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PURPOSE

The purpose of The Journal is to promote legal nurse consulting within the medical/legal community; to provide 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. Please see the next page for Information for Authors before submitting.

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• All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
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When I think about what AALNC has meant to me during my LNC career, many things come to mind, but some of the most lasting impressions are images of networking with my peers and gaining valuable education at the Annual Forum. Whether you are a novice LNC, have been practicing for years, are shy or consider yourself the life of the party, the Annual Forum has something to offer everyone. Not only do you have the opportunity to gain new knowledge from your esteemed colleagues, but the networking and relationship building is second to none.

The Annual Forum is the one opportunity AALNC members have to connect in-person each year. I remember attending my first Forum and not knowing what to expect… I was blown away by the education, and more importantly by how welcome I was as a new LNC. I built relationships there that I still maintain today. These relationships have helped me professionally, of course, but they have also turned into personal friendships. I encourage anyone who has yet to attend an Annual Forum to make 2019 the year you join us! The investment is worth it, and your LNC practice will benefit from the valuable knowledge you bring home.

If you’re looking to join a community of LNCs, learn from some of the top minds in the industry, and make a few friends along the way, the Annual Forum is the place for you. I hope you’ll join me at the 2019 Annual Forum in Louisville, Kentucky, April 5-6. To view more information and to register visit http://www.aalnc.org/page/aalnc-annual-forum-2019-home.

I look forward to seeing you in Louisville!

Sincerely,

Kim Beladi, BSN RN LNCC
Editor’s Note

Welcome to our issue on pediatric and adolescent concerns for legal nurse consultants. While we have a great lineup of authors on these topics, I’d like to get some emails telling me about peds/adolescent cases you’ve had, how they came up, progressed, and resolved. Call it a feedback loop we can use to improve.

I find myself at the end of five years as your editor, having begun on March 1, 2014. This is astonishing. Where does the time go? In these five years the many, many LNCs who have contributed to the editorial committee have done yeoman’s work for you, seeking to present engaging topics that illustrate the breadth of legal nurse consultant practice. It’s no secret that when nurses get together they often come away with new knowledge and insight. Working with these good people who spend a bit of their time sharing their expertise and creativity as only nurses can has been one of the great joys of my own career. Personally, I never get tired of learning new things.

We begin our thirtieth year as a professional publication in 2019. As we do, we want to keep telling you about the expanding opportunities in LNC work. In just these few years I’ve talked with so many of you who have found inspiration in our pages. Some have moved to offer new services to clients, seek a new certification, give a webinar, or begin the move to an entirely new practice area, meeting new challenges with confidence, sparkled by an idea they saw in the JLNC. It’s inspiring, and a bit humbling, to realize that the work we put into it can have such far-reaching effects.

In the last few years working on the JLNC we have intentionally moved beyond the comparatively low-hanging fruit of med mal, testimony, marketing, and getting a business up and running that appeal to new and aspiring LNCs and also offer great opportunities for more seasoned ones to share and mentor those who will be our future. Of course we’ll continue to cover those topics. You can also look for the JLNC to continue to expand coverage of other forms of legal nurse consulting.

Just last night I was speaking to a very experienced nurse life care planner who asked me what I did in my LNC role besides my practice in life care planning. As I described a few of the cases I’ve done in the last year, she expressed surprise at the variety; she had no idea. So here’s the challenge, for all of us: Let’s keep on being surprising. Do you practice in a niche you’d like to see get better exposure? Heed the great publisher Benjamin Franklin, “Hide not your talents / They for use were made / What’s a sundial in the shade?” If you have an elevator speech, share it— with us, your new colleagues at conference, on the legal nurse consulting online discussion groups, with future LNCs, and anywhere else. “This is what I do as a legal nurse consultant. I…”

Wendie A. Howland MN RN-BC CRRN CCM CNLCP LNCC
Pediatrics is Different

Herschel Lessin MD, Senior Partner, The Children’s Medical Group, PLLC

If there is one thing that I have learned in 36 years of general pediatric practice, as well as 31 years serving as a pediatric expert in malpractice cases, it is this: Children are NOT little adults.

The most common mistake doctors, nurses, and attorneys make when dealing with pediatrics is to assume that all you have to do is to take the same approach you take with adults and make it smaller to fit children. Unfortunately, the health needs of children are neither smaller nor the same as those of adults. A completely different approach is needed.

A child may have similar problems such as sepsis, cancer, heart disease and trauma, but the approach to these and other problems is vastly different from the approach one would take with an adult. The presentation, symptoms, progression and outcomes are often very different.

To make matters even more complicated, all of the above factors can change dramatically with a difference of a few months or years of age. The course and prognosis of an illness can be completely different in a 1 month old, a 1-year-old, a 5-year-old, and a 15-year-old. Can the same be said were patient 40, 41, 45, or 55 years of age? Even though they are not often viewed as such, pediatricians are specialists, specialists in children. The reality is that family practitioners only have 3 months training in children, rather than the 3 years of pediatricians’ residency. PAs, NPs, and ER doctors have even less, unless having taken a fellowship in pediatrics along the way. Not keeping these facts in mind can result in losing a strong case, or accepting a case that should never have been brought.

What I would like to accomplish in this discussion is to give LNCs a brief overview of why this is so, use some illustrative case scenarios, and discuss how to select the proper experts in pediatric legal matters. While I am focusing more on acute illness, the principles are often the same for routine check-ups. Evaluating growth and development is the prime directive of pediatrics.

“DOES THIS CHILD LOOK SICK?”

Believe it or not, this is the first thing a pediatrician assesses. After all, the child
Many normal adult laboratory findings and physical measures can be of great concern in a child, and vice versa. Always consider these variations when assessing deviation from SOC.
admitted to the hospital and treated with IV antibiotics until all cultures are negative. Conversely, the presence of a high fever in a well appearing child is not evidence of serious disease when the entire picture is considered.

**Hip dysplasia**  Signs and symptoms differ by age. The typical findings of unstable hips (i.e., Ortolani and Barlow maneuvers) are no longer useful in all infants; range of motion restriction of abduction at the hip becomes the primary symptom after four months of age. Also, the definition of dysplasia has changed from *congenital* to *developmental*, reflecting the concept that hips can dislocate at any time, and making negligence much harder to prove. There is also controversy about when treatment, especially in later diagnoses, can make a difference in outcome.

**Rapid deterioration**  I have reviewed several cases where a child died just a few hours after being seen with a “viral” diagnosis. The problem here is this can happen without any warning in a child who appears well just a few hours earlier. This is often a malocurrence, not malpractice. Treatment for influenza or RSV (respiratory syncytial virus) discovered at autopsy would be very unlikely to have made a difference. The same can be said even in invasive bacterial disease with rapid progression. Sometimes, bad things happen and there was no way to tell based on the appearance of the child or history and physical findings.

**Child abuse**  Presentation varies tremendously by age. I have had multiple cases against pediatricians for failure to report suspected abuse. Age is critical, as any trauma in a non-ambulatory child is suspicious by nature and should not be ignored. Also, a history inconsistent with the nature of the injury must be reported. Clinicians are mandated reporters in all states and cannot incur liability by making a report of suspicion.

*Ed. note: See Fregia, page 12*

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**MEDICATIONS**

A great many pharmaceuticals have neither been tested nor approved in children, yet are used as the standard of care, so pharmacological treatment is fraught with problems. If pediatricians were restricted to using drugs “on label,” we would have very few drugs to use. Therefore just having a non-approved use is in no way proof of negligence. An age-related black box warning, such as the one on antidepressants increasing the risk of suicide in children, is only significant if it is not addressed and discussed with the parent and a plan made. These meds are commonly used in children of all ages despite the black box.

**A FEW SELECTED SCENARIOS**

**Fever**  I have seen several cases where fever in a child less than 4 weeks old was treated as exactly the same as that in an older child. A child of this age should be assumed to have serious bacterial illness until proven otherwise and should be
Not considering the growth curve  Well-child care providers are often tasked with looking for developing problems. Falling off the typical age-related growth curves may indicate many chronic diagnoses that are difficult to pick up unless deviations are taken seriously. Patterns or discrepancies can also vary by age, diet and methods of feeding, and psychosocial factors.

Scoliosis  Treatment and consideration is quite age-dependent. In a teenager, mild degrees are common and need to be followed most closely during periods of rapid growth, which also vary by age. Juvenile scoliosis, on the other hand, has a much higher risk of progression and poor outcome. The clinician must know the difference.

Statute of limitations  The statute for children is much longer than the few years allowed an adult. In children it is usually 2 years after majority, often 20-23 years.

These are only a few scenarios. Therefore it is critical for the case evaluator to double-check and correlate the signs, symptoms, presentation, prognosis, and outcome with the child’s age, development, and history.

PEdiatric EXPerts

It is very important to get pediatric input in nearly all cases involving children. Family practitioners, adult emergency medicine physicians, and EMTs often have extremely limited pediatric training and experience. In areas where pediatricians are common, family practice doctors may not see the volume of pediatric patients needed to realize that kids sometimes are indeed seriously ill. ED physicians may be quite competent for medical emergencies, but given the default in many areas of the country to use the ED for primary care, they are often ill equipped to handle the day-to-day primary care seen by a pediatrician. Lacking the relationship, ability to access past medical history, and difficulty assuring follow up, they often have a difficult time with general pediatric problems. Family nurse practitioners and general physician assistants without specific residency or experience in pediatrics also have very limited training. Even if a pediatrician will not be called to testify due to same specialty rules in various venues, one can be invaluable in pointing out areas for which those same specialty experts can focus.

Depending on the rules regarding supervision in different venues, pediatricians can and should comment on the care provided by mid-level providers whose care can often exceed their expertise and ability to know what they don’t know. To be fair, however, many physicians who may not be up to date suffer from the same malady. It is not appropriate for mid-levels to comment on the standard of care of pediatricians.

A child can die without warning despite appearing well just a few hours earlier. This is often a maloccurrence, not malpractice. Sometimes bad things happen.

STANDARD OF CARE

As an Ivy League-trained, actively practicing community pediatrician I must comment on the exclusive use of academic pediatricians as witnesses in general pediatric cases, especially concerning standard of care opinions. A community pediatrician has a far better perspective on the standard of care than does an academic with very limited time spent in general pediatrics in very different circumstances. Academic primary care clinics bear little resemblance to the real world practice of pediatrics. The volume is less, the time available to spend is greater, and resources are directly at hand and assumed available where they are often not available in the community.

Specialty physicians in or out of academia are often needed to establish causation; relying solely on primary care experts for causation can often be inadequate and dangerous. Such specialists
opining on community standard of care, however, can easily be impeached. I have often commented on how their opinions concerning the 1% complex specialized cases that are referred to them have little to do with the 99% of cases that the general pediatrician sees in practice that the academician never encounters.

I have no problem deferring to specialty opinions about specialty expertise, but will not defer to opinions regarding primary care. Their opinions have little relationship to the standards outside of academia. Furthermore, primary care pediatricians must have an excellent bedside manner and ability to educate in order to survive in the current healthcare environment. Academicians are far more insulated and often less adept at talking to parents, and jurors, in understandable jargon-free language, rather than the pediatric trainees they are used to addressing.

**SUMMARY**

The take-home message is that children are often very different than adults. They have different illnesses that present and progress differently based on size, age, and developmental status. The basis of evaluation of presentation, including the history, also varies by size, age, and development. Their vital signs are different. The prognostic impact of various diseases varies by age. Kids who are injured by medical negligence have a very long time to develop problems and require support, thus accounting for the much higher recoveries in kids, even though the frequency of claims is far less frequent than in adult medicine. The emotional impact of a sick child to a jury generally far exceeds that of a sick adult.

It is a mistake not to consider all of these factors when reviewing cases involving children as the validity of the claim and defensibility of the case often depends upon them.

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**Dr. Herschel Lessin** has been a full-time practicing pediatrician since 1982 and has served as an expert witness in pediatric malpractice litigation since 1987, working for both plaintiff and defense. He is a founding member and Vice President of one of the larger single specialty pediatric practices in the United States, The Children’s Medical Group, PLLC, with 9 offices and 24 practitioners in NY’s Hudson Valley. His practice includes children from birth through college.

Dr. Lessin is active on a national policy level, having been co-lead author on several American Academy of Pediatrics policy statements and technical reports, as well as being a member of the authoring committee on several others. He can be contacted at KidMD3@yahoo.com.

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According to the American Academy of Pediatrics (AAP), each year over 650,000 children are substantiated victims of abuse or neglect, and over 1500 child deaths occur from abuse or neglect. Each year Child Protective Services (CPS) investigate over 2 million reports of abuse or neglect; 18% of those concerns involve physical abuse. (Brown, 2015)

**DEFINING CHILD ABUSE/NEGLECT**

Child abuse takes on many forms; multiple cases of abuse can include more than one.

- Physical abuse: Injury that purposefully causes physical harm or risk of harm by another person
- Medical abuse: A caregiver purposely causes a child to become ill requiring medical attention, putting the child in danger of injury and unnecessary medical care (Ed. note: See Durr, FDIA, page 20)
- Emotional abuse: Injuring a child’s self-esteem or emotional wellbeing with an emotional assault as well as isolating, ignoring, or rejecting a child
- Sexual abuse: A child is exposed to any sexual activity including fondling,

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**Child Abuse and The LNC**

Cybil Fregia, RN, MSN, CPNP-PC

**Keywords:** Child abuse investigation, Child abuse signs, Child abuse litigation, Child abuse, Child maltreatment, neglect, physical abuse

The purpose of this article is to give LNCs the tools they need to collect relevant records, identify possible abuse in them, and assist the attorney in preparing for trial.
oral-genital contact, intercourse, or exposure to child pornography

- Neglect: Failure to provide basic needs including food, shelter, affection, supervision, education or medical care

(Mayo Clinic, 2015)

**SIGNS OF CHILD ABUSE/NEGLECT**

Signs of child abuse or neglect can manifest in different ways. Every child and every situation is different. Injuries oftentimes present themselves in childhood. An injury by itself does not indicate abuse, but knowing how the injury occurred is critical to determining abuse. (U.S. Department of Justice Office of Justice Programs, 2014) Anyone that witnesses abuse, is informed of abuse, or suspects abuse should report concerns as soon as possible.

