

The Journal of
**Legal Nurse
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The Journal of Legal Nurse Consulting

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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 Katie Fitzgerald at kfitzgerald@sba.com or call 312/321-5177.

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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The Journal of

LEGAL NURSE CONSULTING

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Share Your Expertise in JLNC

Lynda Kopishke, MSN RN CLCP LNCC



Attending the national AALNC education conference always provides me with increased energy and enthusiasm. This year's conference gave me an added jolt of motivation and provided me with an awe-inspiring experience I'd like to share.

As the journal editor, I was responsible for speaking at a session entitled, "Writing for Publication." In the past, a small number of individuals who were interested in writing and a few individuals who were curious about publishing attended this session. Imagine my surprise to be faced with 150 people in the audience.

During the hour of the session, I was amazed, inspired and awed by the talent sitting in the room and the willingness of these legal nurse consultants to share their expertise, ideas and experiences. I challenged the attendees to start at the end and to write an abstract for their article. Several LNCs shared their abstract with the group, and the talent that emerged was phenomenal. Attendees promised to expand on their concepts and submit articles for *The Journal of Legal Nurse Consulting* (JLNC). These new beginnings spanned the scope of LNC practice areas. Proposed subjects included those that were clinically based (useful to the LNC for keeping up with practice trends) as well as new areas such as regulatory, criminal, and forensics topics.

The one over riding theme that emerged from this session was that LNCs have knowledge to share and are open to helping the profession grow and expand through written communication. For those of you who didn't get a chance to sit in with these talented professionals, here are some basic tips to stimulate you to write for publication:

- **Look at your concept's angle.** Is this something new to the profession? Does your idea challenge previously published concepts? Do you have a different perspective to share?
- **Write your abstract first.** Discuss what your topic is and why is it important. Outline the main ideas for the topics and demonstrate what will be the outcome of your writing. Once finished start expanding on these ideas.
- **Start writing today!** Set aside time to write every day. Fifteen minutes during a quiet time of the day can produce thousands of words per month. Don't censure yourself while writing, you can always edit later, just let the words flow.
- **Edit at the end.** Go back through your writing when completed with a colored pen and edit the text. Check your references and give credit where due. Write, rewrite and edit again, but remember that the JLNC uses a peer review process. Don't get stymied with the concept of perfection, let the reviewers help you.
- **Submit your article to *The Journal of Legal Nurse Consulting*.** Submit your article and expect to have comments from the peer reviewers. These comments are meant to help you develop your strongest work. If corrections are indicated, carefully consider making them and resubmitting your article.
- **Celebrate your success.** Being published demonstrates your expertise and allows for growth of the practice of Legal Nurse Consulting. Besides your mother, father, husband, wife, peers, children or employer will be so impressed, and this gives you cause for celebration with others!

In 1939, Sir Robert Hutchinson wrote the following quote that is absolutely applicable to LNC practice today; "The amount of writing of a profession is a measure of its vitality and activity, whilst their quality is a rough indication of its intellectual state."

I hope you will consider writing. I'd love to read your work and help you share your experiences and knowledge with those waiting to read your article in JLNC.

Happy writing!

Defending the Negligent Credentialing Claim

Paul K. Reese, Esquire, Karen J. Huff, BSN RN LNCC

KEY WORDS

Credentialing, Hospital Liability, JCAHO, Negligent Credentialing, Peer Review, Privileging

This article provides basic information on negligent credentialing claims and an overview of the role of the LNC when working with an attorney on a negligent credentialing claim.

The article provides highlights of the elements of a negligent credentialing claim, the credentialing process and the components of the file.

In the mid-1980's, in a rural area of the United States, an otherwise healthy 2 1/2 year old toddler first presented to a medical provider complaining of rectal bleeding following a bowel movement. The family's pediatrician was out of town, so they consulted with another local doctor who happened to be a member of their church. After examination, the doctor performed a sigmoidoscopy. In addition, without the parent's permission, the physician performed a biopsy. In doing so, he perforated the child's colon. Peritonitis developed. Follow-up care was seriously criticized, and the child died an agonizing death shortly thereafter. Not only was the operating physician sued, but the clinic/hospital where he performed the surgery was named as a defendant, on a theory of negligent credentialing. Evidence was presented at trial that before the defendant physician came to practice at the clinic he was primarily a family practitioner. Further, before this sigmoidoscopy, the physician had never been granted surgical privileges at any other medical institution. At trial, the hospital was found 18% negligent; the doctor 82%. The total verdict was ten million dollars. On appeal, the verdict against the clinic was upheld on the basis that the hospital had a duty to investigate the background and experience of the co-defendant physician before granting surgical privileges, a classic case of what has become known as "negligent credentialing" (*Roberts v. Stevens Clinic Hospital, Inc.*, No. 345 S.E. 2d 791 W.Va. [1986]).

Historical Background

Although the *Stevens* case was West Virginia's first reported case regarding negligent credentialing, the theory of liability for negligent credentialing appeared in other jurisdictions more than 20 years earlier (*Darling v. Charleston Community Hospital*, No.33 Ill.2d 326, 211 N.E.2d 253 [1965]). In the following 38 years since *Darling*, numerous jurisdictions have recognized a direct claim of liability against a hospital for failure to adequately and properly scrutinize a physician's application for privileges, staff membership, re-privileging and specific procedure privileging. It should come as no surprise that this cause of action has extended to managed care (*McClellan v. Health Maintenance Organization of Pennsylvania*, No. 413 Pa. Super. 128, 604 A.2d 1053 [1988]).

Elements of a Negligent Credentialing Claim

It is fairly well-recognized that the elements of a negligent credentialing claim include:

1. Hospital has a duty to plaintiff to exercise reasonable care in selecting (or supervising) staff physicians;
2. Physician who treated plaintiff was incompetent or unfit and therefor should not have been appointed to the medical staff (or should have been subject to supervision);
3. Hospital failed to exercise reasonable care in appointing physician to its medical staff (or in failing to supervise);
4. Physician was negligent in treating the plaintiff;
5. Negligent treatment resulted in injury; and,
6. Hospital's negligence in appointing physician to its staff (or in failing to supervise) was the proximate cause of the injury (8 Cause of Action 427, 3).

An example of an allegation of negligent credentialing may appear in a complaint in any number of well-pled fashions. Please refer to excerpt below from a complaint drafted by the same attorney who prosecuted the *Stevens* case.

At all times relevant herein, [], a corporation, and [], a corporation, owned and/or were granted the privilege to operate a hospital and medical facility known as [] Hospital in [], which provided medical services and facilities to the general public, and advertised and warranted the same to the general public, including citizens of [] County, [], and included among such services and facilities so provided and advertised and warranted, were general hospital, surgical, medical, anesthesia, and [other] facilities. As a direct and proximate result of the facts and allegations herein above stated, defendants [], a corporation, and [], a corporation, owed a duty to the citizens of the State of [], including plaintiff, to exercise due and proper care in the operation and supervisions of its medical care services and facilities, including hiring of employees, granting of medical staff privileges to physicians who practice at their facilities, and continued monitoring and supervision of care, treatment, and services provided to the public by its employees and medical staff.

At all times relevant herein, defendant [], a corporation, and [], a corporation, negligently failed in their duties to hire, supervise, and administer its medical staff and facilities at [], as the same relates to the hiring or granting of medical staff privileges to [], MD, and/or the supervision and continued monitoring of [], MD.

