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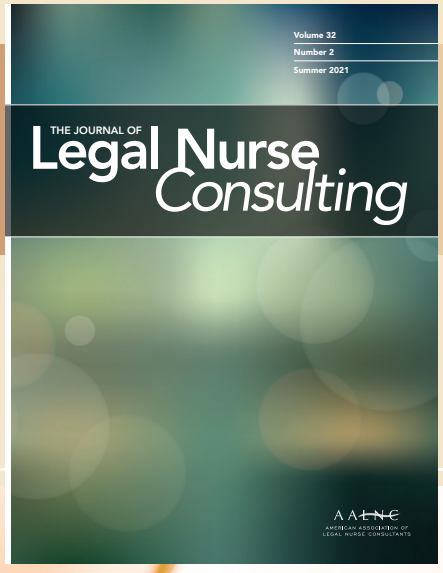

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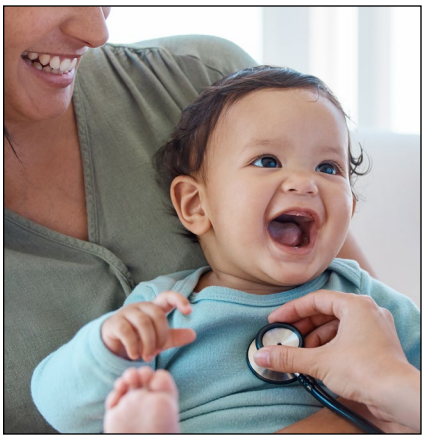

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- writing/APA tips

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PURPOSE

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

MANUSCRIPT SUBMISSION

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

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We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

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The Journal of Legal Nurse Consulting (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The *JLNC* follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: http://publicationethics.org/resources/code-conduct.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

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- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
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- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
- Include a 100-word abstract and keywords on the first page
- Write the manuscript in third person only. If you feel an exception is warranted for the topic of your manuscript, please contact the Editor to discuss.
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Lisa Mancuso,
BSN, RN, CCRN, CLCP, LNCC

President, AALNC

President's Update

We're at that time of year when the heat of the summer is melting into the fresh, brisk breezes of autumn—apple picking, pumpkin spice "everything," and vibrant foliage.

At AALNC, autumn is also the time of year when we are starting our membership renewal campaign and beginning the registration process for our annual Forum. (In case you haven't heard, Forum 2024 will be in Pittsburgh, PA April 18- 20 at the Pittsburgh Omni Hotel: https://www.aalnc.org/Events/AALNC-Annual-Forum)

I interact with a lot of nurses on social media and in "real life." One statement I hear frequently is, "Membership dues are so expensive. I don't see why I need to belong to a professional association." I find this perplexing. I've been a registered nurse for 40 years—I've never NOT belonged to at least a couple of professional organizations. When I research potential physicians, I want to see that they belong to their professional groups. I **expect** my cardiologist to be affiliated with the American College of Cardiology (ACC). I was also very happy when the nurse navigator for my husband's oncologist's practice was a member of the Oncology Nursing Society. Membership in professional associations implies the professional (MD, RN, LNC, etc.) is committed to keeping abreast of the latest knowledge and practices in their specialty.

My typical response is: "If you get just one case through your membership with AALNC, you'll get a return on your investment (ROI) many times over." That's definitely true, but your membership with AALNC offers so much more:

"If you think education is expensive, try ignorance."

– Andy McIntyre

Shared Interest Groups: This is our community for asking questions, getting support, and brainstorming. We have SIGs for Report Writing, Medical Malpractice/Personal Injury, Expert Witness, and the Novice LNC. The conversations have been enlightening and full of information.

Webinars: All webinars give you at least one contact hour for continuing education. This is wonderful for renewing your LNCC, but it's also great because it counts toward the renewal of your nursing license if you practice in a state that requires CEUs. Did you know the average contact hour is $100? As members of AALNC, we have access to TEN webinars per year (a $1000.00 value!)

JLNC: *The Journal of Legal Nurse Consulting* is the only peer-reviewed journal for LNCs. It's published quarterly and includes an article for CEUs as well. The JLNC archives is a wonderful place to research authoritative information for our profession.

Chapters: Over the years I have belonged to nearly all our chapters. I'm currently a member of the Pittsburgh chapter and it's been a wonderful experience. The digital age has allowed us the opportunity to participate remotely. I absolutely LOVE this. I have a local chapter I engage with and enjoy! (There are a few new chapters being developed—stay tuned!)

Bookstore resources: If you haven't shopped in the AALNC bookstore, you are missing out. Your AALNC membership includes discounts for many, many products. https://www.aalnc.org/Resources/Education-Resources

Don't forget to investigate our Affinity Partnerships. These are relationships we have with other professionals who support our goals as LNCs. We have discounts with these sponsors: https://www.aalnc.org/Membership/Member-Discounts

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Editor's Note

I write this note from Ireland where I am attending the *International Academy of Nursing Editors* (INANE) annual conference. This is my first trip to Ireland. My great grandmother and great grandfather emigrated to the United States in the 1920s-1930s. I have had the fortune of traveling to countries and territories outside of the United States before, but there really is something special about visiting the home of origin of your family and ancestors. Please see a special photo I took of the Great Sugar Loaf Mountain near the village of Enniskerry, Ireland included here.

Traveling to other countries can be enlightening and enriching. It can advance and evolve our views of humanity, cultural norms, kindness, food, culture, architecture, art and so much more. It can also help us redefine the things we appreciate (and maybe things we don't exactly appreciate) about our own home country. Of course, there will always be something lovely about visiting a new location because there is a lightness that comes from being on vacation or being away even if it involves business or conferences.

Do we actually really love this place we are visiting as much as it feels like it we do? Are we accurately assessing the location or is it an effect of being "away"? Is it merely a sense of freedom? If we lived in that new location, would we end up being frustrated with the same things we are at home because we had to work and keep up with our obligations? I imagine sometimes this is true. You are who you are to some degree. However, we do also need to find where we are meant to be. Where and what makes our soul shine? Where can we thrive and be our best self? What brings out the best in us? What environment inspires us? Our environments are very important to our quality of life.

I know that mental health experts would say geographical healing isn't going to solve issues, but I tend to think that we can thrive better in certain environments suitable to us as opposed to others. For example, I am a city person. I could not thrive personally in the suburbs. But I completely understand that many friends and family of mine alternatively could never live in an urban environment.

In fact, some people don't even enjoy traveling while others would be forlorn without it. It is vital to find what is best for us as individuals. Traveling ignites something special in me and if it does in you too, I hope you can travel more. I start to plan my next trip while I am still on the current trip. I do have to admit there was something uniquely special about my seeing my great grandparents' place of birth. I could almost hear my great grandmother singing *When Irish Eyes are Smiling* as part of the soundtrack to my trip. I remember her singing and playing the piano when I was a child, and this trip brought these memories flooding back.

See some of the lyrics on the right:

*Maybe I did hear an angel sing?