Indicators of abuse may be very obvious, but oftentimes there may be subtle findings over time. Some obvious indicators:

- Physical
  - Frank report of injury by parent or caregiver
  - Unexplained fractures, bites, burns, bruises
  - Repeated, similar injuries
  - Long-sleeved shirts, long pants
  - Apparent fear of adults

- Neglect
  - Frequent school absences or tardiness
  - Poor parental bonding
  - Inappropriate dress for weather or season
  - Sickly or dirty appearance
  - Poor dental health, lack of immunization, or needed eyeglasses
  - Stealing or begging

(Gill, 2012)

Children who are abused may feel guilty, confused, or ashamed. They may be fear-ful of telling anyone of the abuse. These children may exhibit these red flags:

**Physical Abuse**

- Withdrawal from friends or lack of interest in usual activities
- Changes in behavior like aggression, anger, hostility or hyperactivity
- Changes in school performance
- Depression, anxiety or unusual fears
- Sudden loss of self-confidence
- An apparent lack of supervision
- Reluctant to leave activities, avoiding going home
- Attempts to run away
• Rebellious or defiant behavior
• Attempts at suicide
(Mayo Clinic, 2015)

Emotional Abuse
• Delayed or inappropriate emotional development
• Loss of self-confidence or self-esteem
• Social withdrawal or a loss of interest or enthusiasm in activities
• Depression
• Headaches or stomachaches with no medical cause
• Avoidance of certain situations, school refusal
(Mayo Clinic, 2015)

Caregivers may often exhibit certain “red flag” behaviors or demeanor, such as:
• Shows little concern for the child
• Appears unable to recognize child’s physical or emotional distress
• Denies problems at home or at school
• Blames the child for the problems
• Belittles or berates the child, uses negative terms to describe the child
• Expects the child to provide him or her with attention and care
• Seems jealous of attention other family members get from the child
• Uses harsh physical discipline or asks others to do so
• Demands an inappropriate level of physical or academic performance
• Severely limits the child’s contact with others
• Offers conflicting or unconvincing explanations for injuries or no explanation at all
(Mayo Clinic, 2015)

There may not always be one specific sign or conversation that blatantly identifies abuse. Documentation by medical professionals, law enforcement agency, teachers, counselors or caregivers is necessary to the investigation. The more documented observations and facts surrounding the suspected abuse, the sooner an investigation can begin and the child is protected from further abuse. Observation and listening are key to putting the pieces together.

WHO IS RESPONSIBLE FOR REPORTING ABUSE

The LNC should be aware of reporting requirements in the jurisdiction. All 50 states, the District of Columbia, and U.S. Territories have mandatory reporting laws. Each state identifies a set of behaviors that define abuse and neglect. The Child Abuse Prevention and Treatment Act (CAPTA) defines the minimum definition of abuse and neglect as:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

(Department of Health & Human Services, 2016)

In approximately 48 states, the District of Columbia, and other US territories certain professions are designated as mandatory reporters. It is their duty by law to report any suspected child maltreatment. These professions include, but are not limited to:
• Physicians, advanced practice providers, and other healthcare providers
• Teachers, principals, and other school personnel
• Social workers
• Counselors, therapists, and other mental health professionals
• Child care providers
• Medical examiners or coroners
• Law enforcement officers
(Gateway, 2016)

Not all reporters have to be professionals; anyone that witnesses any form of child abuse may come forward. This voluntary reporting is often referred to as “by permissive reporters.” (Gateway, 2016)

Professionals and laypeople often find it hard to report. People fear “jumping to conclusions,” “getting someone in trouble,” or “getting it wrong,” or may have a lack of faith in the system. “Nonreporting can stem from various reasons, often tied to the correct identification of at-risk children and trust in the Child Protective Services response, and is also subject to individual bias.” (Mical Raz, 2017)

Child abuse has been associated with:
• Perpetrating or being a victim of violence
• Depression
• Smoking
• Obesity
• High-risk sexual behaviours
• Unintended pregnancy
• Alcohol and drug misuse
(World Health Organization, 2016)

Because abuse or maltreatment can leave long-lasting detrimental effects on children, there may be observable evidence such as:

In approximately 48 states, the District of Columbia, and other US territories certain professions are designated as mandatory reporters. It is their duty by law to report any suspected child maltreatment.
the child as well as the family, anyone coming into contact with suspected abuse has a moral and ethical role in providing safety of every child. The benefits of reporting far outweigh the risk of not reporting abuse that may lead to further physical and/or emotional harm and even death. In most jurisdictions a reporter’s identity is not disclosed.

**THE ROLE OF CHILD PROTECTIVE SERVICES**

Once a report has been made to Child Protective Services (CPS), the case-worker follows a standard protocol governed by the state to assess the child’s safety and to assure that the child is not at immediate risk. The CPS worker will then work with the family to reduce the risk of further abuse and help the child cope with the effects of previous maltreatment. (Social Work Degree Center, n.d.) The goal of CPS is “to keep children in their homes when it is deemed safe, and to provide them with a safe environment when they are determined to be at risk.” (Social Work Degree Center, n.d.) Child Protective Services works in conjunction with many professionals and non-professionals. These include:

- Law enforcement officers
- Health care providers
- Mental health professionals
- Educators
- Legal and court system personnel
- Substitute care providers
- Community-based and faith-based organizations
- Substance abuse treatment facilities
- Advocates for victims of domestic violence
- Extended family members and concerned citizens

(DePanfilis & Salus, 2003)

Child Protective Services is typically “the lead agency in coordinating the efforts of the various disciplines working to protect children and to educate the community about the problems of child abuse and neglect.” (DePanfilis & Salus, 2003)

The goal is not always to remove the child from the home. “Involving families and children in ‘the system’ can give them access to services of which they might otherwise remain unaware. Home visits, anger management programs, parenting classes, counseling services, and early childhood education can instill and reinforce more positive attitudes and action, for the benefit of all involved.” (Donna F. Gill, 2012 March)

**MEDICAL RECORD REVIEW**

Timelines are very important in identifying abuse, so a thorough review of the medical record is always warranted. Obtain records from every available source. Start with where the suspected abuse was first reported: the typical mandatory reporters in a medical office, an Emergency Room (ER), a school worker (teacher/assistant/counselor), social worker, or daycare. Then identify other sources of medical records.

Some caregivers will tend to “doctor hop,” going to several different providers to avoid repeat contact to avoid suspicion or documentation. Interview the parents/caregivers to identify all possible places the child was cared for including ER(s) or urgent care(s), primary care providers office(s), clinic(s), and specialists such as psychiatrists, psychologist, or counselors/therapists.
• Physical
  - Failure to thrive, poor weight gain, malnutrition
  - Fractures:
    ▪ Any infant with an unexplained fracture
    ▪ Multiple fractures, especially bilateral
    ▪ Fractures of different ages
    ▪ Epiphyseal separations
    ▪ Vertebral body fractures and subluxations
    ▪ Digital fractures
    ▪ Complex skull fractures
    ▪ Subperiosteal new bone formation
    ▪ Clavicular fractures
    ▪ Long bone fracture, unless child is pre-ambulatory
    ▪ Linear skull fractures
  - Bruising:
    ▪ Multiple bruising in various stages of healing, especially on the trunk
    ▪ Any bruising in a non-ambulatory baby
    ▪ Handprints or oval finger marks
    ▪ Belt marks—long broad band ending with horseshoe shape or puncture from the buckle
    ▪ Loop pattern from cord, rope or wire that has been doubled up
    ▪ Petechiae or injury on buttocks from paddling, severe spanking
    ▪ Ligature pattern on neck, wrists, ankles
    ▪ Gag pattern on corners of the mouth
  - Color of bruises is not reliable for dating, but documentation of colors is important
  - Location of bruises
    - Upper thighs, especially inner thighs
    - Trunk, buttocks
    - Upper arms
    - Sides of face, ears, neck
    - Genitalia
  - Defensive injuries on forearms
  - Bites: Human bites are more superficial than animal, and show up better 2-3 days later
  - Burns (seen in 6-20% of abused children): Cigarette (circular, 8-10mm deep, heaped margin), rope, immersion (sharp line of demarcation or splash marks) or shape of hot object.
  - Trauma to the ear
  - Lacerations
  - Traumatic hair loss
  - Facial injuries without good explanation
  - Oral/dental injuries (torn or bruised frenulum, lips, teeth, palate, tongue or oral mucosa)
    - Injuries from a non-ambulatory child may be “bottle jamming” lacerations or tissue damage to oral structures may come from eating utensils, scalding or caustic liquids
    - Oral injuries/STDs from forced oral sex
  - Injuries requiring diagnostic testing or more thorough examination
    - Head injury, mental status changes
    - Retinal hemorrhage
    - Subdural hemorrhage
    - Intraabdominal trauma, usually to multiple organs
    - Bruising, tearing, bleeding, discharge from the genital or rectal area
    - Diagnosed STD or pregnancy

• Symptoms
  - Headaches
  - Abdominal pain, chronic
  - Abdominal pain, acute—blunt trauma may not show external marks—look for distention, tenderness, absent bowel sounds
  - Vague somatic complaints, often chronic
  - Worsening medical problems, such as asthma
  - Frequent, unexplained sore throat
  - Abnormal weight gain or loss
  - Reluctance to use an extremity
  - Difficulty walking or sitting
  - Genital discomfort or painful urination or defecation
  - Unexplained symptoms—look for poisoning, forced ingestion of water or salt, nonhealing wounds (Ed. note: See Durr, FDIA, page 20.)
  - Vomiting, irritability or abnormal respiration may represent head trauma

• Behavioral clues
  - Infants excessive crying or developmental delay
  - Fear, anxiety, clinging
  - Phobias
  - Nightmares, sleeping problems
  - Bedwetting
  - Social withdrawal
  - Hyperactivity
  - Poor concentration/distractibility
  - Decreased school performance chronic school absenteeism
  - Speech disorders
  - Regressive behavior for age
  - Seems afraid of the parent or caregiver
  - Eating issues
  - Depression, passivity
  - Increased verbal abuse or physically aggressive behavior with others
  - Destroys or injures objects or pets
  - Substance abuse self-harm such as cutting
  - Sexualized behavior symptoms of PTSD
  - Avoidance of undressing
  - Withdrawal to touch, afraid of the exam
  - Overly compliant, especially with difficult or painful parts of the exam

Obtain interviews with as many people as possible who have had contact with the child: healthcare providers, teachers/assistants, school nurses, school counselors, and caregivers outside of the home. As stated earlier in this article, not all signs of abuse are physical. Interviews may reveal changes in a child’s behavior that can be pinpointed to a particular time may be helpful to narrow down a specific episode or start of the abuse. They should not be viewed just as one incident, but collectively.

Certain physical signs and symptoms should be considered red flags. A one-time occurrence is not always suggestive, but multiple red flags indicate a high incidence of abuse. Also be looking for what doesn’t appear in the medical record: non-compliance with medical care, avoidance or delay in treatment, lack of follow-up after injuries or undocumented previous injuries may indicate possible fear of being reported for abuse or neglect.

**Injuries and Symptoms**

The most common are skin injuries, skeletal fractures, and central nervous system conditions. Internal injuries that require diagnostic testing should be documented in the medical records. However, LNCs should become familiar with medical conditions can mimic abuse that should be ruled out, such as:

- Confusing cutaneous lesions (e.g., eczema, hemangiomas, Mongolian spots, molluscum contagiosum, phytophotodermatitis, erythema multiforme)
- Alopecia areata (hair loss)
- Tinea infections
- Accidental fractures; osteogenesis imperfecta
- Hematologic diseases
- Congenital coagulation disorder (e.g., ITP, hemophilia)
- Thrombocytopenia
- Benign external hydrocephaly
- Connective tissue disorders
- Metastatic bone tumors
- Metabolic disorders
- Folk healing practices, (e.g., cupping, coining)

(Gill, 2012, Brown 2015)

Stanford Medicine’s screening for child abuse website (Stanford Medicine, 2018) lists signs to look for (sidebar). Some may also be seen in common childhood illnesses, or not be physical or present visually on physical exam. Some may be identified in the medical record as symptoms or behavioral changes/actions.
PREPARING AND PRESENTING MEDICAL EVIDENCE

After reviewing the records, the LNC can determine what experts are needed to answer important questions before a case can proceed, such as:

- Have the nature and extent of the injury or illness been identified?
- Has the mechanism of injury been identified?
- Does the history the caregiver provided explain the injury?
- Have other diagnoses been explained or ruled out?
- Can the injury be consistent with an accident? The timing of the injury?
- Have all injuries been assessed?
- Has the child received the treatments necessary to treat injury or illness?
- Are there the potential risks for the child from the abusive event?
- Are there long-term medical consequences and what are the possible residual effects of abuse?
(U.S. Department of Justice Office of Justice Programs, 2014)

The LNC assists the attorney decide whether the case requires a fact witness or expert witness. In many child abuse cases, the witness may have firsthand knowledge of a child from previous treatment or examination (The Children’s Law Center, 2010). In cases like these, the line between expert and fact witnessing may be blurred. Experts may include:

- Physicians
  - Pediatricians
  - General Practitioners
  - ER Physicians
  - Intensivists
  - Neurologists
  - Orthopedic Specialists/Surgeons
  - Pathologists
- Radiologists
- Forensic Odontologists
- Psychiatrists
- Psychologists
- Nurse Practitioners/Physician Assistants
- Nurses
- Social Workers/Case Workers
- Professional Counselors, Marital and Family Therapists and Psycho-educational Specialists
- Forensic Interviewers
- Forensic Toxicologists
(The Children’s Law Center, 2010)

Interviewing the child

The child’s testimony may be the most crucial part of the case. Attorneys should be made aware that children are not “little adults” and should be treated differently. Children can be very fragile, but they can also be very resilient.

