Volume 31
Number 3
Fall 2020

THE JOURNAL OF Legal Nurse Consulting



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Legal Nurse Consulting
Volume 31 | Number 3 | Fall 2020




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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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Journal of Legal Nurse Consulting (ISSN 2470-6248) is published digitally by the American Association of Legal Nurse Consultants, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611, 877/402-2562. Members of the American Association of Legal Nurse Consultants receive a subscription to *Journal of Legal Nurse Consulting* as a benefit of membership. Subscriptions are available to non-members for $165 per year. Back issues are available for free download for members at the Association website and $40 per copy for non-members subject to availability; prices are subject to change without notice. Back issues more than a year old can be obtained through the Cumulative Index to Nursing & Allied Health Literature (CINAHL). CINAHL's customer service number is 818/409-8005. Address all subscriptions correspondence to Circulation Department, *Journal of Legal Nurse Consulting*, 330 North Wabash Ave., Suite 2000, Chicago, IL 60611. Include the old and new address on change requests and allow 6 weeks for the change.

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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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- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- 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
- Text: Use APA style (Publication Manual of the American Psychological Association, 7th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- 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.
- Note current retrieval date for all online references.
- Include a 100-word abstract and keywords on the first page
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

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- All photos, figures, and artwork must 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 submitted as a separate file attachment, 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)

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Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. 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.

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Laura Grossman Nissim,
RN MS CNS LNCC
President, AALNC

"When we least expect it, life sets us a challenge to test our courage and willingness to change; at such a moment, there is no point in pretending that nothing has happened or in saying that we are not yet ready. The challenge will not wait. Life does not look back."

– Paulo Coelho

President's Update

Dear AALNC Members,

Once again, I am starting this note during a time in our lives when our world is experiencing tremendous change and unrest. The public health emergency that is COVID-19 has continued to tap the strength of front line workers, though it has 'moved' to other parts of the country. Living less than an hour from mid-town Manhattan made the illness all too real for me. The numbers we hear on the news of positive cases, hospitalizations, and deaths are well beyond what most of us can really imagine. Many nurses in our organization continue to be clinically active and have faced the acuity of this illness and the horrific speed with which it attacks the vulnerable, as well as those who are seemingly not. These professionals have continued to do what they were trained to do - many working dozens of shifts and very long hours; some far from home - regardless of the risks to their own health. As an organization of nurses, we stand and thank you for your selfless work.

We are also living in a time of great upheaval and hopefully change when it comes to how human beings all see and treat each other. For me and the people I love, it comes very slowly. As nurses who care for patients who may be POC or LGBTQ, we hopefully are more color blind as well as gender/sexuality blind. Part of our role as nurses is to educate; we need to keep educating all who will listen that humans are all made up of the same pieces. In light of this period of great unrest, it is timely that the JLNC has chosen to focus the Fall issue on Human Rights, including human trafficking. In the way nurses are taught to be mandatory reporters when we suspect child abuse, perhaps we need to learn about the signs to look for in people who are being trafficked. I believe Julie Dickinson and the JLNC Committee have put together a very informative issue this quarter. I hope the discussion about changes in how we see and treat each other will continue.

Remarkably, our work at AALNC has continued to be as busy, if not busier since my last note. Though our in-person Forum in Denver was cancelled, we are still working very hard to give you (in a multitude of ways) the same wonderful education you would have received on-site. We are turning some of the speaker presentations into webinars, and others may be presented in September 2020 during the **LNC Jumpstart program**. Registration opened for this new adventure on July 14, 2020. Head to the website to explore the day's virtual plans and presentations. You will be able to accrue up to 5.33 CNEs while attending LNC Jumpstart, provided by AALNC. We have also added special deals for those who sign up for the program.

It is clear the world has had to adjust to the issues presented in 2020. AALNC had to do the same. Though we were unable to meet face to face, we have continued to maintain the connections with our members. Your Board of Directors (BOD) has taken a step back to survey and then *many steps forward* while we continue to work as a team to provide the leadership and support for our membership. The members of AALNC are a community; we may have had some rough patches recently, but we continue to persevere as professionals and legal nurse consultants. The BOD has continued to lead during this tough time while our members continue to do the work they do best. Those members and the community they provide continue to be the reason for our organization being a home for all LNCs.

Laura Grossman Nissim, RN MS CNS LNCC

Editor's Note

Julie Dickinson
MBA, BSN, RN, LNCC
Editor, JLNC

Dear JLNC Readers,

Having volunteered for AALNC in numerous capacities over the past 10 years, I am honored to be writing to you as the Interim Editor-in-Chief of the Journal of Legal Nurse Consulting. This journal has been a staple of the association since its first issue was published 25 years ago. Since then, a long line of editors and editorial committee members have given countless hours to bring valuable, peer-reviewed content to the legal nurse consulting community. I look forward to working with the amazing volunteers on the current editorial committee to continue bringing relevant, timely, and quality content to you.

As I am writing this, it is June, and our country is in the middle of a very difficult time. Not only are the effects of the pandemic and re-openings being felt across the nation and world, the generations-long adversities and inequities experienced by minorities are again being brought to the forefront with the hope of sustained change. June is also Pride Month, a time when we celebrate the LGBTQ+ community. As our country takes much-needed and long-overdue steps toward a more egalitarian society, it seems apropos to be presenting this issue devoted to human rights.

You may be surprised to learn from Turkington's article that the inhumane practice of female genital mutilation and cutting occurs in the U.S. She shares subtle clues to look for in school and medical records, the types of experts that may be needed, and the long-term damages these victims may suffer.

Grametbaur's article provides an insightful primer on correctional healthcare, including nursing assessment protocols and scope of practice concerns, and offers helpful considerations and tips for reviewing correctional healthcare cases.

Marriott presents a fascinating case study about a situation frequently encountered in healthcare – a language barrier – and explores how the nurses deviated from the standard of care.

Opioid Use Disorder, a topic that hits close to home for many, is the focus of Hanus' article. He discusses a 2019 decision by the U.S. Department of Justice that Opioid Use Disorder is a disability covered by the Americans with Disabilities Act.

In this issue, you will also find valuable tips on identifying victims of labor and sex trafficking, a glossary of transgender terms, information about hormone regimens for adult transgender persons, and considerations in preventative screenings of transgender persons with past or current hormone use.

Of course, human rights merit more than one journal's worth of consideration, and these issues will remain pressing for all of us far into the future. As you read these articles, please allow them to serve as a small step toward considering how you can embrace diversity, inclusion, equality, and human rights in your professional and personal lives in the years to come.

Respectfully,

Julie Dickinson

Julie Dickinson, MBA, BSN, RN, LNCC

AALNC Continuing Education Opportunities

AALNC offers a monthly Webinar series, extensive online courses, and an annual Legal Nurse Consulting Educational and Networking Forum. Each educational offering attests to AALNC's commitment to delivering quality education to its members and constituents on diverse and dynamic legal nurse consulting topics.

LNC Jumpstart is a half-day virtual program being held on September 11, 2020. Interested in growing your professional network and expanding your legal nurse consulting knowledge? Click here to learn more: http://www.aalnc.org/page/lncjumpstart#About

AALNC's Webinar Series presents informative, educational content on clinical issues, legal nurse consultant (LNC) practice issues, and business issues. Individuals can attend live, interactive monthly webinars or access on-demand webinars. Upcoming webinars include:

- September 2, 2020: Critical Thinking – The Missing Link
- October 14, 2020: Complications of Bariatric Surgery
- November 4, 2020: Intimate Partner Violence

These webinars, as well as those previously offered, can be watched on-demand anytime throughout the year by AALNC members.