The Credentialing Process

To defend a negligent credentialing claim, one must have a working understanding of the process of credentialing and the institutional issues that are typically the focus of that process. A recent article by John Hyde, PhD, *Physician Credentialing: Developing a Proactive Credentialing Process*, published in the January 2003 issue of the *Journal of Legal Nurse Consulting*, provides a good overview. Dr. Hyde discusses some of the standards often identified and accepted as suggested credentialing practice, as well as the internal hospital process of credentialing (Hyde, 2003). Understand and get to know the general, practical credentialing process that your client hospital conducts. Ascertain the elements of the credentialing process. Make sure you have collected and reviewed all state and national standards regarding credentialing which may apply to your institution, as well as any internal hospital bylaws and protocols applicable to the process. Dr. Hyde's article is a good outline of the process.

The Credentialing File

In a case involving an allegation of negligent credentialing one can rest assured that among the first discovery tools employed by counsel will be formal request directed to the hospital for the co-defendant physician's "credentialing file" — the hospital's documented record of its credentialing process as it applies to the physician being sued. Two issues quickly come into play: (1) what are the accepted statutory or common law parameters regarding permissible disclosure of the contents of a credentialing file; and, (2) what can one, or should one expect to, find in a credentialing file?

Peer Review Protection for Credentialing Documents

In West Virginia, like many other jurisdictions, there is a specific code provision which establishes "peer review" protection to the credentialing process and, by extension, to the documents produced in the credentialing process (West Virginia Code, Ann. §30-3C-1, *et seq.*, [1980]). By example, cases which have addressed the peer review protection statute in West Virginia have ruled that the hospital review committee is a "review organization" within the meaning of the statute, and therefore, subject to the privilege (*State ex rel Charles Town Gen. Hospital v. Sanders*, No. 210 W.Va. 118, 556 S.E.2d 85 [2001]). Any similar statutes or case law in the relevant jurisdiction that address privileged protection of the credentialing process must be consulted. If the hospital has the peer review privilege, what protection does it provide?

In West Virginia, a recent case addressed the question of what particular documents or records contained in the credentialing file are discoverable. In that case, it was determined that no privilege attaches to documents or records considered by the review committee, which might be otherwise available from original sources (*State ex rel Scroades v. Henry*, No. 187 W.Va. 723, 421 S.E.2d 264 [1992]). Just what those documents might be is subject to varying analysis and argument. For instance, in West Virginia, certain documents regarding a licensed physician are maintained by the Board of Medicine: licensing information; board certifications; diplomas or degrees; perhaps even school transcripts, all of which might arguably be secured from "independent" sources. Each jurisdiction must be addressed in terms of its particular law, but the issue of peer review or other privilege protection for the credentialing process and records must be considered.

What's in the Credentialing File?

Depending upon the procedure in any given jurisdiction, if the privilege is asserted, it is possible that the court will require a "privilege log" of the contents of the credentialing file, so more particular argument regarding discovery might be framed. In West Virginia, this is a likely event, and may lead to an "*in camera*" confidential inspection of the credentialing file by the judge. While this is certainly no suggestion of what the typical credentialing file might contain, as an example of the types of documents and documentation one might see in a credentialing file, a redacted privilege log used in a recent case is instructive. In a rural hospital, where the hospital's credentialing and privileging was challenged, the following documents were contained in the defendant physician's file:

- Department Clinical Privilege Request Form
- Application for Medical Staff Reappointment & Clinical Privileges
- Correspondence between hospital department chairs and the physician
- Initial Application for Medical Staff Appointment & Clinical Privileges
- Extension of Medical Staff Appointment
- Privileges Approval
- Board of Trustees Meeting Minutes
- Temporary Staff Privileges
- State Board of Medicine Certification
- Verification of Licensure from the State Board of Medicine
- Request to Board of Medicine regarding license current and valid
- CV of the physician
- Certificates of Insurance
- Controlled Substance Registration Certificate
- Verification of undergraduate degree
- Verification of residency
- Verification of medical school degree

- References from medical school professors
- References from hospital CEO to another hospital
- Documentation that physician acted in accordance with the medical staff bylaws regarding medical records completion
- Letter from American Board of [appropriate medical board] regarding certification.

Given the issue of what might be privilege protected, and what might be discoverable from expert interaction, the question arises, what can, or do, you disclose to your credentialing expert? Consult your relevant jurisdiction, rules, procedures, and laws.

The Role of the LNC

When working with an attorney on a negligent credentialing claim, the legal nurse consultant (LNC) can expect to perform certain tasks. Whether the LNC is working for the plaintiff or defense, common duties include: 1) document retrieval and review, 2) performing research to obtain medical literature and standards, and 3) identifying, retaining, and conferring with experts.

Document Retrieval and Review

Critical documents to obtain when reviewing a negligent credentialing claim include hospital bylaws, the physician's credentialing file, and, if applicable, a copy of the contract between the physician and the hospital. A request to the state Board of Medicine (BOM) should also be considered. Procedures for obtaining documents from the BOM may vary, with some states having information accessible via the Internet. In West Virginia, documents in the physician's file are available for viewing at the state BOM office. If the physician is licensed as a DO, or Doctor of Osteopathy, then the Board of Osteopathy is the appropriate board to contact for records.

Critical documents pertaining to the physician's credentialing and privileging process need to be reviewed. The initial credentialing process is done to investigate a physician's education, training, licensure and certification, but the process by which a physician is granted privileges can be more complicated. In the past hospitals simply granted a physician general hospital admitting privileges. Now privilege requests are specific to the physician's practice and training, with evidence of ongoing competency important in the re-privileging process (Zusman, 1990).

Medical Literature and Standards Research

A favorite task of many LNCs is medical research. For a list of helpful Web sites containing credentialing information, please refer to the table on page 7. When searching for information about physician credentialing on the Internet, the LNC will find a wealth of information at the supersite **www.hcpro.com**. This Web site has links to many credentialing resources including the Greeley Company, a nationally recognized consulting firm. To access additional information

about their consulting services for hospitals and legal professionals go to **www.greeley.com**. The reader can review free on-line newsletters, obtain current seminar information, and review an extensive listing of books available for purchase on topics such as corporate compliance, credentialing, healthcare administration, long term care, medical records, and safety. To download sample credentialing policies, procedures, and forms go to **www.credentialinfo.com**. A recent review of the site revealed documents related to application for medical staff appointment, initial appointment policy, reappointment process, handling the impaired or dysfunctional physician, the disruptive physician, allied health professionals, and a fast track credentialing policy. A collection of policies and forms related to physician privileging is available, including the granting of temporary privileges, along with a section on dental, podiatric, and nurse practitioner privileges.

The information gathered during medical research can be very helpful to the attorney or LNC wanting to understand the credentialing process. However, such data may not reflect the community standards for credentialing, so a review of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) credentialing standards is needed. The credentialing process has evolved greatly, and it is important to obtain standards or guidelines in effect at the time the alleged negligence occurred. The LNC working for the defense may be able to obtain the data needed from past surveys if the hospital keeps back issues of JCAHO manuals and records.

Additional information about JCAHO surveys is available via the Internet. Go to the JCAHO Web site at **www.jcaho.org**, and look for the shortcut on the home page to "Quality Check" performance reports for accredited organizations. When selecting this option, the reader will be taken to the next screen, which allows a search of all accredited organizations by geographical area. Such a search can be tailored to pull up all hospitals or long term care facilities in individual cities or counties. The next page lets the reader search for a specific health care facility, find out when the next survey is due, and obtain information about the results of previous surveys.

Identifying and Locating Experts

Another task many LNCs find enjoyable is the process of identifying, locating, and conferring with medical experts. By interacting with experts in a variety of specialty fields, the LNC has the opportunity to advance his or her knowledge base while gathering the information needed to educate the attorney about the medical facts of the case.

In a credentialing case, hospital administrators or physicians with expertise in the credentialing process may be retained as experts. The LNC should look for someone with experience as a member of a hospital credentialing or executive committee. The American College of Physician Executives is a good resource for experts, and additional information can be found at their Web site, **www.acpe.org**. JCAHO physician

surveyors make excellent experts due to their understanding of the standards, and “hands on” experience evaluating hospitals with deficiencies in compliance. Such an expert could speak to whether the defendant hospital’s shortcomings in the credentialing process are similar to problems found in other hospitals, or actually fall below the standard of care.

