Journal of Nurse Life Care Planning

Topics in The Work of Nurse Life Care Planning
JOURNAL OF NURSE LIFE CARE PLANNING

Fall 2013

Table of Contents

80 Ethical Considerations
Linda Husted MPH RN CNLCP LNCC CCM CDMS CRC

88 An Introduction to Evidence-Based Practice for the Nurse Life Care Planner
Judy P. Metekingi MS RN CRRN CDMS CCM LNCC CLCP

93 The Science of Searching Databases: Boolean Algebra as a Tool to Effectively Find Medical, Legal and Other Information
David Dillard BA MLS

100 Vigilance: The Essence of Nursing
Geralyn Meyer PhD RN
Mary Ann Lavin ScD RN FAAN

112 Qualifying as an Expert Witness
Victoria Powell RN CCM LNCC CNLCP MSCC CEAS

123 How to Draft an Expert Witness Retainer Agreement That Prevents Many Problems Life Care Planner Expert Witnesses Face
Steven Babitsky, Esq.
James J. Mangraviti, Jr. Esq.

Departments

75 Editor’s Note
Wendie A. Howland RN-BC MN CRRN CCM CNLCP LNCC

76 Information for Authors

77 Contributors to this Issue

79 Letters to the Editor

83 Ethics in Action: Should I hold a HCPOA?

85 From Novice to Expert: Getting started

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In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work. Other diagnoses may be relevant depending on patient needs.
Welcome to the Fall 2013 issue of the Journal of Nurse Life Care Planning. This issue focuses on issues of practice, some of the nuts and bolts of working as a nurse life care planner, with references and resources from the best.

It’s hard to pick out just one article for special mention here; each will reward careful attention with new ideas, skills, and resources to help you in your expert practice. The time you’ll put into the article on how to use simple Boolean logic for literature searches (now, don’t faint-- it’s really good!) will save you many times over when you need supportive literature. The article on preparing to be an expert witness offers a worksheet to help you help your retaining attorney appreciate your value. I know many of you will be rewriting your contracts after you read the piece on writing effective retainer agreements. The pieces on ethics will provoke discussion; the reprinted classic article on nursing vigilance will help you give your clients new appreciation for all those nursing hours in your plans.

We hope to see you at our annual conference in one of America’s great cities, Philadelphia, November 8-11, 2013. I have just learned today that my very own hard copy of the new Core will be in my hands by then. Plan to pick yours up (at deep discount!) when we are there. We’ll have boxes of them, at long last, and with great pride we hope you’ll share.

Cordially,

Wendie Howland

Editor, Journal of Nurse Life Care Planning

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Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text

Manuscript length: 1500 – 3000 words

- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Set 1-inch margins
- Use Times, Times New Roman, or Ariel font, 12 point
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association)

Art, Figures, Links

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.

Each table, figure, photo, or art should be on a separate page, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

Live links are encouraged. Please include the full URL for each.

Editing and Permissions

The author must accompany the submission with written release from:

- Any recognizable identified facility or patient/client, for the use of their name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.

All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.

All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.

Submit your article as an email attachment, with document title articleName.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Manuscripts not published will be returned to the author. Queries may be addressed to the care of the Editor at: whowland@howlandhealthconsulting.com

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and the nursing profession. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

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David Dillard (“The Science of Searching Databases”) has degrees in history and library science. He has worked at Temple University Libraries since 1970, first in the Business Library; he moved to Reference and concurrently began to learn bibliographic database searching. He now does collection development for Tourism, Hospitality, Sports Management, Recreation, Therapeutic Recreation, Public Health, Kinesiology, Disabilities, Social Work and Communication Disorders. Dave started sharing information sources and answers to questions on internet discussion groups around 1998 and that has grown to a cottage business. He started a network of public search engine indexed discussion groups and archives for sharing of posts of good websites, bibliographies of sources on a wide variety of topics, and news story summaries with source citations and links to those sources. He is a regular on several nursing specialty lists and is very open to contact from anyone to help with searches on any topic.

Linda Husted, MPH, RN, CNLCP, LNCC, CCM, CDMS, CRC (“Ethical Considerations”) is President of Husted Life Care Planning, Inc. in Setauket, New York. Ms. Husted’s focus is on Life Care Planning, Legal Nurse Consulting and Catastrophic Case Management. She has more than 25 years experience in rehabilitation, disability management, workers’ compensation case management and liability reviews. As a rehabilitation specialist and nurse case manager, she developed cost-effective case management interventions on high dollar claims for Fortune 500 Companies as well as life care plans and disability assessments from pediatric to geriatric. She has extensive experience in catastrophic claims involving head injury, spinal cord injury, burns, amputations, multiple trauma and chronic pain. Eighteen years of hospital experience in neuro-intensive care, medical surgical nursing, operating room, recovery room, and labor and delivery also provide her with a solid foundation for legal nurse consulting and life care planning.

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James J. Mangraviti, Jr., Esq. (“How to Draft an Expert Witness Retainer”) has trained thousands of expert witnesses through seminars, conferences, corporate training, training for professional societies and one-on-one training/mentoring. Mr. Mangraviti is a former litigator with experience in defense and plaintiff personal injury law and insurance law. He currently serves as Principal of the expert witness training company SEAK, Inc. (www.testifyingtraining.com). Mr. Mangraviti received his B.A degree in mathematics summa cum laude from Boston College and his JD degree cum laude from Boston College Law School. He is the co-author of twenty-five books on expert witness practice and related topics. He can be reached at 978-276-1234 or jim@seak.com.

continued next page
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Victoria Powell ("Qualifying as an Expert Witness") provides legal nurse consulting, Life Care Planning, medical case management, Medicare set-aside (MSA) allocations, and medical cost projections. She has a special interest in amputation and other catastrophic injuries. She is an active member of the American Association of Legal Nurse Consultants, the American Association of Nurse Life Care Planners, the Case Management Society of America, International Academy of Rehab Professionals, and is a lifetime hall of fame recipient for her contributions to the National Nurses in Business Association. Ms. Powell provides expert witness testimony on Life Care Planning and medical cost projections. Her published works include articles in several journals, numerous chapter contributions, and she served as editor for the text Nursing Malpractice. Ms. Powell is a nationally recognized speaker and regularly presents on a variety of nursing and technology related subjects.
Ethics in Action

I wanted to share a case I had in response to your new column on ethical issues in practice. I received a referral for a LCP on a middle-aged single woman, previously a working professional, who sustained a T-level SCI as a result of a surgical misadventure during a SCS placement procedure about three months prior. She was on high-dose opioids for “failed back syndrome.”

I met her in the skilled nursing facility. She was curled up in bed with excruciating pain and horrible spasms. She was on so much medication that she had impaired mentation, prescribed by the facility’s internist. She was initially transferred to the local rehab hospital who kept her for 2 weeks before discharging her to the nursing facility as they did not think she had much rehab potential. The only specialist she had seen was a neurosurgeon at the University. I set up an appointment for her to see him again, which required ambulance transport.

I was able to garner his support in getting her referred to Craig Hospital and make the requisite MD:MD call. He was unfamiliar with the referral process so I walked him through what he needed to do. I collected records and sent them to Craig, cajoling them to make an exception to their admission rule of accepting transfers directly from an acute setting. I worked with her insurance plan to get them to make an exception to allow her transfer to Craig at 3 months post-injury.

Craig put in a Baclofen pump to control the spasms and got her on an effective yet moderate neuropathic pain medication regimen, weaning her off opioids. As CM, I worked with Craig to implement discharge to a nice semi-independent apartment in a continuum of care facility where she could be largely independent with some ADL supports.

My ethical dilemma was whether to do the LCP based on her existing unacceptable status in the SNF or to use my CM expertise to get her out of it. I found it unethical/morally indefensible that she was being kept in intractable pain and spasms, not being gotten out of bed except for some feeble PT attempts. Initiating CM actions needed would clearly be taking on an advocate role; one could argue at trial that I crossed the line of independent expert to patient advocate. I decided to refer the attorney to another LCP if that were raised by the opposing team. I also considered remaining in the LCP role and asserting at trial that my actions disqualified me as an expert in the case and was professionally inappropriate.

Anonymous submission

Readers: What would you have done?

How to get the JNLCp on a Kindle

This helpful hint came in from a PC user: “I suggest Send To Kindle, available at http://www.amazon.com/gp/sendtokindle/pc

- Install Send To Kindle on your computer, using the same login that you used when you registered the Kindle.
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Wait a few minutes and the file should appear on your Kindle.”

As a Macintosh user I cannot vouch for this method. To download your PDF Journal to your iPad, open it from the email link you received, choosing “Open in iBooks.”
You can then easily sort it into a Library section of your choice, as with any other book. I also keep a selection of redacted LCPs and related documents in one section of my Library to show when I visit clients. Ed.

Letters on any topic are welcome and may be sent to the Editor at whowland@howlandhealthconsulting.com. Letters may be edited for brevity.
Ethical Considerations

Linda Husted MPH RN CNLCP LNCC CCM CDMS CRC

An ethical dilemma can arise when an individual for whom you are creating a life care plan for his or her spouse demands that a certain allowance or service be included in the plan, an inclusion with which you don’t agree. An example of such an allowance could be to relocate from the East Coast to the West Coast. An example of a service could be to provide biweekly psychotherapy sessions for the injured individual’s son for at least ten years (in addition to individual and couples/family counseling). When the allowance and the service are not medically necessary for the injured party, this is, at the very least, a conflict. To further compound the conflict, when the hiring attorney for a life care plan also requests that the allowance and service be included, the conflict becomes an ethical dilemma.

The above ethical dilemma presents an opportunity for the Nurse Life Care Planner to play an important role in individual/family and attorney education and conflict resolution. The Nurse Life Care Planner needs to explain that recommendations made in a life care plan are: 1) medically necessary, 2) related to the injury, and 3) reasonable. This may be easier said than done when the injured individual and spouse are angry, emotionally upset and have expectations that do not meet these three criteria. The individual, family member or attorney may think an allowance or particular service is indeed reasonable and should therefore be included.

In analyzing the situation, the Nurse Life Care Planner needs to consider and weigh all requests, hear all rationales, and in the end include only those goods and services he or she feels confident defending as necessary and reasonable.