Thinking about becoming an LNC? Watch a free recorded webinar like "So You Want to Be an LNC?" or "Ask an LNC" to get a comprehensive overview of legal nurse consulting.

Other Great Educational Products for LNCs:

- AALNC Legal Nurse Consulting Professional Course allows current and aspiring legal nurse consultants the opportunity to continue their legal nurse consulting education in the comfort of their own home, at their convenience. As the gold standard in legal nurse consulting, AALNC created the AALNC Legal Nurse Consulting Professional Course to provide LNCs of all experience levels the opportunity to continue their journey as an LNC. This informative online course, led by AALNC

LNC Jumpstart is a half-day virtual program being held on September 11, 2020.

subject matter experts, provides an interactive learning experience for individuals interested in the unique field of legal nurse consulting. The course is comprised of modules which students may purchase as a package or individually.

- Clinical Specialty E-books are another valuable resource. There are now seven books in the series covering various clinical practice areas, including Ambulatory Care, Assisted Living, Interventional Radiology, Opioids, Pediatric Case Evaluation, Emergency Department Care, and Issues in Residential Care for Individuals with Developmental Disabilities. Check them out here:

  http://www.aalnc.org/page/aalnc-online-bookstore#complete

To review all of AALNC's continuing education opportunities, click here:

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Test Your Case Screening Skills

INTAKE

Michael Herman calls today regarding his granddaughter, Lilly Herman. Michael is in the process of obtaining guardianship of Lilly. Michael's daughter Abby is 19 and planning to enter the military. Lilly's biological father is not involved or on the birth certificate.

On 11/21/11, Abby was induced at Mercy Community Hospital since she was two weeks beyond her due date. She labored for 24 hours, and Lilly was born on 11/22/11. As soon as Lilly was born, she started to have seizures and was not breathing. She was transferred to a tertiary care NICU five hours after birth. Lilly was diagnosed with CP, hypoxic ischemic encephalopathy, blindness, and global delay. Currently, Lilly functions at the level of a 3-month-old.

Michael was present in the delivery room but did not have much to offer about the process and what monitors were there, etc. He believes the pregnancy was uncomplicated. Shortly after birth, Lilly started seeing a neurologist, Dr. Evelyn Brown. According to Dr. Brown, Lilly's body temperature should have been dropped right after birth. This process helps the brain recover and minimizes damages. Michael said he could get the medical records.

Michael would like to bring an action against the doctor and hospital for the oxygen deprivation at or during delivery resulting in CP, amongst other things.

Test Your Case Screening Skills

You decide: reject, or investigate?

Check your answers on page 29.

Female Genital Mutilation and Cutting: A Global Health Concern

Kirsten Turkington, DNP

Keywords: female genital mutilation, female circumcision, female cutting, ritualistic cutting, ceremonial procedures.

Female genital mutilation and cutting (FGM/C) is defined as any ceremonial or nonmedical alteration of the female genitals. FGM/C is a global public health concern steeped in social-cultural history. FGM/C exists worldwide on many continents and in parts of North America, including the United States. Many medical professionals, including legal nurse consultants (LNCs), are unfamiliar with FGM/C. As a result, LNCs may lack comprehensive understanding on how to address the clinical aspects of FGM/C in legal cases. This article reviews the basics of FGM/C, qualifies specific clinical findings, and reviews substantive FGM/C details. The author's intent is to increase LNCs' knowledge and general understanding of FGM/C to enhance their value when working on cases involving FGM/C.

FEMALE GENITAL MUTILATION IN THE UNITED STATES

Female genital mutilation (FGM), alternately referenced as female genital cutting and female circumcision, is recognized worldwide as the ceremonial or ritual cutting of female genitalia. Female genital mutilation and cutting is commonly abbreviated as "FGM/C" in the literature.

According to the United Nations Population Fund (2020), FGM/C is a practice that involves altering or injuring the female genitalia for non-medical reasons. Occasionally, the female genitalia are either partially, or entirely, removed.

As such, the generally accepted worldwide definition is that of the World Health Organization (WHO, 2020), which defines FGM as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." Female genital mutilation and cutting is a harmful practice that spans many ethnicities, religious beliefs, and national boundaries. Shockingly, FGM/C is an unfortunate reality in the United States because of worldwide travel (The Ayaan Hirsi Ali [AHA] Foundation, 2019).

BACKGROUND

The United Nations uses the term "harmful practices" as an all-encompassing term to categorize forms of violence or ritual discrimination. These are practices that are or have become culturally normalized and expected. These discriminatory practices are primarily committed against girls and women (United Nations Children's Fund, 2020a). Nearly one in three females worldwide will experience harmful practices or physical or sexual violence in their lifetime, regardless of their age, background, religion, or country of origin (Equality Now, n.d.). These harmful practices consistently reflect values that hold girls in low esteem (United Nations Children's Fund, 2020b).

Female genital mutilation and cutting is a global public health concern. It is poorly understood but is recognized to have complex legal, ethical, sociopolitical, and cultural considerations (Vissandjée et al., 2014). FGM/C is recognized as a secretive rite of passage that is not discussed outside of the family.

FGM/C is the most severe form of sexual violence a woman can experience in her lifetime. It has existed among different cultures for centuries although the exact origin of FGM/C is unknown (Odukogbe et al., 2017).

Female genital mutilation and cutting is a harmful practice that spans many ethnicities, religious beliefs, and national boundaries.

FGM/C is practiced worldwide despite many countries having laws against it (Daughters of Eve, n.d.). The procedure is often done when girls are very young, contributing to concerns about informed consent. It is unregulated, barbaric, and usually involves some form of physical restraint (WHO, 2020). Many times, a female relative such as mother, aunt, or grandmother does the actual restraining (U.S. Department of Health and Human Services, 2018). Often, paternal relatives lack awareness of the FGM/C procedure.

PROCEDURAL DISTINCTIONS

Individuals who perform FGM/C are called "circumcisers." Most are not medically trained. The vast majority of circumcisers hold traditional community roles. Conventional practitioners include birth attendants, religious clergy, or community elders (Awolola & Ilupeju, 2019; Kimani & Shell-Duncan, 2018).

The FGM/C procedure itself is frequently performed in nonsterile or overtly soiled environments. It is not uncommon for the same circumciser to reuse soiled materials and not wash between patients. Girls may be cut with razors, scissors, rusted knives, broken glass, or other household items (Odukogbe et al., 2017). This leads to increased risk of complications, including infections, deformity, sepsis, and death.

Numerous organizations and international institutions have tried to end FGM/C. The United Nations' Sustainable Development Goals (2020) call for the elimination of FGM by the year 2030. In order to fully understand the extent of the health risks, the procedure itself must be clarified. FGM/C is classified according to types or grades.

TYPES OF FGM

The World Health Organization (2020) classifies FGM/C into four categories. The categories are labeled I to IV and are defined according to the amount and type of damage to the female genitalia. Each category has corresponding medical definitions for the actual procedure. The range of procedures extends from pricking, pinching, and piercing the genitalia to complete blockage of the vaginal opening.

Type I

Type I FGM is a clitoridectomy. This procedure includes either the partial or total removal of the clitoris and/or the prepuce. The clitoris is the small, sensitive, and erectile part of the female genitals, and the clitoral hood (prepuce) is a fold of skin surrounding the clitoris.