As mentioned elsewhere in this article, it is important to carefully consider what documents to provide to the credentialing expert. If the LNC working for the defendant hospital inadvertently sends an expert peer review documents, the protection of these documents can be waived, making them accessible to the plaintiff’s attorney. Additionally, if the physician in question is not an employee of the hospital and has separate counsel, the defense attorney for the hospital will likely want to confer with counsel for the defendant physician regarding what information is disclosed during discovery to the plaintiff’s attorney and other parties.

Conferring with Experts

To provide the reader with additional information about typical documents and hospital policies found in negligent credentialing claims, highlights from a recent conversation with an expert are described. Appointments to the medical staff are usually granted for 2 year periods, with the amount of time stipulated in the hospital bylaws. Some hospitals may chose to make the initial appointment for less than 2 years so that all reappointments are due at the same time. The LNC should look carefully for gaps in dates which may indicate the physician was practicing after his privileges expired. Secondly, if temporary privileges are granted, the bylaws should address the procedure for granting such privileges. Sometimes documentation is missing showing approval from the department head or medical staff. In this scenario, a copy of the Credentialing Committee or Medical Staff Committee meeting minutes may be substituted to prove the committee reviewed the forms and voted to approve the candidate.

Typically the hospital CEO will send a letter to the physician stating that the doctor has privileges, designate the privileges granted, and identify the date the appointment will expire. The credentialing application completed by the physician should include a check off list in which the physician identifies the specific privileges he is requesting. The credentialing committee will need to review educational records and/or continuing education certificates documenting that the physician has completed the necessary training. Some institutions may have a pre-printed form for each specialty or service. For a general surgeon, the application would include a form identifying the types of surgical procedures to be performed.

Additionally, the physician needs to demonstrate current competence in a particular procedure. On the application the physician documents the number of times he has performed each procedure for which he is requesting privileges. Problems can arise if a physician has received training but

then does not perform a procedure for a prolonged period of time. In this scenario, he may no longer be considered competent to perform the procedure without additional training or experience. Upon re-application for privileges, the privilege may be suspended until competence is verified.

If the physician has been granted privileges more than once, any re-privileging documents should be obtained, as available during discovery. Such documents typically include an evaluation of the physician’s competency. JCAHO expects data on drug errors, unplanned return trips to the OR, and patient complaints along with statistical information regarding the number of times these things happened. Also, evidence of continuing medical education is required in the physician’s specialty area. An expert may recognize and opine that JCAHO standards are more “ideal” than what happens in everyday situations. Key elements of the credentialing process should be evident for a strong indication of careful privileging. Hospitals should not treat the re-application process as a rubber stamp.

Special Considerations

Rural hospitals often have difficulty attracting specialists, and for that reason may hire someone with less experience than a large city hospital. This circumstance raises a very real question of whether credentialing standards are different in rural areas and urban areas. Such a discussion is not meant to imply that it is okay for a rural hospital to hire an incompetent physician; however, the standard for credentialing may be less stringent than urban areas.

Rural hospitals clearly face the problem of fewer physicians on staff, making it difficult for existing staff to monitor new physician performance. This can be especially problematic if none of the staff physicians have experience in the new physician’s specialty. In such cases, the hospital may want to consider retaining a physician from a peer review organization to evaluate and monitor the physician’s competence.

Additionally, as medical practice and care evolves, hospitals may offer more and more services that employ medical specialists (and sub-specialists) relatively new to the geographic practice area. What if a hospital hires a specialist in an emerging specialty prior to the development of board certification? For instance, pain management is an example of a field that has evolved over the past decade. Board certification is now available, but many physicians began practicing in this field before board certification was even available. Many institutions now have pain management clinics and offer a wide spectrum of pain management services that were not readily available ten years ago. Pain management physicians often treat terminally ill cancer patients with severe pain; treatment can be rather extreme and carry risks unacceptable to patients that are not near the end of their life. For a pain management practitioner, in an area where there is no other like-practitioner, anesthesiologists, neurosurgeons, or other closely related fields may be the only

source of reasonable oversight in the credentialing process. Flexibility is important, but reasonable oversight and a thorough credentialing process is imperative.

Conclusion

Negligent credentialing claims are being pursued more frequently as a means of asserting an independent claim against a hospital. The informed LNC should be aware of the legal theory behind such cases, have an understanding of the credentialing and privileging process, be wary of potential pitfalls during the discovery process, and know how to provide the support needed for the attorney handling the claim. This article is intended as a general overview of what is involved in defending a negligent credentialing claim. The defense of each case will need to be individualized to include state-specific legislation and case law, along with client-specific hospital policies and procedures.

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Paul K. Reese is a defense attorney with over 23 years of litigation experience. As a member of Steptoe & Johnson PLLC in Charleston West Virginia, his practice primarily involves medical malpractice and as well as general litigation. He regularly defends hospitals, physicians, nurses, physician assistants, nurse midwives and other health care providers in medical negligence and wrongful death actions. He also represents hospitals in negligent credentialing claims.

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Helpful Web Sites for Credentialing Information

www.abms.org	American Board of Medical Specialties
www.accreditinfo.com	Accreditation Information
www.acep.org	American College of Physician Executives
www.ama-assn.org/aps/amahg.htm	American Medical Association Doctor Finder
www.bhpr.hrsa.gov/dqa/	Division of Practitioner Data Banks
www.certifacts.org	Primary source verification
www.credentialinfo.com	Credentialing information supersite.
www.fsmb.org	Federation of State Medical Boards
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Navigating Ophthalmology Records

Norman L. Edelstein, MD

This article provides a template for the numerous ophthalmic terminology and will hopefully allow legal nurse consultants to navigate eye care records with greater insight. The article

offers terminology ranging from visual acuity to peripheral retinal examination.

Interpretation of ophthalmic records is hampered by terminology unique to eye care; by multiple abbreviations and acronyms, many of which are not universally accepted; and by the illegible handwriting of physicians trained to enhance visual performance. Fortunately, these obstacles are decreasing, not in an effort to make life easier for nurse legal consultants, but in response to third party payer demands for legible records with standardized examination formats.

Numerous ophthalmic terminology glossaries and guidelines are available both in print and on the Internet. The following examination template will hopefully allow nurse legal consultants to navigate eye care records with greater insight. (Note: a formal explanation of terminology is beyond the scope of this article.)

Visual Acuity

1. OD-right eye; OS-left eye; OU-both eyes
2. Visual acuity is measured under controlled lighting conditions and is recorded at distance in either feet (e.g., 20/20) or, less commonly, in meters (e.g., 6/6). Near vision is measured in terms of printing types, most commonly Jaeger with J-1 the smallest type size.
 - SC-visual acuity measured without corrective lenses
 - CC-visual acuity measured with corrective lenses, eyeglasses and/or contact lenses
3. Patients with acuity impaired to less than eye chart levels include:
 - CF (counts fingers);
 - HMO (hand motion only);
 - LP (light perception);
 - NLP (no light perception).
4. "Potential" acuity of an impaired eye can be estimated with varied examination techniques to include PH (by pinhole) or PAM (by potential acuity meter/measurement).
5. Visual acuity under less than ideal lighting conditions (e.g., snow, headlights, etc.) can be estimated under simulated conditions and reported as BAT (brightness acuity test), etc.

Adnexa/External:

The ophthalmologist then examines the lids and the tissues surrounding the eyes:

- UL-upper lid (e.g., RUL, LUL)
- LL-lower lid (e.g., RLL, LLL)
- NL-nasolacrimal (tear drainage system)

Conjunctiva and Globe:

The gross examination of the eye itself can include varied non-specific abbreviations.