Discussing the abuse may be hard for the child. The LNC may suggest to the attorney to “reinforce the child’s testimony” by questioning the child about “his or her subjective reaction to the abuse” and “that children respond better to open-ended questions (‘What happened?’) than questions that can only be answered by ‘yes’ or ‘no.’” (Vitelli, 2012) Children may not always show emotion when testifying, but reinforcing a child to always be truthful and give as many details as possible is important. A consulting expert on child development and trauma will be helpful in preparing the attorney to be sensitive in this process. (Orr, 2016)

SUMMARY

From Orr, 2016:

- Review documents related to date and time of injury and the age of the patient at the time of the assault.
- Review documents related to any forensic evidence collected at the time of assault.
- Review documents from child protection agency, social services, crisis centers, psychologists, and SANE-P’s who conducted the examination, and any law enforcement reports, if applicable.
- Distinguish what form of sexual assault occurred at the time of the incident: physical sexual abuse or non-physical sexual abuse.
- Review any documents from community and counseling centers that provide follow-up crisis interventions to patients and their families.

Child abuse is a very sensitive area of the law. Children are some of the most vulnerable clients and we are legally, ethically and morally obligated to protect them; a trial can have a lasting effect on victims and families. It is the LNC’s responsibility to contribute as much medical/nursing knowledge and expertise as possible to the attorney, making a difference in the lives of those who can’t always speak for themselves.

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Factitious Disorder Imposed on Another: A New Name for a Pediatric Medical Mystery

Leslie Durr, PhD, RN, PMHCNS-BC-Retired

One of the most frustrating things pediatric nurses in the hospital experience is when the treatment given to a young patient does not seem to lead to amelioration of the presenting condition. It seems like a straightforward case; the gold standard treatment regimen is in place, but the parent, almost always the mother, insists the child is not better. There may be abnormal lab findings like blood in the child’s diaper or accounts of seizure activity witnessed only by the parent, not by nurses or doctors. The mother is obviously distressed although the child, usually age 4 or under, does not seem unduly upset.

Staff are frustrated and grow impatient with the mother’s protestations that her child is not better. That frustration can turn to anger as the staff considers another diagnosis: Factitious disorder imposed on another. This rather rare condition, formerly known as Munchausen’s syndrome by proxy, can be an ethical nightmare as it brings the legal and medical worlds onto a collision course. This article clarifies how the LNC can help identify this sometimes baffling condition.

Keywords: Factitious disorder, Munchausen’s Syndrome by Proxy, Munchausen, Pediatric patient challenges, Parental role, FDIA, Factitious Disorder imposed on Another, FDIA, Factitious Disorder Imposed on Self, FDIS, Falsification of illnesses or injuries, Conversion Disorder, Child abuse
for examination. The feigned illness is fully conscious on the malingering's part, with inconsistencies in the presentation of symptoms in interviews, and activity and behavior that are incongruent with the claims, and lack of cooperation in treatment efforts. Other factors that suggest the presence of malingering include financial motivation (financial gain) and atypical or exaggerated symptoms that change with suggestion.

Factitious disorders, in contrast, have no profit motive beyond obtaining care and concern for oneself either through one's own symptoms or through those of one's child. In that way, they are more confounding to nursing and medical staff and also, when imposed on a child, can lead to staff becoming angry and punitive. The behavior of any patient who meets the stringent DSM criteria for FDIS strikes the average person as truly insane; the person – parent – who meets the DSM criteria for FDIA often strikes the medical and nursing staff as bad or evil. In neither case is the person obviously exhibiting signs of psychosis or impaired reality.

Diagnosing FDIA is very difficult because of the dishonesty involved and the medical knowledge often held by the mother (who often has a healthcare background). Healthcare professionals must rule out any possible physical illness as the cause of the child's symptoms, and often use a variety of diagnostic tests and procedures before considering a diagnosis of FDIA.

Because the "goal" of FDIA is unconsciously to be the recipient of medical and nursing staff concern and attention, the parent may take their falsification of illnesses and injuries further than is seen in cases of malingering, adding to the threat to the child patient. It is also more likely that the parent will abruptly sever the relationship with the staff if there is frustration with diagnosing the child's condition and skepticism about the parent's claims.

As test results mount up showing little or no evidence of the claimed ailment, the parent may escalate efforts to produce pathology in the child. And failing that, the parent of a patient starting out with FDIA may find it necessary to resort to malingering to "save face" in front of others who question why she is not pursuing legal remedies for the apparent medical malpractice (actually resulting from parent-induced harm). Generally, however, the malingerer will attempt to minimize contact with medical professionals and testing because

DIFFERENTIATING FACTITIOUS DISORDER FROM MALINGERING

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives, such as avoiding military duty; avoiding work; obtaining financial compensation, e.g., lawsuits; evading criminal prosecution; or obtaining drugs. The presence of malingering is often within a medico-legal framework; that is, the person is referred by an attorney to the clinician
each visit or test provides an opportunity for detection; in contrast, the person with factitious disorder welcomes the opportunity to play the role of caring parent to the child patient and finds it intrinsically gratifying.

If a physical cause of the symptoms is not found, a thorough review of the child’s medical history, as well as a review of the family history and the mother’s medical history (who may have factitious disorder imposed on self) might provide clues to suggest FDIA. Often, the individual with FDIA may have other comorbid psychiatric disorders or there may be a history of an older child treated for mysterious illnesses. Sadly, there might even be a history of an older child’s death from some unknown illness. Indeed, the most important or helpful part of the work-up is likely to be the review of all old records that can be obtained. Too often, this time-consuming task is forgotten and the diagnosis is missed.

It is important to remember that it is the adult, not the child, who is diagnosed with FDIA. Including social services and the hospital legal department in reviewing the facts is essential when there is evidence in the records of FDIA.

The first concern is to ensure the safety and protection of any real or potential victims. Since FDIA is considered a form of child abuse, involving Child Protective Services fulfills the healthcare professionals’ duty as mandated reporters. It might be required that the child and other children in the home be placed in the care of a family member considered safe or in foster care. In fact, managing FDIA often requires a team that includes social workers, foster care organizations, and law enforcement, as well as the health care providers.

**TREATMENT OF FDIA**

Successful treatment is difficult because those with the disorder often deny there is a problem. In addition, treatment success is dependent on catching the person in the act or the person telling the truth. People with FDIA tend to be so motivated to obtain the medical care and concern that they become adept at giving misleading information and even begin to have trouble telling fact from fiction.

Generally, FDIA is very difficult to treat and often requires years of therapy and team support. Through all of this, the child’s safety is paramount and although our society takes parental rights very seriously, there are grounds for terminating them. [https://www.childwelfare.gov/pubPDFs/groundtermin.pdf#page=2&view=Grounds%20for%20termination%20of%20parental%20rights](https://www.childwelfare.gov/pubPDFs/groundtermin.pdf#page=2&view=Grounds%20for%20termination%20of%20parental%20rights)

**CASE STUDY**

Many years ago, while serving as the psychiatric liaison clinical nurse specialist for the adult medical units at an academic medical center, I was asked by a colleague to check on a patient who had been admitted to the inpatient pediatric unit with a leg wound that would not heal. My colleague had been seeing the child, age 4 or 5, in the outpatient child and adolescent psych center for behavioral issues, but during this time, the child had had multiple courses of many different antibiotics and antifungals without the wound healing. The child’s wound culture had grown *vibrio*, a bacterium connected with warm brackish water and fish tanks. The mother denied that the child had been in brackish water but admitted there was a fish tank in the home.

During each course of antibiotics as an outpatient, the child’s wound would begin to heal only to become purulent, become worse and the mother would return with her to the doctor. The child had finally been admitted to the hospital for a complete immune system workup to determine if she had some rare disease of her immune system (this was before recent amazing advances in understanding the immune system).

While the lab tests were pending, the healthcare team decided to clean the wound, apply antibiotic ointment, and put a cast on the leg; the hospital social worker and Child Protective Services were already onboard and working with the mother who was decidedly anxious about her child. While offering the mother support, the social workers also kept her from unchaperoned visits with the child.

After about a week, the cast was removed to reveal that substantial healing had taken place and there was nothing wrong with the child’s immune system. The task of protecting this family’s children moved out of the healthcare system.

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**Spectrum of Abnormal Illness-affirming Behavior**

(Eisendrath and McNiel, 2002)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Motivation</th>
<th>Symptom Production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malingering</td>
<td>Conscious</td>
<td>Conscious</td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>Unconscious</td>
<td>Conscious</td>
</tr>
<tr>
<td>Conversion Disorder*</td>
<td>Unconscious</td>
<td>Unconscious</td>
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</tbody>
</table>

*Conversion disorder is a mental condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation and is not intentionally induced.*
realm and into the legal realm, and we had no further involvement.

ISSUES FOR THE LEGAL NURSE CONSULTANT

Reviewing the usually voluminous medical records of a pediatric patient whose parents bring a lawsuit where there is an indication of FDIA will be arduous.

Red flags:
- Non-physiologic physical signs: parent-reported physical signs or symptoms that contradicted typical pathological findings and appeared to require conscious production.
- Physical evidence: physical evidence of a factitious cause of symptoms (e.g., a syringe or surreptitious medication) discovered during the course of medical treatment.
- Atypical course of illness: the course of illness repeatedly did not follow the natural history of the presumed biomedical disease process.

Associated features, although not diagnostic:
- Parent predicts worsening: parent makes accurate and repeated predictions of worsening of the child’s condition.
- Invites invasive procedures: parent requests invasive medical procedures, such as surgery, for the child.
- History includes previous diagnosis of an older child of FDIA, or an older child may have succumbed to a mysterious illness.
- Numerous prior poor outcomes: the patient has an extraordinary number of poor outcomes or failure to respond to medical procedures.
- Parent, usually the mother, has or had employment in a health-related occupation.

If the reviewing LNC is working for the plaintiff attorney, it is incumbent to educate the attorney about factitious disorder imposed on another (FDIA) and the role that diagnosis will play in the course of the litigation.

CONCLUSION

Factitious disorder imposed on another (FDIA) must be viewed as a life-threatening condition associated with significant psychological, behavioral, and iatrogenic complications. It is one of the most difficult situations for a pediatric staff, as they often become adversarial with the parent (mother) to advocate for the child. It may be extremely difficult to imagine how enormous the needs of the mother for care, concern, and connection are that she would put her child in danger.

However, as the mechanisms of social control organizations (Child Protective Services, the courts) gear up, pressure is on the nurse at the bedside and other healthcare providers to remember that, while Provision 2 of the Code of Ethics for Nurses (ANA, 2015) says,

*The nurse’s primary commitment is to the patient, whether an individual, family, group, or community, this must be balanced with Provision 1, The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.*

Although it is rare, FDIA is a very serious form of child abuse with high recidivism and mortality rates. Prognosis is extremely poor if the child is left in the home. The overall mortality of FDIA is difficult to calculate but has been reported in several studies to be between 6% and 10%. Of particular note is the excessive rate of morbidity and mortality reported in siblings of FDIA children. Factitious Disorder Imposed on Another is a real medical mystery.

REFERENCES


Leslie Durr, PhD, RN, PMHCNS-BC-Retired has worked as a clinical nurse specialist in psych nursing in education, home care, acute inpatient units, and women’s corrections and had a private practice of psychotherapy for over 20 years. She was board certified as a Clinical Nurse Specialist in Psych/Mental Health, in both adult and child/adolescent nursing and now holds the certification as a PMHCNS-BC-Retired. Besides doing behind the scenes record review and expert witness work in several medical/legal cases, she has served as a Mitigation Specialist in capital murder cases in Virginia. She can be contacted at lmddoc@gmail.com.
Sexual Abuse Cases and the Legal Nurse Consultant

Cheryl Hobbs RN CEN

Keywords: Pediatric sexual abuse, Child sexual abuse, Sexual abuse investigation, SANE expert

Pediatric patients come in all sizes and at times they are almost as tall and weigh as much as an adult. As a care provider or legal nurse consultant reviewing cases we can’t forget or overlook the reality that they are still pediatric patients. In nursing school we learn developmental stages in anatomy and cognition and how during each stage the pediatric patient views, reacts to, and understands the world differently. Their responses to illness, injury, the healing process, and interactions with others also vary (ENA and IAFN, 2016). The pediatric patient is not a little adult.

You’ve received a pediatric sexual abuse case and you are not a sexual assault nurse examiner (SANE), sexual assault nurse clinician (SANC), forensic nurse examiner (FNE), sexual assault forensic examiner (SAFE), or sexual assault examiner (SAE). Now what?
Records completed by a community program may be housed at the hospital or the outside community program location, or both. You may find incidental information about another service or another person in any records.

