNCs looking for correctional medicine experts may rely on word of mouth and other sources, such as the National Commission on Correctional Health Care (773/880-1460), the Society of Correctional Physicians (800/229-7380), or the American Correctional Health Services Association (877/918-1842). Rosters of recognized expert witnesses, including correctional medical experts, may be found at Web sites like JurisPro (**www.jurispro.com**), Expert Witness (**www.expertwitness.com**), and SEAK (**www.seakexperts.com**).

Should we retain this physician or nurse as an expert? Getting names is the easy part, but deciding on retaining a certain expert requires skill and experience. A preliminary phone conversation will help the LNC to sense the suitability of the expert witness candidate. During the conversation, the expert candidate should be asked to furnish a CV listing all medical and legal training and experience, complete with all cases previously handled and the names of all the attorneys who used the expert's services. The LNC may contact some of these references and gather information on the expert candidate's ability to deliver testimony. A fee schedule and retainer policy should be requested and agreed upon. If the references are good and the CV looks acceptable, a second conversation with the candidate will serve to gauge potential usefulness. A good candidate should listen to the attorney or LNC, be willing to talk on the phone for as long as it takes to understand the case, hint at some strategies, and show an understanding of the issues. During this key interview, the LNC must assess the candidate's ability to condense issues into simple concepts, sort out fact from fiction, problem-solve, and voice medical opinions in a simple, convincing fashion.

LNC's Role in Managing Expert Witnesses

Independent or employed LNCs play a key role in the management of the various correctional expert witnesses a case may require (Paris, 2002 & 2003). Special care may be needed in the handling of expert report drafts. In many State Courts, the opposing attorney is entitled to all drafts and preliminary versions of the expert reports prepared for the other party.

It is common practice on both sides of the bar to verbally discuss the expert's opinion, either on the phone or in person, before committing to a potentially discoverable document. After these verbal reviews, the expert's opinion may be

requested in writing. LNCs also educate less experienced expert witnesses on the differences from simple expert reports, notarized affidavits, and the Rule 26b styled reports required by the Federal Courts.

Preparing the Correctional Health Care Witness

Opposing attorneys may grill correctional health care expert witnesses being deposed or testifying in Court (Paris, 2008). Before depositions or Court trial testimony, expert witnesses are interviewed by friendly counsel and prepared for the experience. A common role for LNCs is to participate in the preparation or "prepping" of the expert. Physicians, especially, are trained to explain matters at length to their patients and may have a difficult time "just answering the question." In addition, the expert's preparation needs to include the ability to anticipate certain questions that recur often in correctional health care litigation. Table 1 on page 18 provides examples of these, with answers that have worked for this author. (The reader may note that no answer fits all occasions and situations and somewhat different answers may have to be considered.)

Conclusion

At present, only a small number of LNCs are engaged in correctional health care litigation. A deterrent to such participation may be a lack of nursing experience in correctional health care. It is true that, if a LNC were to contemplate testifying about correctional medical matters in a deposition or in Court, lack of experience as a provider of correctional health services would be a hindrance. However, a LNC does not need such hands-on correctional clinical experience in order to assist attorneys, prepare case summarizations and timelines, select and prepare witnesses or to assist in correctional health care cases. It is hoped that this brief description may inspire LNCs to consider participating in the exciting, growing field of correctional health care litigation.

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Prior to switching to correctional medicine, **Joseph E. Paris**, PhD MD CCHP-A, had an internal medicine private practice and was never involved in a medical lawsuit. After joining the Florida Department of Corrections in 1985, the author had to learn to testify in his own defense in a few correctional cases. Later on, some Florida DOC Attorneys asked his opinions in cases involving DOC colleagues. Since 1994, attorneys from several states have requested his opinions in correctional health care cases. Paris has given verbal or written medical opinions in some 100 suits, has been deposed more than a dozen times, and has testified in Court four times. In the 1980s and 1990s, Paris rarely interacted with LNCs; however, LNCs working independently or for a law firm have recently retained him as an expert witness in about half the cases. He can be reached at **joeparis@pol.net**.

The Expert Witness: A Critical Role in Successful Litigation

Patricia Fedorka, PhD RNC

KEY WORDS
Expert Witness

In-depth knowledge of the applicable standard of care is a necessity to be an effective expert. Although the nursing expert gives an opinion based on education and experience, this opinion should be supported, when appropriate, by nursing standards. The following article, adapted from the author's presentation at the 2008 AALNC National Educational Conference, provides suggestions and answers to some common questions and concerns regarding the role that the expert witness plays in successful litigation.

The *Legal Nurse Consultant Principles and Practices* text (Iyer, 2003) lists the characteristics of effective experts.

1. Strong teaching skills: the expert is often in the role of teaching the jury the basics of the medical/nursing issues in the case. Nurses are often the best qualified to "teach," using simple vocabulary that we often use in teaching our patients.
2. Open, pleasant manner and appropriate sense of humor: Research has shown that nurses are perceived as trustworthy individuals. The expert's ability to interact with the jury is an important asset in establishing a trusting relationship with the jury.
3. Ability to explain rather than advocate: Although nurses have a duty to advocate for their patients, this is not the role of the expert witness. As an expert, the nurse's role is to clearly explain the medical/nursing scenario to the jury in an impartial manner.
4. Ability to offer and defend concise, clear, and objective opinions: This is an area where standards of care (SOC) play an important role. Although the expert's individual education and experience play an important role in their opinion, the expert's opinions are strengthened when supported by any one of the sources of the standard of nursing care (see Table 1 on page 20). Competent nurses have a duty to take responsibility of staying current in their area of expertise. "Not knowing," therefore, is not a legitimate excuse for not following the standard of care and not functioning within the appropriate SOC.
5. Honesty, integrity, professional responsibility, and ethical conviction: The most important attribute that an expert possesses is integrity. Experts should never allow themselves to be coerced into making statements or opining to a view that the expert believes to be exaggerated or even untrue. Consistency in opinions is easy to maintain over years and a in multitude of situations if you stay true to your convictions.

How is the expert witness defined? What makes nurses qualified to testify as an expert witness?

An expert is defined as "one who has acquired special skill in or knowledge of a particular subject; an authority" (Random House College Dictionary, 1980). In legal nurse consulting, the expert is qualified by the specialized knowledge they possess as a Registered Nurse. A combination of educational background and clinical experiences qualify such experts to testify on areas of their expertise.

What, in your experience, is the desired educational preparation for an expert nurse witness?

Most experts are at the Masters prepared level, although there will be exceptions with witnesses having a lesser or greater degree. An important question to ask is what educational preparation the opposing expert has, and to make sure that one's educational background and clinical experience are similar when possible and appropriate.

What is your opinion on LNCC certification as it pertains to expert nursing testimony? I have heard it can be perceived in a negative light. Do you agree?

Every nursing specialty has certifications that are awarded to practitioners that show excellence in their field. For example, the American Nurses Association (ANA), National Certification Corporation (NCC), and the American Heart Association award certifications for a variety of specialties/competencies. The expert should not be intimidated by opposing counsel or feel the need to "defend" their certification as an LNCC. It is, after all, a sign of excellence in our profession.

Isn't current work experience essential in expert witness testimony?

The nurse should have the clinical experience that lends credibility to his/her testimony. The nurse should be clinically current or at least current at the time of the alleged incident. The attorney will specify their preference when retaining the expert.

How important is current or active practice? Do states require this of their experts to qualify?

It is certainly favorable in the Court's eyes that the expert has a current, active nursing license. Several states, such as Ohio, stipulate that expert witnesses spend 50% of their time in the clinical specialty in which they are offering an expert opinion. (This includes teaching responsibilities.)

As an expert nurse witness, how do you identify and address a potential conflict of interest?