Linda Husted is President of Husted Life Care Planning, Inc. in Setauket, NY, focusing on Life Care Planning, Legal Nurse Consulting and Catastrophic Case Management. She has more than 25 years experience in rehabilitation, disability management, workers’ compensation case management and liability reviews. She has developed cost–effective case management interventions on high dollar claims for Fortune 500 Companies and life care plans and disability assessments from pediatric to geriatric. She has extensive experience in catastrophic claims involving head injury, spinal cord injury, burns, amputations, multiple trauma and chronic pain. Eighteen years of hospital
Ethical dilemmas are likely to arise more frequently as consumers become more knowledgeable and more involved in their health care decisions and treatment choices. This will lead to more informed choices as they consider their health care needs over their entire lifespan. If a life care plan is required, consumers will want to increase their collaboration with the Nurse Life Care Planner during planning process.

This trend of consumer involvement in healthcare decisions began as a concept called "wellness," articulated by Halbert L. Dunn back in the 1950s. Health promotion and the notion of individuals becoming more knowledgeable and involved in their own health care decisions began to gain acceptance in 1979 when Donald Ardell published “High Level Wellness.”

To encourage this trend as well as to introduce consumer protections, in 1997 President Bill Clinton created an Advisory Commission on Consumer Protections and Quality in the Health Care industry and charged the commission to produce a “Consumer Bill of Rights” in health care. On November 20 of that year, Clinton endorsed the Consumer Bill of Rights and Responsibilities recommended by the President’s Advisory Commission.2 (next page)

In the second decade of the twenty-first century, individuals are beginning to assume ever greater personal responsibility for their health. With the economic pressure to reduce this nation’s health care costs, this process is certain to accelerate. According to David Houle and Jonathan Fleece, authors of The New Health Age, The Future Of Health Care In America, individuals will have access to an increasing amount of information and data about health care costs, health care outcomes and treatment options. This development will be an important consideration for Nurse Life Care Planners, who will need to prepare for greater collaboration with all parties in the life care planning process: the injured individual, his or her family, the attorney they hire, the treatment providers, and perhaps ultimately the jury.

Bibliography

New Health Age Publishing: Sourcebooks, Inc.

continued next page
Consumer Bill of Rights and Responsibilities

**Access** to accurate, easily understood Information about health plans, facilities, and professionals to assist consumers in making informed health care decisions.

**Choice of Health Care Providers** that is sufficient to ensure access to appropriate high quality care. This right includes providing consumers with complex or serious medical conditions access to specialists, giving women access to qualified providers to cover routine women’s health services, and ensuring continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition.

**Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a prudent layperson could reasonably expect that the absence of care could place their health in serious jeopardy.

**Participation in Treatment Decisions** including requiring providers to disclose any incentives -- financial or otherwise -- that might influence their decisions, and prohibiting gag clauses that restrict health care providers' ability to communicate with and advise patients about medically necessary options.

**Assurance that Patients are Respected and Not Discriminated Against**, including prohibiting discrimination in the delivery of health care services based on race, gender, ethnicity, mental or physical disability, and sexual orientation.

**Confidentiality** provisions that ensure that individually identifiable medical information are not disseminated and that provide consumers the right to review, copy, and request amendments to their medical records.

**Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process.

**Consumer Responsibilities**, provisions that ask consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, and reporting fraud.

An issue with a vendor

This scenario came from a nurse life care planner. The comments are from a group of nurse life care planners who were asked to share their opinions. Nothing in this column is to be taken as legal advice.

Q.

A broker has managed the monies of a very wealthy widow for many years. After they had gotten to know each other, she asked him to also be her power of attorney, fiscal POA and medical POA. His firm has now advised that it is a conflict of interest for him to do so - correctly so in my view.

The broker wondered if I could serve as her medical POA. Widow has no relatives and her friends have since passed or unable to competently serve as medical POA. I suggested perhaps an attorney but widow is cold to that idea and would like someone who is willing to listen to and understand her desires, someone with perceived compassion.

Should I do this? Under what circumstances, if any?

A.

Based on the information given in the scenario, I do not see any objection in taking on this role. However, if there is additional information that the outcomes of my decisions as the medical POA would somehow benefit me, then I would say there is a conflict. If I am a registered nurse, then I would certainly have the qualifications to assume this role. In addition, my nurse ethics require me to be a patient advocate. I assume the wealthy widow is capable of making her decisions at this point. As long as the wealthy widow agrees to the proposal, then there should not be a conflict. If she is not capable to make the selection, then it should be turned over to the court to decide.

If a broker has asked me as a Nurse Life Care Planner to act as medical POA (power of attorney) for a very wealthy widow and assuming I am interested in doing so, I would agree, given the following circumstances. After first becoming familiar with my state’s rulings on power of attorney, I would make sure that a legal contract is developed specifying any stipulations or expectations of my role as medical power of attorney as well as agreed upon compensation, such as an hourly rate. It would also be important that the contract specify the circumstances involving ending the contract. In addition to having the contract developed preferably by the widow’s attorney and signed by the widow, I recommend my attorney review the contract to ensure there are no contraindications to my signing and fulfilling this role as medical POA.

I am not an attorney, but here are the potential conflicting situations I see in this case:

- If you worked with this client to perform a life care plan
- If you are currently being paid as a case manager for the client

If neither of these situations exist, then why shouldn't you be her power of attorney? She has the right to request anyone she wants. This is usually not a paid role. THAT could cause a conflict whereby if someone is medical POA for a person who is paying them they would possibly have an interest in keeping them "alive" beyond what there wishes stipulate.

How is the attorney involved or what is the prior relationship with the widow? Someone with an appropriate medical education should be the medical POA. In addition it should be someone who has the
time to address the issues that will arise from taking on this responsibility. Depending on the circumstances, it maybe ethical, but not necessarily the most wise of choices.

My thoughts regarding possible ethical issues that could arise relate to whether or not the nurse life care planner would actually have enough time to do this. This is a huge responsibility and one not to be taken lightly. The nurse life care planner may be called upon at any hour of the day to make medical decisions for this woman when she is no longer able to do so. It would be important for the nurse life care planner to research requirements for this role. The American Bar Association provides resources to assist the medical POA with advanced care planning at this website: (Ambar.org/AgingAdvancePlanning). If the nurse life care planner felt he/she was able to take on this role, then I would also suggest meeting with an attorney (and the woman) to review state requirements for being a health care agent, completing required paperwork (to include a living will/advanced directives), and any other documentation which would outline the woman's wishes. If there is a fee involved, which I am assuming there is, I would have a contract detailing all fees, services, etc. and would involve my attorney with drafting it. It would also be beneficial to have a "back-up agent" should the nurse life care planner not be available.

For the next issue: A client has asked me to vet the qualifications of an opposing NLCP. In so doing I discovered that he lists a doctorate from a for-profit school which was shut down for fraud soon after he obtained his degree. He holds a diploma but no degree in nursing. Other than disclosing this to my attorney client, do I have any other ethical duty to report this? To whom? What could be the consequences to his practice?

Send your thoughts on either of these scenarios to the Editor.

Note whether you would prefer to be anonymous if your comments are chosen for publication. Future topics also welcome.
So many unanswered questions after earning certification as a life care planner! How to switch from a full-time nursing job to earning an equivalent income as an independent consultant? How to market the services for new business? Which costing tools to use? How to negotiate or protect your services in client agreements? These and many more questions are part of the transition from novice to expert. This is the first of a series of articles to help the new nurse life care planner along the path to becoming a proficient entrepreneur, expert witness, and life care planner.

To jump-start your practice, make time to attend a life care planner (LCP) conference. Picking the brains of seasoned life care planners and developing new business relationships can be motivating as well as giving you great ideas. Some are the Leisure & Learn Workshop hosted by Caragonne & Associates in Ajijic, Mexico; the AANLCP® Annual Conference; the Kelynco Executive Forum; and the IARP-IALCP International Symposium of Life Care Planning. I attended two such conferences within 7 months of becoming certified and can attest to the fact that it changed my business plan altogether. An unexpected benefit was meeting many seasoned life care planners who were willing to serve as resource and mentors.

Pareto’s Principle, sometimes called the “80/20” rule (Hafner, 2001) is an important first lesson. According to Dr. Hafner:

To maximize personal productivity, realize that 80% of one’s time is spent on the trivial many activities. Analyze and identify which activities produce the most value to your company and then shift your focus so that you concentrate on the vital few (20%).

continued next page
What do you do with those that are left over? Either delegate them or discontinue doing them.

Experienced mentors can help novices identify good business practices and analyze how to apply them. Like life care plans, business plans are individual. Concentrate on the 20% of activities that will produce the most value (80%) to your business.

In a 2010 JLCP Patricia Brock reported on an informal survey of life care planners showing that only one out seven (14.3%) reported a greatly improved financial situation after becoming a life care planner (Brock, 2010). In fact, more than 80% of the remaining life care planners surveyed reported no improvement. It’s possible that they had inadequate business plans that didn’t take account of the “80/20 rule.”

A business plan is vitally important to a successful business. Yet many novices discover that creating one is easier said than done, especially in an industry with little to no statistical or anecdotal data. Therefore, the life care planner must rely on intuition and acumen to discern the best plan and business strategy. Let’s look at some aspects of a business plan to consider.

Your first question is, “What is my time worth?” One of the most important decisions experts need to make is setting the correct rate for their time. (Babitsky, Mangraviti Jr, & Babitsky, 2006) You don’t want to undercharge for work and later risk losing new clients when it becomes apparent you’ll have to raise your fee. And overcharging might decrease potential clients’ willingness to engage you.