Thank you,

Shawna Butler

Shawna M. Butler, DNP, JD, RN, CPHRM

(Credited as lyrics written by Chauncey Olcott & George Graff Jr & music composed by Ernest Ball.)

Shawna M. Butler,
DNP, JD, RN, CPHRM

Editor, JLNC

When Irish eyes are smiling,

Sure it's like a morn in Spring,

In the lilt of Irish laughter

You can hear the angels sing.

When Irish hearts are happy,

All the world seems bright and gay,

And when Irish eyes are smiling,

Sure, they steal your heart away

Medicolegal Issues with Pediatric Informed Consent

Melinda Isaak Carr, BSN, RN, CPN

Keywords: minor, pediatric, consent, legal, assent, law, healthcare provider, guardian, confidentiality

The focus of this article is to inform consultants and health care providers of the different medicolegal issues with adolescent assent and informed consent. Family structure, social circumstances and varied state laws may dictate what is considered legal informed consent for treatment of a minor, with the definition of minor being a moving target.

One of the goals of pediatric health care providers is to encourage children to be invested in their health and to establish a trusting relationship with their healthcare providers, preparing for a lifetime habit of health and well-being. To establish this trusting relationship a fine line must be balanced with children, adolescents, and legal guardians to facilitate communication about health care plans, treatments, and lifestyles. The legality of informed consent between a provider and a patient is different when the patient is a minor. Factors such as maturity level, cognitive capacity, age, legal status, state of residence and type of care being provided all play a part in the decisions made, and who has the right to legally consent. Informed consent incorporates two duties: disclosing

information to patients and their guardians and obtaining legal authorization before undertaking any intervention (Katz et al., 2016). In the following paragraphs, exploration of the different definitions and factors that play a role in legal informed consent of pediatric patients will be presented.

In the United States, informed consent laws vary from state to state making it imperative for pediatric providers to be familiar with the mandates of their state. Many states have different laws and definitions for minors, emancipated minors, mature minors and legal guardianship. Information about the laws governing minor status as it pertains to consent for health care is available through the Center for Adolescent Health and the Law and the Guttmacher Institute.

First let's start with some definitions.

A minor in most states is based on the age of majority, or 18 years of age. Legal consent before this time should be obtained from the parent or in a variety of circumstances, the child's legal guardian which could be other family members, foster parents, probation officers, social workers, or juvenile/family courts.

An emancipated minor has attained legal adult status prior to reaching the age of majority through statutes of the court, but most commonly minors are emancipated through the processes of marriage, military service or living separately from parents and demonstrating independence by managing their own financial responsibilities (Olson, 2022).

The mature minor doctrine (Sigman, 1991) has been established in many states and it recognizes a subset of minors who have the maturity and capacity to understand the benefits, risks, and likelihood of success of appropriate interventions. Age, social situation of the minor, cognitive abilities, and overall maturity are considered in a judicial determination that a minor is sufficiently mature to make legal binding decisions in an otherwise legally incompetent minor (Katz, et al., 2016). Most states also recognize a minor if they are a parent, thereby giving them legal right to consent for themselves and their child. However, it is noted that guidance from the young parent's family is an important aspect of helping the young parent in navigating medical decision-making skills.

This activity is designed to increase understanding of different medicolegal issues with adolescent assent and informed consent.

Upon completion of the learning activity the learner will be able to:

a. Define the different laws and definitions of minor, emancipated minors, mature minors and legal guardianship.
b. Identify the difference between consent and assent as it applies to children and adolescents.
c. Identify issues and requirements of providers for legal consent by custodian.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until June 1, 2026.

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CONSENT VS ASSENT

As a child grows and matures, involvement in medical decision making prepares them for future healthcare interactions. This is where the concept of consent versus assent comes into play. Many children can reason through health care issues with careful explanations that take into account their maturity level. However, it is important to note the dual systems of the brain (cognitive-control system and socio-emotional system) are equally needed for critical decision making and these two systems have different maturation rates. The cognitive control system can mature 10-15 years earlier than the socioemotional system. This maturation imbalance leaves the adolescent more likely to be influenced by peers and family, more willing to take risks, and vulnerable to emotional decisions (Diekema, 2020).

It is desirable to obtain a child's assent to a medical treatment plan or procedure because this engagement is optimal for learning self-care. A child as young as seven years old has the ability to be an active participant in some smaller

Using this shared information approach between the family unit and the healthcare provider often provides an avenue for discussion and a treatment plan that is agreeable to all parties.

Factors such as maturity level, cognitive capacity, age, legal status, state of residence and type of care being provided all play a part in the decisions made, and who has the right to legally consent.

health care decisions and as they mature can make more of their own decisions. A shared information approach is quite often successful. The guardian, child and the health care provider discuss options or pathways in a medical care plan, keeping the explanations on the level of the child. A healthy patient-health care provider relationship is modeled, the family unit is recognized and respected, and necessary medical decisions are obtained. (Katz et al., 2016) An example of this would be for an outpatient minor procedure. Prior to the procedure, such as a small incisional biopsy, the different sedation/anxiety medication options could be discussed with the guardians and the child. Then a sedation care plan could be developed to incorporate the child's desire or need for an anxiolytic and/or the choice of local, conscious, or deep sedation. Care should be taken to explain the different types of reaction and side effects to each option of sedation. This provides the child with choices and a feeling of empowerment over the necessary procedure, while giving them a clear example of how healthcare providers can be trusted partners in care.

Conflict happens when the wishes of the adolescent conflict with the preferences of the guardian. If an adolescent's assent is not obtained, then it is necessary to gain consent from the guardian while providing the minor with choices and options within the perimeters discussed and giving them some autonomy and self-control. It is recommended to pediatricians, when care is administered over the objections of a minor, to apologize to the minor as a show of respect to their personal autonomy (Wasserman et al., 2019).

OBJECTION AND REFUSAL IN ADOLESCENT MEDICINE

Using this shared information approach between the family unit and the health-care provider often provides an avenue for discussion and a treatment plan that is agreeable to all parties. This method of information sharing is appropriate with primary care, small procedures and health style decision making. However, in some cases the minor may refuse all treatment plans. In general, medicine determines the authority for decision making based on appropriate decisional capacity and legal empowerment (Katz et al., 2016), leaving a minor with no recourse when parental rights overrule their objection. In instances where major medical decisions are being made, case law involving minor consent continues to evolve but have, in general, weighed that minors should not be allowed to refuse lifesaving treatment even when parents agree (Freckelton & McGregor, 2016).

Of course, not many health-related decisions revolve around life and death. However, topics that can impact an adolescent's life long-term are reproductive planning and care, gender affirming care and treatment of mental health issues. Confidentiality plays are large part with these medical issues in the relationship between a health care provider and an adolescent. It must be established with some parameters based on certain exceptions including abuse, neglect, self-harm, or violence. Once again, individual state's mandates need to be reviewed to determine confidentiality and care limitations placed on healthcare providers. A full discussion of confidentiality in adolescent health care is beyond the scope of this paper.