Evaluate any potential conflict of interests that would invalidate or cause any possible problems with objectivity. When contacted by an attorney, the expert can ask several questions to help identify potential conflicts. Where does the case originate? Many experts prefer *not* to accept cases that involve local area hospitals. This decreases the chance that the expert might have some knowledge of the health care providers involved and/or the institution. Also, if the expert accepts a local case, he or she should ask the name of the defendants – realizing, however, that when the hospital is named, the individual nurses may not have yet been identified. Obviously, if the expert is acquainted with the plaintiff in any way, she should recuse herself from reviewing the case and offering an opinion.

How do you keep track?

Each expert must develop a system for identifying the cases that they are reviewing or have reviewed to prevent accepting the identical cases from both a defendant and a plaintiff firm. Although this seems unlikely, it can happen – especially when the last name is common such as "Smith." In obstetrical cases, the infant often does not have the same last name as the mother and a misunderstanding can arise. Keeping a spreadsheet of plaintiff first and last names and the law firms who contacted you is a helpful way to prevent confusion.

Should I work for either defense or plaintiff lawyers (but not both) as an expert witness?

Experts who testify for both sides of the legal spectrum are perceived as more balanced. A potential pitfall in expert witness testimony seems to be the strategy of the opposing attorney attempting to have the nurse expert answer questions outside of his or her expertise in an attempt to challenge their knowledge base. The nurse expert must be an expert in the content area in which they are offering the opinion. If opposing counsel can show the expert as being unknowledgeable in their area of expertise, it will be used to discredit the witness. If possible, avoid hypothetical questions that are not based on the issues at hand. If you do address them, you might choose to address them as such: "In answer to your hypothetical, which is not the case here, I would say…"

It seems rather obvious that the nurse expert must be both an educator and translator of complex nursing and medical terms in the courtroom. What are some additional characteristics of the nurse expert as far as communication?

Nurses are usually very good in communications skills that are supportive, encouraging, and non-aggressive. Although this type of communication is appropriate for patient interactions, it is not appropriate for the expert in deposition or trial testimony. Many good references are available to help the expert develop appropriate communications skills that will serve in testimony situations. Also the common pitfalls of testifying are identified. This allows the new expert to learn from others experience and decrease some of the common errors made by new experts. There is no need to learn by trial and error.

It is also of great benefit to attend one or more medical negligence trials to observe the experts as they testify. You can evaluate what characteristics are displayed by a variety of experts and the attorneys questioning them. You can also observe the jury's reaction to the testifying expert.

Do you have any suggestions on where you can gain experience in testifying as a nurse expert?

Understand what is expected of you. There are many excellent resources, including the core text of AALNC, *Principles and Practices*, 2003. The more familiar the expert witness is with the process, the more attention the witness can focus on the substance of their testimony. Depositions and trial testimony have a pattern that they usually follow. Again, there is no need to learn by trial and error.

Table 1. Resources for the Expert Witness to Determine Applicable Standard of Care.

State Nurse Practice Act: There are actions that are limited by individual state nurse practice acts. It is important to note, however, that nurses are allowed to assume "extended roles" or perform advanced nursing implementations only after "competency" has been established.
National nursing organizations: American Nurses Association and professional nursing organizations specific to the area of nursing relevant to the litigation. All nursing specialty organizations set standards as to the expected nursing care is specific situations. Hopefully, these are incorporated into the hospital's policies and procedures, which are also a basis for the standard of care.
Specialty nursing organizations: Most specialty areas in nursing have professional organizations that address nursing care. For example, the obstetrical nurse follows standards that are promulgated by the Association of Women's Health, Obstetric and Neonatal Nurses Organization (AWHONN). AWHONN sets standards that address the frequency of electronic fetal monitoring evaluation among countless others. If the case involves a Caesarian section, the Association of Operating Nurses (AORN) may also play a role. It is the duty of the expert witness to be thoroughly familiar with applicable standards in the case.
Joint Commission for Accreditation of Healthcare Organizations: JCAHO addresses many areas that can be utilized when evaluating standard of care.
Educational literature/textbooks: Core curriculum textbooks used in medical and nursing schools, for instance, as well as professional journals and published research studies are resources.
Defendant's hospital's policies and procedures: Plaintiff's counsel should obtain materials otherwise (not privileged or protected) through the discovery process.
Defendants' competencies /orientation materials/ employment evaluation files: These also should be requested and obtained through formal discovery.

It may be just business for the attorney, but it sometimes seems like a personal attack. How do you handle such situations?

Nurses are often not comfortable with the adversarial relationship that can develop during the testifying process. It is important for the nurse to recognize that all participants play a specific role in the litigation process. The role that the expert witness plays in the litigation process that has already been identified; however, it is just as important that the nurse expert

Continued on page 34

Online References and Resources: Locating Specialty Expert Witnesses

Kara L. DiCecco, MSN RN LNCC

Below is just a sampling of resources for locating expert witnesses in specialty areas, everything from firearms to maritime law. This list is not exhaustive, and this is not an endorsement of any commercial sites or services. As with any online resource, the reader must confirm the authority and credibility of the site independently. Before retaining the services of any expert witness, the LNC is reminded to conduct his or her own research.

Locating Specialty Expert Witnesses

http://www.m3federal.com/expert_witness.htm

M3 Federal Contract Practice Group, LLC

Promotes that limits its dealings exclusively to the United States Federal Government and specific military and civilian agencies. 35 years experience with focus on government contracts. Provides subject related seminars.

http://www.ims-expertservices.com

IMS Expert Services

Establish in 1992, site offers locating and delivering hard-to-find experts across hundreds of practice areas and industries (searchable database by practice area or industry.) Offers to locate "needle-in-a-haystack subject matter experts fully vetted and free from conflict."

http://www.integral-corp.com

Integral Consulting, Inc.

Expertise in environmental litigation experts, risk assessment and toxicology, sediment science and management, air quality assessment, engineering and remediation, natural resource assessment, and more.

http://www.medquestltd.com

MedQuest, Ltd.

Since 1983, offers full range of health care professional expert witnesses. Services include a free online databases of relevant health care litigation articles. Also provides digitalized imaging, medical record retrieval, prescription history, MD sanctions search.

http://www.craigball.com/

Craig D. Ball

Board certified trial lawyer and certified computer forensic examiner. Limits his practice to Court-Appointed Special Master, Electronic Discovery Consultant, Computer Forensic Expert, and Forensic Technology Speaker. Extremely informative Web site and excellent resources.

http://www.tasanet.com

The TASA Group, Inc. (2002) (Formerly, Technical Advisory Service, Inc. since 1961)

Originating with two industrial psychologists with a private consulting firm in 1956, the interview of a newly retired naval officer and a maritime lawyer in need of an expert led to today's TASA Group. Provides list of prior clients and testimonials. Has user-friendly, searchable database and a "think outside the box" feature.

http://www.theroundtablegroup.com

The Roundtable Group

Founded in 1994 by a group of attorneys, business leaders, and professors. It promotes that it provides expertise in all areas and its roster of experts includes former government officials and advisors, leading attorneys, renowned professors, and fellows at think tanks. Provides extensive listing of prior clients and testimonials.

http://www.forensicdjs.com/

DJS Associates, Inc.

A full-service forensic engineering and scientific consulting firm offering 45 years of litigation, claims, and educational support services to the legal community, insurance industry, and government entities. Includes, but not limited to, accident reconstruction, automotive engineering, trucking and tractor-trailer investigations, and high-definition surveying.

http://www.hgexperts.com

Hieros Gamos Experts

Searchable database by subject or state. Well-established legal resource since 1995, informative Web site offers expert related resources including free article database. Home page of http://www.hg.org provides multitude of resources.

http://www.jurispro.com

Juris Pro Inc.

Started by a group of attorneys, this free directory provides easy access to vast array of experts. Unique features in some cases of audio and photo to evaluate the presence of the potential expert. Searchable by subject heading, name, expertise, or state.

http://www.seak.com

SEAK, Inc.