Babitsky et al. propose two steadfast rules for setting fees: 1) Far more experts undercharge than overcharge. This is usually the result of inexperience and a psychological hesitancy to charge a rate of hundreds of dollars per hour. 2) When experts increase their fees, the volume of work they receive increases. Attorneys are paid to win and seek out the best possible experts. Many assume that the expert who charges more is a better expert. This assumption results in increased demand for the “best” experts who charge a premium for their services. (Babitsky, Mangraviti Jr, & Babitsky, 2006)

The eventual decision on the amount to charge also depends on the structure of the consultancy. There are two viable structures for a consulting practice. But to be betwixt and between is bizarre (Weiss, 2011). According Dr. Weiss, one is the “True Solo Practitioner” and the other is the “Firm Principal.” The Firm Principal’s additional staff, corporate structure, and long-term exit strategy goes beyond the needs of a novice. True Solo Practitioners may eventually transition to become Firm Principals if they can build viable and growing businesses. Some life care planners operate as a hybrid of these two models, but this has the tendency to reduce the advantages of either and holds the potential disadvantages of both. Anecdotal evidence suggests that the majority of beginning nurse life care planners are Solos, so we will focus on them.
According to Stephen Fishman, author of “Working for Yourself: Law & Taxes for Independent Contractors, Freelancers, & Consultants,” if you're just starting out, you may have no idea what you can or should charge.

We’ll talk about determining that in our next column!

**Resources to check out:**


According to the American Association of Nurse Life Care Planners (AANLCP), nurse life care planning is the “specialty practice in which the nurse life care planner utilizes the nursing process in the collaboration and analysis of comprehensive data in the preparation of a dynamic document.” (American Association of Nurse Life Care Planners, 2013). The AANLCP promotes the use of the nursing process as the foundational base for the methodology used in the life care planning process. As nurses we are familiar with the nursing process from our earliest days as novice care providers. As life care planners, we make the transition to expert nurses, and with it, the added responsibility of developing a product that is solid and defensible in the legal arena. This article will explore using evidence-based practice in life care planning, and outline the process using a scientific based practice model. This approach does not serve to replace the nursing process, but to augment and incorporate it into the evidence based model as further outlined.

Evidence-based practice is not a new concept and is now firmly embraced by the medical field in an effort to make empirically based decisions in all facets of patient health care. Ingersol (2000) describes it as “The conscientious, explicit, and judicious use of theory-derived, research-based information in making decisions about care delivery to individuals or groups of patients and in consideration of individual needs and preferences.” Why should we incorporate evidence-based practice if we are already using the

Judy Metekingi is the principal owner of Metekingi and Associates PLLC, a Medical Case Management, Legal Nurse Consulting and Life Care Planning Company. With over 28 years experience in life care planning, Ms. Metekingi has written plans nationally and internationally for a diverse clientele. She specializes in adult and pediatric SCI, TBI, and catastrophic injuries. Ms. Metekingi is currently a doctoral candidate in Nursing Education at the University of Utah, with a special emphasis on educating nurses in the life care planning arena, and gerontology care management. She can be contacted at jmetekingi@comcast.net.
nursing process? The reasoning becomes clearer when life care planners are called to testify on behalf of the clients for whom the plan is written.

Nurses who engage in life care planning assume the responsibility of being designated as an expert in their field. A court of law requires foundation, consistent and reproducible methodology, and the use of scientific methods to support any opinions made. Therefore, the NLCP’s approach to determination of patient need and outcome should reflect knowledge at the expert level, including sufficient critical reasoning skills required for any empirically based methodology. The use of evidence-based nursing knowledge is critical to ensure that any and all opinions developed by a NLCP not only provide a life-long map for all of the client’s future care, but also pass muster with the judicial system.

Evidence-based practice and the nursing process are both problem-solving strategies, and their similarities have been noted (Sharts-Hopko, 2003). The nursing process takes nursing practice through problem-solving stages of assessing, diagnosing, outcome identification, planning, intervention and evaluation (Newhouse, Dearhouse, Poe, Pugh and Whitehouse, 2007). Elements of critical thinking are evident during this process as the nurse seeks and synthesizes information, draws conclusions and transfers that knowledge into a plan (Newhouse, Dearhouse, Poe, Pugh and Whitehouse, 2007). However, the inheritance of critical thinking in the nursing process has not been empirically demonstrated (Fesler-Birch, 2005). Tanner (2000) opines further stating, “the concept of critical thinking extends beyond the well-defined nursing process.”

According to Carper (1978) science, ethics, interpersonal relationships between nurse and patient, and the art of nursing define patterns of “knowing.” This concept was developed even further by McKenna, Cutcliffe, and McKenna (2000) when they outlined four different types of evidence (Newhouse, Dearhouse, Poe, Pugh and Whitehouse, 2007):

- empirical: evidence based on scientific research
- ethical: evidence based on nurse’s knowledge and respect for patients values and preferences
- personal: evidence based on nurse’s experience
- aesthetic: evidence based on nurse’s intuition, interpretation, understanding and personal values

Thus we can begin to think of the relationship between “critical thinking and the judicious application of evidence to care” (Newhouse, Dearhouse, Poe, Pugh and Whitehouse, 2007).

Incorporating evidence-based practice to solve or “fix” a problem is evident in the literature, and shows how it can be effective in similar pursuits by other professionals. Polio (2006) relayed his experience as a social worker choosing to incorporate this method as trying to “provide direction on actions within the clinical process.” He also dis-

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cussed the influence of a systematic practice model that uses a “replicable and consistent approach to collecting information, identifying intervention, implementing and evaluating outcomes,” and subsequently implementing evidence into practice (Polio, 2006).

How can nurses begin to incorporate the nursing process into evidence-based practice?

The American Nurses Association (ANA) recognizes the importance of EBP, and has outlined various models for use. These are referenced on their website, (http://www.ANA.org). One such model, especially applicable for NLCPs, is the John Hopkins Nursing Evidence-Based Practice Model and Guidelines (Newhouse, Dearholt, Poe, Pugh & White, 2007). John Hopkins has outlined three cornerstones that form the foundation for professional nursing: practice, education, and research (right).

Nursing practice includes standards of care (protocols and procedures), standards of practice (professional standards such as those published by ANA and AANLCP) and the nursing process. Organizational standards of practice, published guidelines from relevant licensures and certifications such as CRRN from the Certification of Rehabilitation Registered Nurses and LNCC from the American Association of Legal Nurse Consultants, also fall under this cornerstone.

Education reflects the acquisition of nursing knowledge, clinical proficiency, and competency maintenance. Nurses’ academic degrees, (Bachelors, Mas-
ters, Doctorate), additional board certifications, and their maintenance are all relevant when building an evidence-based framework. Experience in all aspects of the nurse experts’ field, whether rehabilitation, case management or other specialties, provides another block in this cornerstone.

Finally and perhaps most importantly, research uncovers new knowledge and clarifies practices based on scientific evidence.

**What are the steps of Evidence-Based Practice?** In general, there are five steps common to most models of evidence-based practice when performing a search. According to Ohio State University (2013), these five steps can be simplified as Ask, Acquire, Appraise, Apply and Assess. They are:

- **Ask:** Form a question in a clinical fashion that becomes the basis of the actual search.
- **Acquire:** Use databases and other sources as already discussed, for evidence or information that pertains to the question.
- **Appraise:** Use critical thinking skills and tools outlined in evidence-based models, appraise all the evidence that is found.
- **Apply:** Decide how to proceed with the information gleaned, again using critical thinking skills.
- **Assess:** Evaluate the decision made on relevant outcomes. In life care planner terms, this means the outcomes of your recommendations.

Planning medical and nursing research can be intimidating. Fortunately, there are any resources available to assist the novice or uninitiated. Many libraries associated with medical schools and hospitals offer guidance and instruction in researching methods and resources. Besides literature, the NLCP can use clinical guidelines and expert opinions. The ANA website has a wealth of resources and links to professional organizations for evidence-based information.

Research also requires clinical judgment and expertise. Nurses who develop life care plans typically have many years of varied nursing practice from which to draw and to apply to opinions regarding recommendations and evaluations.

Finally, patient preference should not be ignored. Melnyk (2011) stated that, “evidence-based nursing is a problem-solving approach to practice which integrates conscientious use of best evidence, in combination with clinician’s expertise as well as patient preferences and values” (p.3). The NLCP should explore what the patient really wants and can and should make these wishes the basis of final rec-
ommendations. This is part of the holistic, collaborative, and team approach necessary for informed decisions. As much as the nurse relies on observations and evaluations, patient and family input is as important as any appropriate evidence to form a sound foundation.

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Old bricks, fall
Barnstable MA
The Science of Searching Databases: Boolean Algebra as a Tool to Effectively Find Medical, Legal and Other Information

David Dillard BA MLS

Users of search tools on the internet have different ways, methods and styles of searching. Alas, some methods used by search tool users do not effectively mine the topic for which they are digging.

When one searches in tools like Google, Google Scholar and Google Books for a single phrase or a single word, one is simply searching for a term or phrase that is of importance to the more complex topic one is seeking to learn about. Such simple searches can result in the consumption of large amounts of time as so much may be written about the word or phrase searched that one will have a hard time finding sources that focus on exactly what the searcher wants to know about that term, because other aspects of the topic are ignored in the search. The searcher hopes to spot sources devoted to the complete topic amongst the sources found searching the one word or phrase. Consider the phrase *life care planning*.

To search this as a phrase, most databases, like Google Books and Google Scholar, require that the phrase be surrounded by quotation marks to make the search tool recognize these words as a phrase. Google Scholar finds 1,600 sources for a search of this phrase, thus:

http://tinyurl.com/k8udk9c

*Life care planning* is discussed in these articles in many contexts: decision making, closed head injury, treatment preferences of cancer patients, end of life care, and more. We know that most professionals indicate that the effective use of time is very important to them. Searching through hundreds or thousands of citations is a very poor use of a large amount of time. It will also result in good sources being missed as fatigue sets in.

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thousands of publication citations to find topically on target publications is a very poor use of a large amount of time. It will also result in good sources being missed as fatigue sets in. How to be more efficient?

Fortunately, there is a better way.
Google, Google Scholar, Google Books, Summon, and Scirus facilitate combining topics so that a search looks not only for various aspects of the topic simultaneously, but also allows the searcher to use synonyms for each major concept. The user can add these synonyms into their search, up to the limit of space allowed by the search tool. To use these techniques of complex searching, one must understand some basic Boolean algebraic methods of search strategy design.

Boolean algebra, also known as symbolic logic, is a discipline taught in mathematics and philosophy as a part of the study of logic. When I was in college, I learned that a math course was required for graduation. Since mathematics causes me terror, high blood pressure, palpitations, and insomnia, I elected to take the much more comforting option of a philosophy course in Boolean algebra rather than a math course in symbolic logic. I did not know then that these were basically the same academic discipline.*

“AND,” “OR,” and “NOT”
In the academic versions of Boolean algebra, unlike its applications to database searching, we learned about the operators “AND,” “OR,” and “NOT” in the context of if/then statements and proof of conclusions that logically result from premises that are assumed to be true.