LEGAL CONSENT BY CUSTODIAN

Many children and adolescents have been separated from their parents because of neglect, abuse or because their parents have been judged as unfit. As a result, there are many children being cared for by grandparents and other family members that legally have no right to consent in major medical decisions. Many times, a caretaker will be granted the ability to consent for minor maintenance health care so that normal activities of daily living can be maintained like immunizations, sick child care and school related requirements. But if a child requires a non-emergent surgery or procedure requiring anesthesia, a caretaker has no legal right to give informed consent. In this circumstance the clinician is required by law to attempt to obtain consent from the legal guardian.

If a child is in foster care or a ward of a county or state, then consents must be obtained from the custodian or social worker assigned to that child. These guardians are temporarily appointed by the courts to protect the interests of the child until custody to another family member or parent is established or the child ages out of the system.

If a treatment is declared a medical emergency, physicians can implement the principle of *in loco parentis* to provide care. In other words, treat now and ask later because the child's well-being requires it. In fact, according to the American Academy of Pediatrics' Policy Statement, "Consent for Emergency Medical Services for Children and

Adolescence" the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates all pediatric patients to be treated in the emergency department regardless of consent or reimbursement issues. As a Federal law, EMTALA preempts conflicting or inconsistent state laws, essentially rendering the problem of obtaining consent for the emergency treatment of minors a nonissue at participating hospitals.

In conclusion, it is recognized that the issue of pediatric informed consent is not a simple process in many cases. As a healthcare provider it is recommended that all attempts to obtain legal informed consent, all conversations regarding consent and with whom these conversations take place, should be documented in the patient medical record. It is also recognized by the American Academy of Pediatrics that a health care professional should always seek assent or consent from the pediatric patient, when possible, based on their maturity and cognitive ability to understand.

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The Anatomy of a Pain and Suffering Report

Francine Barsaloux, MBA, BSN, RN, CMSRN

Keywords: Pain and suffering, report templates, fact witness, medical record summary, psychosocial complications, nursing diagnosis

The new Legal Nurse Consultant (LNC) often seeks out report templates to get a feel for what a report should look like. There are many report templates available in various books and even online. However, it is often challenging to find an example of a pain and suffering report. The goal of this article is to help the new LNC with the logistics of creating their own template for a pain and suffering report.

OVERVIEW

One of the many questions the new Legal Nurse Consultant (LNC) has typically involves report writing. While there are many well-written resources for writing expert witness reports, there is often little educational guidance on the logistics of writing a pain and suffering report. This is because the LNC is writing the pain and suffering report as an expert fact witness and not offering an opinion as a traditional expert witness does (Dickinson & Meyer, 2020). The focus is summarizing the medical record documentation and educating the jury, judge, and attorneys regarding the pain and suffering of the patient. Therefore, the key components of a pain and suffering report will be somewhat different from a traditional expert witness report.

The key components include:

1. Formatting
2. The opening paragraph
3. Qualifications of the LNC
4. A list of documents reviewed to compile the report
5. The social history of the patient
6. The past medical history of the patient
7. A brief introduction of the case
8. Medical record summary
9. Psychosocial complications
10. How to appropriately write a conclusion

FORMATTING

Creating templates for reports is a part of setting up a new company and optimally, it is done prior to the LNC receiving their first case. Each report will be case specific, as there is no "one size fits all" for reports. However, creating the formatting for templates can be the most time-consuming part of writing a report. Once a template with basic formatting has been created, it can be used for subsequent cases (Mangraviti et al., 2014). That being said, each report will have different components depending on the diagnosis. For instance, a medical malpractice case will have some different elements than a personal injury case. As an example, an oncology case will have a chemotherapy component to it that will not be present in a case in which a patient fell. However, basic formatting will remain the same, such as having a cover page, table of contents, header, and footer.

A professional-looking, colorful, cover page, with an appropriately sized and professional style font, the company logo, and/or pictures makes a good first impression on the reader (Mangraviti et al., 2014). Include the company name, contact information, type of report (pain and suffering), patient name, and author (LNC name and credentials). The header on the first/cover page is typically different from the header on subsequent pages as the header on the first page will likely be the company logo. For example, Microsoft Word gives the option of selecting a header that gives you a different first-page header.

The header on subsequent pages can be auto formatted with the report name, patient name, date, and page numbers. This can be placed in the top left or right corners of the page starting on page number two. The date can be set to auto-update in Word and the page numbers will automatically update as you write your report. The footer is typically the company name, website, and phone number and should be at the bottom of every page of the report.

Example of a second-page heading:

Pain and Suffering Report for
Sally Smith
1/1/20203
Page 2 of 50

Example of the footer:

Barsaloux & Associates,
PLLC. | 012.345.6789 |
BARSALOUXASSOCIATES.COM

The use of a table of contents and section headings are particularly important for a pain and suffering report because they tend to be long reports that cover thousands of pages of medical records. Microsoft Word is one example that allows for building and updating a table

This activity is designed to increase understanding of what the logistics of creating a pain and suffering report.

Upon completion of the learning activity the learner will be able to:

a. Define the various components of a pain and suffering report.
b. Identify how to incorporate the ten elements required in the report into a template for an LNC to use for future work product.
c. Incorporate key elements of report learned from examples and sample into an individualized template for pain and suffering reports.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until June 1, 2026.

To receive CE credit, read the article and pass the CE test online at https://www.aalnc.org/Resources/The-Journal-of-Legal-Nurse-Consulting

CEs are free to members during the membership year and can be purchased as a 4-issue subscription of $65/year for non-members.

The LNC should take the time to properly document what qualifies them to be a fact witness in the case.

of contents using their heading styles (Microsoft, 2023). Always remember to update the table of contents as new headings are added. The use of a table of contents with corresponding section headings allows the reader to quickly find what they are looking for and it provides an added layer of organization to the report.

OPENING PARAGRAPH

Always ensure that the top of the first page of the body of the report starts with the date, your attorney client's name, and their contact information. Additionally, the LNC will want to add the patient's name (Re: Sally Smith). Essentially, the report should be started like any other business report or formal letter. Once the formalities of the report are completed the opening paragraph should be brief and state what the retaining attorney requested. This allows the reader to know what type of report was completed, who requested it, and what they will be reading.

For example:

Mr. Attorney,

Thank you for forwarding the medical records for Sally Smith. As requested, I have completed a pain and suffering report with a medical record chronology for Mrs. Smith.

QUALIFICATIONS

The LNC should take the time to properly document what qualifies them to be a fact witness in the case. While the LNC is not offering opinions on the standard of care, the facts within the medical record will be summarized and explained to the jury within the report (Dickinson & Meyer, 2020). Therefore, it is important for the LNC to document what education and experience qualify them to explain the facts.

Areas of importance would include how long the LNC has been practicing, and in what clinical areas of nursing. For instance, for an oncology case, the LNC will want to list how long they have been an oncology nurse, what their area of specialty was (examples are hematology-oncology, surgical oncology, medical oncology, and any specific sub-specialty such as gynecologic oncology) and list the dates of chemotherapy certification. Clinical experience as well as leadership experience, if appropriate, should be documented in this section.