Founded by Steven Babitsky in 1980, SEAK provides a published directory of expert witnesses and IME directory. Provides resources for expert witnesses, including writing workshops and seminars. Informative articles under free resources.

http://www.expertpages.com

Expert Pages

Web site advertises, "the original and leading online directory of expert witnesses." Free directory searchable by topic, name, or state. Collection of free online legal resources and articles.

http://www.intota.com/

Intota

According to their Web site, Intota Experts are peer-recommended authorities who have been carefully selected and rigorously screened for competency and suitability. Also promises a 100% satisfaction guarantee.

http://www.bankingexpertwitness.com/

Capital Finance

Informative site unique to this area of practice. Provides case studies, links to banking industry, and references.

The Expert's CV: A Tool You Can Use

Kara L. DiCecco, MSN RN LNCC

"Learn to question everything. Do not accept everything you hear as truth, even if I say it." – Buddha

Of all the instruments in the litigator's toolbox, the expert's Curriculum Vitae (CV) is often under-appreciated for the extent of its tactical advantage in the litigation process. Consumed with the demands of pre-trial discovery, not all attorneys are aware of the prefatory benefit of using an LNC to exact an analysis of the expert's credentials. To properly function, tools must be calibrated for precision, balance, and performance. The graduations must be checked to ensure the accurate representation for the intended purpose. The rate of error should be a known quantity. Once produced amid the multiple documents, and working within the time constraints of the scheduling order, attorneys may mistakenly use the CV as a simple tire gauge – specifically pulled out to quickly check for over-inflation then placed back in the box to dutifully wait for its next procedural obligation. This article will take a closer look at the expert's CV as a multi-faceted instrument for sharpening the litigator's effectiveness in deposition and at trial.

The legal field is fertile ground for unearthing or masking the truth. The search for truth manifests itself in asking the client to explain the details of the accident one more time as subtle contradictions emerge or facts become solidified. The plaintiff's complaint asserts a *prima facie* case that the defense quickly attempts to dismantle with its own allegations of the truth. The tools of discovery seek to find factual answers under oath. The deposition specifically is designed to uncover inaccuracies and identify areas of weakness and strength. In trial, we mistakenly assume that the jury is incapable of drawing their own well-founded conclusions without gilding the impeachment lily and discrediting the witness. Unfortunately, manipulation of the truth is as much at home in the legal field as it is in politics. Preparing for the adversary's subterfuge can only be countered with adequate preparation.

The terms "CV" and "résumé" are often (and erroneously) used interchangeably. While both serve to provide a record of previous experience and qualifications, their formats assume distinctly different presentations. Résumés are generally produced when the position applied for will generate many responses in the public sector, so the limitation of one to two pages of work experience allows the future employer to screen many potential applications. The function of the résumé is to provide a summary of the work background.

The CV is associated with more academic pursuits and uniquely qualified positions, and it provides a more *detailed accounting* of experience and qualifications unique to the position's requirements. The pool of qualified applicants is anticipated to be relatively small. There is no limitation to the length of pages because the potential employer is specifically interested in the candidate's presentations to professional peer groups and publishing experience reflecting their specialized academic and clinical accomplishments. Table 1 lists the elements that compose a professional CV.

Table 1. Elements of a CV.

Name, address, telephone, e-mail address: Typically centered at the top of the page, often bolded.
Education: Listing most recent first spelling out degrees. (High school is not listed.) Fellowships and residencies go under this heading.
Specialized Training or Certifications: Include the year obtained.
Professional Experience: In the case of health care experience. Include time employed (start and stop by year), position title, name and location of employer. Medical rotations would be listed here if including them.
Teaching Experience: If you have any you want to include.
Presentations: At a minimum, include presentation title, name of group/ society/organization presented to, and year. May include location of presentation.
Publications: As a general rule, greater than four, divide by peer-reviewed and non-peer-reviewed. Citation preference is usually field specific. APA generally acceptable. If article accepted for publication but not yet published, may reflect accepted then date.
Related Awards and Activities: Awards are listed by title and year granted. Dean's list is quarter and year (though not always included). Committee memberships include committee name and time spent on committee.
Professional Affiliations: List current membership and spell out association's full name. Include any professional association offices held.
Licensure: List name of state and type of license only.

The CV (or résumé) also provides a basis for determining the credibility and appropriateness of the expert identified to testify in trial. Interrogatories are the first step to collecting the necessary information regarding the expert witness. Answers to interrogatories, however, will only be as effective as the questions asked; therefore, once produced, the expert's CV should be examined to establish the entire record of higher education relevant to the expert's training and opinion. Additional information regarding the exact license and certification(s) the expert holds, as well as any prior licensures or certifications, should be listed by the expert and researched by the LNC. Use of an online database for credentials check will verify or refute information. The CV should be compared to the expert's written responses. Not all discrepancies are of paramount importance, but the LNC should alert the attorney to any

inconsistencies, enabling the attorney to direct further action if warranted.

The expert's deposition testimony provides the opportunity for the attorney to ask for further elaboration on the timeframes cited, division of academic and clinical time, class ranking, board success rates, sanctions, and fees. Compare this information to the results of the online investigation. Prior testifying experience, and in what capacity (a party to the litigation or as retained for expert opinion), should also be explored in deposition. Adequate preparation entails knowing your expert's answers and responses to these investigations as well.

Working within the attorney's budgetary restraints, locate and review the opposing expert's listed articles or texts related to the material facts of litigation and those that the expert has identified in support of his position. Upon first review of the expert's CV, you may have well into the double-digits of published articles, but from those you can extract for duplicate presentations and, in general, disregard any treatise on "the nucleic proliferation of frozen fungi on cirrhotic rat livers." Due to the specificity of research for funding and the need to control for variables, the actual publications or articles directly applicable to the medical-legal issue is often dramatically narrowed. Those that do survive the relevancy challenge should be obtained, reviewed, and, under the direction of the hiring attorney, provided to your expert for review. You should obtain your own expert's publications and information for review as well to determine what areas the opposing will likely target as weak in your expert's opinion. Table 2 provides a suggested list of questions to explore and consider in evaluating the expert's CV.

Table 2. Evaluating the CV.

Critical Analysis of the Expert's CV
Do responses in the interrogatories match the information in the CV produced in the Request for Production response? Is the CV current? In there an online version of the expert's CV to compare?
Does the expert maintain all licensure(s)/certification(s)? If no, why not?
Does the expert maintain membership in all professional societies/ organizations listed? In good standing?
Who sponsors any academic awards, grants or scholarships listed on the CV?
Are all publications/presentations listed by the expert relevant to the issue being litigated? Pull and review those you can anticipate the expert will rely on for the basis of his opinion. Try **http://pubmed.gov**, an online literature retrieval service or the publisher. Determine the whether or not the information is current to the timeframe of the alleged negligence. Do the articles meet the *Daubert* or *Frye* criteria? Is the expert the lead researcher/investigator or a contributor? Who sponsored or funded the research? What is the expert's authority to write on this subject?
Are there duplicate presentations/articles listed?
What Boards or Committees does the expert serve on?
Additional Thoughts to Ponder
Has the expert testified before? In what capacity? As a party to the litigation or retained for an expert opinion? If party to the litigation, what was the resolution?
Is there public record of the information the expert has provided? Is there published case law in which the expert testified? Is the expert's prior testimony obtainable from a deposition databank such as **http://www.idex.com** or **http://www.trialsmith.com** or listserv (ATLA/AAJ or DRI)? Is the expert's opinion consistent with prior opinions given?
Conduct an online search of the expert. Does the expert's state of licensure list sanctions on line? Try the state's homepage where the expert is licensed. Try **http://www.docfinder.com**. Use an online credentials search, such as **http://www.healthgrades.com** or **http://www.choicetrust.com**. Try **http://www.dealookup.com** (offers a free 30-day trial). GOOGLE the expert's name in quotes to search the Internet (for example, "Jerrod Q. Smith" "MD".) Explore the return hits. Then search images using the expert's name again. Click on the text under the image and review this information. Does the expert maintain a blog or contribute to other blogs? Has the expert taken a contradictory position online in a more informal arena? Try GOOGLE blog search **http://blogsearch.google.com**. Has the expert been posted on YouTube or contributed to a podcast? For information obtainable on Web sites no longer active, try **http://www.waybackmachine.org**. Does their institution or facility have a Web site that promotes their faculty's publications? What is the professional reputation of their current educational institution or facility? What about where they received their training?
How does the expert know the attorney who hired them?
What political interests does the expert hold or support? Any hidden agenda? Any personal bias or axe to grind?