Start the case as you do with any of your other cases: clarify what services the attorney needs and the deadline for your work product. Be honest and inform the attorney about your expertise. Assist your attorney to find a SANE testifying expert, gather the records, put them in order, and make your own notes on the information in them.

**OBTAINING THE RECORDS**

Include any records from other providers, such as:

- ambulance service if one was involved
- police reports
- counselors
- schools
- day care or any care provider
- community programs
- domestic violence advocates

Do some research to know what other programs and assistance might be offered to pediatric patients in the area where the incident occurred (IAFN, 2008). This will allow you to know where to investigate to determine if the patient or family used those services or talked with them for further recommendations or referrals, and if so, to obtain those records.

You may find incidental information about another service or another person in any of these records. Make note of it and why it matters for your attorney.

Alert your attorney that a specific request for sexual assault records and psychotherapy mental health records is needed. These are kept separate from regular medical records for confidentiality to limit unrelated information from being disclosed with other medical records (Ridley, 2001; SAFEta.org, n.d.).

**CARE AND TRANSFER RECORDS**

Some hospitals may use their own staff or outside community program staff with an office in the hospital to assist victims (IAFN, 2017). Check to see whose services were used and what information and records they have. Records completed by a community program may be housed at the hospital or the outside community program location, or both. If the program keeps records at both sites, check to see if they are the same or altered, and if the patient had more visits with the program after the original hospital contact(s.)
When you identify where the patient was seen and examined, obtain their policies on managing the sexual abuse patient. Some hospitals, especially smaller and rural ones, do not have SANE nurses. Best practice is for the examinations to be completed by SANE-educated practitioners but where that is not possible the hospital may still have to provide this service (IAFN, 2017).

Obtain facility policies on care. Interviewing pediatric patients is best completed by someone with education and training in the most appropriate manner and environment (Newton and Vandeven, 2010). If the hospital where the patient presented is one that does not have a SANE program or SANE providers, the hospital may have arrangements or contracts with other hospitals, SANE nurses or community services that care for sexual abuse patients (JCSA, 2010). They may have a policy that the SANE provider will come to their hospital or to transfer the patient to a facility that has one (IAFN and ENA, 2017).

Patients have the right to refuse transfer (Selde, 2015) and to stay at the original facility. When the patient is a pediatric patient and not of age to consent to or refuse treatment, a parent or legal guardian decides. Is the person accompanying patient suspected of the abuse or attempting to cover up information (HHS, 2013)? Is the parent or legal guardian able to consent or refuse (Selde, 2015)? If staff recommended patient transfer for specialty care, was the recommendation refused (Magauran, 2009)? If so, look for a transfer form indicating the transfer was refused, the reason of refusal, and signatures from the provider, the parties involved, and witnesses. The form should have a signature section with designated signature lines (SAFEta; Ridley, 2001).

It is important to remember this is a traumatic time for the ones involved and it can take a tremendous effort to just show up at the facility. To have to consider leaving and going to another facility may have been something they just could not manage. There may also be other reasons that transfer was refused (JEMS, 2015). Look for documented reason(s) and include that in your notes.

On the other hand, if the child was transferred, review the transfer records for information on whether the child was transferred by emergency medical service (EMS), other transfer service, or allowed to go by a privately-owned vehicle (often abbreviated as POV). Transfer records will specify the times the child and guardian left one facility and arrived at the other. If they left by POV, arrival time at the other facility would be on the that facility’s records; these will allow you to have an idea whether the child went directly from one facility to the other. This would be important to the case to indicate whether there was time to allow for a change of clothing or another stop that may have caused possible contamination of
If the hospital where the patient presented does not have a SANE program or SANE providers, the hospital may have arrangements or contracts with other hospitals, SANE nurses or community services.

**CHAIN OF EVIDENCE**

Wherever an exam or interview was completed, be sure to look for documentation of the chain of evidence for the sexual assault kit, the clothing, and any other items. Determine whether the items were hand-carried around by staff, or locked in a secure area with restricted access. Every person that had possession of the items needs to be identified and to have signed the chain of evidence (OVM, 2016). The documentation should have all those names and titles and that of the law enforcement officer that picked up the items (Orr, 2016).

Be sure all records are complete.

**SUMMARY**

All LNCs can assist with SANE cases. As with any other case involving a specialty, the LNC can gather records, find experts, and scan the cases. Obtaining the records, arranging them along with any other information, and placing them in chronological order with your notes will save time and will assist the specialist to review the records and prepare an expert analysis.

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Cheryl Hobbs RN CEN is a Certified Emergency Nurse and former practicing Sexual Assault Nurse Examiner (SANE). After taking the SANE course she and six other SANE nurses set up a SANE program at their hospital. She has served on the National Council of State Boards of Nursing NCLEX review panel three times, has been a guest lecturer at a local college, assisted the KU School of Law with mock jury trials, and volunteers her LNC for Police Department Detectives and the District Attorney (DA) Offices assisting in their fiduciary abuse unit. Her assistance with the first DA case brought about a change in the way they handle their cases. She continues to work with attorneys on abuse cases, medical malpractice, insurance cases, emergency department cases, personal injury and others. She may be contacted at cheryl@classactconsulting.com
How is human trafficking possibly related to legal nurse consultants? Good question! I’m glad you asked.

LINKING TRAFFICKING TO LEGAL NURSE CONSULTANTS.

We are nurses, compelled to protect and care for the vulnerable. Leaving bedside care doesn’t change that. As LNCs we have many ways to help our attorney colleagues identify and support people who are vulnerable and / or maltreated.

Victims of human trafficking for sex and labor include the most vulnerable people in every country, and that includes our own. Many often think that human trafficking and slavery just does not happen in the USA, but trafficking breadth and severity in the United States is much greater than most of us know. Victims are predominantly young women, girls and children; fewer young men and older people are also exploited, but not any less severely (FightTheNewDrug.org, 2018).

The United States has several initiatives at all government levels working to end modern slavery. So does the internation-
The International Bar Association (IBA) published its position paper on Human Trafficking and Public Corruption in 2016 appealing to the legal profession in all countries to become more aware and engaged. Corruption in law enforcement and legal communities, disturbingly, perpetuates the problem (IBA, 2016). We work alongside our attorney colleagues in a common cause with different perspectives. Your attorney client may be focused on legal aspects of a problem and overlook a diagnostic indicator we as nurses would pick up. Being aware of the internationally recognized definition of trafficking types and becoming familiar with signs and symptoms associated with the types of human trafficking prepares us to collaborate more effectively with the attorney client and be a valuable partner in a solution should the opportunity present itself.

PRESENTATIONS

Most common is the young teenage girl, who may or may not be unhappy or abused at home, lured by the attentions of a seemingly devoted new “boyfriend” who manipulates and then forces her into sex trafficking through coercion and threats. Migrant individuals from poorer countries are sold or enticed by a better life, only to find themselves as indentured servants without freedom of movement, working 20 hours a day for almost no pay and subject to physical and emotional abuse by their “employer.” Children are abducted to be sold or abused in child pornography, or to be offered for illegal adoption. Older immigrant family members may be forced to beg to pay for room and board or exploited for their access to benefits as an older adult.

WHY DOES THIS EXIST IN THE US?

Most disturbing is that it is so prevalent in the United States. We, as an American culture, have an insatiable desire for everything: money, power, chocolate, or desires much darker and more unsettling. Driven by excess, there are those who will go to extraordinary lengths to feed their demons. The American drug problem is a significant driver of the illegal sex trafficking trade and vice versa. As prominent advocate for trafficking victims startlingly notes in his TEDx talk: “...you can sell a kilo of heroin once, you can sell a fourteen-year-old girl 20 times a night 365 days a year” (Talbott, 2013), as a renewable resource to fuel and support drug and gang activities. With opioid addiction on the rise, so is the trafficking of humans used to fund it. The cycle is perpetuated further because these same drugs maintain continued compliance of trafficking victims.

Sex trafficking is but one piece of the picture. Domestic servitude as nannies, massage parlor workers, housekeepers, field laborers, construction workers, even roofers is prevalent. Many trafficked persons arrive as immigrants fleeing oppressive governments and gang violence, either legally or illegally, in search of a better life the US. But there is also a shocking number of victims who are Americans, which may be more difficult to detect sometimes if we do not know how to see it.

CONTROL

How are victims prevented from leaving their traffickers? The traffickers control their movement, finance, and communication by:

• making threats against family members
• threatening reports to immigration officials
• blackmailing with photos or evidence of illegal behaviors or compromising positions shared with law enforcement, schools or families
• confiscating passports and other means of identification that would allow travel or legal work eligibility
• restricting telephone and internet access

UNDERLYING FACTS

Studies that attempt to quantify the magnitude of illegal labor and sex trafficking are difficult to design. Trafficking is clandestine, with approximately 40 million victims worldwide, though actually numbers are difficult to determine. (TheFreedomChallenge.com, 2018) Multiple estimates range in numbers regarding trafficking victims in the US. Polaris operates the National Human Trafficking Hotline and has received 40,200 reports of cases since December 2007 (HumanTraffickingHotline.org, 2018). However, the Department of State reported that nearly 78,000 victims were identified in 2016 and when tallied against the Global Slavery Index,
which provides country rankings regarding numbers of people bound in modern slavery (GlobalSlaveryIndex.org, 2018), the number of victims rescued is less than 0.2 percent. Only about 1% of survivors are recovered (Enos, 2016).

We’ve learned from survivors that approximately 87% were seen by a healthcare provider while they were under the control of their trafficker (Finnegan, 2016); 63% had been to an emergency room (Chambers, 2017). These may be visits for accidents or they may result from a sudden illness related to the work performed (STDs, drug overdose or toxic exposures for example). They may also be seen for pregnancy and delivery or abortion, and for exacerbation of a previously undiagnosed or untreated/under-treated chronic illness, such as diabetes.

Healthcare providers are the most likely people to encounter and identify a victim for rescue. There may be tell-tale notes to indicate a previously undetected victimization. A patient may have (Chambers, 2017):

- illnesses and injuries associated with sex trades
- tattoo brandings
- pregnancies in minors
- poor dentition and malnutrition
- multiple old fractures on x-ray
- other signs of trauma without correlating histories
- labor-related injuries
- toxic exposures without required protective devices (gloves, hardhats, respiratory filters, etc.)
- inappropriate dress for weather and age
- lack of eye contact
- a “handler” or controlling partner who provides answers for the patient
- inability to provide a valid birthdate, or one inconsistent with appearance and physical development
- inability to provide address, phone number, or even indicate that he/she knows in what city or state he or she is in
- no cell phone, possibly indicating lack of contact or inability to communicate outside of the handler
- cash payment arrangement for the visit; it would be unusual to see a visit submitted for insurance reimbursement, although it is a possibility with teens lured away from families
- (in children) precocious sexualized behavior or language.

HOW IS THIS ISSUE ASSOCIATED WITH LEGAL NURSE CONSULTANTS?

Awareness is always the beginning of change in any issue. Legal nurses work in all aspects of healthcare and litigation support. Some practice in hospitals at the bedside, in risk management, or as department and service line leadership. In LNC work, reviewing records, interacting with families, visiting the attorneys’ clients, side-by-side work with attorney clients are all activities that may lead the prepared LNC to recognize and acknowledge victims. More initiatives that provide support and legislative remedies for trafficking survivors present opportunities for the LNC to assist in this area.

EXAMPLES

In your clinical activities, documentation can make the difference in obtaining justice for victims when a trafficker is apprehended. The following are examples of circumstances where trafficking is likely present.

**Domestic servitude** You, the emergency room nurse, worked with immigrant cases for one of your attorney clients. A nanny presents to the emergency room with her employer. Burns and various signs of trauma (perhaps all minor) in different stages of healing are present. She does not know her address and when asked for identification reports that the employer keeps it safe for her. You recognize these signs of domestic servitude and report your concerns to the proper authorities.

**Children** As a school nurse, you see children of all ages and all kinds of family dynamics. You know students who exhibit behavioral issues that range from acting out, displays of overt defiance and aggressive behaviors, to those demonstrating social isolation or self-harm. You may see some who seem precocious or use language inappropriately mature for their age. You may see symptoms that suggest an STD or notice a lack of basic preventive care. These all follow many other childhood issues, frequently related to organic and social concerns in child mental health, dysfunctional families and parenting, and psychosocial issues. These may be issues seen in trafficked children.

A study in 2008 at the John Jay College of Criminal Justice found that boys comprised fifty percent of trafficked children (Chin, 2014), so be alert to both genders being victimized. LGBT and transgender children are most vulnerable. Trafficked children attend school! They may hide in plain sight, being trafficked by a parent or trusted family member and do not consider themselves to be victims (Department of Education, 2015).

What might not be so obvious in school-aged trafficking is the teenager from the middle to upper class family, with adequate resources, proper preventive care, and good grades. These young people may be victimized by traffickers because they are looking to be rebels, or they need to feel the attention of a romantic attraction, or seek the life of a more mature person promised by a trafficker who grooms them with promises of presents, money, modelling careers, adventures, or love and companionship in exchange for compliance.
Criminal cases  You may have an interest in working with criminal defense attorneys. Your attorney client has taken the case of a young woman being prosecuted for prostitution. You discover that she was a minor at the time of her alleged offense. The prevailing mantra of advocates for trafficking survivors is, “There is no such thing as child prostitution, it is always child rape.” Armed with this knowledge, you may be the one person who alters the course of this young woman’s life and helps to get her the services she needs rather than a criminal record.