Pupils and Irises:

Pupillary responses are impaired by both eye and/or neurologic diseases.

- PERRLA-normal Pupils are Equal, Round, React to Light and Accommodation
- NR-non-reactive
- APD-afferent pupillary defect (indicative of a neurologic problem)

Motility:

Evaluation of eye movement

- EOM-extraocular muscles
- E or ET (eyes turn in)
- X or XT (eyes turn out)
- NPC-near point of convergence
- NPA-near point of accommodation

Six muscles are attached to each eye:

- MR (medial rectus);
- LR (lateral rectus);
- SR (superior rectus);
- IR (inferior rectus);
- SO (superior oblique);
- IO (inferior oblique)

Visual Field:

Measurements of peripheral visual function

- GVF (gross visual fields) or CVF (confrontation visual fields)—gross estimates of visual field function
- FTC-full to confrontation
- HVF-Humphrey visual field; (Humphrey Instruments is the most common manufacturer of automated field units)

Slit Lamp or SLE:

The examination now proceeds to the interior of the eye using a Slit-lamp biomicroscope.

1. Cornea-the window part of the eye
 - CA-corneal abrasion
2. Anterior chamber (AC)-the clear space between the back of the cornea and the front of the colored part of

the eye (iris)

-F&C-flare and cells (indicative of an inflammatory process in the eye)

-PAS-peripheral anterior synechiae or PS-posterior synechiae—(Synechiae are adhesions.)

-VH-an estimate of the depth of the anterior chamber space

3. Lenses-any clarity change in the human lens is cataract formation, which can be related to aging, trauma, etc.

-NS-nuclear sclerosis

-ASC-anterior subcapsular

-PSC-posterior subcapsular

-IOL-intraocular lens

-PC-posterior chamber (the area behind the iris) or posterior capsule (the tissue intentionally left in the eye after cataract surgery)

Intraocular Pressure Measurement (IOP):

- TA or Tapp-tension measured by applanation
- TP or Ttp-tension measured by tonopen

Examination of the posterior portions of the eyes is next performed, frequently after pupillary dilatation by drops (M 1-1% Mydracyl; Neo-2 1/2 Neosynephrine)

Central Retinal Area to Include Optic Discs (Nerves)

- C/D-cup to disc diameter of the optic disc
- NFL-nerve fiber layer

Peripheral Retinal Examination

1. RD-retinal detachment
 - F/F-floaters and flashes
 - PVD-posterior vitreous detachment
 - V or VIT -vitreous
2. Macula—the point of best vision
 - ARMD-age-related macular degeneration
 - ERM-epiretinal membrane
 - CME-cystoid macular edema
 - CSME-clinically significant macular edema
3. Retinal/macular vascular changes include a large number of abbreviations:
 - NVD-neovascularization of the disc (nerve)
 - NVE-neovascularization elsewhere
 - CRAO-central retinal artery occlusion
 - BAO-branch artery occlusion
 - CRVO-central retinal vein occlusion
 - BVO-branch vein occlusion

Diagnoses, Additional Testing, and Treatment Suggestions Follow the Examination.

These common ophthalmologic problems are described using multiple abbreviations:

1. Glaucoma
 - COAG-chronic open angle glaucoma
 - NAG-narrow angle glaucoma
 - Gonio-gonioscopy (an instrument used to examine the drainage mechanism in the eye)
 - ALT -argon laser trabeculoplasty
 - Trab-trabeculectomy (a surgical procedure)
2. Cataract
 - Ks-keratometry (measurements of the front surface of the eye)
 - AL-axial length (the length of the eye)
 - ICCE-intracapsular cataract extraction (the entire lens is removed; this procedure is seldom performed today.)
 - ECCE-extracapsular cataract extraction (the lens is removed in portions, most commonly by phaco-phacoemulsification.)
 - YAG-a laser procedure occasionally needed after cataract surgery.
3. Diabetic eye disease
 - DR-diabetic retinopathy
 - BDR-background diabetic retinopathy
 - PDR-proliferative diabetic retinopathy
 - FA-fluorescein angiogram
 - PRP-panretinal photocoagulation
 - ETDRS-early treatment diabetic retinopathy study

The analysis of ophthalmic medical records should become less complex as more ophthalmologists find it necessary to structure examinations to comply with standardized templates and as electronic records minimize the use of abbreviations. Thus, for these cases, data review by the nurse legal consultant may indeed become easier.

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An Eye For An Eye: How American Juries Evaluate Vision Loss Cases

Terry C. Cavanaugh, Esquire

KEY WORDS

LASIK, PRK, Neuroophthalmologist

The purpose of this article is to offer some thought on how the American legal system values the loss of an eye or total loss of

vision. The article discusses total blindness, blindness in one eye, visual impairment and minor eye injuries.

The American legal system does not, thankfully, follow the Old Testament admonition that if you cause the loss of someone's body part you must sacrifice that same part yourself. Instead, our jurisprudence provides compensation in the equivalent of dollars.

The American jury has practically unfettered discretion as to how much it can order as compensation for pain, humiliation, disfigurement, lost wages, loss of the pleasures of life, et cetera. Generally speaking, the standard for reversing a jury's verdict is whenever the verdict is so enormous that it "shocks the conscience of the Court," a fluid and moving standard, I can assure you.

One of the dreaded complications all of us fear is the loss of our vision. Many people seem to have, quite legitimately, concerns of contracting cancer or suffering a debilitating stroke, and our hearts go out to a severely disabled baby. Blindness is a phenomenon that not only provokes the sympathy of a jury, but plays upon one of those deep fears that we all have that our life would be ruined, if we could not see¹.

Putting aside the fact that some people can suffer a loss of sight yet do quite well, I submit that for most people the loss of vision is perceived as one of the ultimate catastrophes and one that may suggest to a jury that a generous verdict is in order. If so, how much? The purpose of this article is to offer some thought on how juries in this country (and this Commonwealth) value the loss of an eye or total loss of vision.

Total Blindness

First, awards and settlements for "total blindness" are of course, significantly higher than other types of eye injuries. Moreover, settlements are significantly lower than verdict awards. In "total blindness" cases, Plaintiff retained both eyes but received no benefit from their function. The award range for jury trial is as follows:

- Total Blindness
- Verdict Median \$3,695,000
- Verdict Probability Range \$1,008,585 - \$6,634,250
- Verdict Range \$52,000 - \$62,800,000
- Verdict Mean \$6,833,218
- Awards of \$1,000,000 + 81%
- Settlement Median \$850,000
- Settlement Probability Range \$240,000 - \$1,500,000

- Settlement Range \$30,000 - \$10,800,000
- Settlement Mean \$1,455,321
- Settlements \$1,000,000 + 42%

Blindness in One Eye

The next category is blindness in one eye. This category is defined as those individuals that retain the eye itself, but receive no benefit from its functions.

- Blindness in One Eye
- Verdict Median \$510,000
- Verdict Probability Range \$226,250 - \$1,070,036
- Verdict Range \$8,060 - \$9,900,000
- Verdict Mean \$1,070,435
- Awards of \$1,000,000 + 27%
- Settlement Median \$375,000
- Settlement Probability Range \$142,500 - \$750,000
- Settlement Range \$5,001 - \$3,664,900
- Settlement Mean \$620,134
- Settlements \$1,000,000 + 15%

Visual Impairment

The next category for evaluation would be visual impairment claims in which the injuries are severe enough to reduce a plaintiff's ability to see, but do not result in blindness. Included in this category are injuries that are frequently seen in ophthalmology malpractice claims following LASIK (Laser In-Situ Keratomileusis) or PRK (photorefractive keratectomy) procedures. Injuries include scarring of the cornea or retina, loss of the lens, corneal erosion, dislocation of the lens, a detached retina, permanent pupil dilation, alteration of the retinal pigment epitheliums, and a ruptured cornea.