For example:

- George W. Bush was a president of the United States.
- George W. Bush is a son of a president of the United States.
- Therefore, there is someone who was both a president of the United States and a son of a president of the United States.

Source: Internet Encyclopedia of Philosophy Propositional Logic; References and further reading at http://www.iep.utm.edu/prop-log/

I passed the course with a B, thanked each and every star in the firmament and went on to wonder who in the real world would ever use this nonsense.

Around ten years later, I decided to learn to use bibliographic databases to help people find information on topics they needed to learn about. I continued next page

*I also did not know that the philosophy professor had gotten his doctorate at the University of Chicago while studying under the guru of logical positivism, Rudolf Carnap. Dr. Carnap wrote such books for light reading as these:

- The Logical Structure of the World: And, Pseudoproblems in Philosophy
- The Continuum of Inductive Methods
- The Logical Syntax of Language
- Introduction to Semantics and Formalization of Logic
- Studies in Inductive Logic and Probability
- Meaning and Necessity: A Study in Semantics and Modal Logic

Any one of these titles would be perfect for a nice day under the beach umbrella, as I am sure you will agree.
opened system manuals and guides to searching to find Boolean algebra including Euler’s Circles and Venn Diagrams come back to haunt me. I now was very glad I had had a solid course in this field to serve as a basis for understanding searching logic and research strategies.

**Euler’s Circles** show in a diagram how the Boolean operators “AND” and “OR” and “NOT” function not only for logical problems but also in finding information in a search of a database for a research topic. *(Here’s a Euler’s Circle diagram of the British Isles to give you an idea. Ed.)*

**Boolean algebra works in database searches like parentheses do in arithmetic.** Parentheses change the order of operations in a problem involving a string of numbers separated by operations, addition, subtraction, multiplication and division. Old calculator manuals often showed problems in which the numbers were all the same and in the same order and the operators between them were all the same. All that changed was the position of the parenthesis and all four answers were different. For example, here are two ways to use the same numbers and operations in order, with different results:

**Choice 1:** $4 + 2 \times 3 = (4 + 2) \times 3 = 6 \times 3 = 18$

**Choice 2:** $4 + 2 \times 3 = 4 + (2 \times 3) = 4 + 6 = 10$

In database searching, generally speaking, the use of parentheses in searching separates synonyms or words intended to have the same effect on an overall topic (and are combined with the Boolean “OR” operator) from the several groups of synonyms that are combined with the Boolean operator “AND.” Therefore, searching *life care planning*, a

*continued next page*
A database can find one or more terms from each of the groups of synonyms in any publication listing shown.

Here is a simple example of this kind of search and some of the results found with it. Always remember to capitalize “AND” and “OR” when used in a search as Boolean operators.

(“life care planning” OR “life care planner” OR “life care planners”) AND (“terminal illness” OR “hospice care” OR “end of life”) AND (effectiveness OR success OR outcomes OR benefits OR failure OR failures)

Clearly this search is much more specific than a search of just *life care planning*. It results in 688 sources in Google Scholar. See them at: http://tinyurl.com/mvfx93w

The search results for this search include articles like these:

- Development of a peer education programme for advance end-of-life care planning
- Recognising and managing key transitions in end of life care
- Evaluating a peer education programme for advance end-of-life care planning for older adults: The peer educators’ perspective
- Effectiveness of end-of-life education among community-dwelling older adults
- Attitudes and preferences of Korean–American older adults and caregivers on end–of–life care
- Two and a half weeks: Time enough for end-of-life care planning?
- Physicians' attitudes and practices regarding advanced end–of–life care planning for terminally ill patients at Chiang Mai University Hospital, Thailand
- The supportive care plan: a tool to improve communication in end of life care

- Editorial: End of life care in dementia. Research needed urgently to determine the acceptability and effectiveness of innovative approaches
- Drifting in a shrinking future: living with advanced heart failure
- Do personality traits moderate the impact of care receipt on end-of-life care planning?
- “I don’t want to talk about it.” Raising public awareness of end-of-life care planning in your locality
- Use of the stages of change transtheoretical model in end-of-life planning conversations
- Life-sustaining medical devices at the end of life
- Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making

Granted these titles cover a variety of topics, but they are closer together in general themes than the search results were for a search of just the phrase *life care planning*. Indeed, you might encounter sources covering important aspects of this complex topic that you didn’t consider in your original notion of the kind of article you expected to find.

**However, when results vary widely** from the topic(s) needed, it is a good idea to look at each group of synonyms used in a search to see what can be changed to make a search more effective. **The key to effective searches is a foundation of well- and carefully-selected terminology.** If you put wrong numbers in your tax return, your estimated tax return will be wrong. If your choice of words in a search is not careful, you may see many or mostly inappropriate sources in the search results. Databases are not mind readers.

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Applying Boolean Logic to Your Search Topic

Now, let’s see how you can effectively apply Boolean logic to a medical science research topic, the effectiveness of treatments for chronic regional pain syndrome.

In searching the phrase in Google we discover this phrase quickly as well: complex regional pain syndrome.

We also find this: reflex sympathetic dystrophy.

Therefore our first group of synonyms can be made up of these terms. Remember, phrases are always searched within quotation marks.

(“chronic regional pain syndrome” OR “complex regional pain syndrome” OR “reflex sympathetic dystrophy”)

These terms come to mind when thinking of both pain and treatment for the treatment aspect of this search.

• treatment
• therapy
• counseling
• drugs
• prescription medicine
• physical exercise
• yoga
• acupuncture
• alternative medicine

These then would be put this way:

(treatment OR therapy OR counseling OR drugs OR “prescription medicine” OR “physical exercise” OR yoga OR acupuncture OR “alternative medicine”)

Finally we look at terms that suggest outcomes or effectiveness of treatment

• “evidence based practice” OR
• “standards of care” OR
• “standard of care” OR
• outcomes OR
• longitudinal OR
• effective OR effectiveness OR
• “best practices” OR
• results OR
• benefits OR
• “qualitative research”

These would then be put this way:

(“evidence based practice” OR “standards of care” OR “standard of care” OR outcomes OR longitudinal OR effective OR effectiveness OR “best practices” OR results OR benefits OR “qualitative research”)
this exceeds the number of characters allowed in a search of Google Scholar and other such tools, so we’ll have to eliminate some terms while keeping what we think are the best. Leaving the terms for the medical condition untouched, we can remove, from the second group, these terms:

- counseling
- “prescription medicine”
- “physical exercise”
- yoga
- acupuncture

From the third group I will remove:

- “standard of care”
- effectiveness
- results
- benefits
- longitudinal
- effective
- “qualitative research”

So, finally, the search is written as this:

(“chronic regional pain syndrome” OR “complex regional pain syndrome” OR “reflex sympathetic dystrophy”) AND (treatment OR therapy OR drugs OR “alternative medicine”) AND (“evidence based practice” OR “standards of care” OR outcomes OR “best practices”)

This search in Google Scholar lists 9,750 results and can be viewed at this web address: http://tinyurl.com/me9ghgz

This search leads to source titles like these:

- Short-and long-term outcomes of children with complex regional pain syndrome type I treated with exercise therapy
- Economic evaluation of spinal cord stimulation for chronic reflex sympathetic dystrophy
- Physical therapy and cognitive-behavioral treatment for complex regional pain syndromes
- Pain and reduced mobility in complex regional pain syndrome I: outcome of a prospective randomised controlled clinical trial of adjuvant physical therapy versus occupational therapy
- Adjuvant physical therapy versus occupational therapy in patients with reflex sympathetic dystrophy/complex regional pain syndrome type I
- Does evidence support physiotherapy management of adult Complex Regional Pain Syndrome Type One? A systematic review
- Long-term outcomes during treatment of chronic pain with intrathecal clonidine or clonidine/opioid combinations
- Defining the therapeutic role of local anesthetic sympathetic blockade in complex regional pain syndrome: a narrative and systematic review
- Long-term outcomes of spinal cord stimulation with paddle leads in the treatment of complex regional pain syndrome and failed back surgery syndrome
- Psychological and behavioral aspects of complex regional pain syndrome management

Want more? The following links give the results for the same search in three other databases:

Google Books
http://tinyurl.com/n4whngt

SCIRUS
http://tinyurl.com/n7lrt4y

Temple Summon Search
http://tinyurl.com/ktnmfp

Summary
The more you learn to think clearly and precisely in organizing your searches and applying Boolean concepts to them, the more effective and on target
your search results will become. The computer has taken researchers away from the print index restriction of looking under one subject heading at a time. You will find that Boolean operators will help you make a computerized database search tool an effective, efficient instrument for finding needed information on precise topics. Below are links to some web sources that explain the use of Boolean operators for searching databases and more information on Euler’s circles.

**MIT Libraries**
Database Search Tips: Boolean Operators
http://libguides.mit.edu/content.php?pid=36863&sid=271373
[All the tabs on this guide could help you learn to be a better searcher!!!]