Federal law does not require proof that a defendant used force, fraud, or coercion to determine the action of trafficking when the victim is a minor, defined as under 18 and does not differentiate between children who are citizens and those who are not here legally (Section 1591) (The United States Department of Justice, 2018). However, decriminalizing child victims of sex trafficking is still a struggle as evidenced by the story of Cyntoia Brown. She was 16 when, after being drugged and repeatedly raped, she finally found the courage to shoot and kill the 43-year-old pedophile to whom she was sold. She has been in prison for 13 years of her life sentence (Williams, 2017).

Domestic violence A trafficking victim may be identified when injuries require medical care or draw the attention of others. Perhaps you are building your LNC practice through working with the district attorney’s office and addressing medical issues through records analysis. You could help to build the case against the trafficker. Through reviewing records related to domestic violence, you discover information in the record that leads you to believe a family member or a boyfriend was trafficking the victim. This scenario is not uncommon in my experience, and it happens with adults, teens and children of all ages.

LNC-RELATED TRAVEL LNCs who provide DME / IME or visit families to do assessments related to cost projections or life care plans may encounter victims in their travels. The larger hotel chains, like Marriott and Hilton, have instituted staff training for recognizing victims trafficked through their hotels (Hogan, 2018). They teach employees to look for these signs, among others:

- minors being brought in through entrances other than the lobby
- multiple visitors to rooms
- loud noises from rooms
- filming equipment
- late night check in and check outs
- minors travelling with adults that do not appear related
- inappropriate dress for age

Should you notice these signs, report to the hotel management and do not engage with suspected trafficker directly for your own safety.

You can help by being alert but also in a more practical way by contributing to a database that helps law enforcement determine locations of victims. Go to Traffickcam.org and download this free app on your smart phone. When in the hotel room, you will take and upload photos of the room to be included in a database. Geolocation of your position will validate the hotel’s location. Traffickers frequently take photos of their victims while in hotel rooms and upload them for advertising. The photos in the database can identify the location of photos seized or found through internet trafficking sites.

CURRENT LEGISLATION It is good practice to become familiar with legislative processes, cycles, and actions, especially those promulgated to assist victims. Being knowledgeable helps victims, and showing interest in advocacy also demonstrates dedication to the legislative efforts and contributes to your credibility as a trusted partner to your attorney colleague. It provides you common ground in helping those who lack a voice. Here are four examples of recent bills:

  This bill died in a previous session of Congress, as it did not pass before that session ended. However, it was reintroduced as H.R. 767 and is still proceeding through the process having passed the House and has now been referred to the Senate.


  “This bill directs the Department of Health and Human Services (HHS) to establish a pilot program, to be known as Stop, Observe, Ask, and Respond to Health and Wellness Training (or SOAR to Health and Wellness Training), to train health care providers and other related providers to: Identify potential human trafficking victims,
numbers for the program operating before the pilot program." This is especially pertinent to risk managers and clinical educators as it suggests future mandates for healthcare provider training.

• **H.R.2803 Abolish Human Trafficking Act of 2017**. Identical bill CRS. 7/12/2017. [https://www.congress.gov/bill/115th-congress/house-bill/2803?q=%7B%22search%22%3A%5B%22h.r.+2803%22%5D%7D&r=1](https://www.congress.gov/bill/115th-congress/house-bill/2803?q=%7B%22search%22%3A%5B%22h.r.+2803%22%5D%7D&r=1)

Referred to the Subcommittee on Crime, Terrorism, Homeland Security, and Investigations. This bill sets forth many measures to address the prevention and punishment of human trafficking and to assist trafficking victims. Included among these are provisions about:
- Restitution for victims;
- Funding of investigations of offenses relating to sexual abuse of children;
- Grants to states and localities and other entities for victim service assistance;
- Training of health, victim service, and federal law enforcement personnel, including through a victim screening protocol by the Department of Homeland Security;
- Penalties imposed for slavery offenses, sex trafficking of children, and repeat convictions for transportation for illegal sexual activity and related crimes;
- Travel to engage in any illicit sexual conduct;
- Designation of additional Department of Justice resources for prosecution and service coordination;
- Penalties for offenses involving organized human trafficking, sexual abuse, sexual exploitation, or transportation for prostitution or any illegal sexual activity; and
- Studies of the physical and psychological effects of serious harm to victims.


This is a link to an article regarding human trafficking regarding an initiative at Mass General headed up by Dr. Wendy Macias-Konstantopoulos. There may be similar initiatives where you practice.


work with law enforcement to report and facilitate communication with such victims, refer victims to social or victims service agencies or organizations, provide such victims with coordinated care tailored to their circumstances, and consider integrating this training with existing training programs. The pilot program must include the functions of the training program with the same name that was operating before this bill’s enactment and the following initiatives: Engaging stakeholders to develop a flexible training module, supporting training in diverse health care sites, providing technical assistance to health education programs, developing a strategy to incentivize the use of training materials developed under this bill and the implementation of a nationwide health care protocol, and developing a methodology for collecting and reporting data on the number of human trafficking victims served in health care settings or other related provider settings. The pilot program is authorized through FY2022.

HHS must report on the number of facilities operating under the pilot program, the number of providers trained through the pilot program, and these
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If a bill does not make it through all legislative steps during each Congressional session (House, House committee, Senate, Senate committee, House and Senate reconciliation and revisions, enrolling by the Government Printing Office and then to the President for signature or veto within 10 days), it is stricken from the rolls at the beginning of the new session. Interested parties should follow bills important to them and press their representatives to take actions promptly.

REFERENCES
The World Health Organization (WHO) has been improving maternal morbidity and mortality rates globally since shortly after its inception. Adolescents are among those at highest risk for pregnancy and delivery complications. These issues are not confined to developing countries, but are global, found in countries of all income levels (World Health Organization [WHO], 2018). Years of studies and statistics demonstrate the same problems facing an adolescent when attempting to navigate their worlds after the discovery of pregnancy: risk of rejection by peers, family, and the father of the baby; financial and educational challenges; and increased physical and mental health risks compared to women having children in their 20s and 30s. Proper screening for potential risk factors and advocacy with courts and social service providers will be key to providing proper care and support. Fail-

In 2015, a total of 229,715 babies were born to (US) women aged 15-19 years.” (Centers for Disease Control and Prevention [CDC], 2017, para. 1) These numbers do not include elective terminations, or pregnancies that did not survive to term. Pregnancy complications can be even more daunting when an adolescent faces the decisions that may arise. Many concerns fall on providers, nurses, and legal teams advising and reviewing the applicable laws. Knowledge of the laws and state policies pertaining to adolescent pregnancy will be pertinent to providing the best care, guidance and records reviews. This article summarizes some of the increased legal risks teens face, and aims to provide guidance and reference to medicolegal complexities.

Adolescent Rights: Pregnancy and Parenting

Jill Guenther BSN, RNC-OB, C-EFM

**Keywords:** Statutory rape, teen pregnancy, teen parents, parental rights, custody.
ure to properly screen adolescents for these issues will leave them at significant risk. Screening needs to be ongoing and develop as the relationship between adolescent and various service providers progresses; providers must remain open, caring, and friendly to create a bond of trust, or adolescents will not believe in those caring for them, nor will they want to follow guidance being offered. These mothers can differentiate between care that is adolescent-friendly and care that is not (Peterson, Davies, Rashotte, Salvadore, & Trepanier, 2012).

**LEGISLATIVE ISSUES**

This vulnerable population needs support and protection from predators and legal loopholes. Many states have created various forms of legislation to help protect them. These include “Romeo and Juliet Laws” designed to recognize the difference between young love and the carnal acts of predators. States also have various laws that pursue statutory rape, establish paternity, and assist with child support. Jurisdictions have differences including age of consent, acceptable age gaps, and clauses for preexisting juvenile relationships; establishing paternity and the age of both parties will be critical. Examining any potential causation that may be related to paternity, abuse, or neglect can weigh heavily on outcomes.

Consider this hypothetical situation: An adolescent female presents to the labor and delivery unit with complaints of bleeding and abdominal pain. She reports no history of falls or trauma and tells the staff the father of the baby is not involved. As labor progresses, staff provide appropriate interventions. However, the fetus suffers anoxic insult and is expected to be permanently disabled, and the young mother spends days in the ICU recovering. The adolescent and her parents seek legal advice; the case is reviewed. Discovery reveals that the teen knows who the father of the child is. He falls under the state’s statutes to be charged for statutory rape. Further, he was physically abusing her regularly, with the most recent occurrence being the day she presented to the hospital. Originally treated as medical malpractice, this case has now taken a very different turn.

**HEALTH AND SAFETY**

Sadly, one in five pregnant teenagers fall victim to domestic violence during their pregnancies (Harner, Burgess, & Asher, 2001). This abuse may come from their own parents, the fathers of the unborn children, or their peers. Caregivers must establish the relationship and safe environment and monitor physical and psychological behaviors carefully to guide care and needed interventions. Physical assessments for signs of violence, lack of self-care, and poor nutrition should be documented in each trimester (Jordan, n.d.), and more often if needed, for baseline and comparison. Providers and nurses who fail to screen their patients for all risk factors along or facilitate access to community resources can and should be held accountable for a breach of duty, if those failures to educate and screen led to injury. This may be difficult to prove as the parties point fingers at each other, but it should be closely considered. Documentation will be key here.

One might assume that an otherwise young, healthy female in an established safe environment should be able to carry a pregnancy without the issues that can affect an older woman, but that is simply not true. Women under the age of 18 are at greater risk of late entry into prenatal care. As a consequence, they have:

- double the rate of low birth weight and small for gestational age infants
- triple the infant mortality rate
- increased rates of preterm labor, preeclampsia and anemia
- higher rates of sexually transmitted disease and substance abuse in the form of binge drinking (Jordan, n.d.).

Many of these and other issues can be associated with poor nutrition, poor self-identification, and mental and physical immaturity.

Proper knowledge and monitoring a teen mother for potential issues is critical to ensure safety for mother and child. She needs education and reinforcement about the importance of a healthy diet and lifestyle modifications while the fetus develops. She needs monitoring not only for obvious signs of developing problems, but subtle changes as well. Is she staying on track with proper weight gain, is she starting to miss appointments, is her blood pressure shifting, is the fetal growth staying on track, are her laboratory values within normal limits? These are some of the areas an LNC should discover in the record.

**Standards of care resources**

Resources for maternal care including recommended standards of care can be found within many governing bodies of obstetrical practice for nurses and doctors; these include but are not limited to:

- The American Congress of Obstetricians and Gynecologists (ACOG)
The adult parents of the adolescent may have no rights in deciding for their adolescent child, and are frequently caught unaware when presented with this information (Association of Women’s Health, Obstetric, and Neonatal Nurses [AWHONN], 2017). Medical emancipation laws apply not only to pregnant adolescents, but also to those living apart from their parents or who are financially independent from their parents (Hamer et al., 2001).

Details can vary greatly. For example, an adolescent mother can provide consent for the circumcision of her newborn, but an adult parent must sign consent for the teen to have an epidural during labor (Wilkinson, Edmonds, & Carroll, 2018). In New York a pregnant adolescent signs her own consent forms and makes her own decisions in relation to her pregnancy and child, but she is not emancipated. For example, should she have appendicitis, the medical personnel would need to seek the signature of an adult guardian to perform an appendectomy. “In Pennsylvania, a 16-year-old teenager is competent to consent to sex with a man twice her age, as well as care for his child, but is not competent to terminate the pregnancy.” (as cited by Hamer et al., 2001, p. 142).
Privacy: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides exceptions to state privacy laws and provider / health plan discretion (as cited by AWHONN, 2017). This means that, depending on state statutes, an adolescent has the right to privacy regarding certain health care issues. Many states allow this privacy for reproductive care, substance abuse counseling and mental health care services.

Reaffirmed on September 19, 2017, AWHONN’s Position Statement titled: Confidentiality in Adolescent Health Care points out that, “Adolescents are entitled to the same legal rights to confidentiality as adults, and nurses should ensure that these rights are guaranteed.” (Association of Women’s Health, Obstetric, and Neonatal Nurses [AWHONN], 2017, para. 1). AWHONN includes the Role of the Nurse in its statements, “It is the nurse’s responsibility to be aware of the state and federal regulations related to the confidentiality rights of adolescents. Significant variations exist between states, and failure to remain current with these laws may negatively affect professional practice and the nurse-patient relationship” (as cited by AWHONN, 2017, para. 6).

CONCLUSION

The complexities of cases involving adolescents, pregnancy, and legal rights can be overwhelming, likely exceeding those for an adult. They should be best addressed by tackling each area separately and then looking at the areas of overlap. Was the adolescent following the guidelines set for her by her obstetrical provider, and taking proper care of herself? Did the providers and nurses address all the needs of the adolescent and watch for those subtle shifts in the teen’s status? Were the teen’s rights violated, or was the pregnancy the result of an unlawful carnal relationship? Katz recommends that courts, advocates, and social service providers look at some of the major problems that effect adolescent parents, among them housing, public benefits, education, medical care, and legal rights to maintain the integrity of the family (Katz, 2006).

Additional information sources:

- The Guttmacher Institute provides a resource for State Policies on Teens at: https://www.guttmacher.org/united-states/teens/state-policies-teens
- Society for Adolescent Health and Medicine provides multiple resources at: https://www.adolescenthealth.org/Home.aspx
- The American Academy of Pediatrics provides considerations at: https://www.aap.org/en-us/Pages/Default.aspx

Recommended reading:

- When the child is a parent: Effective advocacy for teen parents in the child welfare system. Temple Law Review.