- Visual Impairment
- Verdict Median \$73,918
- Verdict Probability Range \$22,110 - \$254,500
- Verdict Range \$10,000 - \$5,100,000
- Verdict Mean \$240,058
- Awards of \$1,000,000 + 5%
- Settlement Median \$50,000
- Settlement Probability Range \$15,000 - \$172,500
- Settlement Range \$1,500 - \$2,500,000
- Settlement Mean \$193,266
- Settlements \$1,000,000 + 5%

Minor Eye Injuries

The final category is labeled “minor eye injuries”. This examines cases of minor injuries to the eye ball and the surrounding area. Examples of minor eye injuries include contusion, laceration, scratches and abrasions to the cornea or lens, dry or irritated eyes, mild burns, lacrimal apparatus damage, etc. There is no permanent visual impairment suffered with the injuries included in this category.

- Minor Eye Injuries
- Verdict Median \$13,054
- Verdict Probability Range \$4,137 - \$62,854
- Verdict Range \$279 - \$674,750
- Verdict Mean \$68,625
- Awards of \$1,000,000 + <1%
- Settlement Median \$11,450
- Settlement Probability Range \$3,800 - \$ 32,500
- Settlement Range \$500-\$250,000
- Settlement Mean \$31,742
- Settlements \$1,000,000 + <1%

An analysis of recent verdicts shows that vehicular accidents account for 26% of the cases of visual loss claims. Medical malpractice claims are 28% of the total Of those cases involving losses from a number of causes (premises liability, business negligence, personal negligence, product liability claims and medical malpractice claims) only product liability claims causing blindness are larger than medical malpractice claims. The median malpractice claim for injuries of every sort is \$256,250.

Let's take a look at some of the cases:

The case of *Fang v. Kremer* was decided a year and a half ago in Philadelphia. A 30-year-old female CPA underwent LASIK to correct nearsightedness at her physician's office. After the surgery, Ms. Fang suffered from farsightedness and double vision. She brought suit after the second surgery failed to correct these problems. Plaintiff contended that the laser was off-center; the doctors countered that the plaintiff's condition was an unexpected reaction to the procedure.

A jury awarded \$800,000.

In the case of *Wright v. DeAntonio*, a 35-year-old man suffered permanent blindness due to medical malpractice. Mr. Wright had consulted a neurologist for treatment of headaches and vision problems and the neurologist diagnosed Mr. Wright's condition as pseudotumor cerebri, benign intracranial hypertension and referred Mr. Wright to ophthalmologists. Plaintiff claimed that he should have been referred to a neuroophthalmologist, who could have easily provided surgery to relieve the pressure in the eye. Instead, due to a lack of definitive treatment, the plaintiff sustained damage to his optic nerves and his blindness became irreversible.

A jury in Philadelphia awarded \$5,000,000.00. The case was ultimately settled for \$3,500,000.00 in accordance with a \$1,500,000.00/\$3,500,000.00 high/low agreement.

Pittsburgh takes a more conservative view. In *Hatalsky v. Strand Attic, Inc.* Trading and Doing Business as The Attic - A Gathering Place, an Allegheny County jury was faced with this factual scenario.

Mr. Hatalsky brought a negligence action against a bar. He was in a stall in the men's room when an individual either kicked or pushed open the stall door causing the coat hook on the back of the door to pierce Mr. Hatalsky's eyeball. Significant injury ensued, including a right eye subretinal bleed, a choroidal rupture and a laceration of the right eyelid. An Allegheny County jury thought that case was worth \$7,102.63.

My point is that although each case of course turns out different facts, there is a huge latitude in the value that different juries in different parts of the state and country place on the loss of an eye.

A legal nurse consultant might offer invaluable help to a lawyer by researching the value of a particular injury. Some excellent resources exist, including *Personal Injury Valuation Handbook, Jury Verdict Research Series* published by LRP Publications and Pennsylvania Damages, *Personal Injury Verdicts and Settlements*, 2002 Edition authored by Tracey R. Rich, Arthur S. Zanan and Suzanne N. Rosin and published by George T. Bisel Company, Inc.

End note

- 1 One of our law clerks (who researched information for this article) is the granddaughter of a blind couple who raised five children. Not only did her grandparents lead what appear be normal lives, they had, in addition to daytime jobs, a band known as “Marge and Her Man” that entertained the citizens of Harrisburg for many years.

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Principles of Pediatric Home Care

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KEY WORDS

Acute Care, DME, DNR, No Code, PALS

This article will focus upon those standards of care applicable to private duty nursing in the pediatric population and will address those children dependent upon technology. The article

offers an overview of transition from hospital to home care, admission to a home care agency, maintenance of home care and discharge of the home care services.

Principles of Pediatric Home Care

In today's healthcare climate there is an ever-escalating urgency to move patients through the acute care hospital and back into the home setting. This results in patients being discharged with more complex medical needs (McWilliam & Sangster, 1994). This trend is present within the pediatric population and includes children who in the past may not have survived their serious illnesses (Patterson et al, 1992). A population of children dependent upon technology for survival has been created and many of these children are at home with care being delivered by a variety of caregivers (Scannell et al, 1993). This is generally the population who receive pediatric private duty home care.

Although home care may include both home health visits and private duty nursing, this article will focus upon standards of care applicable to private duty nursing in the pediatric population and will address children dependent upon technology. Home care is very different than acute or primary care. In both the acute care and primary care settings, the patient receives care within the controlled setting of the hospital or clinic. The hospital and the clinic are the domain of the healthcare worker and most healthcare workers and families have an understanding of the boundaries prescribed by this setting. In home care, the setting belongs to the child and family, making the boundaries much less clear, especially for the healthcare provider (Scannell et al, 1993).

The Transition from Hospital to Home Care

Determination of Home Care Candidacy

When the child in question is a child dependent upon technology, home care actually begins in the hospital. There are many questions that must be answered before a referral is made to a home care agency. The most important question is whether or not the child can be safely cared for in the home setting. This is a multifaceted question. The child must be medically stable (Cross et al, 1998; Jerome-Ebel, 1996). The home must be adequate to support the medical needs of the child. For example, a child with ventilator-dependence cannot be discharged to a home that has inadequate electrical capacity. The next challenge is that of caregivers. Are the parents willing and motivated to care for the child in their home (Harrigan et al, 2002)? In a single

parent situation, is there another person willing to act as a back-up caregiver? Can the family recruit enough lay caregivers in order to allow the family to function normally? Are the lay caregivers capable of learning the care necessary? In a study that examined the adequacy of discharge planning in the pediatric population, five complications were associated with less than adequate discharge plans. Three of the five complications were related to family issues. These included family availability, family cooperation, and family ability to learn the child's care (Proctor et al, 1995). Funding is another concern that must be addressed. It must be identified as to whether the child's payor source will approve funding for home care and if so, how much. Once all these issues are positively resolved, referrals for home care can be made.

Referral to Home Care

It is a joint responsibility of the hospital making the referral and the home care agency accepting the referral to ensure that the care to be provided for the child in the home can be done so in a safe manner. Two issues have a significant impact upon the referral process. One is the payor source. The other is where the patient resides. Insurance and managed care companies may have contracted private duty providers and durable medical equipment companies. Rural areas may not have providers with pediatric expertise (Cross et al, 1998).

The hospital must properly assess the child for candidacy as a home care patient and make a referral to an agency appropriate to the level of care required by the child. If the hospital deems that the preferred providers of the payor source are not appropriate for the pediatric level of care required by the child, it is their responsibility to advocate for the needs of the child (Cox, 1996). The payor source may not have previously dealt with a child requiring this level of care. Educating the case manager for the payor source as to what is necessary to ensure the safety of the child can resolve such problems..