Not all information suggested in researching the expert's CV will be relevant, subject to the rules of discovery, or necessarily admissible at trial. All information researched and obtained should be available through resources attainable by the public at large. The LNC may never need to know if the attorney and expert are friends outside the courtroom, and even if they are, this does not necessarily preclude an honest, well-founded opinion. Not all attorneys will attempt to skirt the edge of professional ethics in presentation of their expert witness or cast dispersions in cross-examination of yours; but on occasion, it does occur. Being prepared for this tactic is key. As the saying goes, "Forewarned is forearmed." Pulling back the paper curtain to determine if indeed you really are in the presence of "the great and powerful Oz" can be a valuable asset to any attorney and his client.

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Effective Preparation of the Expert Witness for Deposition

AALNC Lexington, Kentucky Chapter: Rose Clifford, RN LNCC (President), K.C. Wagner, RN (Director-at-Large), Donna Hunter-Adkins, BSN RN CCM CLCP LNCC (Past President).

Q: I have been asked to assist in the preparation of the expert witness for deposition, how do I do this? Where do I begin? What is important to cover?

A: Begin with a list of important points to be covered. Identify the attorney's goal in witness preparation and strive to achieve witness credibility.

One of the most important requests the attorney may ask a legal nurse consultant (LNC) is to assist in preparing the expert witness for deposition. Let's face it: cases are won and lost on expert testimony. Even with the greater weight of excellent evidence-based theories on your side, cases can easily fail without effective expert witness preparation. According to trial consultant Gabriel (2006), "There is just no escaping it: no matter how good the evidence, that evidence depends heavily on the messenger and on the strength of the testimony" (p. 2):

> The overall goal of witness preparation is to improve communication skills: increase the witness's ability to respond to questions, control the level of detail in his or her answers, heighten jury opinion of the witness's level of knowledge, educate the jury on key background issues and show conviction in all responses (p. 3).

Whether it is deposition or trial, the witness's ability to clearly communicate his or her knowledge confidently is essential to the positive outcome of the case. Effective preparation will help the expert to understand the process, know the purpose and focus on the facts.

Preparation time of experts varies from a brief telephone call to a one-on-one in-person pre-deposition conference lasting several hours to all day. It may occur just prior to the experts' deposition or the day before. Expert Neville (2002) noted, "The length of time of the preparation is related to the complexity of the case, the role of the expert, and the issues and money at stake" (p. 1). It is also directly related to the experience of the litigator and to the testifying experience of the expert.

Understanding the Deposition Process

An effective expert witness must clearly understand the entire deposition process. Explain what is going to happen at the deposition, who is going to be asking the questions, who will be present (opposing counsels, court reporter), who might be present such as the defendant nurse or doctor, hospital risk manager or the injured party, length of time of the deposition, where the parties will be seated, breaks, what to expect and appropriate etiquette (rules of the deposition).

A deposition is a sworn testimony in the form of questions and answers taken before a court reporter outside of the courtroom, usually in an attorney's office, conference room or hotel suite. Prepare the expert for the following:

1. Your attorney will not be conducting the deposition or asking the direct questions. He already knows your opinion on the issues whereas opposing counsel does not.
2. Your attorney may choose not to ask any question during your deposition or make a lot of objections.
3. The expert is not allowed to ask the deposing attorney questions.
4. The attorneys involved are all colleagues and in some cases long-time friends who will be friendly, polite, and cordial to each other prior to the deposition, but once the deposition has begun they will be ardent adversaries. When the deposition is concluded, they will again be friendly. Don't let this throw you.
5. The deposition style of opposing counsel, if known, should be explained to the witness. For example, is the attorney polite, or arrogant and condescending? Will he or she pose questions crisply, or engage in long prefatory statements before getting to the actual question. Will he or she stray from case-related questions to the totally irrelevant? Depending on the deposing attorney's style of questioning, she may ask your name and contact information and then immediately launch into a direct asking for all your opinions upfront.
6. Lines of questioning will address any prior statements, opposing views, content of opposing expert's opinions, reports, and hypothetical situations.

7. The expert will be asked for her opinion regarding opposing expert's report and if she has any criticisms of it or the care rendered.
8. Opposing counsel will repeatedly attempt to solicit inconsistent testimony in order to undermine the expert's credibility, especially if you are highly believable, trustworthy, and sincere.
9. The expert should not argue with opposing counsel.
10. Be pleasant and cordial, but do not engage in conversation with anyone other than your attorney.

The expert is expected to review all records, documents and communication prior to and in preparation for his deposition. This should include the complaint and answers to interrogatories; it is part of the process.

Knowing what is Expected

Explain to your expert witness precisely upon what subject matter (points) the expert will be expected to express an opinion. This may be better left to the attorney, but an experienced LNC, especially an in-house consultant, will be expected to review the exact issue or issues that the expert is expected to address. The LNC does not tell the expert what to say but reinforces the issue to which the expert is expected to render an opinion. Sacramento litigation attorney Vincent DiCarlo (2008) instructs attorneys that "for an expert's testimony to be credible, he or she must be reasonably well-informed on any and all issues in the case that might relate to the basis or the ultimate opinion expressed by the expert" (p. 2).

Let the expert know that her opinion or testimony is permitted only if she is declared to be an expert in a specified field. This declaration is made after the witness is sworn in and before she is permitted to testify.

As a result, the LNC may reiterate the attorney's explanation of Daubert to prepare the witness for anticipated deposition questions. *Daubert v. Merrell Dow Pharmaceuticals* (1993) held that, under the Federal Rules of Evidence 702, "to be admissible, an expert witness must be screened based on: 1) certain qualities and that his or her underlying testimony must be both 2) reliable and 3) relevant" (p. 593). To be admitted as an expert, the expert must be qualified based on "knowledge, skill, experience, training or education" (*Daubert*, p. 588), so the initial deposition questions will focus on those requirements and will last from a few minutes to hours. The expert is expected to know their curriculum vitae in detail.

> Justice Blackmun listed some elements that help identify the presence of scientific method in testimony: 1) if the theory or technique is one that can be, and has been tested (hypothesis testing); 2) has been subject to peer review and publication; 3) if known or potential rate of error exists; 4) if there is an existence and maintenance of standards; and 5) if "general acceptance" has a bearing on the inquiry. (*Daubert*, p. 597, 593-4)

"Relevance means that the expert's testimony must 'fit' the facts of the case" (p. 592). In other words, the expert's opinion cannot be "just an opinion" or based solely on what he or she does at the hospital. It cannot be junk science. It must take into consideration the facts of the case and properly apply those facts to the research. The expert's opinion is expected to be based on good science, research that is peer reviewed, and commonly accepted standards of care that have been tested and verified in evidence-based practice. Testimony has to "fit" the issue and be relevant. Research is more convincing if it is reliable. Helping the witness to understand the rules will ultimately prepare him for potential lines of questioning.