Type II

Type II is an excision. This includes a partial or total removal of the clitoris and the inner labia, with or without excision of the outer labia.

Type III

Type III, also called infibulation, is the most severe form of FGM. Type III is the intentional narrowing of the vaginal opening by creating a seal over the opening. The seal is formed by cutting and repositioning the inner or outer

United States Census data estimates FGM increased by 35% between 1990 and 2000.

labia, with or without removal of the clitoris. Often, only a small opening (the size of a corn kernel) is left open, which impedes urinary and menstrual flow. The result of this procedure is significant scarring.

Infibulation significantly impacts sexual health, urinary health, and reproductive health. Patients with infibulation often require reversal procedures called deinfibulation. The reversals are selectively used to permit intercourse and facilitate childbirth. Reversals are not always successful, and failures lead to additional complications such as pain, trauma, and fetal complications during childbirth. Patients may also require, or request, deinfibulation for general health and wellbeing.

Type IV

Type IV encompasses all other harmful female genitalia procedures done for non-medical purposes. This includes pricking, piercing, incising, scraping and cauterizing, burning, or branding of the genital area.

HEALTH RISKS

All of the FGM/C procedures come with risks; FGM/C is not safe. There are no health benefits linked to FGM/C. In fact, the procedure itself is quite harmful and contributes to many physical and emotional complications. FGM/C is a direct cause of severe, ongoing medical problems and meets the generally accepted definitions of child abuse in the United States and abroad.

FGM/C intentionally harms or alters the female genitalia for non-medical reasons. A communal circumciser often performs the traditional procedure. The technique is primitive and lacks basic necessities to ensure patient safety and well-being. However, many groups continue to engage in FGM/C on the basis of outdated or unsupported religious or cultural beliefs. FGM/C is an ongoing, worldwide human rights violation.

Advocates for medicalization (having the procedure performed by a trained medical professional) feel the medicalized procedure is less dangerous; this is untrue and contradictory to scientific logic. Medicalization is no less barbaric than traditional FGM/C methods. Often, these medical procedures are performed outside of traditional medical environments, although they may include marginally cleaner equipment. Ultimately, FGM/C medicalization directly violates international medical ethics (United Nations Population Fund, 2018).

FGM/C complications are complex, multifactorial, and include physical, psychologic, and sociologic manifestations (Klein et al., 2018; Todkari, 2018). Complications can be acute or chronic, mild or severe. Many complications are lifelong concerns (Behrendt & Moritz, 2005; Kobach et al., 2018; von Rege & Campion, 2017; Tol et al., 2013). Sepsis and death are the most extreme outcomes.

Regularly identified FGM/C complications include acute, chronic, and nonspecific pain; pelvic infection; dermatologic infections; and genitourinary infections. Patients can experience menstrual irregularity and childbirth complications. Urinary complications include frequency, urgency, and dysuria. Sexually, victims may experience anorgasmia (inability to obtain orgasm), difficulties with intimacy, and obvious physical abnormalities related to the procedure and resultant scarring. Victims often experience depression, anxiety, and posttraumatic stress symptoms. Many victims struggle with lifelong physical complications and ongoing self-image disturbances.

ROLE OF HEALTH PROFESSIONALS

Health professionals play an important role in FGM/C education, early identification of at-risk women, and general clinical training (Kabiru, 2018). Unfortunately, there are limited training opportunities for health professionals to obtain sufficient education (Kabiru, 2018; Kimani & Shell-Duncan, 2018), which can aid in patient screening and accurate identification of FGM/C in the clinical setting.

The United States falls behind in both training and treatment (Johansen et al., 2018). Clinically, school nurses are often the first to identify at-risk children. Some indicators of FGM/C susceptibility are identified through attendance records and increased or prolonged absences. There may be frequent illnesses that are either unspecified or directly relate to female concerns. Other societal indicators include prolonged vacations and international travel, particularly during summer breaks (Nowak, 2016).

FGM/C is underreported in the United States. A combined lack of clinical awareness and provider training is a contributing factor. United States Census data estimates FGM increased by 35% between 1990 and 2000. At-risk females numbered nearly 228,000 with nearly 63,000 of them under the age of 18. Recently, U.S. numbers of at-risk females increased from 228,000 to over 500,000 in 2012 (Goldberg et al., 2016). Current numbers are unknown.

Worldwide underreporting is primarily due to the culturally-sensitive nature of FGM. This is complicated by deep

religious affiliations and by cultural and societal beliefs. Increased training, education, awareness of victimology, and access to advocacy services improves clinical identification. This may lead to an increase in lawsuits requiring legal nurse consultants' expertise.

LEGAL NURSE CONSULTANT ROLE

Legal nurse consultants (LNCs) play an important role in FGM/C cases. The LNC is often called upon to perform initial case assessments, conduct background research, review medical records, prepare chronologies, and obtain experts.

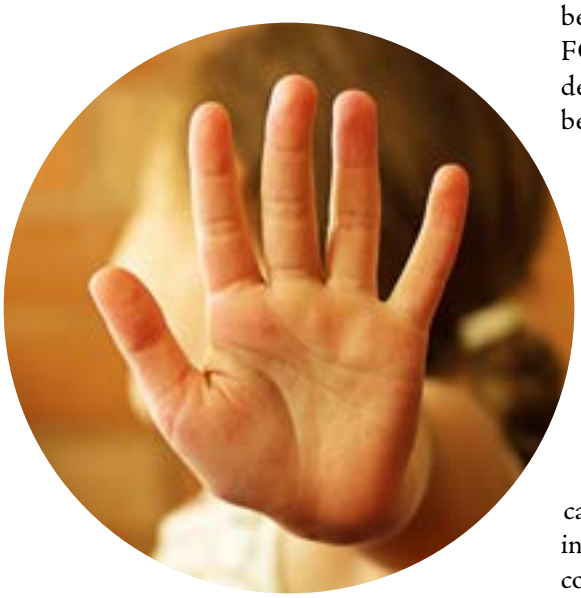
Assessing Cases

FGM/C cases may present as civil or criminal cases. Civil cases may involve family law to address child custody, visitation concerns, and medical procedures without dual parental consent. Civil cases may include school-based delinquency or attendance issues for child victims and drug or alcohol related disturbances in adult FGM/C victims. Mental health issues are an additional concern. Depending on the case details, medical malpractice and professional negligence cases may be brought along with criminal cases. Criminal cases can be the direct result of child abuse and child endangerment concerns.

FGM/C procedures are frequently not documented. If FGM/C is medicalized, many FGM/C providers either do not document according to professional standards of care or document in a subversive way. Therefore, cases often lack medical records or other specific documentation. LNCs may need to work with law enforcement to obtain victim statements and interview witnesses.

The LNC's case assessment requires a thorough review of case details. Cases may not present initially as FGM/C, but details can emerge as records are obtained and reviewed. Assessing details about a victim's age, specific circumstances, social environment, economics, and country of origin are all important considerations in FGM/C cases.

The LNC also identifies gaps in the records, conducts any necessary background research (although this is often limited in FGM/C cases), and educates the legal team on the medical aspects of the case.



Obtaining Experts

In medical malpractice cases, the LNC should locate a provider who has familiarity with the specific medical procedures performed. The clinician must be knowledgeable about potential FGM/C complications and FGM/C as a global public health issue. Depending on the victim's resultant medical issues, a panel of experts may be needed. Such experts may include healthcare providers in obstetrics and gynecology, urology, surgery, and pediatrics.