There are two primary issues to consider when choosing a provider for a technology dependent child. The first is pediatric expertise and the second is level of care. Even if an agency states that they can deliver care for pediatric patients, they may not have pediatric expertise or high-tech pediatric

expertise. In many states there are no standard criteria as to which agencies may designate themselves as “pediatric specialists.” An agency may have several nurses who have some level of pediatric experience. The agency may then state that they have pediatric expertise. They may, in fact, be quite capable of providing dressing changes for a child, but that is quite different than caring for the child with ventilator dependence. That becomes more an issue of level of care. There are very few agencies that have nurses able to care for a patient who is ventilator dependent and even fewer that are able to provide competent care for the child who is ventilator dependent. Choosing an agency without appropriate experience both at the staff nurse and supervisory levels can compromise the safety of the child.

Decisions regarding the agency’s capabilities are not the sole responsibility of the hospital personnel. The home care agency has the obligation to accurately assess the child’s level of care needs in order to determine their ability to staff the case appropriately. This not only refers to having personnel capable to care for the child given his level of care, but also the availability of such caregivers for the number of hours approved for the child’s care.

The above issues are not limited to only the pediatric private duty nursing agency. These issues also apply to the durable medical equipment (DME) company. It is important for the DME company to have equipment that is appropriately sized for the pediatric patient. It is also critical that the DME company providing the ventilator employs a respiratory therapist with pediatric expertise. The respiratory therapist provides follow-up education to the family regarding much of the equipment in the home. The respiratory therapist also manages the high-tech equipment and supply needs for the technology-dependent child.

Identification of the Primary Care Physician

In order for a home care agency, to accept a child for services, it is necessary to identify a primary care physician who will assume medical care and management of the pediatric private duty case (Berger et al, 1998). In rural areas this can be difficult. Continuing to have the physician from the pediatric intensive care unit manage the case in the home care setting may not be optimal or even possible. Additionally, the physician assuming this role will need to accept responsibility for the child’s routine medical needs, such as immunizations. The primary care physician will also need to update the plan of care orders on a routine basis to assure care in the home is appropriate.

Admission to the Home Care Agency

Consent and Code Status

Like all health care agencies, admission to the home care agency requires executing a written informed consent for services provided by the home health agency. Caregivers from the agency should not provide care to the child until the parents or guardians sign the consent forms. Another issue

that must be addressed as soon as the child reenters the home is code status. Much of the time the child returns home with full code status, but there are instances in which the child may be a “no code” or “do not resuscitate” in the home. In some states this requires specific forms developed by the state to direct pre-hospital emergency workers not to resuscitate the patient. If those forms are not appropriately completed, the patient may be mistakenly, but legally, resuscitated.

Education and Competence of Caregivers

In the hospital, health care professionals are directly responsible for the care of the patient; however, with pediatric private duty home care, the care is provided by family members as well as health care professionals (Patterson et al, 1994). Because funding sources rarely provide 24-hour nursing care and home care companies generally cannot guarantee 24-hour coverage on an extended basis, family members often deliver medical treatments in the absence of the licensed caregivers (DeWitt et al, 1993). This makes it critical that the skills and knowledge base of the family regarding the care of the child be validated and reinforced (Harrigan et al, 2002). This education should have begun while the child was still in the hospital. Caregivers should have been educated in disease process including the ability to assess the child for deterioration or signs and symptoms of infection. They should be able to perform skills necessary to deliver the care required by the child as well as demonstrate appropriate use of the medical equipment (DeWitt et al, 1993). Upon discharge of the child from the hospital, the home care agency nurses need to validate these skills and this knowledge prior to leaving the family alone with the child. If there is significant doubt regarding the ability of the family to appropriately intervene on the child’s behalf in the absence of the nursing staff, the agency must halt plans to decrease nursing below 24-hours per day until the education can be reinforced and validated or the child must be readmitted to the hospital.

Competence of caregivers refers not only to the family members delivering care but also to the agency’s licensed caregivers scheduled for shifts in the child’s home. The agency has the obligation to staff the child’s case with nurses who have been oriented to home care and to that particular child’s case (Jerome-Ebel, 1996). The nurse’s knowledge base and skill level should be equivalent to that skill level required for the child’s care.

Delineation of Responsibilities in Home Care

It is important in the admission process to begin to develop boundaries by discussing very specifically with the family those tasks that will and will not be performed by the agency personnel. Family members should participate in this discussion by setting their boundaries as well within their home (Ahmann, 1996). This communication should include discussion regarding expectations necessary to continue private duty nursing in the home including the expectation that physician’s orders will be followed.

Maintenance of Private Duty Home Care Cases

Coordination of Care in the Home

Each home care case needs one individual to act as coordinator of care (Bond et al, 1994). This professional assists the family in coordinating the child's care. At a minimum, the child will have a primary care physician, home nursing services and home medical equipment services. Often there are numerous other services involved including several medical specialists, a physical therapist, an occupational therapist, a speech therapist, and educational services. Each agency may approach care coordination in a different manner, but often the nursing supervisor of the case acts as the care coordinator.

The Plan of Care

In home care, the plan of care is a combination of physician, therapy, and nursing orders that make up all of the tasks that are to be carried out by the home care agencies. When a child is discharged from the hospital, the discharging physician will write orders that will be incorporated into the plan of care. In most cases, the primary care physician then assumes responsibility for additional orders. For the child who has multiple specialty services, the primary care physician should oversee the management and medical orders to avoid confusion and overlap. In a home health agency the primary care nurse often collaborates with the therapists and physician to develop a plan of care which is then submitted to the physician for signature. Once the plan of care is signed, all items contained within it become physician's orders and must be carried out. It is the responsibility of the agencies providing care to assure that the plan is kept in the child's home and that physician's orders are appropriate and current. Nurses, therapists, and the family members participating in care should be made aware of updates and changes in the plan.

Emergency Interventions

Family members should be prepared for situations that might escalate to emergencies in the home (Neal & Kieffer, 1998). For example, the child with a tracheostomy is at risk to occlude his tracheostomy tube. Suctioning the airway may clear some obstructions, but often the trach tube must be changed to provide a clear airway. This requires that the caregiver be competent in the techniques of suctioning and the rapid change of the trach tube. Prior to discharge from the inpatient setting, caregivers should have validated competence in infant/child CPR, suctioning, appropriate use of an ambu bag and changing of the tracheostomy tube. These skills should be evaluated in the home care setting and reinforced on a regular basis to increase confidence and competency on the part of the family.

The child with technology-dependence should not be left with anyone other than a trained caregiver whether the caregiver is a nurse, a family member or a friend of the family. In order for this to occur, a realistic plan must be

developed prior to the discharge of the child from the hospital (Cox, 1996). This plan should not rely solely on the nursing agency for backup. The number of nursing care hours provided at the time of discharge may be decreased over time. In addition, there are instances when it will not be possible for the agency to provide a nurse. Severe weather or emergency situations may preclude the arrival of a nurse for a specified shift. Family members should be able to safely care for their child in the absence of the nurse.

In the event of an emergency involving the child, the family will assume responsibility for the care when there is no nurse in the home and may need to assist as directed when a nurse is in the home. If the situation cannot be rapidly resolved by those in the home, such as that described in the above situation, then assistance should be summonsed using 911 or local emergency medical services. When a situation escalates beyond minor intervention to emergency maneuvers, it has intensified past the normal competence of home health care providers. It is unrealistic to expect the pediatric home care nurse to be certified or to utilize pediatric advanced life support skills (PALS) within the home. Equipment and medications needed for PALS protocols would not be available in the home care setting.