In some jurisdictions, documenting professional qualifications is legally required and failure to properly do so may disqualify the LNC as a witness (Mangraviti et al., 2014). The LNC should discuss with their retaining attorney the scope and extent of the documentation of qualifications for their jurisdiction, as well as attach a copy of their curriculum vitae (CV) to the report. The CV should include a full list of the LNC's education, professional certifications, licensors, current memberships, and a list of any authored publications. The retaining attorney may also ask for a list of cases in which the LNC gave prior testimony (Mangraviti et al., 2014).

LIST OF DOCUMENTS REVIEWED

The LNC should list all medical records and documents reviewed for the case. This includes but is not limited to the complaint, deposition transcripts, expert witness reports, medical records, interviews, and any patient assessments or interviews that were performed by the LNC. Numbering this list or using a bullet point format will help give organization and structure to this section of the report. The LNC should ensure that this list is complete, accurate and that any request for additional documents is submitted to the attorney-client as soon as possible.

SOCIAL & PAST MEDICAL HISTORY

Establishing the patient's baseline prior to the injuries or allegation allows for an accurate assessment of how the injuries affected the patient. For instance, a patient with a past medical history of diabetes may suffer complications from an injury that not everyone else would. Therefore, it is important to ensure a thorough review of the medical records is completed for an accurate past medical history. Additionally, a thorough social history is also warranted as it allows the LNC to gauge the impact the injuries have had on the patient's ability to work and engage in social activities.

Interviewing the patient and performing a nursing assessment, if possible, is critical to this part of the report. Family members and caregivers can also be interviewed. When the patient is deceased or otherwise unable to participate in an interview or assessment, the LNC can gather the needed information from the medical records and if available, the patient's deposition testimony. The social and past medical history sections of the report are typically presented in a numbered or bulleted fashion.

BRIEF INTRODUCTION

Providing a brief introduction to the case is optional, but helpful because it gives a nice transition before the reader jumps into the chronological medical record summary. The introduction is a paragraph or two with a brief description of the injury or allegation and how it has affected the patient's life.

For example:

Mrs. Smith was diagnosed with a fractured hip in January 2022, resulting from a fall. Mrs. Smith has endured pain and suffering from multiple surgeries, physician visits, radiology testing, physical therapy, occupational therapy, and complications from procedures. Mrs. Smith suffers from long-term residual effects of the initial fracture including a nonhealing wound, loss of independence, emotional distress, and anxiety.

MEDICAL RECORD SUMMARY

The medical record summary will make up the bulk of the report. The body of the report including the length will depend on the retaining attorney's request. It is important to note that every attorney typically wants the pain and suffering report done differently. It is imperative that the LNC clarify the retaining attorneys' preferences for the format and content of the medical record summary. For instance, the retaining attorney may want a narrative chronology or a brief overview of the medical records with a separate chronology in table format.

While there are typically medical records submitted for review dated prior to the injury or allegation, start the medical record summary with the date of the initial injuries. Medical record information prior to the date of injury can be summarized in the past medical history section. For example:

Mrs. Smith presented to the emergency department (ED) on January 7, 2022, with complaints of right hip pain secondary to a fall at the grocery store. She was evaluated and diagnosed with a right hip fracture.

Stating the facts of the clinical documentation within the medical records through the use of charts, graphs, tables, pictures, and colors will help summarize relevant information in an easy-to-read format (Table 1, Pain Medication Summary).

Notice that the table covers several key components when explaining pain without having to write it in narrative form. The reader can see what pain medications the patient received, whether or not they were adequate, and the opioid equivalency to each drug anytime a change was made. There are many opioid equivalency calculators available online that can be used to give an approximation of the equivalency.

DATE	PAIN MEDICATION	DOSES GIVEN PER DAY	COMMENTS	SOURCE
1/7/2022	Morphine 2mg IV	1 Dose Given	Pain level was 10/10 with an unacceptable response to morphine charted at 8/10	Valley Hospital
1/7/2022	Hydromorphone (Dilaudid) 1 mg IV	3 Doses Given (the equivalent of 12 mg of IV Morphine)	Pain Level 8/10 resolved to 4/10	Valley Hospital
1/8/2022	Hydromorphone (Dilaudid) PCA drip bolus rate of 0.2 mg every 10 minutes as needed	4 mg Dilaudid was delivered (the equivalent of 67 mg of oral oxycodone) 19 doses were attempted and 14 doses were delivered	Postoperative pain level was rated at a 10/10; a basal dose was added of 0.5 mg per hour in addition to the bolus doses; the pain level resolved to a 3/10 after the addition of the basal dose	Valley Hospital
1/9/2022	PCA was discontinued; the patient was transitioned to 5 mg Oxycodone every 4 hours by mouth	6 doses were given (the equivalent of 1.8 mg IV Dilaudid)	Pain level ranged from 7/10 to 2/10	Valley Hospital

Table 1: Pain Medication Summary

Explaining equivalency is important because the readers of the report will most likely be laypeople on a jury. For example, a layperson would not be expected to know how much stronger Dilaudid is than morphine. Organizing the pain medications that were administered with corresponding equivalencies helps to explain the severity and duration of the pain the patient experiences.

Additionally, the use of pictures or diagrams is very helpful when explaining a procedure or medical condition. When possible, use actual patient pictures, such as the appearance of a non-healing wound or procedural pictures. Often the medical records will contain photographs of the plaintiff's medical conditions which can be copied from the medical record and pasted into the report for the jury to review. When using pictures from the internet, always ensure the pictures are cited appropriately in text and on your reference page, and comply with copyright rules.

PSYCHOSOCIAL COMPLICATIONS

The psychosocial complications that a patient experiences from an injury should be thoroughly explained to the jury. The psychosocial portion of the pain and suffering report is the explanation of the suffering of the patient. This would include, for example, psychological distress, impaired family relationships, emotional stress related to economic burdens, sexual dysfunction, and long-term residual issues including the side effects of treatment and/or medications.

Psychological distress related to an injury can result in depression, anxiety, suicidal ideations, and suicide attempts, and may include impairment of the injured party's interpersonal interactions with others. If the patient has a past medical history of psychological diagnoses and treatment prior to the injury, a comparison of psychological issues prior to the injury versus post-injury would be warranted.

Additionally, how were the patient's family members affected by the change in the patient post-injury? How is the patient's psychological distress affecting interpersonal relationships? What is the economic burden on the family as well as the patient? Is the patient still able to work? If not, how has that impacted the family financially?

Sexual dysfunction is often an area that is left out of pain and suffering reports. However, it is an area in which many patients suffer and should be addressed in the report. For instance, sexual dysfunction is common among female cancer survivors and can cause impaired body image, low self-esteem, psychological distress, and decreased quality of life (Bober, 2022). Sexual dysfunction can be devastating to intimate partner relationships. The impact that sexual dysfunction has on the patient's relationship as well as any treatment received should be thoroughly vetted by the LNC and explained within the report.

Side effects of treatment, procedures, and medications should be addressed along with any long-term residual the patient is having. For instance, are there long-term side effects from chemotherapy administration? Does the patient have a permanent appliance such as an ostomy, a urostomy, peg tube, tracheostomy, or any other permanent reliance on a medical device or equipment? If so, a thorough explanation of how it affects the patient's quality of life is warranted.