FGM/C survivors experience high levels of psychological trauma for a variety of reasons. The LNC may need to locate mental health experts such as counselors, social workers, clinical psychologists, and psychiatrists. Consultants on posttraumatic stress disorders and trauma-informed care are especially helpful. Forensic experts experienced in human abuse, interpersonal violence, domestic violence, and injury pattern identification are also beneficial given the complexities of FGM/C cases. Depending on the case details, law enforcement experts may be needed to delineate specific criminal code violations.

LNCs may also research a recognized FGM/C advocacy group to facilitate finding an expert for the case. Plaintiff LNCs may also use this research to propose having an advocate help the victim during the case and beyond.

Future medical costs can be significant in FGM/C cases. These costs often involve ongoing medical evaluations, counseling services, surgical revisions, or subsequent corrections. Recurrent genitourinary and skin infections are common. These require medications and ongoing treatments. Ultimately, damage cases will probably require future cost estimates and life care plans to properly determine related expenses. Overall, FGM/C is a complex condition that engages the full scope of LNC practice.

SUMMARY

Women worldwide are at risk for FGM/C. Despite efforts to eradicate FGM/C on a global basis, societal,

Cases may not present initially as FGM/C, but details can emerge as records are obtained and reviewed.

cultural, and religious beliefs remain steadfast for continuing the outdated practice. FGM/C results in physical, emotional, and legal complications that must be addressed. Legal nurse consultants are increasingly more likely to encounter FGM/C cases in the United States. Having the clinical knowledge, tools, and expert resources to properly address the nuances of FGM/C will allow for solid case analysis. The LNC's ability to anticipate appropriate case needs is vital. All nurses and health professionals are encouraged to learn more about diagnosis, treatment, and complications to properly address victims. Health professionals, and legal nurses in particular, must recognize this is a prevalent, often underreported condition with significant risk of complications.

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Catching the Chain

Working on Correctional Cases

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Keywords: corrections, correctional nursing, civil rights, prison health care, American Correctional Association, National Commission on Correctional Health Care, correctional institutions, Correctional facility, deliberate indifference, inmate patients

This article provides an overview of the correctional system and the incarceration process. Through discussion of the nursing assessment protocols and scope of practice considerations, it offers the legal nurse consultant an understanding of the framework for the delivery of health care to inmate patients.

"Don't do the crime if you can't do the time" is a phrase most people have heard. Yet, what does the average lay person really know about what occurs in the nation's jails and prisons? Likewise, most healthcare professionals do not know anything about the provision of medical care to incarcerated populations. Legal nurse consultants who are working on correctional cases involving medical- or mental health-related allegations should have a general understanding of the provision of healthcare to inmate patients and of the standards of care in correctional healthcare.

Today, correctional cases have become extremely high stakes, with millions of

dollars commonly awarded in damages. This, coupled with the widespread filing of correctional cases, has resulted in some professional malpractice insurance companies no longer offering policies for correctional nurses.

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HISTORY

Originally, jails were only meant to detain miscreants until a trial was held and the sentence could be carried out (Crime Museum, 2017). In ancient times, prisoners were usually sentenced to death or slavery (Crime Museum, 2017).

In 1166, Henry II constructed the first prison and instituted trial by jury (Prison History, 2020). The Magna Carta, in 1215, stated no man could be imprisoned without trial (Prison History, 2020). Once the prisoner was tried, the sentence was carried out immediately. Prisoners, including children, could be sentenced to hanging, whipping, the stocks, or transportation to penal colonies, including the Americas (Crime Museum, 2017).

Many inmates perished of disease when transported to the colonies or died from abuse while serving their sentences (Crime Museum, 2017). In the United States, the first prison was Philadelphia's Walnut Street Prison, which opened in 1790 (Biggs, 2009). Designed, built, and operated by the Quakers, it was constructed to punish and rehabilitate criminals and is considered the birthplace of the modern prison system (Biggs, 2009). It used isolation and total silence to control, punish, and rehabilitate the criminal (Biggs, 2009). The Quakers believed the program provided prisoners with time for reflection on their crimes, encouraged repentance, and resulted in prisoners leaving prison rehabilitated (Law Library, 2020). This philosophy produced the term "penitentiary," which derives from the Latin word for "remorse" (Law Library, 2020). However, as the Quakers discovered and as remains true today, extreme isolation (such as solitary confinement) causes suicides, psychosis, and other severe mental health issues in the incarcerated population.

Moreover, these early prisons were overcrowded and dirty. Today, jails and prisons remain overcrowded and have been described as a "petri dish" for disease (Williams et al., 2020). Certainly, diseases like coronavirus and tuberculosis (TB) endanger jail and prison populations just as they do the non-incarcerated population.

TYPES OF FACILITIES

There are numerous types of correctional facilities from small, rural jails to large, sprawling state prisons. There are police holding cells, small lockups, juvenile facilities, adult and juvenile boot camps, work furlough facilities, and immigration detention centers. Correctional facilities can be managed by federal, state, county, city, or private contractors.

While often used interchangeably, the terms "prison" and "jail" actually denote different types of correctional facilities. Prisons are typically run by state or federal government and house convicted offenders sentenced to more than one year of incarceration (Eckenrode et al., 2020). Jails are generally run by a local municipality or county, house convicted offenders sentenced to less than one year of incarceration (typically for misdemeanor offenses), and house pre-trial detainees (Eckenrode et al., 2020).

Prisons generally have well-defined policies and procedures, and in some states, different prison complexes are specifically designated to house inmate patients with chronic health conditions, mobility issues, advanced age, and skilled nursing needs. They generally have the accommodations and policies to accommodate the provision of long-term care to inmate patients. Rural jails are often small, underfunded, and staffed by healthcare providers who may have little or no knowledge of national correctional healthcare standards. A rural jail may have inadequate policies and procedures or, in some cases, none at all.

THE FRAMEWORK

All correctional facilities, whether run by the city, the county, or the state, should have administrative policies and procedures, including those for the provision of healthcare. Privately-operated jails and prisons have written contracts with corporations that provide correctional healthcare.

The administrative policies of government-run correctional facilities define the chain of command. They should note the responsible health authority and provide an outline for the provision of care. County and state facilities will contract with existing community hospitals and resources for the provision of specialty care, emergency care, and hospitalization. The contract will detail the parameters of the agreement between the public entity and the private provider.

Privately-run correctional facilities contract with corporations that provide correctional healthcare. These contracts specifically outline the corporation's responsibilities, including

Correctional cases involving medical or mental health-related allegations almost always involve the alleged violation of the inmate patient's civil rights.

the number of staffing hours and type of staff provided. The contract should also address how pharmacy services, outpatient services, specialty care, emergency care, and hospitalization will be provided. Usually, the contract includes provisions for the handling of inmate medical records, including that all healthcare records are left with the county or state in the event the contract is cancelled. The contract will also clearly state the amounts of liability insurance the corporation must carry. Some corporations include a statement accepting liability in the event of litigation.

In some states and some very rural correctional facilities, there may be no on-site healthcare staff. In this instance, security policies should address the procedures for providing inmate patients with access to health care including routine, specialty, and emergency care. Without on-site healthcare staff or such detailed and specific security policies, decisions regarding the provision of healthcare are left to security staff with minimal medical training, often with tragic outcomes. Thus, correctional litigation in states with minimal regulations governing correctional healthcare can be very problematic, especially for defense.