Home care in and of itself incurs some level of risk for the child. The family and caregivers must recognize and accept this risk prior to entrance into home care (Cross et al, 1998). The very purpose for pediatric home care is the reintroduction of the child into a normal family setting in order to assist in the child's developmental progress while allowing technology-assisted medical care to continue. Introduction of an intensive care unit into the child's bedroom is not the purpose of home care (Harrigan et al, 2002). If the child is so fragile that he cannot survive without regular advanced medical interventions, he is not a home care candidate.

Weaning of Home Health Care Hours

The goal of home care as stated above is to reintroduce the child into the home safely. This generally begins with the child and family requiring 24-hour a day support for a period of time. Within a reasonable period of time, nursing hours should be decreased allowing the family members to care for the child for portions of the day. This must be determined on a case-by-case basis and supported by the payor source. The weaning plan should be made in collaboration with the family prior to the child's discharge from the inpatient setting. There should be some level of flexibility in order to ensure the safety of the child as well as the comfort level of the family. If the child's medical condition is one that will continue to require technology, it may not be safe for nursing to withdraw completely and some level of care may continue to be provided for years.

Discharge from Home Health Care Services

Discharge from pediatric private duty nursing may occur for a number of reasons (Agazio, 1997). The child may

improve to the point medically that the care is no longer necessary. Infrequently once they feel comfortable with the care of the child, the family may decide that they no longer wish to have nursing services. If the parent changes jobs or the company employing the parent changes the insurance provider, that coverage may not utilize the particular agency that the family has been using. Often the payor source will require the discharge of the patient. This is rare in the case of a child who requires mechanical ventilation, but frequently occurs in the case of children with less technological requirements. Another reason for discharge may be due to the child becoming an adult. Agencies providing care to pediatric patients generally have an age limit within their scope of practice and discharge the child or transfer the child to an agency that cares for adults. On rare occasions, the nursing agency may find it necessary to discharge the child due to the inability to staff the case. This may occur due to repeated conflicts between parents and nursing staff members. In home care the parent may request a certain nurse not return to their child's case and this should generally be honored. However, there may be limited availability of nurses with the expertise needed to provide the specific level of care that a particular child requires. If the agency is unable to staff the number of hours the child has approved, the case may have to be discharged.

Discharge of the child from services must be a planned event and the family should be involved in the planning of this. Termination of pediatric private duty home care can often precipitate feelings of crisis for families who have become dependent on nurses for assistance in the home (Agazio, 1997). Families should periodically be reminded throughout the course of the case that the goal is to discontinue or decrease nursing services. Regardless of the reason for terminating services, the nursing agency must follow specific rules regarding the discharge of a patient. Abandonment of the patient holds serious consequences through regulatory bodies for both the agency and the licensed nurse participating in such a practice. Unless there is a serious risk of harm to the home care nurse(s), the discharge should be planned jointly and time for the development of alternative coverage plans for the child's care should be allowed.

Other Issues in Private Duty Nursing

Training of Caregivers

Home health agencies are obligated to provide adequate training of their staff. This training should be documented in the employee's file. Just as the family caregivers' skills must be validated, so must the skills of the nurse. In addition, the skill level of the nurse must match the skill level of the patient. A nurse who has never cared for a patient with a tracheostomy or for a child who requires mechanical ventilation should never care for these patients independently in the home without an appropriate time period for orientation with a skilled preceptor. Parents should not be required or

expected to teach skilled care to licensed caregivers. They may, however, be asked to participate in the orientation of staff by providing specific information about their child. Input from parents may also be valuable feedback for supervisory personnel regarding the interactions between the new nurse and their child.

Suspected Abuse and Neglect

The legal definitions for abuse and neglect vary between states (Ahmann & Mitnick, 1996). However, all nurses are bound to report evidence of abuse and/or neglect. In most states, the licensed nurse is responsible to report suspected abuse and/or neglect regardless of the agreement of the agency with that nurse's findings. Documentation of neglect is usually more difficult than abuse, and noncompliance with the plan of care is even more difficult to define. All of these issues should be carefully documented and discussed with the child's primary care physician.

Patient Abandonment

Nurses caring for a child in the home must turn their care over to another nurse or a trained adult at the end of the shift. At no time is it acceptable to leave a pediatric patient in the home without a trained caregiver to assume the care. Family members must be readily available to assume care when the nurse's shift ends. This should be thoroughly discussed during the admission process. It is unacceptable for a family member to be absent when the nurse's shift has ended.

When parents make arrangements to leave town, they are responsible for designating another trained adult to assume the role of primary care giver during their absence. The nursing agency should not allow a case to be staffed without a designated back-up caregiver. Home care is family-centered care and the child is not normally an around-the-clock responsibility of the home care agency.

Death in the Home

Code status of the child should be clearly designated in the admission process. There are times when a terminally ill child and the parents want the child to be at home when death occurs. Many times these children are receiving nursing services to ensure the child's comfort. If the child is expected to die in the home, planning regarding what will need to occur at the time of death should be the focus of the child's care plan. States vary as to their requirements and regulations for code status in the home and, regulating who can pronounce a child dead in the home (Miller-Thiel, 1996). Many states have specific criteria that allow a registered nurse to pronounce patients in the home.

If a child dies in the home unexpectedly, emergency medical services or the appropriate authorities must be notified. The home care agency and their staff should be aware of the necessary procedures. When there is an unexpected death in the home, or if abuse, neglect, or other foul play is suspected, it is likely that the medical examiner will

examine the body. Specific regulations may vary state to state (Miller-Thiel, 1996).

Implications for the Legal Nurse Consultant

Many of the standards discussed within this article are pertinent when the legal nurse consultant (LNC) reviews the care delivered to a pediatric private duty patient. If an incident has occurred in the home shortly after the child was discharged from the hospital, it may be important for the LNC to have not only the records for the home health agency but also the records from the hospital. This would be especially true if there were questions posed regarding the suitability of the child for home care services, the suitability of the home or the ability of the parents to care for the child safely.

The hospital records might also be helpful in discovering the role the payor source played in choosing the home care agencies. The records from both the hospital and the home care agencies should be examined carefully for evidence of appropriate teaching and validation of skills related to emergency situations. There should be evidence that the education was reinforced once the child was in the home and that skills were validated prior to leaving the child alone with the parent. There should be unmistakable documentation that physicians' orders were being followed both while the nurse was present and while the child was in the care of the family. If there is documentation regarding issues of family compliance, the chart should demonstrate that the home care agency has addressed these issues appropriately. "The point at which such instances cross the line into reportable neglect or abuse depend in part on the definition of abuse and neglect in the state in which the services are provided" (Ahmann & Mitnick, 1996, p. 43). Documentation in the chart should also indicate that the nurses were being supervised in the home.

Along with the child's chart, the LNC may want to consider requesting any additional referral forms that were generated. Also, scheduling records, personnel files of the nurses involved in the issue, and the personnel file of the nursing supervisor may provide further insight. Finally, if there are questions about decreasing hours or about the agency's discharge of the case for reasons other than payor issues, all records related to scheduling may be requested.

In addition to requesting and reviewing the patient and the agency records, the LNC should research the rules and regulations governing home care in the state in which the child received care. Some states have few specific rules governing those caring for patients outside of government funded programs, but many states utilize Medicaid regulations as the minimum standard.

Conclusion

Pediatric private duty home care is very specialized. Standards are very different from standards in hospital or outpatient centers. When reviewing legal cases that include this type of care, the LNC needs to identify what the

appropriate standards are given the state in which the child resides and the level of care the child requires. Because these cases are very specialized, it may be most beneficial to locate and hire a nurse with expertise in this type of care to assist in identifying the specific standards. Additionally, other experts such as home care respiratory therapists and physicians who have knowledge regarding pediatric home care may assist in this matter.