**Basic Database Searching Techniques**
Indiana University Libraries
Bloomington
http://www.libraries.iub.edu/?pageId=1002224

**Video**
https://www.youtube.com/watch?v=lHznshgcVDk
(Describes how to build a search using a multistep tool, an EBSCOHost Database)

**Searching Databases: Boolean Basics**
San Diego State University Library & Information Access

**Introduction to Boolean Logic**
PubMed Tutorial

**Advanced Database Searching**
Crowder College
http://crowder.libguides.com/content.php?pid=163246&sid=1378633

**Database Searching and Boolean Operators**
http://tinyurl.com/mwh79wp

**More Database Searching and Boolean Operators**
http://tinyurl.com/kuz4uhp

**Euler’s Circles:**
- Applied Logic: How, What and Why: Logical Approaches to Natural Language
- Volume 247 of Synthese Library, ISSN 0166-6991
- Volume 247 of Synthese Library: studies in epistemology, logic, methodology, and philosophy of science
- Editors: László Pólos, M. Masuch
- Publisher: Springer, 1995
- ISBN 0792334329, 9780792334323
- 392 pages
- Logic as a Foundation for a Cognitive Theory of Modality Assignment, on page 321
- View the illustration on page 338 to see examples of the use of Euler’s Circles.
- http://tinyurl.com/mmgpdom
Caring is a central element of nursing practice (Potter & Perry, 2001). Leininger (2001) and Watson (1994) developed nursing theories that espouse the primacy of caring in nursing. Benner, Tanner and Chesla (1996) also affirmed that caring is a primary function of the nurse in their study of expertise in nursing. The American Nurses Association (ANA) (2003) stated that an essential feature of professional nursing is the provision of a caring relationship that facilitates health and healing. Yet nursing, as one of a multitude of health care professions, does not have a monopoly on caring. Physicians, pharmacists, physical therapists, and occupational therapists all have references to caring in their literature (Fjortoft & Zgarrick, 2003; McLeod, 2003; Ries, 2003; Sachs & Labovitz, 1994; Stiller, 2000; Wright & Carrese, 2001; Wright-St. Clair, 2001). What, then, makes caring by the nurse different from care received from other health professionals? Valentine (1997) has suggested that caring is a mul-

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A multidimensional concept that consists of attributes of the nurse including professional knowledge, vigilance, and therapeutic communication. Knowledge and communication are required elements in the practice of all health professionals. We submit, therefore, that professional vigilance is the essence of caring in nursing, and, as such, defines the key role of nursing within the health care system.

Vigilance has been defined as "a state of watchful attention, of maximal physiological and psychological readiness to act and of having the ability to detect and react to danger" (Hirter & Van Nest, 1995, p. 96). Drawing upon and adding to the precision of this definition, professional nursing vigilance may be defined as a state of scientifically, intellectually, and experientially grounded:

- Attention to and identification of clinically significant observations/signals/cues;
- Calculation of risk inherent in nursing practice situations; and
- Readiness to act appropriately and efficiently to minimize risks and to respond to threats.

Professional nursing vigilance is based on nursing knowledge and is prerequisite for informed nursing action. Vigilance is the backdrop against which professional nursing activities are performed. It is the sustained attention, the perpetual scanning, that must always be present as nurses practice. Vigilance is not the action of taking the vital signs, dressing the wound, or starting the IV. It is the "watch-ful-ness" that is always a part of the nurse’s thinking process as activities such as these are completed. The purposes of this article are to provide support for the idea that vigilance constitutes the essence of nursing practice and to suggest an alteration in nursing terminology that will reflect the fundamental nature of vigilance in nursing.

**Historical Support**

Nightingale (1860/1969) recognized the importance of vigilance in nursing. In Notes on Nursing, she wrote:

> The most important practical lesson that can be given to nurses is to teach them what to observe — how to observe — what symptoms indicate improvement — what the reverse — which are of importance — which are of none — which are evidence of neglect — and of what kind of neglect. All this is what ought to make part, and an essential part, of the training of every nurse (p. 105).

Nurse scholars have repeatedly acknowledged that observation is a vital element in the practice of nursing. In their 1939 text, The Principles and Practice of Nursing, Harmer and Henderson devoted an en-
tire chapter to the observation of the patient. They stated:

The habit of observation is one of the most (if not the most) essential qualities in nursing. ...The responsibility [to observe] is distinctly that of the nurse, for during the greater part of the time she is the only one present to care for the patient and thus to observe and report. Without close observation...a nurse can not carry out the first essentials in nursing—those measures not prescribed by the doctor but dictated by the underlying principles and methods of nursing itself (p.219).

In another early text, McClain (1950) proposed, "in observing the nurse must know what she is looking for and, to a certain extent, what she is likely to find. Observation is based on knowledge, interest and attention" (p. 51).

The appreciation of this ability of nurses to recognize important cues in their patients continued into the era of the grand nursing theories in the 1970s. Carper (1978) identified the ability to perceive as part of the aesthetic pattern of knowing in nursing. She defined perception as the "active gathering together of details and scattered particulars into an experienced whole for the purpose of seeing what is there" (p. 17). King (1971) and Orem (1985), among others, affirmed the importance of perception as an important nursing ability.

Theoretical Support

Current professional and lay literature is replete with stories of errors in the health care system and with issues that revolve around patient safety. In 1999, the Institute of Medicine concluded that at least 44,000, and perhaps as many as 98,000, people die in hospitals each year as a result of preventable errors (p. 1). This report received an enormous amount of attention in both lay and professional nursing press. Clearly, the public and the profession are concerned with our ability to be vigilant caregivers.

Curtin (2003) presented an integrated analysis of nurse staffing and its effect on patient outcomes. She concluded that nursing staffing had a definite and measurable impact on patient outcomes, medical errors, length of stay, and patient mortality. Why does having an adequate number of nurses at the bedside result in these improved outcomes for patients?

We submit that appropriate staffing allows nurses to maximize their practice of professional vigilance for their assigned patients. There are limits to the human ability to sustain vigilance. To prevent airline disasters, air traffic controllers are allowed to accept responsibility for a limited number of planes. Likewise, nurses can only be reasonably expected to

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"watch out" for a certain number of patients. The optimal practice of professional vigilance is critical to ensuring the safety of patients in health care settings. The question is: How is professional nursing vigilance practiced to maximize intended patient outcomes and minimize adverse outcomes?

Exploring the concept of vigilance in psychology can suggest an answer to this question. Loeb and Alluisi (1984) conceptualized vigilance within the theory of signal detection. According to this theory, vigilance is the search for signals. Signals are events that the individual determines to be indicators of something significant and always occur against a background of "noise." The challenge for the individual is to correctly determine if the signal is indeed significant or merely a manifestation of background noise. For instance, is that ringing sound really the telephone (a signal) or part of the background noise (television, radio, stereo) that is typical of the everyday hubbub in a home?

The mental processes that individuals use to differentiate signals from noise have been studied extensively in psychology and, to a lesser extent, in nursing. In a grounded theory study of women with migraine headaches, vigilance was conceptualized as "the art of watching out," predicated on a particularized knowledge of the condition in each respondent (Meyer, 2002). Vigilance resulted in a decision to take, or not to take, an action. Vigilance was not seen, felt, or heard by others. It was only through the action that resulted from "watching out" that others could infer that vigilance had occurred. The elements of vigilance derived in the migraine study have been adapted for relevance in nursing: attaching meaning to what is, anticipating what might be, calculating risks, readiness to act, and monitoring the results of interventions (Figure).

**Attaching meaning to what is.** The first component of vigilance Meyer (2002) defined was attaching meaning to what is. Attaching meaning is a basic element of nursing practice. When a nurse walks into a patient’s room, he or she begins to scan the patient and the environment for signals. Questions immediately arise: "What is going on here?" "What does it mean?" "Is it significant?" Assessments follow the questions to determine the "what is." Nurses spend much of their time with patients gathering data: taking vital signs; auscultating heart and lung sounds; observing performance of activities of daily living; and ascertaining capabilities. Gathering and recording data is

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only one part of the nurse’s responsibility in patient assessment. To complete an assessment, the nurse must attach nursing meaning to what is heard, seen, and felt (Orem, 2001). Attaching meaning to observations allows the nurse to make inferences about what observations require intervention and what observations are "within normal limits." Attaching meaning allows the nurse to differentiate signals from noise.

Nurses attach meaning to "what is" in the context of their knowledge, experience, and education. This is the pattern recognition phenomenon described by Benner (1984). To recognize patterns, nurses must not only have abstract knowledge about the phenomenon at hand, they must also have developed the intellectual capacity to contextualize and to adjust what is known to the particular case (Paul & Heaslip, 1995). The expert nurse who detects a slight change in the breathing pattern of a patient, and knows that the change requires immediate intervention, is attaching meaning to what is. This is why educated, experienced, professional nurses are valuable at the bedside of the patient. Their ability to perceive signals and to determine the relevance of those signals cannot be matched by unlicensed personnel taught only to collect and record health data at prescribed intervals. Such personnel might be able to gather data accurately, but they do not have the educational preparation and scientific background needed to attach meaning to those data.

In brief, to recognize patterns is to attach meaning to the assessment of the "what is." The attachment of meaning leads to making nursing diagnostic statements (Figure). Stating the diagnosis is not professional vigilance; it is an informed action that results from that vigilance. It is only through that action, however, that others see that vigilance has occurred.

**Anticipating "what might be."** While assigning meaning to "what is" actually happening with a patient is an essential facet of nursing practice, the ability to anticipate and observe for "what might happen" is another critical component of professional vigilance. Consider the case of Mr. P., an 86-year-old patient with a history of atrial fibrillation who was being maintained on warfarin sodium at home. Mr. P. is immediately postoperative following an emergency hip pinning. His nurse decides to take vital signs more frequently than ordered, repeatedly

*continued next page*
checks his dressing and assesses his mental status with every encounter. Mr. P.’s nurse is attaching meaning to "what is" but is also asking, "What might happen here?" "How will I know?" This nurse knows that Mr. P. is at significant risk for hemorrhage and is watching out for what might happen; for what might be called the "need for rescue."

The term "failure to rescue" has recently received attention in the nursing literature (Clarke & Aiken, 2003). Failure to rescue is defined as a clinician’s inability to save a hospitalized patient’s life in the event of a complication (a condition not present on admission, such as hemorrhaging in the case of Mr. P.) (Clarke & Aiken, p. 43). To "rescue" a patient appropriately, the nurse must be able to anticipate when complications are likely to occur and rapidly recognize cues that indicate that problems are beginning. Surveillance, involving frequent assessments, is required, as is the ability to analyze information and react to the implications of that analysis in a timely manner. Reacting to information and intervening appropriately are the result of professional nursing vigilance and will often include both independent nursing action and mobilization of other members of the health care team.