The expert should be advised as to what the attorney wants to accomplish in deposition. The Lectric law library excerpted from their expert list:

> If the case is definitely headed for trial, all adverse counsel wants is for you to say something on the record that can be used to beat you up. Counsel may tell you that he is just trying to understand your opinions, but that is not true. She is trying to make a record helpful to her side, nothing more, nothing less. Your client wants you to answer truthfully, but to say as little as necessary to answer the question. (p. 1)
>
> There are other times, however, when your client's goal is to convince his opponent that it's time to make a serious attempt at settlement. In those cases, it may be necessary to volunteer information in order to make sure that adverse counsel gets it. If counsel learns about everything that you will say at the time of trial, he may decide that a trial is not the best course to take. (p. 2)

The expert is expected to know the goal of the deposition. If not advised, he should ask in the preparation phase.

Discovery Includes the Expert

The expert needs to know that the full scope of discovery includes the expert. The expert must understand that her entire case file, everything that is shown to her, anything that she reviews, or anything that she brings to the deposition is discoverable by opposing counsel. That includes the contents of her briefcase, pockets, or purse. Anything that may have a bearing on the expert's opinion such as records, documents, notes, research, or medication is fair game for opposing counsel to review. DiCarlo (2008), noted:

> The expert should be reminded that putting preliminary opinions, impressions or other thoughts in writing makes those preliminary opinions, impressions or other thoughts discoverable and may also create a waiver with respect to any prior preliminary opinions, impressions or other thoughts (p.2).

The expert needs to know what he or she has been given to review during the course of the discovery, when it

was received, and in what order he or she received it. Make sure that the expert has examined all medical records and enough material to provide a credible basis for his or her opinion including subsequent treating, pre-existing and/or updated records.

In preparation for deposition, the attorney and the LNC need to review the entire file, including every piece of paper, with the expert. Alabama attorney M. Clay Alspaugh (2000) was clear:

> Should there be information in that file that needs explanation, that information should be reviewed with the expert in detail. Should there be portions of the testimony of witnesses that he might have relied on in developing his opinion then anything adverse in that testimony and/or statement should be gone over with the witness in order to explain any difference or discrepancies between what the witness might have said and what his ultimate opinion is (p. 20).

Essentially, anything the expert sees, says, does, or relies on to render or formulate his opinion is discoverable. Alspaugh (2000) advises: "If less than the entire discovery has been provided the expert you need to discuss why portions of the file he did not see bear no effect on his opinion" (p. 21).

Ethical at all Times

The expert needs to be constantly and consistently ethical. The "gold standard" in expert testimony is to tell the truth.

- Credibility is everything.
- Give only unequivocal honest answers.
- Rely only on facts that can be proven.
- Do not stretch the truth.
- Do not overstate your opinion.
- Do not destroy documents.
- Testimony must be consistent from case to case.
- Preserve credibility by maintaining a balance between plaintiff and defense cases, clinical practice and legal case reviews.

Importance of Nonverbal Communication

Nonverbal language is more persuasive that verbal because the communication is interpreted on a very personal level. Effective witness preparation should include a discussion of the importance and use of nonverbal language. The trial consulting group *Synchronics* identifies five nonverbal attitudes that make a difference in the favorable reception of expert witness testimony. In deposition, opposing counsel will subtly evaluate the expert on nonverbal communication and how the jury will perceive the credibility of the expert. Two of the five attitudes include keeping the abdomen open (for instance, not keeping one's arm crossed) and keeping hands visible.

At deposition, experts are positioned behind a large conference table in adversarial positions. They are seen as being closed off when they cross their arms across their abdomen. *Synchronics Group* suggests:

> During deposition and at trial they will want to put their arms on the arm of the chair, instead of folded over their chest or in their laps; unbutton their suit jacket; and avoid stacking papers and/or books in front of them. Keeping an open abdomen is a courageous, receptive posture reflecting self-confidence and sincerity (p. 1).
>
> Experts, like some people, approach…
>
> …life like a poker game: cautious, leery and holding their hands close to their chest so no one can see what's up their sleeve. This attitude may be appropriate in some places, but not inside the courtroom. Experts want to keep their hands visible, indicating that they come before the jurors hiding nothing. Let go of a balled fist and show an open palm. The open palm is an especially appropriate expression of cooperation; people use this gesture when they greet each other, shake hands, and ask for understanding. When addressing jurors, experts will want to use the open palm as an expression of their good will… (p. 2).

… or in deposition, where honest credibility is just as important. According to attorney Sheeny (2004), "The more awareness a witness has regarding his or her presentation style and nonverbal cues, the better the chance that the witness will exhibit the qualities of expertness, attractiveness, and trustworthiness."

Know How to Answer the Questions

All witnesses, but especially expert witnesses, need to be prepared as to how best to honestly answer the questions posed by opposing counsel. Litigation attorney Vincent DiCarlo succinctly explains:

- The expert should be reminded that many attorneys will deliberately ask misleading questions and that he or she should not attempt to answer a question unless the meaning is easily understood. The expert should not try to answer ambiguous questions. The expert should be very careful to avoid answering any question that mischaracterizes any prior testimony or misstates the facts.
- The expert should be reminded that he or she should not allow opposing counsel to proceed at an uncomfortable rate. If opposing counsel asks the questions "rapid-fire," the expert should not allow this to cause him or her to rush.
- To the extent that the expert is aware of any mistake in his or her testimony, he or she should correct it before the end of the deposition after conferring with counsel. The expert should, accordingly, request a recess and should advise counsel of the mistake. Together, counsel and the expert should agree upon the best way to correct the record.

- The expert should fully review any document about which he is asked before answering any questions pertaining to such document. The expert should not assume that he or she is already sufficiently familiar with the document.
- The expert should be wary of questions designed to tempt him beyond the confines of his defined expertise (p. 4-5).

Additional preparation should include explanations of state-specific laws or terms that the expert will face within the course of the deposition such "more likely than not," "medically necessary," or "gross negligence." Physician experts like to deal in medical *possibility*, but the law requires causation to be proven by a lesser standard: a preponderance of the evidence, medical certainty, or the "more likely than not" rule, depending on the state.

Table 1. Tips from a Plaintiff LNC in Witness Preparation.

Make sure the witness has been thoroughly prepared. This means that all of the records have been submitted and the deponent has had the time to review them. There is nothing worse than realizing during the deposition that all of the records were not received and/or reviewed. This may even result in the witness being disqualified as an expert in the case.
Do a little research on the opposing attorney and discuss this attorney's style of questioning with the deponent. This will help the witness to be less intimidated if he or she understands the deposing attorney's demeanor and strategy style.
Dress appropriately, especially if the testimony is to be videotaped. Although a deposition is not as formal as trial, the testimony is as important as trial testimony and may sometimes be used as trial testimony. Casual attire may convey that the witness is cavalier about the issues in the case. Avoid chunky or flashy jewelry. Avoid wearing a piece of jewelry in poor repair, as nothing is more distracting than feeling your necklace slide down your dress or blouse! If wearing pantyhose, make sure they fit. Do not wear blouses with buttons; they may gape open or unbutton at an inopportune time.
Avoid repetitive habits such as twirling your hair, tapping a pencil, scratching your head, biting your nails, looking confused, or exhibiting an audible tick or constant twitch. Although they are unconscious habits, they may convey a sense of uncontrolled nervousness and put you at a disadvantage. Always remember that your demeanor is on display and is being evaluated.
If at all possible, review past depositions so that your testimony is consistent. Always be honest in your replies. There is nothing wrong with saying, "I don't know" or "I don't remember."
Always give yourself time to think before answering. This will also give your attorney time to object if necessary.
Remember to eat prior to being deposed. A low blood sugar is bad for the brain, and you need your brain cells to function at a high level.
Ask for a break at any time. If you leave the room with your attorney, take your documents with you.
Do not take any items with you that you do not mind sharing with the opposing attorney and the court. This means textbooks, sticky notes, illustrations, pictures, etc. Discuss this with your attorney prior to the deposition. Pay particular attention to what items have been subpoenaed to be brought to the deposition and take only those items.
Always remain polite, attentive, and professional.