INMATE RIGHTS

The 8th and 14th amendments to the United States Constitution provide the framework for inmate rights. The 8th amendment protects against cruel and unusual punishment (National Constitution Center, 2020a). The 14th amendment provides the right of due process (National Constitution Center, 2020b). Unsentenced inmates have at least the same rights as convicted prisoners (Perez, 2017).

All incarcerated populations have several fundamental rights related to health care. Inmate patients have the right to access both routine and emergency care without barriers (National Commission on Correctional Health Care, 2003). It is up to the responsible health authority to identify and eliminate any barriers to care. Correctional facilities must provide emergency care and respond to sick call (i.e., inmate requests for nonemergent health care attention). Institutions must also provide access to specialists and inpatient hospitalization (Rold, 2003).

Inmate patients are entitled to professional medical judgements made by qualified health care professionals. This does not mean the medical decisions must be right, just that the healthcare professional who decides to treat is appropriately qualified (Rold, 2003). Once treatment is ordered, correctional facilities must provide that care without significant delay (Rold, 2003).

The inmate patient has the right to receive care for "serious" medical need. Generally, a medical need is "serious" if a physician diagnosis mandates treatment or is so obvious that even a lay person can easily recognize the need for intervention. A condition does not have to be life-threatening to be considered "serious" (Rold, 2003).

Correctional cases involving medical- or mental health-related allegations almost always involve the alleged violation of the inmate patient's civil rights. To establish such a violation, the plaintiff must demonstrate the institution and/or healthcare staff showed "deliberate indifference" in providing healthcare. In determining "deliberate indifference" to serious medical needs, the courts generally look at three factors: the amenability of the patient's condition to treatment, the consequences to the patient if treatment does not occur, and the likelihood of a favorable outcome (Rold, 2003).

STANDARD OF CARE

Each state has various regulations and/or penal codes addressing the provision of health care to its incarcerated population. Some states, like California, have extensive regulations while other states, like Colorado, have almost none. Individual facilities will also have policies and procedures for the provision of care to inmate patients; these should incorporate the state's regulations. Many states' Departments of Corrections have searchable policies and procedures available online.

Several organizations have promulgated standards for correctional health care. Two of the most prominent are the American Correctional Association and the National Commission on Correctional Health Care (NCCHC). These organizations, and others, also provide accreditation services to correctional institutions. By successfully completing the accreditation process, a correctional institution demonstrates they deliver healthcare that "meet[s] nationally established and accepted standards for the provision of health services" (NCCHC, 2020a).

The standards published by these organizations are their "recommendations for managing the delivery of medical and mental health care in correctional systems" (NCCHC, 2020b). They address the administration, operation, and performance of healthcare functions and provide a framework for the provision of safe, effective, and adequate healthcare. The national standards of care address the responsible health authority, medical autonomy, credentialing, staff orientation, parameters for policies and procedures, and other administrative topics. They also provide guidance for facility operations, such as patient safety, pharmacy services, the proper handling of patient records, and the provision of specialty services. The standards for patient care and treatment provide a framework for intake screening, health assessments, mental health care, dental care, sick call, coordination of care, and discharge planning (NCCHC, 2014), but they do not provide a step-by-step guide to the provision of treatment of specific medical, mental health, or dental conditions. The NCCHC also provides practice guidelines and white papers for specific health conditions and medical-legal issues.

The Federal Bureau of Prisons has standards of care available online, including clinical guidelines for the treatment of specific healthcare conditions. Government agencies such as the United States Marshals Service and the United States Immigration and Customs Enforcement have standards of care related to the provision of healthcare to those in their custody. (See the "Resources" section at the end of this article.)

When evaluating a case, the prudent legal nurse consultant (LNC) will research the relevant rules, regulations, policies and procedures, and promulgated standards for the correctional institution in question. The standards published by various organizations are recommendations or guidelines and should be viewed as such when evaluating the provision of correctional healthcare. The standards utilized for a case must have been in effect at the time of the care in question. The LNC should also determine if the correctional facility was accredited at the time the care in question was rendered.

THE INCARCERATION PROCESS: ARREST THROUGH RELEASE

Generally, the incarceration process begins with arrest. The arrest may be made by any number of agencies. The arrestee may be taken to a holding cell and then transferred to a jail, pris-

Each state has various regulations and/or penal codes addressing the provision of health care to its incarcerated population.

on, or other detention facility. If the arrestee is injured, unstable, or has an urgent medical need, the arresting officer should have the arrestee evaluated and cleared in an emergency room before transporting the arrestee to a correctional facility.

If the arrestee is kept in a holding cell for any length of time, the arresting officer should inquire about any serious medical or mental health problems that would make it inappropriate to house the arrestee in this situation. If the arrestee has medical and/or mental health issues beyond what the holding facility can handle, the arresting officer should have the arrestee evaluated and stabilized in an emergency room or transferred to a correctional facility capable of providing the necessary care and observation.

Immediately upon transfer and entrance to the receiving correctional facility, the arrestee should undergo an intake screening. This screening is either completed by qualified healthcare staff or trained correctional staff. The screener should inquire about medical, mental health, and dental problems; current medication; injuries; pregnancy; suicidality; drug and/or alcohol abuse; and TB or other communicable diseases. Inmate patients should then be referred to appropriate healthcare providers in a timely manner. The healthcare provider performing intake screening or receiving a referral from the intake area must determine if the inmate patient meets criteria for entrance into the facility, will remain stable through booking and housing, or needs referral to an emergency room.

Intake remains an area of extremely high liability for healthcare staff. Arrestees often arrive after altercations and accidents or are under the influence of various substances. Many arrestees arrive to a facility suffering from untreated or inadequately treated medical or mental health conditions (such as hypertension, diabetes, cardiac disease, acute alcohol or drug withdrawal, and active psychosis) and may be incapable of providing needed health information. Any arrestee who suffers from an acute illness or injury or who is unconscious, disoriented, or in any way unstable should be refused by the screener for acceptance to the facility and appropriately transferred to an emergency room for evaluation, stabilization, and treatment. Even if a trained security staff member or other healthcare provider performs the intake screening, an RN usually makes the decision to refuse an arrestee.

Depending on the situation, either the arresting officer will transfer the arrestee to an emergency room or facility staff will contact emergency medical services for transport. Failure to provide appropriate transportation to an emergency room from the facility is a frequent area of liability. For example, transporting an inmate patient in cardiac arrest to an emergency room via a patrol car would not be appropriate. "Prisoners are entitled to the same standard of healthcare as the general public without discrimination" (Penal Reform International, n.d., para. 9).

Intake remains an area of extremely high liability for healthcare staff. Arrestees often arrive after altercations and accidents or are under the influence of various substances.

Arrestees should also receive a mental health screening at intake. Jails and prisons have become acute mental health care facilities. Nationwide, there is a shortage of mental health beds, and many mental health patients unfortunately find themselves in jails and prisons. Some jails and prisons have the capacity to handle inmate patients suffering from acute, unstable mental health conditions. Many more do not have trained staff or appropriate facilities to house inmates with acute exacerbation of mental health conditions. Facilities who keep an inmate patient who may be incoherent, violent, agitated, and unable to perform activities of daily living greatly increase their risk of liability. If a facility does not have the capability to care for a mental health patient in crisis, generally the only option is to transport the patient to an emergency room. Often, emergency rooms will attempt to transfer the inmate patient back to the facility. Correctional healthcare staff must be assertive in refusing to accept any patient for whom safe and adequate care cannot be provided.