Calculating the risk. Understanding the risk inherent in any course of action is another aspect of vigilance (Figure). Rarely in nursing practice is an intervention totally risk free. The frail, emaciated patient for whom the nurse elevates the head of the bed to facilitate breathing has an increased risk of developing a pressure ulcer on his coccyx due to shearing and friction. Lowering the head of his bed may reduce his pressure ulcer risk, but will increase the work of breathing. Administering opioids for pain to bedridden patients may increase the risk of pneumonia by depressing respirations, but may reduce the risk of pneumonia by enhancing mobility and permitting nursing-prescribed deep breathing and coughing. Allowing the woman with Alzheimer’s disease to wander in a restricted area may increase her risk of injury, but decrease her agitation. Helping the adolescent with diabetes configure his meal plan to incorporate a fast food meal eaten with friends may have some short-term risk, but may result in better overall diet adherence. Nurses become adept at seeing and calculating the risk inherent in these and other courses of action, and juggling that risk to maximize intended, and minimize unintended, patient outcomes. This ability to weigh and...
minimize risk is a characteristic of professional vigilance.

**Staying ready to act.** Readiness to act is another key component of the nurse’s ability to "watch out" (Figure).

Every Kelly clamp taped to the bed of the patient with a chest tube and every suction machine on standby at the bedside of a patient being fed for the first time following a stroke are testaments to a nurse’s vigilance. Public health nurses who go out into the community with their well-stocked "nursing bags" are staying ready to act, as are nurses who can be counted on to have tape or scissors or an alcohol wipe in their lab coat pockets. This readiness is about more than mere convenience. It is born of a knowledge base that allows the nurse to know what things might be required in what situations, and to make sure that intervention can be accomplished quickly when necessary.

**Monitoring results/outcomes.** The final component of vigilance Meyer (2002) uncovered was monitoring results. This is fundamental to nursing practice. Nurses project and monitor the achievement of outcomes on an ongoing basis. Because nurses are often the only health care professionals at the bedside of hospitalized patients for 24 hours a day, they are charged with monitoring the results of not only their own interventions, but of the interventions of others. The physician will ask about the patient’s response to furosemide administered last evening and the physical therapist will ask about whether or not there has been any improvement in the patient’s ability to transfer from bed to chair. By monitoring the effectiveness of actions, and making judgments about what interventions work, or don’t work, in specific situations, nurses continually adjust patient care and build the multifaceted knowledge base that Benner (1984) described as a characteristic of expertise in nursing.

**Vigilance and Nursing Terminology**

Vigilance is the mental work of nursing; it is a prerequisite to informed nursing action. Because this mental work is the essence of nursing and one of the nurse’s primary functions in the health care system, it should be described and included in our nursing terminology. Samuel Johnson, an influential English lexicographer of the 18th century, said, "Language is the dress of thought" (1905/1967,p. 58). The advancement of the profession of nursing requires that we name those things we spend so much time and
Beginning nursing students often hear, "If you didn’t chart it, you didn’t do it." This maxim may be hyperbolic, but it indicates that the failure to communicate the nurse’s work renders it invisible to others. As nursing documentation becomes increasingly computerized, it will become vital to enter terms that represent the mental work of nursing to convey nursing’s contribution to patient care, aggregate and analyze nursing data, and facilitate payment for nursing activity. It has been relatively easy for nurses to document what they do. Nurses routinely chart the medications they have given, the treatments they have done or the teaching they have initiated. Unfortunately, it has not always been as easy for nurses to attach a label to what they think and to communicate the judgments that result from the mental work of professional vigilance.

Diagnosis of phenomena is an essential step in the application of theory to explain a condition and to determine actions to be taken for treatment. In the 1980 Social Policy Statement on nursing, the ANA stated that the phenomena for which nurses were responsible were brought into focus by naming or diagnosing them (ANA, 2003, p.42). The 2003 Social Policy Statement identified the use of judgment and critical thinking in the application of scientific knowledge to the process of diagnosis as one of the essential features of professional nursing (ANA, p.5). In 41 of the 50 states and the District of Co-

Figure. Professional Nursing Vigilance

![Diagram of Professional Nursing Vigilance]

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lumbia, the nurse’s responsibility to diagnose is delineated in the nurse practice act (Lavin, Avant, Warren, Craft-Rosenberg, & Braden, 2003). Nursing diagnoses reflect the clinical judgments made by professional nurses.

North American Nursing Diagnosis Association (NANDA) International (2003) defined a nursing diagnosis as a clinical judgment about individual, family and community responses to actual or potential health problems or life processes (p. 263). Vigilance is the basic skill that nurses need to make these judgments. NANDA International stated that a nursing diagnosis must be one for which the nurse can select nursing interventions and be held accountable for the outcome. This type of nursing diagnosis is familiar to most nurses. Labels such as "ineffective airway clearance," "activity intolerance," "self-care deficit," and "risk for falls" are NANDA-approved diagnoses and are used in many standardized documentation systems. These labels could be considered central nursing diagnoses because they reflect independent nursing practice.

Nurses have long known that not all phenomena for which they are concerned are well represented by current nursing diagnosis terminology (Carpenito, 2000). Nurses who observe the patient with brittle diabetes for hypoglycemia or hyperglycemia, the newly post-operative hip pinning patient for hemorrhage, or the postoperative thyroidectomy patient for hypocalcemia are certainly practicing the vigilance that is the essence of nursing. However, current diagnostic language does not include appropriate terms to represent the identification of these risks, even though this type of vigilance is fundamental to nursing. We propose that a second type of nursing diagnoses is needed, one which is called surveillance diagnoses.

A surveillance diagnosis, like a central diagnosis, is a clinical judgment about individual, family, and community responses to actual or potential health problems or life processes. For surveillance diagnoses, the nurse is accountable for professional vigilance and the recognition (or diagnosis) of the problem, but is not solely accountable for the interventions or outcomes. Rather than selecting interventions independently, the nurse participates, interprofessionally, in the ongoing management of the problem. Surveil-

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lance diagnoses are risk diagnoses, for example: risk for hypoglycemia; risk for hemorrhage; risk for increased intracranial pressure; risk for hypokalemia; and risk for deep vein thrombosis.

A search of the nursing literature demonstrated that diagnoses of this type are of interest and concern to nurses. We conducted a search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) from 1982 through 2005 via the Ovid database on March 23, 2005. We entered the term hypoglycemia and limited the retrieval to nursing journals; 466 articles were found. When we limited the search to diagnosis, prevention and control, risk factors, and symptoms of hypoglycemia, 183 articles were retrieved - more than one-third of the total.

Clearly, recognizing and controlling risk for conditions such as hypoglycemia is an integral part of nursing practice. A classification of surveillance diagnoses will enable nurses to name this important work and claim it as a nursing responsibility.

Often, central and surveillance diagnoses exist in tandem. For example, an older adult patient with poor eyesight who is receiving medication for hypertension has a surveillance diagnosis of "risk for orthostasis." For this diagnosis, the nurse would be monitoring changes in lying, sitting, and standing blood pressures and consulting with the primary care provider and pharmacist about altering the medication regimen if the problem becomes severe. This patient also has a central diagnosis of "risk for falls related to orthostasis and poor eyesight." As with the surveillance diagnosis, this diagnosis calls for clinical nursing judgment, but it also calls for independent nursing action to treat with teaching, safety measures, and more frequent observation. Even though these are both risk diagnoses, there is an important difference. The nurse shares responsibility for the management or prevention of the orthostasis, but is independently accountable for preventing falls in this patient.

Conclusion

Vigilance is the essence of caring in nursing and nursing terminology should adequately reflect this fundamental aspect of our work. Florence Nightingale’s soldier patients acknowledged her vigilant presence by referring to her as "the lady with the lamp" when she walked among the cots at Scutari. Today, nurses are similarly engaged in watching out

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for their patients to promote their recovery and ensure their safety. Vigilance in nursing requires both caring and expertise (Cullens, 1999). We must be able to name this vigilance, describe it, and communicate it, or risk having this unique aspect of our work be invisible to others. Nursing terminology, as the external manifestation of professional thinking or the "dress of our thoughts," must be revised to encompass all the mental work that nurses do, not just those aspects that reflect independent nursing practice. Both central and surveillance diagnoses have a place in nursing language.

Nurse caring is actualized through vigilance. As Nightingale (1860/1969) said, "For it may be safely said, not that the habit of ready and correct observation will by itself make us useful nurses, but that without it we shall be useless with all our devotion" (p. 112). It is time to make sure that our nursing terminology represents both our caring and the primacy of our professional vigilance.

References

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Fall sheep
Qualifying as an Expert Witness

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Abstract: This article will discuss the basic principles of qualifying as a witness for expert testimony. A worksheet approach is used to assist the nurse life care planner in determining how he or she meets federal requirements of Rule 702. By mapping his or her qualifications in this manner, the life care planner is well prepared for meeting Daubert challenges and can assist the retaining attorney in presenting the qualifications to the court. Furthermore, by using this method, the expert gains confidence when providing testimony and can better support the recommendations included within the life care plan.

An expert witness is one who is allowed to provide opinion testimony at trial which is based upon his or her specialized knowledge, experience, or training. The expert witness was created and the use is maintained by the legal system. The courts and their legal counsel have focused much energy in litigation on defining the parameters of expert testimony. Because the expert’s ability to offer opinions can be a powerful influence in trials, the courts must ensure that the expert’s testimony is an effective aid to the court rather than a burden or hindrance. In an attempt to ensure this, the courts have defined the role of expert witness and developed formal rules regarding evidence.

The expert witness performs two primary functions. The expert serves a scientific function by collecting, testing, and evaluating evidence and forming an opinion as to that evidence. The nurse life care planner as an expert typically collects data, assesses, and evaluates then produces a report which confirms, substantiates, and concludes. He or she also serves in a forensic role by then communicating that conclusion or opinion (and its basis) to the court. The purpose is to provide information that makes something more evident than it was before. The statements made by an expert should be those on which a juror or judge can base a belief as to their accuracy.

Before testifying before a jury, an expert witness must be qualified by the court by meeting certain admissibility standards. Typically states use either Frye or Daubert definitions related to expert witness testimony. Some legal scholars argue that a state’s choice to follow either Daubert or Frye ultimately makes little difference in how judges handle scientific evidence.
A 2005 study published in the Virginia Law Review, found “no evidence that Frye or Daubert makes a difference” (Cheng and Yoon).