Table 2. Top Five Tips from a Defense LNC in Witness Preparation.

1. Tell the truth. That way, your testimony should be less stressful. Look at the glass as half full, and put your testimony in a positive light.
2. Never guess or speculate. If you do not know something or do not remember, just say so.
3. Answer only the question asked. Do not volunteer information that was not requested. Make opposing counsel work to extract information from you. Nurses tend to want to help people – that includes lawyers questioning them. Do not do it.
4. Never argue or become defensive. You are being evaluated as a witness for trial. Stay calm, even if you feel like you are in an uncomfortable situation.
5. Never answer a question you do not understand. There is nothing wrong with asking to have a question re-phrased until you know exactly what is being asked.

Conclusion

Preparing the expert that appearance is everything is most advisable. The *Synchronics Group* advises:

> Good experts must appear self-confident – but not arrogant. Polite – but not obsequious. Well dressed – but not too flashy or slick. They need to speak directly to the point – no waffling – without sounding blunt. Good experts can communicate to the jurors that they believe in their case, that they are sincere, without being perceived as an advocate. And while these experts must project an aura of objectivity and lack of bias, at the same time, they have to successfully convince the jurors that their interpretation is the right one. Experts need to boil down complicated, esoteric material into easily understandable pieces of information that make sense to a lay audience, without appearing patronizing (p. 1).

The demeanor of the expert will significantly affect the outcome of the case. Effective witness preparation by the legal nurse consultant and the attorney does not change the content of the testimony but affects the demeanor of its delivery and ultimately its persuasiveness to the jury.

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Don't Let Shock Take You by Surprise

Sarah Kaminski, BSN RN LNC

Defining shock and its treatment modalities continues to evolve. If an emergency physician has a current understanding of shock, he or she can recognize shock at an early stage and initiate appropriate, timely intervention. Without timely intervention, the patient in shock will follow the route of multi-organ system failure and death. Early recognition of shock and appropriate intervention is vital in reducing morbidity and mortality associated with this syndrome. Regardless of the etiology of shock, the general approach to a patient in the early stages follows similar principles.

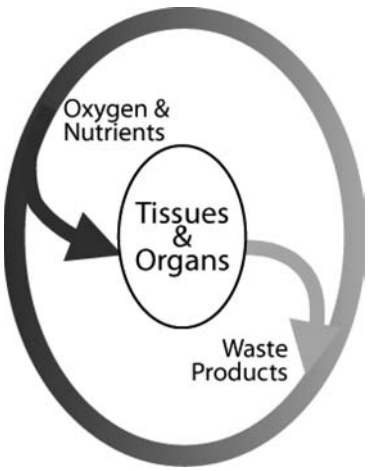
Tintinalli, Kelen, and Stapczynski (2004) define shock as "circulatory insufficiency that creates an imbalance between tissue oxygen supply and demand" (p. 219). Shock is an acute syndrome in which the circulatory system is not able to meet the metabolic demands of the vital organs with adequate oxygen and nutrients. There is also inadequate removal of the waste products of cellular metabolism (see figure 1).

According to Aehlert's *Pediatric Advanced Life Support Study Guide* (2005), "Shock may be associated with normal, low, or high cardiac output, but in all forms of shock the cardiac output is inadequate to sustain tissue perfusion and oxygen function." If not corrected quickly, shock results in organ dysfunction, cellular and organ damage, and death of the patient.

Case Analysis

This author's first case as an independent legal nurse was a plaintiff case. Hypovolemic shock was not diagnosed in a 5-year-old girl named Katie. The analysis, after reviewing Katie's medical records, was that the ER physician and nurses took an apathetic approach to her diagnosis and treatment during the first 3 hours of her emergency room stay. If Katie's caregivers had understood and immediately recognized her shock state and initiated appropriate and early intervention, it likely would have prevented her death

Figure 1. Cellular Metabolism.



Steven Kaminski, PhD

According to Katie's medical records, in her 5 years and almost 7 months of life, she was a chronically ill child. She was diagnosed with pharyngitis 15 times, upper respiratory infection 11 times, ear infection 6 times, allergies 4 times, sinus congestion 3 times, urinary tract infection 2 times, and influenza once. There were several occasions when Katie had nausea/vomiting with unknown etiology, but possibly due to her frequent use of antibiotics. This problem was a serious issue when she presented to the ER in December 2000, and it was sub-optimally managed at that time.

On December 15, 2000, Katie presented to the local ER with her mother at approximately 9:30 p.m. The nurse notes state that she had been seen by her primary care physician on December 12 for nausea/vomiting, lack of appetite, and inability to tolerate the ingestion of food or fluids. The notes also stated she was treated for strep throat at the time of the clinic visit and had vomited four times on December 14. She had a fever on December 14 but was afebrile on December 15. She had been unable to tolerate Amoxil and had complained of abdominal pain. Katie was seen by Dr. P, whose physical exam of Katie showed her throat was reddened with exudate, abnormal tympanic membranes (dull), and inflamed lymph nodes of her neck. Katie was diagnosed with vomiting, tonsillitis, and pharyngitis. She was given a shot of Phenergan and a shot of Bicillin. No labs were performed. She was discharged home with instructions for her mom to push fluids and follow-up with the clinic doctor in 48 hours. Her mother was also instructed to return to the ER with Katie if her condition worsened.

On December 16, Katie's grandmother called the clinic at 4:50 p.m. to report that Katie's condition had worsened. She was advised to bring Katie back if she had not voided at least three times in 24 hours. Katie's grandmother stated that Katie had voided only once in 16 hours and would take nothing to drink and complained of feeling badly. The nurse advised Katie's grandmother to contact the doctor and to return with Katie to the ER. At 9:04 p.m., Katie presented to the ER with her grandmother, who stated that Katie had been vomiting, couldn't tolerate any fluids, and was not improving. She also stated that Katie was short of breath. The set of vital signs recorded on the Point of Entry Sheet were: axillary temp.-98.8, pulse-108, resp.-20, and oxygen saturation (SaO2)-100%.

According to Dr. P's assessment at 9:15 p.m., Katie's respiratory rate was 30, and she had decreased activity and was lethargic. She had decreased urination and mottled skin. Dr. P noted that her clinical impression was "sepsis?" It was also noted under the diagnosis section on the ER Point of Entry History sheet that Dr. P's initial diagnosis was, "dehydration/sepsis."

Between 9:35 and 10:00 p.m., the nurse notes state there were several unsuccessful attempts made to insert an IV in Katie's extremeties. There was no mention of transferring Katie to a facility where they would be able to gain IV access. At 10:15 p.m., the nurse notes reflect that Katie's family attempted to give her oral fluids, and that Katie was not vomiting at that time. A nurse note at 11:00 p.m. states Katie was taking some oral fluids, but an amount or type of fluid is not specified. In deposition, her family stated they were giving her juice and soda. There is no record of any output.

The next nurse note at 11:30 p.m. states that Katie was more alert, but her peripheral cyanosis warranted her transfer to the ER's critical care room. The next notation at 11:55 p.m. states that the nurse was unable to measure the oxygen saturation, and that Katie's hands and feet were becoming cyanotic. At 11:55 p.m., Katie was moved to the critical care room, and oxygen was applied at 100% via a non-rebreather face mask.

On December 17, at 12:25 a.m., right and left intraosseous lines were inserted. Approximately 3 hours and 15 minutes had elapsed from the time of Katie's arrival at the ER until any IV access was obtained. With her presenting symptoms of dehydration, negligible urine output, nausea/vomiting, lethargy, low blood pressure and diagnosis of sepsis; IV access, and fluid administration were indicated immediately upon her arrival.