The addition of nursing diagnoses to this section of the report is appropriate. While the LNC is not qualified to provide medical diagnoses, they are qualified to provide nursing diagnoses. Nurses use their clinical judgment to form a nursing diagnosis. The nursing diagnosis reveals the human response to health conditions, life processes, or susceptibility to that response, by an individual, caregiver, family, group, or community (Herdman et al., 2021). At this point in the report, the patient has already been assessed either through a review of the medical records and deposition testimony or via interview and assessment of the patient by the LNC. The next logical step would be to formulate the nursing diagnosis.

Example:

Appropriate nursing diagnoses for Mrs. Smith based on the documentation available for me to review include:

1. Anxiety related to surgical complications as evidenced by verbalization of fearfulness and non-healing wound.
2. Dysfunctional gastrointestinal motility related to narcotic dependence as evidenced by constipation.

Documentation of the problem-focused nursing diagnoses helps confirm the patient's human response to the

The LNC should list all medical records and documents reviewed for the case. This includes but is not limited to the complaint, deposition transcripts, expert witness reports, medical records, interviews, and any patient assessments or interviews that were performed by the LNC.

injury. Additionally, the use of nursing diagnoses will help dignify the patient's susceptibility to future undesirable human responses related to the injury.

CONCLUSION OF THE REPORT

The conclusion of the pain and suffering report should include confirmation that the medical records reviewed accurately reflect the patient's pain and suffering. While the LNC is not offering an opinion on the standard of care, it is important that the jury knows that the facts within the medical record documentation support the patient's pain and suffering. The conclusion should be a brief paragraph describing which components of the medical record support the patient's pain and suffering.

Example:

Based on a reasonable amount of nursing certainty, it is my opinion that the facts within the medical records accurately reflect Mrs. Smith's pain and suffering as evidenced by the injury-related need for multiple procedures/radiology studies, narcotic dependence, multiple physician visits, continual physical therapy/occupational therapy, emotional distress (depression, anxiety, suicide attempts/ideations), and the permanent requirement of the use of a walker.

I specifically reserve the right to add to, amend or subtract from this report as new evidence comes into discovery or as new opinions are formulated.

REFERENCE PAGE

The use of a reference page with credible up-to-date sources is essential to the LNC's credibility. The reference page allows the judge, jury, and all attorneys involved in the case to know where the LNC retrieved the educational information within the report. The citation format is a personal preference of the LNC. UpToDate uses the American Medical Association format which is what the author prefers as well. The LNC should always consult with the retaining attorney regarding any special requests for citation format. Helpful tips for the reference page include making sure links work properly and that there are references for any pictures or diagrams used within the report. There are multiple citation-generating websites that can be used to help with formatting references including references for pictures or diagrams.

The focus is summarizing the medical record documentation and educating the jury, judge, and attorneys regarding the pain and suffering of the patient.

CONCLUSION

A well-organized, thoughtful, and comprehensive pain and suffering report is invaluable and adds an educational component to any personal injury or medical malpractice case. One of the greatest responsibilities a nurse has is to educate the patient on disease processes, treatments, medications, and the human response to disease or injury. Patient education is something that every nurse is taught in nursing school and is a key component of building trust with the patient. Educating a jury, judge, and attorneys via a pain and suffering report mirrors the experience the nurse has at the bedside with the patient. The LNC uses clinical experiences, education, and medical literature research to explain the patient's pain and suffering. The facts of that pain and suffering are gathered from the supporting clinical documentation within the medical records, through patient interviews/assessments performed by the LNC, and by reviewing deposition testimony.

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Clinical experience includes Oncology (including chemotherapy administration, bone marrow transplant, hematologic oncology, gynecologic oncology, surgical oncology, and medical oncology), Med-Surg, cardiac, and Intermediate Care.

Francine founded Barsaloux & Associates, PLLC. in 2021, a Legal Nurse Consulting company to provide high-quality, customized healthcare consulting solutions to the healthcare, legal, informatics, and insurance industries.

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The Criminalization of Human Errors in Healthcare

Julie Dickinson MBA, BSN, RN, LNCC, CPHRM

Keywords: criminal charges, felony, homicide, prosecution, human error, system errors, latent errors, active errors

Criminally charging healthcare providers for human errors has been the subject of much discussion in recent years. This article explores how criminal prosecution does not improve patient safety or protect the public. Instead, the focus should be on improving the healthcare system to minimize latent errors.

The focus of recurring headlines and much discussion in the healthcare industry has been a case in which a Tennessee nurse was charged with reckless homicide after inadvertently administering a paralytic instead of the intended sedative. She was found guilty of criminally negligent homicide and gross neglect of an impaired adult in March 2023 (State of Tennessee v. Vaught, 2019; Kelman, 2022). While some may argue that criminal prosecution for causing patient harm is appropriate, in actuality the prosecution of well-meaning clinicians for inadvertent errors does not protect the public.[1]

CRIMINAL PROSECUTION FOR CLINICIAN ERROR

While the occurrence of a healthcare provider facing felony charges after a patient death is not frequent, the Tennessee case was not an isolated event in the United States.

In 1990, a nursing home physician in New York was charged with reckless endangerment in the second degree and willful patient neglect following a patient's death from chemical peritonitis (inflammation of the membrane that lines the abdominal wall and covers the abdominal organs) after he mistook the

[1] The focus of this article is on cases in which there was no alleged intent, e.g., no murder charges or claims of euthanasia.

patient's peritoneal dialysis catheter for a gastrointestinal feeding tube, ordered the administration of a feeding solution through the dialysis catheter, and later delayed her transfer to a hospital. The physician was convicted of reckless endangerment in the second degree and willful violation of the health laws of New York (People v. Einaugler, 1994; Einaugler v. Supreme Court, 1996; Filkins, 2001).

In the late 1990s, three nurses in Colorado were indicted for criminally negligent homicide for their role in the death of a newborn who was ordered to receive intramuscular penicillin G benzathine but was administered a 10-fold overdose intravenously. Two of the nurses (the neonatal nurse practitioner and the nursery nurse) pled guilty, but due to the terms of their plea agreement, they avoided jail time and their records would be expunged of the felony conviction after two years (Hurley & Berghahn, 2010). The third (obstetrical) nurse went to trial and was found not guilty (People v. King, 1998).

In 2006, an obstetrical nurse in Wisconsin was charged with neglect of a pregnant patient causing great bodily harm after unintentionally administering an epidural anesthetic intravenously instead of the intended penicillin, resulting in the death of her teenage patient (the baby survived following an emergency cesarean section). The nurse pled no contest to two misdemeanors (unlicensed/non-pharmacist dispensing of prescription medication and possession/illegally obtaining a prescription medicine), was found guilty, and was placed on probation for two years during which time she was forbidden from working as a critical care nurse (State of Wisconsin vs. Thao, 2006; Wisconsin Board of Nursing v. Thao, 2006; Hurley & Berghahn, 2010).