While in custody, if the inmate requires care for a minor or non-emergent medical condition, the inmate must submit a request to be seen on sick call. Sick call requests should be addressed in a timely manner. Depending on the problem, healthcare staff will treat minor problems using nursing assessment protocols or refer the inmate patient to the appropriate provider. Referrals to a higher-level provider or outside specialty care should be both timely and appropriate.

Inmate patients being transported to an outside healthcare appointment should arrive with the appropriate information needed for the provision of care and should return to the facility with orders from the outside provider for treatment, medications, or diagnostic testing. Facility healthcare staff should track

Nursing assessment protocols provide registered nursing staff information and guidance on the expected treatment of specific healthcare conditions.

outside appointments and follow up on orders for care and treatment. All orders for care and treatment from an outside provider are generally approved by the appropriate medical, mental health, or dental providers in the receiving correctional facility.

Inmates who remain incarcerated will usually undergo a more in-depth physical exam. Depending on the state and the facility, these health assessments may or may not be mandated.

Discharge planning, although important, may or may not be provided. On release, an inmate patient should have prescriptions for vital medications and follow-up appointments for necessary care. Some facilities and systems provide good discharge planning; however, most do not. Much depends on the type of facility, the state, and state regulations. Since prisons are generally equipped to provide long-term care to inmate patients, they typically have excellent discharge planning. Because of the transient nature of jails, where inmates often stay for short periods of time or are released quickly after a court hearing, discharge planning is difficult.

NURSING ASSESSMENT PROTOCOLS

Registered nurses (RNs) are the backbone of correctional facility healthcare. They provide initial care to inmate patients from intake through release. Nursing assessment protocols provide registered nursing staff information and guidance on the expected treatment of specific healthcare conditions; they generally provide algorithms for the provision of routine and emergency care for everything from athlete's foot to cardiac arrest.

On intake, the RN either performs the intake screening or reviews the intake screening forms completed by other trained staff. The RN then evaluates and refers new inmates with health problems to the appropriate provider. When an RN determines during intake evaluation that an arrestee needs to be examined in a hospital emergency room, the RN refuses to accept the arrestee until further, appropriate treatment is obtained by the arresting agency.

The RN is a first responder for emergencies within the correctional facility and also provides routine sick call for inmate patients. The RN uses the nursing process to assess and refer inmate patients to the appropriate provider in the case of illness or emergency.

Nursing assessment protocols generally contain standing orders allowing the RN to give medications in certain instances. Usually, the nursing assessment protocols allow RNs to give over-the-counter medications in specific circumstances, usually the treatment of minor conditions. In the event of a life-threatening emergency, nursing assessment protocols often allow the RN to administer a prescription medication, such as nitroglycerin for acute chest pain. The nursing assessment protocols may allow the RN to start oxygen or an intravenous line in an emergency.

Generally, nursing staff have a great deal of autonomy in the provision of care to inmate patients. This requires that correctional nurses possess excellent nursing assessment skills as well as in-depth knowledge of the facility's nursing assessment protocols and accepted nursing practice.

Registered nurses should have training documented in their personnel files for appropriate use of nursing assessment protocols. Some facilities provide skills evaluation on an annual basis. Often, skills evaluation is based on mastery of emergency assessment protocols along with various targeted nursing assessment protocols.

When reviewing a correctional healthcare case, the LNC must review the relevant policies, procedures, and nursing assessment protocols. The LNC then evaluates the appropriateness of the nursing assessment protocol and whether the RN followed the protocol. Nursing assessment protocols should be evaluated for adherence to generally accepted treatment parameters for a medical condition, the appropriateness of any standing orders, conformance to

The LNC should be aware of the practice parameters for all involved care providers and evaluate the appropriateness of correctional job assignments within that context.

the nursing process, and adherence to nursing scope of practice. As discussed further in the next section, all nursing staff should work within their scope of practice, and the LNC must evaluate for this when reviewing a correctional healthcare case. The LNC should also obtain and review the correctional RN's personnel file to review documentation pertaining to training and ongoing skills evaluations.

SCOPE OF HEALTHCARE PRACTICE

Correctional facilities employ many different types of licensed healthcare personnel. Depending on the type and size of the facility, healthcare employees may include physicians, mid-level providers, RNs, licensed practical nurses (LPNs), nurse aides, medical assistants, dental technicians, dentists, x-ray technicians, pharmacy technicians, medication technicians, emergency medical technicians, and paramedics.

Facilities utilize healthcare personnel in many ways, so when evaluating a correctional healthcare case, an LNC should review the facility's job descriptions and assignments to ensure all healthcare staff practiced within their legal scope of practice. The LNC should be aware of the practice parameters for all involved care providers and evaluate the appropriateness of correctional job assignments within that context. Were healthcare staff members working in assignments that were beyond their scope of practice, education, or training? If one member of the healthcare staff is working outside the relevant scope of practice, it is likely other staff members may also be practicing outside their scope of practice. For example, LPNs can only perform simple assessments such as normal and abnormal; essentially, they may only collect and report data (National Association of Licensed Practical Nurses, 2020). An LPN cannot assess at the level of a RN and, therefore, should not be assigned to perform any task requiring in-depth assessment such as nurse sick call.

The relevant scope of nursing practice is determined by that state's Nurse Practice Act, which defines the practice and parameters of nursing in that state. It also usually details the educational curriculum for RNs, LPNs, and often nurse aides and medical assistants. The specific governing body may vary from state to state. For example, in some states, a Board of Nursing regulates the practice of both LPNs and RNs. In other states, there may be separate boards. In some states, the governance of medical assistants and nurse aides is the responsibility of the Board of Nursing. In other states, this responsibility falls under the Department of Health or another division of state government.

The American Nurses Association also addresses the scope of nursing practice in the provision of care to inmate patients. This can be another resource for the LNC.

EXPERTS

Once a plaintiff firm decides to further investigate a potential correctional healthcare case or once a defense firm is assigned such a case, a correctional expert should be retained. As with any standard of care expert, the appropriate correctional healthcare expert should be a similar healthcare provider (in education, training, and experience) to the one whose (in)actions are being questioned.

In summary, correctional cases have many components that make them extremely complex to evaluate. Generally, the LNC performing an initial review must evaluate care in the context of the nursing process; the applicable scope of practice; industry guidelines and recommendations; the relevant rules and regulations; and the facility's policies, procedures, job descriptions and assignments, and nursing assessment protocols. These will help clarify the major issues, highlight potential deviations from or adherence to accepted norms, and assist the LNC in evaluating the (in)actions of the correctional healthcare providers.

RESOURCES:

1. American Correctional Association: www.aca.org
2. American Nurses Association: https://www.nursingworld.org/
3. CorrectionalNurse.net: https://correctionalnurse.net/
4. Department of Justice: https://www.justice.gov/
5. Federal Bureau of Prisons: https://www.bop.gov/
6. Federal Bureau of Prisons' Clinical Guidelines: https://www.bop.gov/resources/health_care_mngmt.jsp
7. ICE Detention Standards for Medical Care (See Part 4.3): https://www.ice.gov/detention-standards/2019
8. National Institute on Correctional Healthcare, https://www.ncchc.org/

9. U.S. Marshals Service's Prisoner Health Care Standards: https://www.usmarshals.gov/prisoner/standards.htm

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Language Barrier & Standard of Care:

A Case Example

Elizabeth Marriott, RN

Keywords: Language barrier, mitigation of risk, causation, standard of care, duty of care, negligence

This article explores nurses' duty to effectively communicate with patients and caregivers and to mitigate the risk of communication failure during that process. A case example involving a language barrier is offered to explore how healthcare provider negligence and causation can be established when this duty is breached.