Since her ER presentation, Katie had not voided; at 12:25 a.m., a foley catheter was inserted with 100 ml of urine returned, which amounted to 100 ml of urine in 19 hours. Normal urine output for a child is > 1ml/kg/hr. Urine outputs < 0.5ml/kg/hr are considered significantly decreased. Minimum hourly output for Katie should have been 23 ml. With a weight of 23kg (50lb), and 100 ml of urine in 19 plus hours, this equates to an hourly output of approximately 5.2 ml/hr. Such a low output can be secondary to dehydration, renal failure, and shock. Urine output is directly proportional to glomerular filtration rate and is, therefore, a good reflection of cardiac output. This poor urine output was an indicator that Katie was in a seriously compromised medical state.

At 12:55 a.m., intravenous fluids were initiated, and at 1:03 a.m., Katie was transported to a tertiary care facility for treatment. Her only vital signs recorded at the time of transfer were: blood pressure-77/40, pulse-130, resp.-28.

Upon arrival at the tertiary care facility at approximately 1:30 a.m., she was admitted to the pediatric floor. At that time, her capillary refill was 5-6 seconds, and her skin was pale and gray. She exhibited some lethargy but was still verbal. Her vital signs were: pulse-120-140. resp-48, blood pressure-84-systolic, temp-99.8. The nurses were unable to obtain an oxygen saturation. Katie's diagnosis was documented as shock. Very shortly after Katie's arrival to this medical center, she became unconscious and apneic. She was intubated and defibrillated multiple times, but all attempts at appropriate resuscitation failed, and Katie was pronounced dead at 2:51 a.m.

As evidenced by this case, when Katie presented to the ER, the signs of shock were subtle because her body was still compensating. By taking a thorough medical history and paying astute attention to Katie's history and her symptoms, coupled with the suspicion of dehydration/sepsis, however, the physician had the opportunity and time to appropriately treat Katie and prevent her from progressing to decompensated and then irreversible shock.

A legal nurse consultant (LNC) reviewing such cases involving shock must employ a critical analysis of the pathophysiology, categories, stages, and treatment of shock to accurately determine whether negligence has occurred.

Pathophysiology of Shock

Shock affects all of the body's organ systems. Alterations in the cardiovascular system affect cardiac output, blood pressure, and tissue perfusion. The work of breathing is increased, which leads to muscle fatigue and respiratory distress. Decreased renal perfusion leads to oliguria (decreased urine output), which in turn often leads to renal failure. Blood being shunted to protect the vital organs leaves the abdominal (splanchnic) circulation vulnerable and can cause intestinal ischemia. Microcirculatory flow is impaired due to clumping of neutrophils and platelets, and fibrin deposition. Disseminated intravascular coagulation (DIC) can be produced by activation of this coagulation cascade. Altered mental status can be caused by hypoxia, hypercarbia (abnormally increased arterial carbon dioxide tension), and hypoperfusion of the brain.

When shock occurs, chemical mediators are released in response to hypoxia and tissue ischemia. Many of the systemic manifestations of shock are a result of these mediators. They affect myocardial function, pulmonary and systemic vasomotor tone (pertaining to the nerves having muscular control of the blood vessel walls in regard to expansion and contraction), vascular integrity, and platelet function. According to Strange and the American College of Emergency Physicians, (2002), "In a certain sense, shock behaves as an acute systemic inflammatory disease" (p. 11).

Categories of Shock

Shock is generally classified into four different categories: hypovolemic, cardiogenic, obstructive, and distributive. Distributive includes septic shock and neurogenic shock.

Hypovolemic shock can be obvious or subtle. It is often due to blood loss but may be due to other forms of fluid loss such as vomiting, diarrhea, or burns. There is decreased intravascular (circulating) volume, which severely reduces cardiac output, in turn reducing venous flow back to the heart. Hypovolemia is the most common cause of shock in children, most often due to water losses associated with diarrhea and vomiting.

Cardiogenic shock is due to pump failure (loss of myocardial muscle function), heart valve dysfunction, or arrhythmia, and can usually be distinguished from other forms of shock

because of signs of heart failure. These would include auscultation of rales in the lungs, a gallop cardiac rhythm, enlarged liver, and jugular venous distension. Cardiogenic shock is often caused by myocardial infarction. In a child, it may be caused by congenital heart disease, viral myocarditis, drug ingestion, metabolic disorder (hypoglycemia), or postoperative complications of cardiac surgery.

Obstructive shock is caused by medical emergencies such as cardiac tamponade, tension pneumothorax, and massive pulmonary embolism. These conditions can cause an acute decrease in cardiac output, which results in shock. If diagnosed and treated promptly, these emergencies can be reversed.

Distributive shock is caused by a reduced systemic vascular resistance (SVR), which may result in inadequate cardiac output despite normal circulatory volume. The reduced SVR occurs because of vasodilatation and pooling of blood in the peripheral blood vessels. The causes of distributive shock are anaphylaxis, central nervous system or spinal injuries (referred to as neurogenic shock), drug ingestions, or sepsis.

Sepsis is the most common cause of distributive shock, carrying a mortality rate of 40-80%. It can be caused by any class of organism, although gram-negative and gram-positive bacteria account for most cases. The lungs, abdomen, and urinary tract are the most frequent sites of infection. Fungi, mycobacteria, rickettsia, viruses, or protozoans can also cause sepsis.

Neurogenic shock is caused by traumatic spinal cord injury or adverse reaction to an epidural or spinal anesthetic.

Stages of Shock

Shock can be compensated, decompensated, or irreversible. Although blood flow may be maldistributed in compensated shock, tissue perfusion is maintained and cardiac output is adequate. Symptoms of compensated shock include tachycardia, slightly delayed capillary refill (> 2-3 seconds), tachypnea (rapid respiration), orthostatic changes in blood pressure or pulse, and mild irritability. These symptoms are a result of the body's effort to compensate for shock by increasing cardiac output in order to maintain perfusion of the vital organs (brain, heart, kidneys). Tachycardia is the earliest and most sensitive sign of shock in children.

In decompensated (also called late or uncompensated) shock, the compensatory mechanisms begin to fail because they are unable to meet the metabolic demands of the tissue. Symptoms of decompensated shock include more severe tachypnea, tachycardia, mottled or pale skin, cool extremities, markedly delayed capillary refill (> 4 seconds), hypotension, and decreased renal perfusion that causes decreased urine output. There can also be ischemia of the GI tract. With septic shock, fever or hypothermia can occur and mental status can progress from irritability to agitation, confusion, hallucinations, followed by alternating periods of agitation and lethargy (or stupor), and finally coma. Systemic inflammatory response syndrome (SIRS) refers to multi-organ dysfunction that occurs secondary to ongoing shock and exaggerated inflammatory responses.

Adult respiratory distress syndrome (ARDS) can also occur even in babies and children as shock progresses. ARDS is caused when there is damage to the capillary endothelia in the lungs that allows fluid to eventually leak into the alveolar spaces. This prevents adequate gas exchange, and as the damage continues, the pediatric patient will demonstrate dyspnea (air hunger resulting in labored or difficult breathing), tachypnea, cyanosis not responsive to oxygen therapy, decreased lung compliance, and alveolar infiltrates.

With irreversible shock, the cell damage is so severe that cell death begins and ultimately results in multiple-system organ failure. At this stage, even if the child is resuscitated, long-term survival is unlikely due to eventual end-organ failure.

Treatment of Shock

Strange and the American College of Emergency Physicians (2002) note that "Early recognition, aggressive intervention, and continual reassessment are the keys to successful treatment of shock in children" (p. 11). Regardless of the etiology of shock, initial treatment should be similar and consist of basic life support. This includes: airway maintenance, oxygen, cardiopulmonary resuscitation, intravenous access, and fluid resuscitation. The basic defects in shock are hypovolemia, microcirculatory dysfunction, tissue ischemia, and cardiovascular dysfunction. The longer each of these defects is allowed to exist, the more severe each becomes. This is the reason that prompt and aggressive treatment of shock is mandatory.