REFERENCES


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Working With Young Adults Exhibiting Psychiatric Symptoms: The Mental Health Forensic Consultant Role

Carolyn Martello Spaulding, Esq.

Keywords: informed consent, surrogate, Conservatorship, Guardianship, Conservator, Guardian, Health Care Agent, Health Care Proxy, treatment, mental health treatment, confidentiality, forensic, revolving-door hospitalizations, transition age youth, mental health, legal consultant, capacity, competency, incapacitated person

Most people who suffer from mental illness during their lifetime first experience symptoms as young adults. Recent studies show that first episode treatment is singularly effective in reducing the long-term impact of psychotic illness; however, young adults also have the lowest rates of treatment compliance. For many, this period can be the start of a years or even life-time cycle of deterioration comprising a repeated, revolving-door of hospitalizations, decompensation, criminal activity, homelessness, and other dangerous activities.

This article explores the forensic concept of informed consent. It also explores the law related to surrogates, guardians, and health care agents and how these constructs can serve as tools for forensic clinicians in navigating effective work with these vulnerable young individuals facing mental health struggles.

INTRODUCTION
Tragically, young adulthood is a time when many patients begin to exhibit symptoms of previously dormant or new mental illness (Kessler, Amminger, et al., 2007). This allows parents little time to prepare before their children are legally deemed adults and are granted the legal presumption of capacity. Early treatment and intervention into mental health issues is critical. Scientific research has shown that the longer individuals delay or avoid treatment for psychiatric symptoms (Rosenbaum, 2016b), the worse their overall prognosis (Rosenbaum, 2016b). Recent studies have shown that first-episode treatment of mental health disorders may be singularly effective (Kane, John, Robinson, Delbert, Schooler, Nina, Mueser,
Penn, Rosenheck & Addington, 2016; Rosenbaum 2016).

Our government and mental health care systems are limited in their ability to protect these vulnerable youth (Rosenbaum, 2016b; Interdepartmental Serious Mental Illness Coordinating Committee, 2017). In December 2017, a federal committee reported on the treatment of mental illness in America (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Its findings were tragic: the committee reported, “Too many people with serious mental illness (SMI) and serious emotional disturbances (SED) do not get the treatment and support they need. Fragmented systems provide incomplete services that do not draw on available evidence. The result is needless suffering for individuals and families and increased risk of incarceration, homelessness, disability, poor physical and mental health outcomes and early death” (Interdepartmental Serious Mental Illness Coordinating Committee, 2017 at 1).

This lack of adequate government support places the onus on parents and loved ones to take proactive steps, including retaining mental health attorneys and forensic consultants, to assist in bringing these young adults to appropriate treatment.

This article provides a framework for a forensic consultant to consider. The first section will discuss the threshold tests forensic consultants may best use to determine whether an individual patient can provide “informed consent” in Massachusetts. The second and third section will discuss Health Care Proxies and Surrogates. The fourth section will discuss Guardianship in Massachusetts and is further broken into subsections: (A) the clinical standard for Guardianship, (B) the qualifications forensic consultants need to provide the clinical support necessary for Guardianship, (C) the privacy implications involved in a forensic consultant providing the support for Guardianship. Finally, the concluding section will explore the role of mental health forensic consultant in assisting families by bridging some inadequacies of the legal and medical systems.

CAN THE PATIENT PROVIDE INFORMED CONSENT TO RECEIVE TREATMENT?

Medical professionals must receive informed consent from a patient prior to providing treatment (Harnish v. Children’s Hospital Medical Center, 1982). This requires full disclosure to the patient and as a result that the patient understand the risks and benefits, side effects, and possible outcomes of treatment choices (Harnish v. Children’s Hospital Medical Center, 1982). It is not always possible to get this informed consent from the patient directly, as sometimes, the patient lacks the capacity to provide such consent.

The lack of capacity to provide informed consent typically arises in two contexts: when the patient is a minor (and the law presumes incapacity) and when the patient is an adult but has diminished capacity that effects the ability to provide informed consent.

A minor child is legally incapable of providing informed consent to receive treatment. The law generally attributes legal custody to the minor child’s mother and father, permitting them to speak for their children.

Once a child becomes an adult at age 18, another rule kicks in: adults are legally presumed to have capacity to undertake any legal act, unless specifically found to lack such capacity (American Bar Association Commission on Law and Aging and the American Psychological Association, 2005). Determining whether an individual has the capacity to make a specific decision depends on the action in question (American Bar Association Commission on Law and Aging and the American Psychological Association, 2005).

A physician has a duty to disclose to his patient all significant medical information that a physician possesses or reasonably should possess that is material to the patient’s making an informed judgment (Harnish v. Children’s Hospital Medical Center, 1982). The patient must then provide informed consent to such treatment after a full disclosure of the benefits, risks, side effects and possible outcomes of the treatment choices (Harnish v. Children’s Hospital Medical Center, 1982; Superintendent of Belchertown State School vs. Saikewicz, 1977). Courts have noted “the privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs” (Harnish v. Children’s Hospital Medical Center, 1982 at citing Canterbury v. Spence, 1972 at 789).

Clinicians must remember that the evaluation of an individual’s capacity to provide informed consent is specific to the particular treatment sought. For example, a patient with schizophrenia and delusions may be capable of understanding treatment for a heart attack, but incapable of determining treatment for his mental health condition (Ahmed, 2001). Some have estimated that between 40 to 50 percent of people with serious untreated mental illness have anosognosia, a deficit of self-awareness in which a person with a disability seems unaware of its existence. (Rosenbaum, 2016, citing What is Anosognosia, Backgrounder).
IF AN ADULT CANNOT PROVIDE INFORMED CONSENT: HEALTH CARE PROXY

If an individual over 18 has diminished capacity, a forensic consultant may first evaluate whether the patient can be assisted in understanding the medical decision with supports, or whether the patient has capacity to voluntarily sign a health care proxy (HCP). The capacity to sign a HCP is interpreted under the standard for contractual capacity (American Bar Association Commission on Law and Aging and the American Psychological Association, 2005). Contractual capacity is the ability to understand “the nature and quality of the transaction, together with an understanding of its significance and consequences” (Farnum v. Silvano, 1989 at 204).

A patient must understand both the general nature of the health care decisions he or she is delegating, and also trust the nominated Health Care Agent (Agent) to decide on his behalf (American Bar Association Commission on Law and Aging and the American Psychological Association, 2005). This is very different than the standard required to provide informed consent to make medical decisions.

This divergence opens several planning opportunities when working with adults without capacity to make an underlying medical decision, but do have capacity to execute a HCP appointing an Agent. In those cases, the patient may execute a HCP, appointing an Agent who may later act on the patient’s behalf in making medical decisions. The HCP includes the authority to make medical decisions other than those specifically excluded (MGL Ch.201D Section 5). An Agent may use the HCP only after it is activated by a provider who indicates that the patient cannot make or communicate medical decisions (MGL ch.201 D Section 6).

A patient may revoke the HCP at any time if he or she has sufficient capacity to do so (MGL ch.201 D Section 7). If an Agent takes an action contrary to a patient’s expressed wishes, that action shall be deemed a revocation of a HCP (MGL ch. 201 D Section 7). However, if an individual attempts to revoke the authority, either through action or expression, an Agent maintains standing to file a special legal action seeking a court determination that the patient lacks capacity to revoke the HCP and therefore that it remains in full force and effect over patient’s objection (MGL 201D Section 17). See Chart 1: Comparing Massachusetts Guardianships with Health Care Proxies with Conservatorships.

IF AN ADULT CANNOT PROVIDE CONSENT: SURROGATES

Some states also recognize the ability of a different surrogate decision maker, such as the patient’s spouse or close family member, to make medical decisions if the patient is not competent and no guardian or conservator has been appointed. Massachusetts is one of only four states that does not have a statute authorizing a surrogate procedure under

| Chart 1: Comparing Massachusetts Guardianships with Health Care Proxies with Conservatorships. |
|---|---|---|
| **Guardianship** | **Health Care Proxy** | **Conservatorship** |
| Does not require Court action to create | X | |
| Requires Court action to create | X | X |
| May override patient’s expressed wishes | X (limitations in the community on enforcement) | Only with Court “affirmation” | X |
| Includes authority to admit/commit to mental health institution | No longer allowed in Guardianship (requires Commitment action) | X (unless excluded from authority included) | No. Only over finances |
| Includes authority to admit to a nursing home | X (With extraordinary finding that such placement is in the person’s “best interest”) | X (unless excluded from authority included) | No. Only over finances |
| Includes authority to make decisions over antipsychotic medication | Only with annual review and extraordinary court authority | X (unless excluded from authority included) | No. Only over finances |
| Requires reporting to Court | X (Care plan for all guardianships. Roger’s Monitor Report (if guardianship excludes extraordinary authority to monitor treatment with antipsychotic medication.) | None | X (Inventory, annual accounts, and in some cases a Financial Plan) |
Lack of adequate government support places the onus on parents and loved ones to take proactive steps, including retaining mental health attorneys and forensic consultants, to assist in bringing young adults to appropriate treatment.

Any circumstances (DeMartino, Erin, Dudzinski, Doyle, Sperry, Gregory, Siegler, Sulmasy, Mueller, Kramer, & DeMartino, 2017). However, there has been pending legislation in Massachusetts, which could create a framework for surrogate decision making. Of the states that have surrogacy statutes, 35 create a hierarchy of relatives, partners, and friends (DeMartino, 2017). All such 35 states grant a spouse the highest priority (DeMartino, 2017). However, they differ on what other priorities exist involving others such as parents, children, siblings, friends and domestic partners (DeMartino, 2017). Even in states that do not formally recognize surrogate decision makers, many hospitals have internal policies governing priorities for surrogate decision makers (DeMartino, 2017). The appropriateness and suitability of surrogate decision makers is critical to ensuring the patient is protected and well-cared for; however, there are limitations to the ability to receive full information to discern the suitability of the surrogate under current surrogacy statutes (DeMartino, 2017).

If an Adult Cannot Provide Consent: Guardianship

Forensic consultants should also evaluate the possibility of a guardianship by a third party to whom the court grants authority to make personal decisions in those specific areas the individual is found to lack the decision-making capacity to decide for him or herself.


Clinical Standard for Guardianship in Massachusetts

Under the Massachusetts version of Article V of the Uniform Probate Code, a Guardian may be appointed if a moving party can show by a preponderance of the evidence that a three-prong test is satisfied: (1) the person for whom a guardian is sought is an “incapacitated person”; (2) the appointment is necessary or desirable to provide continuing care and supervision of the person; and (3) that person’s needs cannot be met by less restrictive means, including use of appropriate technological assistance (MGL Ch. 190B Sec. 5-306 (6)-(8)).

The Massachusetts Probate Code defines an “incapacitated person” as an individual who has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance (See MGL Ch. 190B Sec. 5-101(9)).

Applying the Standard for Guardianship to the Patient’s Situation

Clinicians vary widely on their application of guardianship law to their patients for many reasons. Prior clinicians may not have had the benefit of thorough review of the facts and law. Treating clinicians work under the constraints of short term hospitalizations and in crowded settings with multiple patient responsibilities (Rosenbaum, 2016a). One study found treating physicians are highly biased in favor of finding their patients have the capacity to make a medical decision (Rosenbaum, 2016A; Raymont, 2004). There are many ethical issues that arise for the treating clinician that may sway him or her one way (Rosenbaum, 2016a; Rosenbaum, 2016b). Biases inevitably come into play.

Mental health forensic assessment requires subjective assessments of the law as applied to the specific patient (Rosenbaum, 2016a). It is important for the forensic consultant to thoroughly consider each case presentation, including extrinsic information, closely and to not be unduly predisposed by prior statements by prior treating clinicians or third parties who may be biased, not have received as comprehensive historical information, spent sufficient time, or have equivalent forensic education.
FORENSIC CONSULTANT QUALIFICATIONS TO PROVIDE CLINICAL SUPPORT FOR GUARDIANSHIP IN MASSACHUSETTS

In Massachusetts, a guardianship may be supported by medical testimony or certificate signed by a registered physician, certified psychiatric nurse clinical specialist, a licensed psychologist or a nurse practitioner, “professionally competent to complete a medical certificate” (MGL Ch. 190B Section 5-303 (12)c; Massachusetts Uniform Probate Court Practice XXII). If the guardianship also includes a request for treatment with antipsychotic medication, the court shall also consider the testimony or affidavit of such other person so authorized by law to prescribe antipsychotic medication (MGL 190B section 5-306A (a); Standing Orders of the Massachusetts Probate and Family Court, Standing order 4-11 – section 1). See Chart 2, Clinician Qualifications to Support Guardianship in Massachusetts.

PRIVACY IMPLICATIONS

Relevant privacy rules and regulations are detailed in several sources including: the psychotherapist-patient privilege, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and doctor/patient confidentiality rules. Patients, their appointed fiduciaries, or their agents may authorize a doctor to disclose medical records or information under these unless specifically limited to exclude that authority. However, the more complicated situation exits when there is no one to authorize disclosure. Each of the privacy rules have exceptions to disclosure when danger is present.