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Ethical Dilemmas: Options for LNCs

AALNC Greater Detroit Chapter

Question: What options do Legal Nurse Consultants and /or Case Managers have when ethical dilemmas arise within their practice?

Answer: Ethical issues are a regular occurrence in the Legal Nurse Consultant's and Case Manager's work process. Some ethical issues can lead to moral distress, which refers to the anxiety caused by unclear decision making of common conceptions of what is right and what is wrong. The legal nurse consultant and case manager resolve ethical dilemmas through comparable methods. When solving these dilemmas the legal nurse consultant and case manager need to follow their professional scope of practice and code of conduct.

Both the legal nurse consultant and nurse case manager are first governed by the code of ethics for nurses. Weber(2001) determined that "the profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy."

Weber(2001) further detailed eight sections in the code of ethics for nurses.

1. The nurse, in all professional relationship, practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for and strives to protect the health, safety, and right of the patient.
4. The nurse is responsible and accountable for individual nursing practice.
5. The nurse owes the same duties to self, as to others, including the responsibility to preserve integrity and safety, to maintain competence, and continue personal and professional growth.
6. The nurse participates in establishing, maintaining and improving healthcare environments.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

The Case Manager

Along with the code of ethics for nurses, the case manager is regulated by the Case Management Society of America (CMSA) ethical principles. Standards of Practice(1995) defines the four measurement criteria that influence case management decision making.

1. The case manager provides service with respect for the autonomy, dignity, privacy, and rights of the individual.
2. The case manager acts as a client advocate, instilling information to the individual for an informed health decision.
3. The case manager respects the individual's right to privacy by judiciously sharing only that information relevant to his/her care and within requirements of law.
4. The case manager seeks appropriate resources and consultations to help formulate ethical decisions.

The case manager utilizes both the code of ethics for nurses and the CMSA code of conduct when faced with something that doesn't feel right, uncomfortable situation. There are a lot of pressures, social, economic, and spiritual placed on the case manager in the decision making process.

A recent case study by Thomas and Mooney(2003) found that the following situation typically resulted in an ethical dilemma for the case manager. In this situation, the case manager is working with a patient who was injured on the job. Coincidentally, the case manager finds out that the person has cancer. This additional diagnosis could affect both insurability and employment. Should the case manager notify the client's employer or the client's insurance company?

No, says Thomas and Mooney(2003) the case manager's loyalty clearly should be to the client. The diagnosis of the new cancer information is confidential between the case manager and the client. The employer need only know the medical that is relevant to the work injury.

Within this same study by Thomas and Mooney(2003) it is suggested that the case manager who is confronted with an issue that just doesn't feel right should ask themselves "Am I truly doing the right thing at the right time for the right reason?" For the case manager, the first step toward resolving the ethical dilemma is to present the issue to their supervisor and ask for their direction.

If, following the discussion with supervision the case manager is still not comfortable with the recommendation(s), then they should consult other case managers to see how they handled similar situations. Meaney(2002) found that a case manager often gets their best advice from their peers who may have faced the same question.

Legal Nurse Consultant

Similar to the case manager, the legal nurse consultant's ethical conduct is directed by the code of ethics for nurses and also ruled by the American Association of Legal Nurse Consultant code of ethics.

Bogart(1998) explains that the code of ethics and conduct is based on beliefs about the nature of individuals and society. Individual differences should not influence professional performance and practice as stated in the seven parts of the AALNC code of ethics.

1. The legal nurse consultant performs as a consultant or an expert with the highest degree of integrity.
2. The legal nurse consultant uses informed judgment, objectivity, and individual competence when accepting assignments.
3. The legal nurse consultant maintains standards of personal conduct that reflect honorably on the profession and abides by Federal and State laws.
4. The legal nurse consultant provides professional services with objectivity.
5. The legal nurse consultant protects client privacy and confidentiality.
6. The legal nurse consultant is accountable for responsibilities accepted and actions performed.
7. The legal nurse consultant maintains professional nursing competence.

Ethical dilemmas, Bogart(1995), for a legal nurse consultant arise out of differences of opinion regarding the conduct, execution of a case including intake, review, forming an opinion, billing and working with or as an expert.

When a legal nurse consultant encounters an ethical issue that causes moral distress, that issue is the legal nurse consultant's business and/or personal relationships outside their employment Bogart(1995) describes that the legal nurse consultant may have knowledge of or relationship with others through business organizations and so forth that may lead to be perceived as a conflict of interest. Bogart(1995) defines this conflict of interest as information about a client held by a member of the legal team that if revealed may cause prejudice to the client.

The best method of addressing ethical dilemmas for the legal nurse consultant is prevention. Bogart(1995) states that "through self knowledge, scrupulous work to identify and handle appropriately any conflict of interest before the case is accepted."

Ethical problems should be approached systematically and appropriately. Bogart(1995), incorporating the following five steps.

1. The legal nurse consultant needs to collect data, form a problem and describe a specific dilemma.
2. The legal nurse consultant needs to identify his/her personal biases and his/her sympathy regarding the issue.
3. The legal nurse consultant should identify all other possible points of views or avenues relevant to the problem.

4. The legal nurse consultant should analyze with the assistance of peers, all the issues taking into account the code of ethics as the 'operative' tool.
5. The decision by the legal nurse consultant should be acted upon to the best of his/her ability.

Summary

Consequences of unethical behavior for both the legal nurse consultant and the case manager may result in a revoked license or certification, or even a lawsuit.

Therefore, the key skill in avoiding unethical behavior(s) for both the legal nurse consultant and case manager are; effective communication, listening, and group discussion with peers. H. Landry and M. Landry(2002) propose that a course in Ethical/Legal Issues be taught as part of the curriculum in nursing school, and that more seminars should address professional awareness of ethics.

A sample survey about ethical education and process given to legal nurse consultants and case managers resulted in measurements that majority ruled work experience and peer conference contributed the greatest in ethical decision making and the ethical decision making process involved; information gathering, research, review scope of practice, and peer conference.

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Book Review

Your Career in Nursing: Manage Your Future in the Changing World of Healthcare

Annette T. Vallano, MS, RN, CS

Kaplan Press, 2002

Annette Vallano should win an award, go on the talk show circuit and be put in charge of nursing's future. In her book, *Your Career in Nursing* she goes beyond the routine pep talk concerning networking, resume writing and continuing education to describe an epiphany of sorts, that could lead nursing toward true empowerment.

In Part Two, the author focuses on the concept of self-employment in nursing. Whether it is actual self-employment or the attitude of self-employment makes little difference according to Vallano. She encourages nurses of all ages, specialties and genders to, "Invest in yourself as if you were a corporation." Vallano suggests that as a professional, nurses should direct and control their work environment. Vallano also provides the readers with clear instructions on developing and implementing a business plan. To help the reader shift thinking from that of dependent employee to independent nurse entrepreneur, Vallano describes the

continuum of work, ranging from employee mentality to a self-employed attitude. Vallano clearly exposes the variety of options open to nurses who pursue self-employment.

Your Career in Nursing is well-written and gives clear examples and directions to the reader. This book happens to be for nurses, but its concepts could easily be applied to any profession. The book mainstreams the nursing profession into the world of business. Whether you elect to be an entrepreneur or not, just thinking like one can be beneficial for nurses.

The concept of the self-employment attitude should be taught in every nursing classroom, only then would the future course of nursing be altered and nursing shortages be averted. This book should be required reading for nurses everywhere. Thank you Annette Vallano for helping to direct a promising future for nursing.

Reviewed by Sally Jennings, RN

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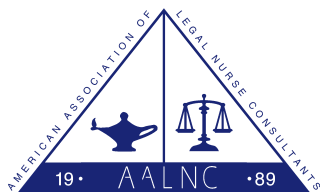
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