Rule 702 of the Federal Rules of Evidence (next page) and state laws serve to define the expert witness. In a very simplified description, Rule 702 states that the opinion of an expert must be reliable, relevant to the issues of the case, and will help the jury understand the evidence or to establish fact(s) of issue in the case. The basic requirements are divided into four parts: qualifications, reliability, helpfulness, and foundation (Hutchinson). The Daubert court determined this fourth helpfulness element required that the opinion have a “valid scientific connection to the pertinent injury” as a precondition of admissibility (Hutchinson). Qualifying as an expert is not usually a problem so long as the expert is able to demonstrate how his or her knowledge, skill, experience, training, or education is relevant to the opinions offered in the case.

The retaining attorney is responsible for convincing the judge that the witness possesses specialized experience and training. The opposing attorney then has the right to cross-examine the expert witness in an attempt to disprove his or her qualifications. Questioning is typically focused on the expert’s background, training, education, skills, experience, and knowledge. [Figure 1] The expert must have specialized knowledge, ability beyond that of a layperson. The expert does not need to be the best in his field and has to meet only a minimum standard to satisfy the rule. Education and degrees are often highly regarded as evidence of expertise; however one does not have to be an alumnus of an Ivy League school. According to James J. Mangraviti, Jr., Esq. of SEAK, the vast majority of top notch expert witnesses have ordinary academic backgrounds and many expert witnesses without any college degree whatsoever commonly testify.

This means one does not have to be advanced in a life care planning career in order to be a successful

States that Follow the Federal Daubert Standard

- Alaska
- Arizona
- Arkansas
- Colorado
- Connecticut
- Delaware
- Georgia
- Hawai‘i
- Idaho
- Indiana
- Iowa
- Kentucky
- Louisiana
- Maine
- Massachusetts
- Michigan
- Mississippi
- Montana
- Nebraska
- New Hampshire
- New Mexico
- Ohio
- Oklahoma
- Oregon
- Rhode Island
- South Dakota
- Tennessee
- Texas
- Vermont
- West Virginia
- Wisconsin
- Wyoming

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expert witness. Life care planners should never assume that they must have completed many years in the field, written a certain number of plans, or accomplished particular milestones to serve as expert

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witnesses. Mangraviti reminds us that there is an important conjunction in the rule: the word or. The expert needs to have knowledge, skill, experience, training or education. The conjunction is or, not and. This means that in Rule 702, only one of the above five are needed, not all of them.

An expert witness can also be qualified based on experience and skills alone, e.g., in the Supreme Court case of Kumho Tire, perfume testers were given as an example of experience-based experts. The expert witness must be able to explain how his experience is sufficient as a basis for his opinion and how the experience is applied to the facts of the case. (See Hutchinson’s Appendix B for the 2000 amendments to Rule 702, plus advisory notes.) For example, many life care planners have previous experience in case management that could be qualifying under the standards.

As discussed, there is no absolute rule as to the degree of knowledge required to qualify a witness as an expert in a given field. Witnesses must be skilled in the subject matter. They may be found eligible through knowledge, training, education, skill, experience, or a combination of these factors. At a minimum, the expert witness must know the underlying methodology engaged and relied upon as a basis for their opinions.

Qualifying as an expert witness is usually easy if you limit your testimony to areas in which you possess ample knowledge, skill, experience, training, or education. Background knowledge includes state of art technology, literature review, and experience culminating in an opinion based upon a reasonable degree of scientific certainty. Background information must be “of a type reasonably relied upon by experts in the particular field.” For example, an accident reconstructionist could not rely only on statements made by bystanders (Hutchison, citation 22). Foundational data must be accurate and accurately reflect the undisputed circumstances of the case (Hutchison, citation 23). Even if the expert’s technique is valid, his opinion is not reliable if he misuses the methodology (Hutchinson, citation 28).

**Methodology**

Methodology is the practice, procedures, and/or rules used by those working in a discipline or engaging in an inquiry. It is not a package of various methods, but rather the designed process for carry-

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ing out research or the development of a life care plan and not some tool or instrument. Frameworks containing basic assumptions and ways of practicing commonly accepted by a life care planning association members, such as the AANLCP Standards of Practice (2012), satisfies most criteria for methodology.

Daubert defined the standard for evidentiary reliability. Generally the requirement is that the expert’s methodology must be grounded in the methods and procedures of the field of expertise. Daubert suggested the guides for evaluating the opinions, but the elements applied vary with the type of discipline involved.

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Figure 1: Sample questions used in qualifying the expert witness.
The methodology should be reliable, consistent from case to case, transparent in a way it could be replicated and is understood, valid, relevant to the individual’s situation, and through. It is not sufficient to simply cite reliable principles and methods then reach a conclusion without demonstrating how the opinion relied on the methodology. Ask yourself questions such as:

- What methods or procedures were used during the client evaluation?
- Is this method an accepted and commonly used method in life care planning?
- How reliable are results obtained using such a method?

Then qualify the methodology to the current case:

- How do the facts at hand apply to this particular test?
- How were the data collected and the test(s) conducted?
- How were the results verified?
- Who, if anyone, has further reviewed the findings/used these findings?

Knowing the methodology is especially important when it comes to meeting the next step: the presentation of the expert to the court.

**Presenting the Witness to the Court**

Generally in order to qualify an expert witness, introductory questions are posed from the retaining attorney regarding the expert’s professional background. This serves two goals: to demonstrate to the judge that the expert possesses at least the minimum qualifications to give an opinion on a particular subject, and to persuade the jury or fact finder that the expert’s judgment is sound and the opinion(s) correct. It is the second goal that stresses methodology used.

Some opposing attorneys might offer to stipulate to the qualifications of an expert without the introductory questioning. This is done in an attempt to prevent the jury from hearing the expert’s credentials. Attorneys can avoid this tactic by advising the court that the jury would have to hear the qualifications in order to adequately judge the witness’ credibility. This can be especially important when this expert is better qualified than the opposition.

Because the retaining attorney may not fully understand a nurse life care planner’s licensing, credentials, training, and education, it is important for the nurse life care planner to know the information which meets the criteria for qualifying as an expert and provide this in an organized fashion. Some life care planners have found it helpful to share the information in an outline format so that the attorney has a “script” that can be used in introductory questioning are posed to the expert on the stand in the qualifying process. This outline can also highlight experience or education that is of particular importance in the specific case for which the life care planner is attempting to qualify. The worksheet that at the end of this article might be the starting point for such an outline for retaining counsel.

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It is not necessary to reveal every single distinction of one’s qualifications. The jurors are less likely to connect with an expert if they feel resentment by an immodest display of awards, degrees, and accolades. This can also result in decreased believability of the testimony by said witness. It is the attorney’s job to ask the appropriate questions to elicit the credentials rather than the witnesses parading their accomplishments in front of the court. Once the questioning of the witness has concluded, the court then makes a ruling on whether or not the witness will be accepted as an expert in their field. Once competency is satisfied, a witness’ knowledge of the subject matter affects the testimony’s weight and credibility. (Sapir http://www.chm.uri.edu/forensics/courses/Appendix%20-%20forensic%20science%20&%20expert%20witness/Voir%20Dire.pdf)

By following a systematic approach, life care planners not only reveal how the standard was met, but also becomes more confident in their bases for qualification, which is often helpful on the witness stand. By fully understanding the nuances of qualifying as an expert, the life care planner gains confidence, provides the retaining attorney a script for qualifying questions, and meets or exceeds the standards of the court. The expert is presented to the court to provide information to the trier of fact. The role is an important one and is not to be taken lightly. By studying the Federal Rules of Evidence against the life care planner’s own background, and outlining their qualifications in the attached worksheet, the planner demonstrates credentials in a confident and systematic way to assist the retaining attorney in representing those qualifications to meet the requirements while bolstering self-confidence on the stand.

continued next page
Worksheet

Step 1-Education and formal training:

This includes formal education, training, academic qualifications, and credentials.

If an expert witness is highly accredited in his field, the retaining attorney should put greater emphasis on the expert’s formal education, training, academic qualifications, and credentials. For example, it is more effective to elicit a medical expert’s formal training while in school than simply having him state where he attended nursing school and completed his education.

The amount of information necessary to convey to the court regarding the witness’s educational background depends entirely on the circumstances of the case. A combination of an impressive technical background in addition to an expert’s humanity is a recipe for success. As an example, one expert was especially persuasive when he had a unique combination of four certifications that no one else in the world had.

List any formal education, training, academic qualifications, and credentials. Be sure to point out specific information regarding your education that may make you uniquely qualified.

**Example:** Graduated from ABC School of Nursing with honors  
Completed BSN with XYZ College of Nursing  
Kelynco 40+ hours of classroom education  
FIG Services-40 hours of education  
University of Florida-continuing education classes in Risk Management, Forensic Nursing  

Worked in a burn unit. Started case management in 1990 and experienced burn patients with ongoing needs. Have a family member who was involved in a fire. Attend numerous educational conferences each year on the subject matter.

Step 2-Experience:

While experience alone may be enough to qualify an expert witness, experience coupled with education or actual training in the expert’s field will demonstrate that he is not only well-versed in an area, but that he has direct experience, as well. For example, if a medical professor is called to testify as an expert to the appropriate standard of care in a malpractice case, and he has current experience in a clinical practice as well, his credibility will be enhanced. With practical experience beyond the academic credentials elicited, the expert will no longer be subjected to the question “Professor, when was the last time you actually handled a case?”

Now, list experience not included in the attainment of your academic degree or certifications. Think about how your experience is particularly meaningful in the case in which you plan to testify.

**Example:**

Nurse since 1994  
Case manager since 2002  
Life Care planner since 2007  
Been in practice as a consultant since 2005  
60+ cases in litigation  
100s of cases managed as case manager  
Special interest in amputation and complex orthopedic injury-patients/clients with amputee patients as young as 18 months old; and as complex as bilateral arm loss, and even quad amputees. Very few people have experience with children and quad amputees are even rarer. Have worked on trials in and out of the state and as far away as Australia.

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Step 3-Additional Considerations:

In addition to an expert’s education, training and experience, there are many other qualifications that can speak to an expert’s credibility. For instance, licenses and certificates, professional associations, awards, research and publications, teaching positions, and of course prior testimony, are all relevant. (citation 49) Many experts devote a large portion of their careers to the forensic side of their respective professions and therefore it is also effective to establish that the witness has testified on both the plaintiff and defense sides. This demonstrates that he is not dedicated to a particular side or a particular type of case.