In Massachusetts, physicians have a duty to not make out-of-court disclosures of medical information without a patient’s consent, unless disclosure is necessary to meet a serious danger to the patient or others (Supreme Judicial Court Advisory Committee on Massachusetts Evidence Law, 2018, citing Alberts v. Devine, 1985). There is an exception to the Massachusetts psychotherapist-patient privilege when disclosure is necessary to establish need for hospitalization or imminently dangerous activity (Supreme Judicial Court Advisory Committee on Massachusetts Evidence Law, 2018). HIPAA also allows for exceptions, safe harbor provisions for when disclosure is “in the best interests of the individual” if the disclosure is to family and close friends involved in care, or even generally to prevent serious and imminent threats to a patient’s health and safety (U.S. Department of Health and Human Services, Office for Civil Rights, n.d.; 45 CFR 164.501 (b)(1)(i), 164.510 (3), and 164.512(j)(1)(i) ).

A clinician seeking authorization to provide medical support in a guardianship or conservatorship hearing may warn a patient that the results of an examination may be used against the person and will not be privileged (Commonwealth v. Lamb, 1974). The Legislature has provided that the Massachusetts social worker patient privilege and psychotherapist patient privilege do “not prohibit the filing of reports or affidavits, or the giving of testimony . . . for the purposes of obtaining treatment of a person alleged to be incapacitated provided however, that such person has been informed prior to making such a communication that they may be used for such purpose and has waived the privilege (MGL Ch. 190 B section 5-306A). This exception allows forensic consultants a safe harbor if they provide an appropriate warning. See Chart 3, outlining safe harbors forensic clinicians may use in these situations.

BRIDGING THE INADEQUACIES OF OUR CURRENT LEGAL AND MEDICAL SYSTEMS.

The first onset of mental disorders usually occurs in childhood or adolescence (Kessler, 2007). This population in the transition age years of 16-25 is the least likely to receive treatment for a mental health disorder. (Kessler, 2007; Zajac, Sheidow, Ashili, & Davis 2015; Kim-Cohen, Caspi, Moffitt, Harrington, Milne, Poulton & Prior, 2003). These years are critical, presenting life-altering choices and challenges as young individuals make decisions that will affect long-term career paths and independent living arrangements (Zajac, 2015, The National Academies Press, 2014). The longer psychosis is left untreated, the worse the long-term effects from the illness:

- decline of neurocognitive functions
  - IQ
  - problem solving
  - planning
  - concentration

| Chart 2: Clinician Qualifications to Support Guardianship in Massachusetts |
|---------------------------------|---------------------------------|
| **May Support Guardianship by Medical Testimony or signed Medical Certificate** | **May support extraordinary treatment with Antipsychotic medication** |
| Registered Physician | any such person authorized by law to prescribe antipsychotic medication. |
| Certified Psychiatric Nurse Clinical Specialist | |
| Licensed Psychologist | |
| Nurse Practitioner | |
• increase of psychiatric symptoms
  – hallucinations
  – delusions
  – paranoia
  – social withdrawal
  – irritability
  – lack of insight

These symptoms all worsen the longer the patient goes without treatment, and many can then become irreversible (Rosenbaum, Lisa, 2016b). This can be the start of an extensive cycle of deterioration that involves poor life choices and repeated revolving-door type hospitalizations, joblessness, victimization, substance abuse, decompensation, criminal activity, homelessness, or even death. Of the 9.8 million U.S. adults with serious mental illness, about forty percent receive no treatment in any year (Rosenbaum, 2016b).

State law authorizes treatment for patients that are a serious danger to themselves or others (MGL Ch.123). However, as soon as the immediate danger is resolved (or is perceived to be resolved), the patient is often discharged to the same insufficient setting with written directions to follow up with outpatient treatment. It is dangerously commonplace for persons with serious psychiatric disorders to repeatedly cycle through the disjointed components of the mental health and criminal systems, with hospitals and clinicians seeing patients only during and in the immediate resolution of crisis situations and not assisting with maintenance. These individuals routinely fail to follow up with outpatient treatment. Make no mistake, individuals with serious mental illness and, who are not receiving any treatment, are suffering (Rosenbaum, 2016b). State law provides for surrogates, health care proxies, and guardians to assist persons with diminished capacity.

The breakdown of our local, state and national governments to manage and assist individuals with psychiatric disorders effectively places an imperative on family members to assist in getting their children and loved ones to the most appropriate treatment at the earliest possible time. These family members require the competent and passionate assistance of mental health attorneys and forensic consultants to assist them in getting their loved one support and assistance. Forensic consultants must closely review the details within the framework of the law and medicine, to assist this vulnerable population in escaping this cycle of deterioration.

REFERENCES

LAWS
Massachusetts General Laws chapter 201D: Health Care Proxies.
Massachusetts Uniform Probate Court Practices, Rule XXII (Amended effective November 16, 2010).
Standing Orders of the Massachusetts Probate and Family Court, Standing order 4-11 – section 1

States that have adopted some version of Uniform Probate Code.

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Uniform Guardianship, Conservatorship or Other Protective Arrangements Act, Copyright 2018 by the National Conference of Commissioners on Uniform State Laws. All Rights Reserved.

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Institute of Medicine [IOM] and National Research Counsel [NRC], Investing in the Well Being of Young Adults, Washington, DC; The National Academies Press, 2014.

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Attorney Martello Spaulding works to assist family members seeking Guardianships and Conservatorships over persons with diminished capacity, which enable them to receive medical treatment and/or financial protection. She also assists families in drafting estate plans that create a legacy for future generations. She is experienced in drafting and administering Special Needs Trusts, which allow families of disabled individuals to provide for their relatives well into the future years without affecting their qualification for public benefits. She may be contacted at cmartello@blakelaw.com
NICA: Neurological Injury Compensation Association

Kathryn Natale, RN, MSHS

Keywords: Birth injury lawsuits, Birth-related neurological injury, Neurological birth injury, Obstetrics and birth injuries, Florida Birth-Related Neurological Injury Compensation Association, NICA, Neurological Injury Compensation Association

Florida and Virginia passed legislation creating the Birth Related Neurological Injury Compensation Plan / Program, respectively. In Florida, the Plan is administered by the Florida Birth-Related Neurological Injury Compensation Association (or NICA). While the Florida and Virginia plans have similarities, this article will discuss the Florida program specifically.

WHAT IS THE NICA PLAN?

In the mid-1980s some states were challenged to stabilize malpractice insurance and encourage physicians to provide obstetrical services to patients, seeking an innovative solution to address the physically, financially, and emotionally catastrophic impact of neurological injury to newborn babies occurring during labor and delivery. Florida and Virginia passed legislation creating the Birth Related Neurological Injury Compensation Plan / Program, respectively. In Florida, the Plan is administered by the Florida Birth-Related Neurological Injury Compensation Association (or NICA). While the Florida and Virginia plans have similarities, this article will discuss the Florida program specifically.

If the administrative law judge determines that an infant has sustained a qualifying birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth in a hospital, compensation is provided for lifetime medical care and many other benefits. NICA benefits are awarded to the infant’s parents or guardians, in periodic payments or a lump sum payment, not to exceed $100,000. In the case of an infant’s death following a live birth, a death benefit is available for the infant in the amount of $10,000. Reasonable expenses for filing the claim, including attorney’s fees may also be awarded.

The underlying rationale was to eliminate the need for legal proceedings while providing care for birth-injured infants and reduce the financial burden on medical providers and families. Florida Statutes Chapter 766.301 to 766.316 is best summarized by the draft Motion to Abate provided by NICA: “The Plan was created in 1988 by the Florida Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries in an effort to stabilize and reduce the malpractice insurance premiums for obstetricians in Florida to ensure such services will be available in the future.”
FUNDING FOR NICA
The Plan is funded by a combination of state funds, physician fees, and hospital assessments. Physicians who do not practice obstetrics or choose not to participate in the Plan are required by Florida law to pay $250 annually into the Plan. Hospitals pay $50 per live birth. An obstetrician wishing to participate in the NICA Plan is currently required to pay a $5,000 fee each calendar year. The NICA website lists participating physicians for each year; participation is required for the year in which the injury occurred. In addition to payment into the Plan, participating physicians and hospitals with participating staff physicians are required to give notice to their obstetrical patients of the Plan; the required forms and brochures are provided by NICA. Signed patient receipts for required brochures and acknowledgement of participation by the hospital and/or physician may play important roles in any later litigation.

QUALIFYING CONDITIONS
Limitation on any claim under the Plan is barred if filed more than five years after the birth of an infant alleged to have a birth-related neurological injury. Additionally, the civil action statute of limitations is tolled by the filing of a claim under the Plan. The time such claim is pending or is on appeal is not computed as part of the period within which such civil action may be brought.

A birth-related neurological injury, as defined by the Florida statute requires:

- The infant must be born alive
- The infant must weigh at least 2,500 grams for a single gestation or, in the case of a multiple gestation, an infant weighing at least 2,000 grams
- The infant must be delivered in a hospital
- The injury must be to the brain or spinal cord
- The injury must be caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period
- The injury must render the infant permanently and substantially mentally and physically impaired

Disability or death caused by genetic or congenital abnormality are excluded from eligibility, as is injury resulting in physical impairment only, such as a brachial plexus injury.

FILING A CLAIM
A claim must be filed by the child’s legal parent or guardian. NICA will provide assistance in filing a claim and does not require an attorney. However, if an attorney files the petition, reasonable attorney’s fees may be awarded.

Forms can be downloaded from the NICA website or filed online. The petition requires a $15 filing fee; it must be accompanied by the relevant medical records for mother and child including fetal monitor strips, supplied to NICA at the petitioner’s expense.

The petition is filed with an administrative law judge [ALJ]. The legal opinion on the NICA website by Wilbur E. Brewton, General Counsel of NICA states an ALJ “has the exclusive jurisdiction to determine if a claim is compensable under the Plan and whether the notice requirements in s. 766.316, Florida Statutes, are satisfied.”

Most appropriately interpreted by an attorney, it is important to be aware that the Florida Statute 766.303 provides for exclusiveness of remedy, meaning that other claims for the same injury cannot be made.

“(2) The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, her or his personal representative, parents, dependents, and next of kin, at common law or otherwise, against any person or entity directly involved with the labor, delivery, or immediate post-delivery resuscitation during which such injury occurs, arising out of or related to a medical negligence claim with respect to such injury; except that a civil action shall not be foreclosed where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under ss. 766.301-766.316. Such suit shall be filed before the award of the division becomes conclusive and binding as provided for in s. 766.311.

(3) Sovereign immunity is hereby waived on behalf of the Florida Birth-Related Neurological Injury Compensation Association solely to the extent necessary to assure payment of compensation as provided in s. 766.31.”

Disability or death caused by genetic or congenital abnormality are excluded from eligibility, as is injury resulting in physical impairment only, such as a brachial plexus injury.
COLLATERAL SOURCES
The Plan is considered the payor of last resort. Therefore, NICA will not cover items or services received or entitled to under private insurance, health maintenance organizations, or government programs such a Medicaid. The Florida statute states compensation for “actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel.”

Family residential or custodial care is defined as care normally rendered by trained professional attendants which is beyond the scope of child care duties, but which is provided by family members. Family members who provide nonprofessional residential or custodial care may not be compensated under this act for care that falls within the scope of child care duties and other services normally and gratuitously provided by family members. Family residential or custodial care shall be performed only at the direction and control of a physician when such care is medically necessary.

A legal nurse consultant screening a case with possible birth-related neurological injury in Florida must determine the answers to the following initial questions:

- Did the baby weigh at least 2500 gm or 2000 gm) if multiple gestations?
- If the answer to any of these questions is no, then the baby is not eligible for NICA benefits. It may yet be a medical malpractice case; the statute of repose should be reviewed by the attorney.
- Key components and questions to answer during a review of the birth record indicating a possible birth-related neurological injury to note are:
  - Was the baby born alive? Any breaths after birth? Fetal heart tracing stop?
  - Low Apgar scores
  - Was there meconium staining?
  - Pathologic fetal acidemia with umbilical artery pH <7.00.
  - Diagnoses such as cerebral palsy or hypoxic ischemic encephalopathy (HIE)
  - Was the baby immediately admitted to NICU after birth? The injury must occur during labor, delivery, or immediate resuscitation after birth.
  - Any seizures? Immediately after birth?
  - If in NICU, why and how long? Look for injury to the brain or spinal cord caused by oxygen deprivation or mechanical injury.
  - Review brain imaging studies and/or EEG to provide timing of injury.
  - Was the infant on a ventilator?
  - Did the infant have feeding problems?
- Qualifying for NICA benefits require proof of permanent, substantial, physical, and cognitive impairment. Key components and questions to answer during a review of the subsequent record indicating a possible birth-related neurological injury to note are:
  - Any seizures after discharge? Controlled on medications or continued seizures?
  - Follow up brain imaging studies and/or EEG if done.
  - Continued breathing problems? Tracheostomy?
  - Feeding problems? Does the baby require a feeding tube?
  - Cortical blindness?
  - Look for developmental milestones, age-specific, response to people, mobility (rolls over, crawls, walks), muscle tone (holds up head, hypotonia), verbal ability (babbling, talking), etc.

For over 25 years Florida Birth Related Neurological Injury Compensation Plan administered by NICA continues with its mission to “To encourage physicians to practice obstetrics and make obstetrical services available to patients. To stabilize and help make malpractice insurance available to all physicians. To provide needed care to injured children.”

RESOURCES
What is NICA? http://www.nica.com/
https://www.vabirthinjury.com/

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The Sandwich Deposition
Otherwise known as...The Sammich Depo

Anonymous

There comes a point in the life cycle of a legal nurse consultant when they have just had it, the jig is up, and the sky has fallen. For me this day was October 23, 2012. It was a Tuesday, and the weather matched my mood; cold, drizzly and it seemed the sky was spitting tiny frozen droplets of water, each aiming for my head.