In the late 2000s, a pharmacist in Ohio was charged with reckless homicide and manslaughter after a toddler died while undergoing chemotherapy. The pharmacist had checked and dispensed the chemotherapy solution, which had been prepared by a pharmacy technician using 23.4% sodium chloride instead of 0.9% sodium chloride. The pharmacist pled no contest to involuntary manslaughter and was sentenced to six months of imprisonment, six months of home confinement, three years of probation, 400 hours of community service, and a $5,000 fine (State of Ohio v. Cropp, 2007; Institute for Safe Medication Practices [ISMP], 2009).

Relatively few fatal medical errors are criminally prosecuted, which illustrates the irregular, inconsistent, non-standardized application of criminal law to such errors.

Not only do such felony charges span healthcare professions and states across America, but they also span the world as well. In England, an optometrist, two general practitioners, a colorectal surgeon, a locum consultant anesthetist, and a pediatric trainee doctor have been charged with gross negligence manslaughter in separate cases (Dyer, 2017; Dyer, 2016a; Dyer, 2016b; Dyer, 2016c; Ameratunga et al., 2019). Similar charges have also been reported in New Zealand, Japan, China, and Canada (Ameratunga et al., 2019; Hiyama et al., 2008; Leung, 2018; McDonald, 2008). The outcomes of these domestic and international felony charges varied and included jail time, probation, an overturned conviction, plea deals to lesser misdemeanor or felony charges, dropped charges, and not guilty verdicts.

Relatively few fatal medical errors are criminally prosecuted, which illustrates the irregular, inconsistent, non-standardized application of criminal law to such errors. Where is the line drawn, why, and who draws it? Because the line is obscure, criminal charges are not deterring "criminal" behavior, because healthcare providers are left to speculate when their actions may cross the line.

Furthermore, these criminal cases focused on errors that resulted in death, but not all healthcare errors are fatal or even cause harm. Thus, the severity or outcome bias inherent in criminalizing fatal errors is not protecting society against similar future errors. It punishes the unlucky and rewards the lucky by magnifying the human errors when system workarounds lead to a fatality and ignoring the human and system[2] errors when the same behaviors do not have fatal consequences (Marx, 2019). For example, the Tennessee nurse's workaround of overriding a medication dispensing cabinet[3] received intense

[2] For the purpose of this article, "system" and "healthcare system" refers to healthcare institutions/organizations that are affiliated through ownership or management.

[3] A medication dispensing cabinet (or automated dispensing cabinet) is a decentralized medication dispensing and tracking system that provides computer-controlled access to medications at the point-of-care. Healthcare providers (e.g., nurses) access the cabinet in the patient care area by logging into the system (using a password or fingerprint, for example), choosing the patient, and selecting the desired medication from those ordered for that patient. The cabinet then provides access to the specific compartment that contains the selected medication. See Pickle, J. (2021, November 23). *How automated dispensing cabinets (ADCs) revolutionized point-of-care medication administration?* Biomedical Health & News. https://biomedj.org/healthcare/automated-dispensing-cabinets-adcs-revolutionized-point-care-medication-administration/ Overriding the cabinet means bypassing the list of ordered medications and selecting a medication that does not appear on that patient's medication list.

critique, but other nurses who cared for the same patient overrode almost 12 medications prior to the subject nurse's fatal override (ISMP, 2022).

What is consistent throughout these cases, though, is that the healthcare providers were fallible humans working in very complex systems carrying on the inherently risky business of patient care.

PATIENT HARM AND DEFECTIVE HEALTHCARE SYSTEMS

According to the World Health Organization (WHO), the risk of being harmed during healthcare is 1 in 300, whereas the risk of being harmed during air travel is 1 in 1 million (WHO, 2019). The 14th leading cause of global morbidity and mortality is patient harm (WHO, 2019). In high-income countries like the United States, 1 in 10 patients are harmed while receiving care in a hospital, and nearly 50 percent of the adverse events that cause this harm are preventable (WHO, 2019).

Most medical errors are the result of faulty systems (Institute for Healthcare Improvement [IHI], 2022). Overlooked system issues – such as technological, environmental, cultural, and workflow difficulties – force the humans operating within these flawed systems to compensate by creating workarounds/safety bypasses to complete their tasks. These bypasses (such as overriding a medication dispensing cabinet) are a direct consequence of defective systems, not of willfully reckless clinicians.[4] Individual healthcare providers have negligible, if any, control over every aspect of the complex system in which they work, which is why holding a single person accountable for a primarily system-derived outcome is not an approach that will yield meaningful patient safety results. Imprisoning a single clinician does not protect future patients from harm, because it does not correct the latent system failures that lead to the harm.

In a complex system such as healthcare, patient harm can occur when latent and active errors intersect. Latent errors are the obscure system design or process failures that enable harm to reach a patient by creating conditions that allow a clinician to make an active error (Patient Safety Network, n.d.). For example, per the aforementioned Ohio pharmacist's incident description, his active error of dispensing an incorrectly compounded medication was allowed by various latent system failures, including:

- Routine computer maintenance delaying the printing of medication labels which created a backlog of orders which caused staff to feel rushed,
- An interdepartmental miscommunication which amplified the time pressure on staff,
- Reduced staffing,
- No rest breaks, and
- A small, cluttered work area in which materials used to compound multiple medications for multiple patients were present, leading to an incorrect assumption about the materials used for the solution in question (ISMP, 2009).

This is not to say that clinicians have no accountability or responsibility – they absolutely do – but singling out and criminally charging the clinician who happened to be closest to the patient harm, who made the final and obvious error in a series of preceding latent system and active errors, will not prevent the same active error from happening again. In fact, the Institute for Safe Medication Practices (ISMP) reported, "errors that were eerily similar to the event [in the aforementioned Tennessee case] were reported to ISMP before (*and since*) the event, including incorrectly retrieving vecuronium from an [automated dispensing cabinet] after searching for Versed by entering just the first two letters, VE" (ISMP, 2022, para. 15, emphasis added). Focusing on the low-hanging fruit and isolating an individual healthcare provider's actions from the context of the complex, dynamic system in which those actions occurred does not address the larger system issues that continue to put patients at risk. For example, in the Colorado case, the Institute for Safe Medication Practices "identified over 50 different failures in the system that allowed this error to occur, go undetected, and, ultimately, reach a healthy newborn child, causing his death. Had even just one of these failures not occurred, either the accident would not have happened, or the error would have been detected and corrected before reaching the infant" (ISMP, 1998, para. 3). Criminally prosecuting the healthcare provider nearest to the patient harm is an inadequate solution given the complexity of the healthcare system and the number of departments and clinicians interacting to provide care to a single patient; it is not protecting society as a whole, as criminal law is intended to do.