List any licenses held:

License
- Hold unencumbered RN license in the state of Wyoming

Certifications
- Certified in Case Manager in 2004
- Certified Nurse Life Care Planner by NLCP Cert Board
  - 65-70 hrs of classroom education-major dx
  - 50 hrs home study with development of LCP
  - Four hour exam
  - 60 hours CEUs every 5 years
- Certified Life Care Planner-ICHCC in 1999
  - 120 hours of specialty training in LCP with 16 hrs in methodology and standards of practice
  - Minimum of 3 years’ experience in the field in the immediate 5 years preceding application for certification

- 80 hours of continuing education units over 5 years with 8 hours in ethics
- Case manager or Rehab background required

Conferences
- Attend no fewer than three major conferences per year such as
  - Annually AANLCP Conf
  - International LCP Conf
  - Association of Rehab Professionals Conf
  - Leisure and Learn Workshop
  - LCP Symposium
  - Trial Lawyers Association
  - State Specific Work Comp Commission Conf
  - Annually attend NAMP-SAP conference

Professional associations
- AANLCP
  - Editorial board member from 2005-present
  - Conference Committee for 2009-2011

- Marketing Chairperson 2009-2011
- NNBA
  - Lifetime Hall of Fame Recipient in 2011
- AALNC
  - Past President of State Chapter
- CMSA
  - Active member of County Chapter
- ARN since 2010

Publications
- Numerous publications as seen on CV (list pertinent ones to the case in question)

Teaching positions
- Adjunct faculty; contributing to University of Texas Forensic Science Course
- Numerous ABC educational events
- Teaching attorneys, nurses, community

Prior testimony
- Began testifying in 2000
- State and Federal court
- Never a Daubert Challenge

Example:

Licenses
- Hold unencumbered RN license in the state of Wyoming

Certifications
- Certified in Case Manager in 2004
- Certified Nurse Life Care Planner by NLCP Cert Board
  - 65-70 hrs of classroom education-major dx
  - 50 hrs home study with development of LCP
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  - LCP Symposium
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- Teaching attorneys, nurses, community

Prior testimony
- Began testifying in 2000
- State and Federal court
- Never a Daubert Challenge

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Step 4: Identify with the jury:

By making the expert a three-dimensional person (e.g., asking a series of personal questions – married, children, hobbies, etc.) while avoiding braggadocios language, retaining counsel is able to make the expert come alive for the jury. Moreover, the jury’s ability to understand that an expert engages in far more than just a daily business routine increases the chance that an expert will be viewed as someone the jury can relate to and trust. A large component in the development of the three-dimensional expert is by humanizing him for the jury. For example, if the expert is an oceanographer, he should tell several Jacques Cousteau-like stories about descending to the sea floor in a submarine. Being a “local boy” could also carry weight with a jury. A Mississippi jury will likely give the testimony of a local doctor from Ole Miss greater weight than the testimony of a doctor from Harvard.

List several things the retaining counsel can share with the jury that would increase the likelihood of being seen as a three dimensional person rather than a hired gun.

Example: Married, mother of four, grandmother of seven. Previously owned a store in the same small town as the trial. Registered nurse. Self-employed for the past 15 years. Graduated from ABC School of Nursing in 1990. I have been writing nursing care plans since I began nursing school in the mid 1980s. I am certified as a case manager, a nurse life care planner, and am also an author, presenter, etc. and have a special interest in burn cases such as this.

Step 5-Outlining your qualifications for retaining counsel

Now that you have evaluated all the ways in which you qualify as an expert, think about the specific case in which you plan to testify. How do you specifically have expertise of value in this particular case? Use the steps above to create an outline that can be provided to retaining counsel during a preparatory meeting.

Example:

**Education and formal training**
- Graduated from ABC School of Nursing-with honors
- Completed BSN with XYZ College of Nursing
- Kelynco 40+ hours of classroom education
- FIG Services-40 hours of education
- University of Florida continuing education classes in Risk Management, Forensic Nursing

**Experience**
- Nurse since 1994
- Case manager since 2002
- Life Care planner since 2007
- In practice as a consultant since 2005
- 60+ cases in litigation
- 100s of cases managed as case manager

**Additional considerations**

**Licenses**
- RN license in the state of Wyoming

**Certifications held**
- Certified in Case Manager in 2004
- Certified Nurse Life Care Planner by NLCP Cert Board
- 65-70 hrs of classroom education-major dx
- 50 hrs home study with development of LCP
- Four hour exam
- 60 hours CEUs every 5 years
- Certified Life Care Planner-ICHCC in 1999
- 120 hours of specialty training in LCP with 16 hrs in methodology and standards of practice

**Certificates received**
- Completed education in emergency burn management with Major Hospital; a 16 hour course
- Hold a certificate for first responder class and current CPR certificate

**Professional organizations**
- AANLCP
- Editorial board member from 2005-present
- Conference Committee for 2009-2011

Minimum of 3 years’ experience in the field in the immediate 5 years preceding application for certification
- 80 hours of continuing education units over 5 years with 8 hours in ethics
- Case manager or Rehab background required

**Certificates received**
- Completed education in emergency burn management with Major Hospital; a 16 hour course
- Hold a certificate for first responder class and current CPR certificate

**Professional organizations**
- AANLCP
- Editorial board member from 2005-present
- Conference Committee for 2009-2011

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Step 6- How can you connect to the jury?

**Example:** First became acquainted with burn injuries when my family member suffered a severe burn in a motor vehicle accident. I was a teen at the time, but this is when I realized I wanted to become a nurse.

Now connect the dots by providing a few lines in conversational form that indicates expertise without braggadocio.

**Example:** I am lucky to have worked in many years in orthopedics and neurology which provided an excellent background when I began working in the burn unit. I began in case management in 1990 where I first worked with burn patients on their ongoing care needs. I have had the opportunity to manage the care for 27 burn patients in the past three years. Two of these cases became the subject of publications for our local association’s journal. One week each summer, I volunteer with the local burn camp for kids. In the past I have provided safety education to employers related to burn hazards and emergency treatment. I learned about what Medicare’s expectations are with regard to the cost of ongoing care by having written many cost projections for the insurance carriers for settlement negotiations and by writing and submitting several MSAs to CMS related to burn injuries.

References

Executive Summary
The authors serve as consultants who assist expert witnesses. Each and every week expert witnesses contact us to help solve problems that arise in their practices. The inescapable fact is that 90% or more of the problems we are presented with could have been prevented, solved, or mitigated by a well-drafted expert witness contract.

Problems That Can Be Solved by Bullet-Proofing Your Retention Agreement

**Problem #1: Getting purposefully conflicted out of the case.** Attorneys will “retain” you without committing to paying you anything and without asking you to bill any time on the case. The purpose is to lock you up and prevent you from working for the other side. **Solution:** Clause specifying non-refundable retainer.

**Problem #2: Not getting paid.** Solutions: Clauses specifying that you must be paid in full before reports are issued or testimony is given. Additional clauses allowing for interest and attorneys’ fees; stating that retaining counsel is responsible for paying your deposition fees (this also protects against your deposition fee being reduced by the court as unreasonable); stating that the contract is made with the law firm, not the attorney or the client; stating that you can withdraw if not paid.

**Problem #3: Incomplete documentation.** Solution: Clause requiring the attorney to provide all relevant non-privileged documents.

**Problem #4: Adverse Daubert challenge you are unaware of and that ends your career.** Solution: Clause requiring you be notified of Daubert and similar admissibility challenges.

**Problem #5: Not being properly prepared.** Solution: Clause that allows you to withdraw if not prepared by the retaining attorney.

**Problem #6: Conflicts of interest.** Solution: Clause requiring you to be notified of parties and lawyers and allowing your withdrawal if there is a conflict of interest.

Steven Babitsky, Esq., and James J. Mangraviti, Jr., Esq., are the creators of SEAK’s Expert Witness Retention Contract. Both are former litigators who have trained thousands of expert witnesses. They are the co-leaders of the annual National Expert Witness Seminar and have co-authored numerous texts on expert witnessing including How to Market Your Expert Witness Practice and The A-Z Guide to Expert Witnessing. Steve and Jim currently serve as Principals of SEAK, Inc. – The Expert Witness Training Company. For more information, please visit www.testifyingtraining.com.
**Problem #7: Storage costs.** Solution: Clause specifying that files will be destroyed 30 days after the engagement ends.

**Problem #8: Not knowing when a case settles.** Solution: Clause requiring notification from counsel upon final disposition of case.

**Problem #9: Unethical attorney.** Solution: Clause allowing you to withdraw if the attorney breaches ethics rules.

**Problem #10: Interrogatories prepared without consulting you (such that you may not agree with them).** Solution: Clause requiring your advance approval of interrogatories.

**Problem #11: Not given enough time or resources.** Solution: Clause allowing you to not offer an opinion if you are not provided with adequate time or resources.

**Problem #12: Last-minute cancellations.** Solution: Clauses specifying cancellation fees for last-minute cancellations.

**Problem #13: Being taken advantage of on travel matters (for example, flying Southwest and making 3 connections to save money).** Solution: Clause specifying direct flights where available.

**Problem #14: Scheduling conflicts.** Solution: Clauses specifying when you are unavailable and requiring certain notices for deposition and trial testimony.

**Problem #15: Stuck working for a sleazy or incompetent successor law firm.** Solution: Clause specifying you are under no duty to work for a successor firm.

**Conclusion**

The key to dealing with most of the problems expert witnesses face is to prevent them before they occur. A well-drafted expert witness retention agreement covering the above items is your best defense against such problems.

There are three ways to obtain such an agreement. First, an expert can use the above list as a starting point and draft his own agreement. Second, an expert can hire an attorney on an hourly basis to draft an agreement. Finally, experts who would like a peer-reviewed, widely accepted agreement used successfully by over 1,500 experts should consider SEAK’s Expert Witness Retention Contract.

Keep in mind that whatever agreement you use should never be presented as, “Take it or leave it” to a prospective client. Experts should consider making reasonably requested modifications. Also keep in mind that a fair and balanced retention agreement can serve as a very effective early warning system. A lawyer who flat out refuses to sign such an agreement may not be one you want to work with.
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