Nurses are the healthcare professionals who are most often responsible for providing education and discharge instructions to patients and their primary caregivers. As such, they have a duty of care that includes ensuring effective communication of medical information. When this duty of care is not fulfilled, a breach of the standard of care has occurred.

Approximately 4.7% of the United States population aged 5 years or older does not speak English well or at all (Rumbaut & Massey, 2013). This equates to more than 14 million people – all of whom are potential patients with a language barrier to communication in the healthcare setting.

When a patient or primary caregiver does not understand medical information communicated by a healthcare provider, it creates the potential that

directions related to care will not be followed. In the case of discharge instructions, a lack of understanding by a patient or primary caregiver could lead to a misunderstanding of the signs and symptoms to watch for, when to report to a healthcare provider, or when to report to an emergency department. This, in turn, can translate to poor outcomes for patients.

Several studies have been conducted on the effects of communication failures related to language barriers. These studies show repeatedly that miscommunications related to language barriers can have negative consequences for patients (Meuter et al., 2015). As a result, healthcare institutions have taken steps to mitigate this risk. Many hospitals have instituted policies outlining steps that are to be taken by healthcare providers when educating persons who do not speak English as a primary language. In the case example presented below, the hospital's policy dictated the use of translation services, which were readily available via phones used exclusively for translation. Written discharge instructions were available to be printed in the native language of the patient's primary caregiver.

In this case example, the standard of care for communication when there is a language barrier was breached in the following respects: failure to provide appropriate discharge education, failure to document accurately within a medical record, and failure to follow hospital policy and procedure. A line of causation was drawn between the patient's death and the nurses' failure to provide the patient's primary caregiver with education and discharge instructions in a language she could understand.

The patient, a child less than one year of age, initially presented to the emergency department with a three-day history of fever and vomiting. The patient's primary caregiver, the patient's mother, accompanied the patient. The mother spoke no English; she was fluent in Spanish.

A chest x-ray revealed a button battery in the patient's thoracic inlet. The battery was removed via esophagoscopy, and the patient was noted to have esophageal erosions. The patient was admitted to the hospital after the procedure. The patient's mother was given education regarding the procedure and the child's medical condition in English, per the documentation within the medical record. The nurse who gave this education documented the patient's mother had no barriers to communication and that her preferred language for medical instruction was English. Less than 96 hours later, the patient was discharged to the care of the mother, who was given printed discharge instructions in English. These instructions detailed the signs and symptoms to watch for that could be indications of bleeding at the site of the battery extraction, fistula formation, or infection.

Twelve days later, the mother brought the patient back to the emergency department with a fever, cough, and congestion. The patient was sent home with a diagnosis of airway inflammation and with discharge instructions, in English, to follow up with a primary care physician within 72 hours. The medical record again noted the mother to have no barriers to communication and to be English-speaking.

Less than 20 hours later, the mother brought the patient back to the emergency department, now with neck pain. The treating physician in the emergency department documented a possible facial droop. The diagnosis given was viral infection, and the mother was again given English discharge instructions that directed her to follow up with a primary care physician within 72 hours.

Just over 24 hours later, the mother returned the patient to the emergency department, because the patient still had an unresolved fever. In addition, the mother reported the child was also having occasional jerking, rhythmic movements. This time, the charting nurse noted the mother was Spanish-speaking, but no translator was provided. The patient was again diagnosed as having a viral illness, and the mother was given English discharge instructions identical to those she received during the previous visit.

Less than 24 hours later, the patient returned to the Emergency Department via ambulance, unconscious and hemorrhaging from the mouth. The patient was found to have a fistula into the carotid artery at the site of the button battery extraction; the fistula was caused by the contents of the battery that had leaked due to corrosion prior to its extraction. The patient had watershed infarctions and anoxic injury to the brain related to lack of cerebral blood flow secondary to the fistula. The patient also had osteomyelitis of the vertebrae closest to the site of the fistula, as well as an abscess and a staph infection. The patient died from these maladies just over 24 hours after admission.

Studies show repeatedly that miscommunications related to language barriers can have negative consequences for patients.

Breaches in the standard of care occurred during each hospital visit leading up to the final admission and the patient's demise. On each visit, the hospital's policies regarding accurate medical record documentation were violated each time a nurse documented the primary caregiver was English-speaking, had no barriers to communication, and preferred to communicate in English. The patient's mother spoke a negligible amount of English, could not carry on a meaningful conservation in English, and certainly could not appropriately comprehend and digest education and discharge instructions in English. The hospital's policy related to use of translation services was violated by these services not being used to meet the needs of a non-English-speaking primary caregiver.

But what was most important in this case was the nurses' effective failure to provide discharge instruction at all after each hospital visit. Because the patient's primary caregiver was unable to understand the discharge instructions provided to her, the patient was effectively discharged without any instructions. What should have been included in those instructions were signs and symptoms of bleeding from the site of extraction, anoxia, and infection (such as the fever the patient experienced for several days). The primary caregiver should have been given education in her native language related to button battery ingestion and its possible sequalae, including that such sequalae could take several weeks to manifest symptoms.

As a direct result of the nurses' breach in the standard of care, the patient's mother was not appropriately informed of the signs and symptoms of possible sequalae of button battery ingestion. She did not know the stiff neck could be a sign of infection caused by flora from the digestive tract leaking into the spinal column. She was unaware the jerking motions she observed in her child could be signs of intermittent brain hypoxia. She had no idea her child could have tissue necrosis, creating a fistula between the trachea and carotid artery that could lead to a stroke.

It was the responsibility of the nurses caring for the patient to educate the patient's primary caregiver regarding all of these signs and symptoms, to make sure the primary caregiver understood who to contact in the event these symptoms occurred, and to inform the caregiver of the potentially life-threatening nature of these symptoms. This patient died because the primary caregiver did not understand the patient's condition; this could have been easily remedied through the use of a translation service, as dictated by hospital policy. This patient died because the primary caregiver was unsure of what symptoms needed to be reported to a healthcare provider and was unaware of what those symptoms could indicate; this problem could have been easily remedied by the provision of discharge documentation in the primary caregiver's native language, as dictated by hospital policy.

In this case, the breaches in the standard of care by the bedside nurses responsible for patient and primary caregiver education and discharge instruction were used to draw a direct line of causation to the patient's death. It was put forward that the failure of the

Editor's note: This case study presents a focused look at how bedside nurses deviated from the standard of care during their communications with the patient's caregiver. While this language barrier was the focus of the article, the case study raises other questions beyond the scope of the article. What role did the emergency department physicians play in the overall communication failures? How did physician negligence (such as failure to diagnosis and failure to communicate) contribute to the outcome? Were both physician and nursing breaches a proximate cause to the patient's death? How did the caregiver communicate the patient's symptoms (such as neck pain) to the healthcare providers? How did the caregiver give informed consent for the treatment rendered? Prudent legal nurse consultants will identify and ask these questions (and more) when evaluating cases.

nurses to educate the primary caregiver not only fell below the standard of care but fell into the realm of gross negligence. The nurses were aware the mother spoke no English and still did not attempt to have pertinent medical information and instructions translated for her understanding, even though utilizing translation services was as simple as picking up a phone. This case settled out of court in favor of the plaintiff.