PREVENTING PATIENT HARM THROUGH SYSTEM IMPROVEMENT

To protect patients, all workarounds, all errors, all questionable and risky behavior and decisions – regardless of the outcome – must be identified and critically analyzed to find opportunities to improve the system and reduce, if not

[4] In the just culture model, recklessness is defined as "the conscious disregard of a substantial and unjustifiable risk. It is seeing, in the conscious part of [the] brain, a substantial and unjustifiable risk, and with that knowledge, choosing to follow through with [one's] conduct" (Marx, 2019, p. 2). The conscious recognition of the risk of one's conduct is how recklessness is distinguished from negligence, which is failing to see the substantial and unjustifiable risk that should have been seen. "In recklessness, [they] ignore the risk [they] see; in negligence, [they] don't see the risk that [they] should have seen" (Marx, 2019, p. 2).

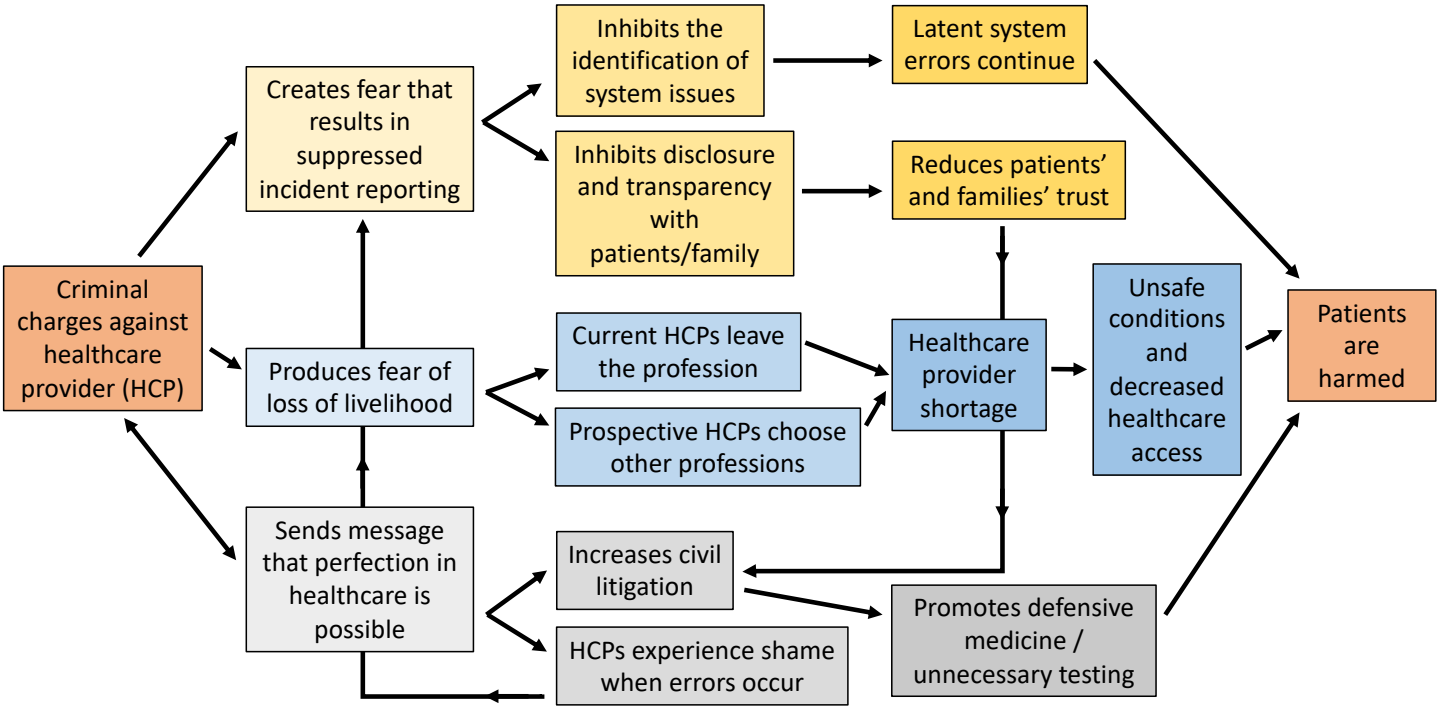

Figure 1: Sample Table

eliminate, the need for workarounds. Improving these system flaws by building redundancies into the system (multiple layers of safety barriers) and people-proofing the processes will help prevent inevitable human errors from reaching and harming patients (Philipsen, 2011).

For a healthcare organization to shift from being reactive (responding after patient harm occurs) to proactive (identifying and addressing system issues/workarounds after a near miss occurs), frontline clinicians (those who provide direct patient care and thus are directly interacting with the system day in, day out) must be comfortable reporting near misses/close calls, errors, adverse events, and concerns to the organization (e.g., quality management department, leadership, etc.) and then freely and honestly discussing the incidents. Such reporting is typically highly encouraged by organizational leadership and quality management staff but does not always occur due to fear (including fear of self-incrimination, punitive repercussions by leadership, etc.), a culture of blame and shame, lack of trust, time constraints, busyness/workload, etc. Within the healthcare system, such honest, open, and frequent reporting requires a culture of psychological safety; a just, non-punitive culture; and trust that the institution will act upon the information provided. Outside of the healthcare system, it requires an absence of fear of criminal repercussions. According to numerous healthcare organizations, entities, and professionals, the long-term consequences of criminally prosecuting healthcare providers lead to more, not fewer, errors and patient harm; see Figure 1 (IHI, 2022; The American Association of Nurse Attorneys [TAANA], 2011; American Nurses Association, 2010; Association of Perioperative Registered Nurses; 2018; ISMP, 2022; Iacobucci, 2018; Leung, 2018; Ameratunga et al., 2019). Criminal prosecution of healthcare providers creates fear in other clinicians - fear of criminal and civil legal action and that the information shared in event reporting and resultant quality improvement activities could be discoverable in legal proceedings and thus be used against them to apportion blame and find fault.[5]

That fear inhibits incident reporting, without which system issues cannot be identified and corrected – leading to more patient harm. Criminal prosecution of clinicians also causes current and prospective healthcare providers to fear losing their livelihood, so they exit their profession (or take non-clinical positions) and choose another career path, respectively. The resultant shortage of bedside clinicians creates unsafe conditions and decreased access to healthcare – leading to more patient harm. Criminal prosecution of healthcare providers also sends the message that perfection in healthcare

[5] One (older) report identified that the San Francisco County Superior Court ruled there is no statutory protection for peer review materials in criminal cases as there is in civil cases (West, 2009). In the U.K. case against the pediatric trainee doctor, while educational reflective documents written by the trainee after the patient's death were not evidence in court, aspects of her reflections were "fed into the trial" and may have indirectly affected the trial (Samanta & Samanta, 2021).

This is not to say that clinicians have no accountability or responsibility – they absolutely do – but singling out and criminally charging the clinician who happened to be closest to the patient harm, who made the final and obvious error in a series of preceding latent system and active errors, will not prevent the same active error from happening again.

is an achievable goal (which it is not). Due to this expectation of perfection, clinicians feel shame when errors occur, so they hide the errors (i.e., they do not report incidents). The suppressed error reporting prevents organizations from being transparent to patients/families and disclosing adverse events, which reduces trust and results in more civil litigation. Increased civil litigation also results from the message of attainable perfection in the provision of healthcare.