The primary focus of treating children in shock is oxygen delivery to the tissues. As airway and ventilatory effort is being assessed, 100% oxygen should be delivered to the child via a bag-mouth-valve apparatus. If there is any question that the airway is obstructed or that ventilatory effort is inadequate, insertion of an artificial airway is indicated. Oxygen saturation should be measured throughout this entire process either by checking arterial blood gases (ABG's) or pulse oximetry.

Vascular access is vital to treatment. If peripheral access is unattainable, a central vein should be accessed. The femoral vein is preferred in young children. If a central vein cannot be accessed, an intraosseous line should be placed. Once venous access is established, 0.9% normal saline or Ringer's lactate in the amount of 20 ml/kg should be infused as rapidly as possible. The child should be reassessed for response to the fluid by looking at arterial pressures, heart rate, oxygenation, capillary refill, urine output, and level of consciousness. If hypotension and other negative symptoms persist, an additional 20 ml/kg should be infused. For patients who do not respond to the initial fluid bolus, invasive hemodynamic monitoring should be considered. If there is a delay in transfer to the ICU, this monitoring can take place in the emergency department. If this monitoring is not available in the ED or an ICU bed is not available, changes in the child's vital signs and perfusion can be used as a guide for fluid management. Monitoring heart rate, capillary refill, mental status, and urine output (at least 1 ml/kg/hour) is helpful in determining

the amount of fluid needed. As Fleisher and Ludwig (2000) emphasize, "The important point to remember is that, in most cases of shock, not enough fluid is given and the child remains in relative hypovolemic shock" (p. 54).

Concurrent with achieving vascular access, venous blood samples should be obtained for complete blood count, platelets, prothrombin and partial thromboplastin times, electrolytes, blood urea nitrogen, creatinine, glucose, and blood culture (if indicated). An arterial blood sample should also be obtained. Laboratory tests specific to diagnosing shock are lactate and mixed venous PO2. Elevated lactate (>2mmol/L) indicates anaerobic metabolism due to underperfusion of tissues. Reduced mixed venous PO2 (<28 mm Hg) obtained from the pulmonary artery indicates vigorous extraction of oxygen from tissues due to underperfusion.

Vasopressor drugs should be considered for patients who continue to have signs of decreased cardiac output after receiving 60ml/kg of fluid. Dopamine is the current drug of choice to improve cardiac function and improve circulation. At low doses (2 mcg/kg/min), Dopamine increases renal blood flow, thereby increasing urine output. Mid-range doses (5-10 mcg/kg/min) increase cardiac output. Early on, improvement in perfusion is seen as evidenced by increased urine output and blood pressure, and warming of the extremities. Epinephrine, Dobutamine, Amrinone, Isoproterenol, Nitroprusside, and Norepinephrine may also be used depending on the child's response to Dopamine, age, and type of shock.

In suspected septic shock, broad-spectrum antibiotics are given until blood culture and sensitivity results are available. Antibiotics are also chosen based on age. Presumptive antibiotics should not be delayed even if lumbar puncture is not immediately possible.

Sodium bicarbonate may be given to maintain an arterial pH of at least 7.20. Calcium should be given to maintain an ionized calcium level greater than 1.15 mmol/L. Recent research, according to Fourrier, et al. (2002), has shown that continuous infusions of recombinant Protein C decreases mortality in septic shock. Its action is to reduce systemic inflammation by inhibition of thrombosis.

Prompt recognition and treatment of underlying diseases and conditions that cause shock is the best way to prevent shock from occurring. Once shock is suspected or diagnosed, treatment must proceed quickly before damage to vital organs occurs. The goals of treatment are: adequate blood pressure (90-100 systolic for a 6-year-old child or within 40 mm Hg of patient's normal BP), optimal neurological status, adequate urine output (1 ml/kg/hr), heart rate < 100, warm skin with brisk capillary refill (< 2 sec), and bowel sounds present. Lactate level should be < 2 mmol/L and mixed venous PO2 > 30 mm Hg.

Conclusion

In Katie's case, when she presented to the ER on December 16, 2000, her clinical parameters indicated that she was in a state of compensated shock requiring immediate intervention. The medical records reflect a delay in treatment. Throughout the course of her stay in the ER, she progressed from compensated shock to decompensated shock, and the window of opportunity to reverse the shock was missed. By the time she arrived at the tertiary care center, she was in a state of irreversible shock, causing the resuscitation attempts to fail.

LNCs need to understand the syndrome of shock, whether they are working in a clinical setting or reviewing a case for an attorney-client. Early diagnosis requires a high index of suspicion because hypovolemic shock is the most common form of shock world-wide. We cannot let shock take us by surprise.

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The Expert Witness: A Critical Role in Successful Litigation

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maintains a professional demeanor during the testimony. Using sarcasm, displaying anger, and becoming flustered only diminish the effectiveness of the expert's opinion. The role of the opposing counsel *is* to discredit the experts' testimony as well as they can. This may be done in ways that often appear misleading and/or unethical. If the witness knows that opposing attorneys have a variety of strategies to accomplish this goal, they are better-prepared and less likely to exhibit behaviors that only diminish their own testimony.

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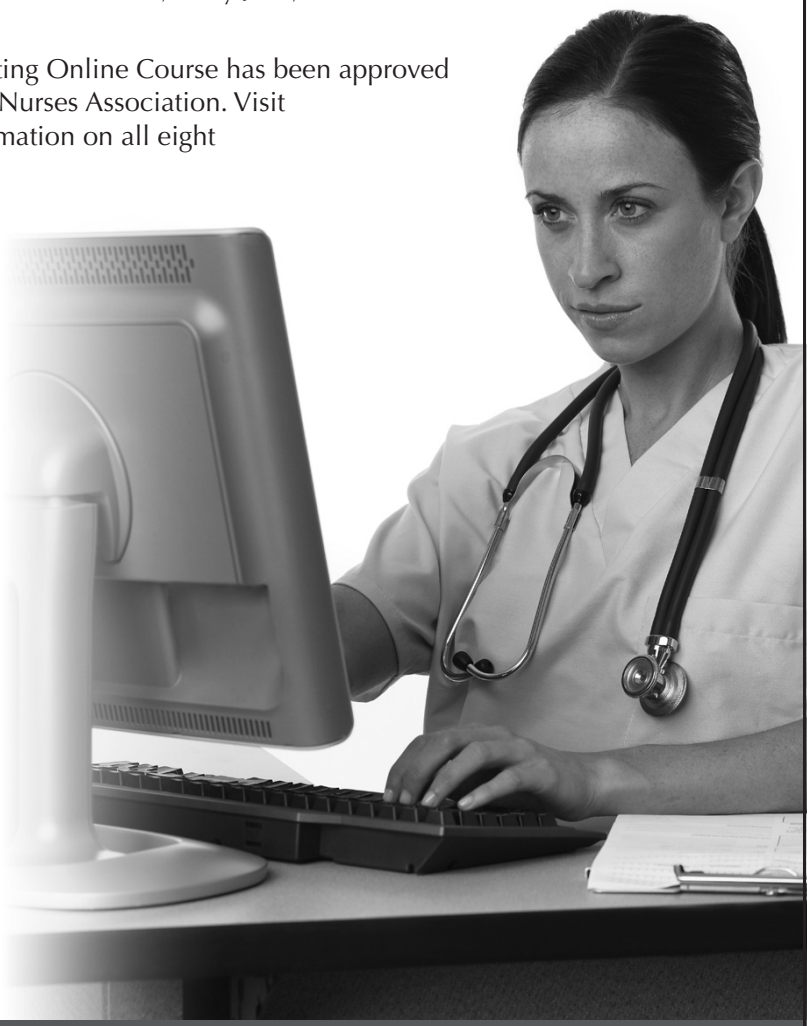

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