Approximately six hours into opposing counsel’s inquiry, my mind was exhausted. Recall of specific details, dates, days and emails were swarming through the sludge of what was once my sharp and skilled brain. Two attorneys came prepared from the dark side (opposing counsel). When I say prepared I do not intend to mean they were all that and a bag of chips, I mean they were hell bent on making sure that my thoughts were not certain.

They were typical attorneys who wanted to win. From the beginning pleasantries of “Hi how are you doing today blah-blah-blah...” I could feel the piercing stare of...well I can’t say his name, so I will call him Captain Underpants, CU for short. He was oddly tall with a short crew haircut, and I could tell he worked out. I remember thinking that his shirt barely covered the muscles of his arms, begging to be noticed (just if it seems like this sentence is worded so it inclines I noticed CU’s muscles in a good way, nothing could be further from the truth. When I read this sentence back to myself I throw up in mouth a little and must swallow har – gulp, just to get my eyeballs to keep moving). His sidekick, or rather what more seemed like his Mother Superior, was well put together, almost too perfect. Her blonde hair was styled in a half straight-half curly short mullet and her clothes were impeccably well coordinated. She too had a piercing stare, but at least when I looked in her eyes there was some semblance of compassion. Especially after six hours of CU screaming at me and slamming his hands on the table, asking me trick questions I could (should) never answer in any legal proceeding. Lawyers do that sometimes. It doesn’t even need to be planned or well thought out – when they see (or think they see) weakness in their opponent, warning bells go off and lights and sirens come from nowhere and then...they attack.

On paper things appear much different than what is happening in the moment. For example, CU would ask me a question the first time in a calm, sensible manner. If I didn’t answer his
question exactly as he anticipated, or
if he wanted to ruffle my feathers, he
would stand up and raise his voice and
at the end of the question slam his hand
down on the table, lean over and stare
straight into my eyes, looking for some
body language that would tell him “it’s
time” - time to pounce. Think about
this for a minute or two. To the judge or
anyone else reading the deposition, all
they see are words. He doesn’t see body
language. Despite all the jungle thwarts-
red antics, the appearance to the reader
is only that one question was asked a
second time. All the drama is missed,
tucked away in CU’s magic lawyer box.

So, after six hours of CU’s huge arms
flailing and hand slamming, I felt wilted.
I must have looked like it also because
Mother Superior called for lunch.
Thank God, I thought. I was starving,
and I figured maybe some food would
help keep my nerves un-rattled. CU was
really starting to irritate me! I looked
over at the attorney who hired me (I
will call him...Stitch) and I failed to see
the confident, young strapping lad that
once told me I had performed an excel-
"[Image 221x47 to 577x239]lent job on this case. He was slumping
in his chair staring at his computer and
I had to kick his foot under the table
to get him out of his trance and find
some existence of life. I swear he wasn’t
breathing, or maybe sleeping with his
eyes open – when I kicked him he took
a deep breath and said, “Yes, let’s eat!”
This is when I freaked out. I could
handle CU and Mother Superior, but
my own attorney already looked like a
kicked puppy! For a moment I pictured
myself in a tiny boat in the ocean with
one broken oar, paddling like crazy to
get myself back to shore.

The keen senses of a wild animal
occasionally allow the body to disregard
hunger, particularly when imminent
victory is noted. CU saw the look on
my attorney’s face, noted his body
language and immediately chuckled,
then bellowed, “You know I have a few
more things I would like to clarify, if
nobody has any objections? Just two
or three questions to clear up this last
point…” Well that was well played,
wasn’t it? Who would say no to Captain
Underpants and his loud voice, slam-
mimg hands and diva-like drama? So, we
trudged on. I am certain my ears were
flaming red. I was not only hungry, but I
was pissed at my attorney. How dare he
slump in his chair and not pay attention
to the tongue thrashing happening less
than twelve inches from his own body!

Another hour of CU wadding up paper
and throwing it on the table, pacing and
whirling. Yes, he was whirling. A whirl is
when one is pacing back and forth and
all the sudden stops. Instead of a full
twirl at 360-degrees, they...whirl about
180-degrees and come face to face with
the opponent and go silent. I think they
must teach that in lawyer school. Whirl-
ing 101 for attorneys.

The last question that CU asked me
changed the tone of the entire day, plus
put off lunch for about three more
hours. But Stitch’s objection and answer –
my wonderful smart, super attorney
– when I heard the words come out of
his mouth I could have dunked his head
in ice water and held it until he turned
blue. I didn’t but I wanted to. The line
of questioning CU had consistently
referred to was my communication with
our expert witness. Basically, CU was
trying to get me to say I had somehow
communicated inappropriately either by
email or phone conversation – he was
looking for anything that would get this
physicians opinion thrown out and me
discredited.

Our expert physician was a good one.
This entire case was a good one. A
young girl was playing on some jungle
gym monkey bar thing unsupervised.
She was supposed to be supervised but
the party responsible neglected to fulfill
that responsibility; at least until she fell
and got hurt. The young girl dislocated
her elbow and shoulder; pulled muscles
and tore ligaments - it wasn’t a pretty
picture. Then she needed several sur-
geries and the medical cost projection I
completed should have been more like
a life care plan – there were permanent
damages and the costs in this projec-
tion at first glance were ridiculously
high, I said at first glance. My work was
accurate however in hindsight, I likely
should have turned the case over to a
life care planner and continued my part
back stage. It was just too big of a case.
Unfortunately, my pride and lust for
litigation kept me from handing it over
to anyone, a very big fault on my end.
My attorney was smart and young and
hungry (for a win...were you thinking
Subway? We’ll get there, just keep read-
ing), as was I.
Anyway, our physician agreed about the permanent damages and his suggestions to return her back to as normal as possible included more surgeries, more recovery time, much more bouts of therapy and many life changes. And those were just the physical implications. It had been over a year since her fall and because of the injuries there were beginning issues with depression that had not existed in her life prior. Besides all of that, her immediate family had little resources and what little they had were dwindling to nothing. This girl was a dancer. She danced competitively and had done so since she was in pre-school. She was twelve years old and had not stopped growing yet, and unfortunately, the injuries resulting from her incident would prevent the affected arm from growing normally, preventing her from dancing in competitions as she would have but for the injuries. And her parents believed she was an Olympic prospect that would never regain her dream. Oh yes, CU was not the only one who brought the diva-drama. It was everywhere. Everywhere except with my hiring counsel!

Captain Underpants continued his full court press, diligently attempting to get me to admit to things that did not exist. Specifically, he was trying to open more room for discovery. He wanted me to say something that would allow him insight into the intricacies of the email conversations between myself and the expert physicians opinion. At first, I wasn’t sure what he was searching for and then I realized, he wanted to read the emails for himself, he wasn’t interested in my opinion at all. I would not give it to him. Once I figured out what he was after there was no way I would allow his tiny eyeballs in my email conversations, and he was getting impatient. CU changed his tactics. He would ask me the questions but then look at and make eye contact with my attorney. I knew this would work, my attorney looked like he needed a steam shower and some food. I often wonder what law students do in the dark corners of litigation class, now I know. They perfect their skill of finding the exact precise moment to blow things up and then they light a match.

The last thing I remember out of CU’s gnarly lips were “So you are telling me (directed at me but he was looking at the puny little man that hired me) that your email contact with this expert existed but most of your conversation was by phone?” It was a stupid question and one asked and answered at least a hundred times during the proceeding hours. I never admitted to any email communication. This is another thing that lawyers do, at least this one did during this deposition. They put words in your mouth and hope you admit to something that didn’t happen and then sit back and watch you unravel as you try to explain. Stitch was dreaming and instantly woke up or maybe he was delirious from hunger, but it was at this point he decided he was the one being deposed. During my silent stare at CU, trying to think whether I should provide the same answer or give a different one than before, Stitch spoke up. He not only spoke up but his voice was loud and unaltered; he reminded me of my father when he was at the end of his rope, ready to go outside and cut a switch.

I looked in horror as he bellowed, “Objection.”

“So God and finally!” I thought. The little man finally found his voice and is coming in to protect me. Unfortunately, protection was the furthest thing from his mind. To this day I do not understand what was going through his mind because the next few minutes invited sheer panic in my uncomfortable office chair.

“Objection. She has already answered this question many times and you continue to restate her testimony differently. Here. This is all there is.” And with that he flipped open his laptop and flipped it around to Mother Superior, so she could see everything. I think I died in that moment. Nothing like this had ever happened before, and everything I remember learning from my colleagues and other hiring counsel is that you never ever let them in. You never ever open yourself up for further and unnecessary discovery. And for God’s sake you never ever ever flip open a laptop and tell OC to have a look!

The room fell silent. There was a very dark (yet hopeful – you should have seen CU’s face!) air settling down around me and all I could think was “Oh my God!” My next thoughts, or rather waves of intense searching for thoughts, were of my email communication with the physician expert. Had I emailed anything inappropriate? Or better, had I emailed anything that could be interpreted as inappropriate? Had I said anything in an email to my attorney or the expert that would blow this case to Hell? And the bigger question, had my attorney? Mother Superior and CU could not unglue their eyeballs from Stitch’s laptop. I am convinced they were trying to accept what my attorney had done and then come up with a quick plan on how to make the most
In the time it took me to go get lunch Stitch realized what he had done, and I could clearly see the freak-out all over his face. This thing could not be undone.
great, but unfortunately it was now sliding down his very expensive tie in an avalanche of lettuce and olives. The chicken draped across his once white pin-striped shirt and slid down to the top of his belt and fell to the table in front of him. He just stood there. I just stood there. Neither of us knew what to do. I was certain I would never work for him again whether it be his decision or mine, and I remember thinking of before when I could have held his head under ice water and not let go. My body realized that the ice water thing would have been at least a misdemeanor if not a felony (depending on whether I allowed him to come up for air) and instead it took the next logical action; I threw his sandwich at him.

By nature, my attorney was a cool guy. I still believe he wanted to laugh at what I had done. Had this been a lover’s argument or a disagreement with one friend and I ended it by throwing a sandwich, each party involved would have curled up in laughter – but at this moment on this day, curling up in laughter – although an option – was not what happened next, and that was... nothing. My attorney calmly reached across the table and picked up a napkin and started grooming his shirt and tie. He didn’t say a word! Sure, I surprised him, but I didn’t think he would go all commando silent on me!

After a few more long and tempered minutes, he spoke, “Cin, did you happen to get me a soda, and could you please hand me the potato chips, unopened?”

I wanted to crack up laughing. I wanted to roll around on the floor and just squeal with delight. Instead I said nothing and handed him the bag of chips and his drink. He had finished cleaning his suit and tie when opposing counsel came through the front door. By this time, I had shuffled my way around the long conference table on the same side as my attorney. I looked at Mother Superior’s face as she slowly guided her eyes across the front of Stitch’s chest. It appeared she was trying to figure out why his shirt and tie and suit coat collar was stained. Her gaze then fell to the pile of used-up napkins on the table in front of him. She looked over at CU and moved her eyes quickly back and forth from the table, then to Stitch, then back at him. About fifteen seconds passed and I could tell they were quickly putting the pieces together about why my attorney looked like he did, and why I (likely) had the look on my face I did. I could tell they were secretly and silently hysterical, they wanted to laugh and point and jest. I still believe they talk about this deposition. This is one they will likely never forget. I am the one who won the diva-drama contest for all time – I threw a loaded sandwich at my own counsel!

The remainder of the day was spent in mostly silent photocopying and an occasional break for a phone call. When OC decided it was time to wrap-up, Mother Superior turned and said, “We are going to stay in town for a few extra days. It will give us time to gather the remainder of the new discovery and we will need to reschedule the remainder of this deposition for another day or two this week. Please be available for approximately twelve hours between Thursday and Friday.”

I looked over at Stitch. He looked frazzled and beaten down. The events of what happened that day were finally coming clear for him and I could tell he regretted his decision. What he said next surprised me, but not really. Instead of confirming the schedule for the remainder of the deposition he looked right at Mother Superior and said, “How about you and I meet here in the morning around nine? We can finish getting all of the paperwork you need and discuss how we would like to proceed?” She looked at him with what
who has ever been deposed learns something different from each deposition, from each preparation for deposition and for each reflection of how well we did during deposition.

I could have learned from this one and still wish to have that attorney-client conversation. Unfortunately, this little happening was many years ago and I probably will not ever have that conversation. I have many, many take-aways that I kept with me and learned from for future run-ins with opposing counsel. I am working on calming my nerves and my temper when things go wrong, and after that day I ensure that I never fetch lunch and if I have to anyway, I get something that will look good on a suit and tie.

assume that I was invited to the events for the next day. I wasn’t invited.

“Let me give you a call tomorrow, Cin, and we can go from there.”

That was the last time I heard from him. He didn’t return my phone calls. He disregarded my request for payment for work performed. He disappeared. I spoke with the expert physician and he was very stand-offish, like walking on pins and needles through the one conversation. I am still not sure what happened. I am not sure had I done something wrong and Stitch just wanted me out, so he threw me under the bus instead of being an honest and competent man…I have absolutely no clue. Sometimes it bothers me. Anyone who has ever been deposed learns something different from each deposition, from each preparation for deposition and for each reflection of how well we did during deposition.

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Looking Ahead…

XXV.1, Spring 2019 — Perioperative Care

XXV.2, Summer 2019 — Issues in the ED

XXV.3, Fall 2019 — Subcontracting and Legal Nurse Consulting

XXV.3, Winter 2019 — Nursing Practice and New Nurse Author Supplement

XXVI.1, Spring 2020 — Implantable Devices