More civil litigation promotes defensive medicine, i.e., ordering additional/unnecessary testing – which leads to more patient harm.

Proponents of criminally charging healthcare providers for fatal errors have equated it to charging drivers distracted by their cell phones who kill someone with their vehicle. While there may be some superficial parallels to draw, the driving analogy fails to account for the lack of willful recklessness, the context (system) in which healthcare providers work, and the effect on society's safety. Distracted drivers make a *conscious* choice to engage in reckless, unsafe, and illegal behavior and to disregard its known risk. They are acting independently (not within the constraints of a complex system), and thus criminal sanctions will deter this reckless behavior and protect society by removing unsafe drivers from the streets. Conversely, the clinicians in these cases were not making *conscious* decisions to be reckless, to ignore substantial and unjustifiable risks.[6]

While they knowingly engaged in workarounds that were normalized, engrained in the organization's system and processes, and thus were routinely used by numerous clinicians, they either failed to see the potential risk of performing the workaround (because it regularly occurred without error) or they underappreciated it and perceived it to be a justifiable means to the end of providing patient care in a timely manner (Marx, 2019). These workarounds (drifting into "at-risk" behavioral choices, as it is termed in the just culture world) are the result of complex, substandard systems. Automatically removing an individual clinician who made an inadvertent mistake from the healthcare setting does not change the faulty system that necessitated the workaround; the defective system persists, which continues to endanger patients by allowing other clinicians to engage in the same workarounds. Thus, the focus and the path to patient safety must be proactively improving system design, thereby reducing the need for such workarounds (Marx, 2019).

CLINICIAN AND ORGANIZATION ACCOUNTABILITY

The blame-free culture within a healthcare system that creates psychological safety for incident reporting does not negate clinicians' and organizations' accountability for their contributions to errors. There must be shared accountability between the healthcare provider(s) and organization.

On the individual clinician level, accountability and responsibility include being mindful, consciously present, and focused on the task at hand. They involve minimizing or eliminating distractions as needed and when performing higher-risk work. They also include minimizing workarounds/safety bypasses, avoiding assumptions, and seeking clarification/confirmation instead. Individual clinicians are also responsible for consistently and diligently following relevant policies and procedures as well as foundational patient safety practices such as patient identification and the rights of medication administration. Such policies, procedures, and practices are in place to protect the patients. Proactively, healthcare providers have a responsibility to maintain vigilance against complacency and drifting into at-risk behaviors and correcting oneself and others when such behaviors are observed; to advocate to leadership about systems issues, processes, or conditions that require improvement; and to consistently report errors and near misses. After an incident occurs, account-

[6] This also argues against the effectiveness of criminal charges in deterring "criminal" behavior in healthcare providers for inadvertent errors, because there was no *conscious* decision to be reckless so criminal charges will not elicit change.

ability and responsibility include reporting the incident; actively participating in the incident investigation and analysis; actively participating in making the necessary system changes; acknowledging one's mistake(s) and the resultant harm; engaging in education, coaching, retraining, and remediation; and talking with others about the incident and mistake so the lessons can be more broadly applied.

Institutions, in turn, have a responsibility to prioritize patient safety and create a blame-free environment that allows clinicians to report near misses and patient safety events. They must be willing to listen and learn when clinicians share their concerns and report incidents. Organizations must invest time and resources in investigating events and in making the identified improvements that will positively affect patient safety. They must also proactively and continuously review alerts, bulletins, warnings, and other information put forth by national patient safety organizations, analyze this information relative to their organization's processes and systems, and devote the necessary resources to reconcile any discrepancies and implement recommendations and best practices.[7]

ALTERNATIVE SOLUTIONS TO CRIMINAL PROSECUTION OF CLINICIANS

Given the system issues that are pervasive in cases involving fatal medical errors, some have advocated for corporate manslaughter charges against healthcare institutions and their leadership (decision-makers) for their role in leading and allocating resources in such a way that patients could be harmed (Kazarian, 2019; McCartney, 2018). Others have advocated for a no-fault system like that in New Zealand, which implemented theirs upon finding that "criminal law was poorly designed to deal with the complex mix of error, violation, and system failure that typically characterise the deaths that lead to [prosecutions of health professionals for gross negligence manslaughter]" (Ameratunga et al., 2019, p. 2; Kazarian, 2019; Iacobucci, 2018).

Additionally, given the complexities and nuances of both the provision of care and the healthcare system, a state's professional licensing board (comprised of peers to the subject clinician) is a more suitable and reliable avenue for evaluating care rendered, examining allegations of harm, upholding professional standards of practice, and determining appropriate sanctions (including restricting or revoking a license). This administrative route still protects the public but more appropriately "reflects failures in clinical practice rather than any suggestion of criminality" (Ameratunga et al., 2019, p. 3; TAANA, 2015).

CONCLUSION

There will always be errors when humans are involved.[8] Thus faulty healthcare systems and latent failures that allow those predictable human errors to reach patients are the actual causes of harm. Because criminalizing human errors in healthcare does not correct or prevent these causes, it does not protect society and the patients who entrust their care to healthcare systems. In fact, it has the opposite long-term effect. Understanding that imperfect humans are practicing the imperfect art of medicine in an imperfect system allows the focus to be on the most reliable way to prevent patient harm: continually refining and improving the dynamic system.

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[7] For example, in 2016, the year prior to the fatal Tennessee incident, the Institute for Safe Medication Practices issued two publications pertaining to the risk of, and errors related to, neuromuscular blocking agents (ISMP, 2016a; ISMP, 2016b). Both offered recommendations and best practices to minimize errors related to these high-risk medications.

[8] This is important education for a jury when a criminal trial involves the inadvertent error of a healthcare provider. Lay jurors need to be taught about the system failures and latent errors, human fallibility and human factor design, system redesign, the differences between recklessness and at-risk behavior, the normalization of drifting behavior, outcome bias, confirmation bias, inattentional blindness, alert fatigue, etc. (ISMP, 2022).

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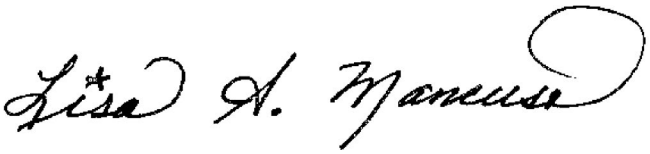
President's Update *continued from page 4*

LNC Jumpstart: This was developed in response to the COVID 19 pandemic when we had to cancel our Forum. It was a huge success and has become an annual tradition. https://www.aalnc.org/Events/LNC-Jumpstart This year it's on Friday, September 8th and the focus is on report writing.

Finally, I would like to remind you all that your AALNC membership gives you access to our association management team: https://www.aalnc.org/About/Board-Staff

If you reach out to info@aalnc.org or call 312.321.5177, you'll likely speak to Melissa Van Fleteren or Sree Rajesh. In the unlikely event they can't help you, they'll direct you to the person who can! Both the voicemail box and the email box are monitored. Do not hesitate to reach out for help.

Wishing you a prosperous Autumn and a little pumpkin spice sprinkled in your coffee and tea!



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