The responsibility of the nurse as educator is one of nursing's oldest and largest roles. As shown in the case, a breach in this primary nursing duty can have fatal consequences and legal ramifications.

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U.S. DOJ Says Opioid Use Disorder is an ADA-Covered Disability

James Hanus, RN, BSN, OCN, MHA

Keywords: Department of Justice, Americans with Disabilities Act, opioid use disorder, disability, Suboxone, opiates, opioid crisis, opioid treatment

In 2019, the U.S. Department of Justice (U.S. DOJ) found a primary and specialty care outpatient practice violated Title III of the Americans with Disabilities Act of 1990 (ADA) when it refused to accept a new patient appointment upon learning the patient was taking a legally-prescribed controlled substance to treat a medical condition - Opioid Use Disorder (OUD). The U.S. DOJ determined the refusal to accept the patient with OUD denied the patient medical care because of a disability and therefore was in violation of the ADA.

Over the past several years, legal nurse consultants have seen almost weekly, if not daily, news stories about the "opioid crisis" and the increasing number of people who are addicted to opioids or dying from overdoses. According to the Centers for Disease Control and Prevention (CDC, 2020), in 2018, there were 168,158,611 opioid prescriptions, which equated to 51.4 prescriptions for each 100 persons. The CDC (2020) also noted, in 11% of U.S. counties, there were enough opioid prescriptions written for every person in those counties to receive a prescription.

"The Complainant is a person with a disability because he has OUD."

Opioid Use Disorder (OUD) is defined as "the chronic use of opioids that causes clinically significant distress or impairment" (Dydyk et al., 2020, para. 1). It "can involve the misuse of prescribed opioid medications, the use of diverted opioid medications, or the use of illicitly obtained heroin. OUD is typically a chronic, relapsing illness, associated with significantly increased rates of morbidity and mortality" (Hackett, 2019, para. 3-4). It affects 16 million people worldwide and 2.1 million people in the United States (Dydyk et al., 2020). For patients with OUD who have achieved abstinence through medically-supervised withdrawal or other means, opioid replacement therapy (such as with Suboxone or methadone) aims to prevent relapse.

Opioid Use Disorder was at the center of a United States Department of Justice (U.S. DOJ) investigation involving a complaint under Title III of the Americans with Disabilities Act (ADA).

According to the settlement agreement, in November 2017, a prospective patient called Selma Medical Associates (SMA) in Winchester, Virginia for a new patient appointment with its family practice group (U.S. DOJ Civil Rights Division, 2019a). During the call, this prospective patient disclosed he was taking Suboxone for OUD. At that point, SMA told him it was their policy to not accept any patient being treated with narcotic controlled substances, such as Suboxone, for OUD.

The prospective patient filed a complaint with the U.S. DOJ, and he ("the Complainant") alleged SMA discriminated against him in violation of Title III of the ADA, 42 U.S.C. § 12181-12189. The U.S. DOJ investigation determined the following (U.S. DOJ Civil Rights Division, 2019a):

- SMA is a place of public accommodation as defined by 42 U.S.C. § 12181(7)(F) and is thus subject to the requirements of Title III of the ADA;
- "The Complainant is a person with a disability because he has OUD" (para. 6);
- SMA regularly rejected prospective patients, including the Complainant, who were being treated with narcotic controlled substances such as Suboxone;
- "By refusing to accept the Complainant for a new family practice appointment solely because he takes Suboxone, Selma Medical discriminated against him by denying him the full and equal enjoyment of … and … opportunity to participate in or benefit from the goods, services, … being offered by Selma Medical" (para. 7.d.). This violated 42 U.S.C § 12182(a) and 12182(b)(1)(A)(i).
- "By turning away the Complainant and other prospective patients who are treated with narcotic controlled substances, including Suboxone, Selma Medical imposed eligibility criteria that screen out or tend to screen out individuals with OUD." (para. 7.e.). This was in violation of 42 U.S.C § 12182(b)(2)(A)(i).
- SMA "failed to make reasonable modifications to policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities" (para. 7.e.), which violated 42 U.S.C. §12182(b)(2)(A)(ii).

Under the terms of the settlement agreement reached between the U.S. DOJ and SMA (U.S. DOJ, 2019; U.S. DOJ Civil Rights Division, 2019a), SMA will:

- Not deny services based on disability, including opioid use disorder;
- Not apply standards or criteria that screen out individuals with disabilities;
- Adopt non-discrimination policies, train staff on its non-discrimination obligations, and report on compliance;
- Notify the U.S. within 30 days of a request for new treatment by any individual with OUD or for continued treatment by any individual whose OUD status becomes known to SMA, inform the U.S. of the sta-

tus of such requests, and provide an explanation and documentation for any such requests that are denied;
- Pay $30,000 in damages to the Complainant; and
- Pay a $10,000 civil penalty to the United States.

Referencing the settlement agreement with SMA, Assistant Attorney General Eric Dreiband of the U.S. DOJ Civil Rights Division stated "'This agreement ensures that people in recovery from an opioid use disorder do not face discriminatory barriers to health care services…Unlawfully denying services to individuals with disabilities because of their medical conditions subjects these individuals to unwarranted stigma and harm and will not be tolerated by the Department of Justice'" (U.S. DOJ, 2019, para. 4).

Two other recent U.S. DOJ settlements with healthcare institutions concerning OUD discrimination include Athena Health Care Systems in 2019 (U.S. DOJ Civil Rights Division, 2019b) and Charlwell Operating, LLC in 2018 (U.S. DOJ Civil Rights Division, 2018). Both operated nursing homes in Massachusetts.

The SMA case, along with these other similar cases, places every healthcare facility, provider, and employee on notice that the U.S. DOJ considers OUD to be a disability under the ADA. These cases demonstrate the U.S. DOJ is willing and able to use its full authority to enforce the ADA rights of anyone with OUD. Legal nurse consultants' knowledge of OUD and the ADA could be invaluable in assisting with actual or potential complaints of discrimination under the ADA.

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Check Your Answers

Test Your Case Screening Skills Page 7

Disposition: Investigated

This case was investigated due to the baby's catastrophic injuries. Review of the labor records and EFM strip revealed many hours of tachysystole during a Pitocin induction, during which time the Pitocin was never decreased or stopped. In fact, it was robotically increased at the ordered intervals to the maximum dose, despite persistent tachysystole and signs of fetal distress on the EFM strip. Expert nursing and obstetrical reviews on the liability issues and pediatric neurology reviews on the causation issue were favorable, and the case was commenced. A nurse life care planner was hired to document future medical and nursing care needs. After several years of discovery, the case was settled a week into trial.

Identifying Victims of Human Trafficking:

What to Look for in a Healthcare Setting

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Healthcare providers may come into contact with victims of human trafficking and have a unique opportunity to connect them with much needed support and services. Anyone in a healthcare setting may be in a position to recognize human trafficking – from clerical staff to lab technicians, nursing staff, ambulatory care, radiology staff, security personnel, case managers, and physicians.

The following is a list potential red flags and indicators that medical providers may see in a patient who may be a victim of human trafficking. Please note that this list is not exhaustive. Each indicator taken individually may not imply a trafficking situation and not all victims of human trafficking will exhibit these signs. However, the recognition of several indicators may point to the need for referrals and further assessment.

RED FLAGS AND INDICATORS

General Indicators of Human Trafficking

- ☐ Shares a scripted or inconsistent history
- ☐ Is unwilling or hesitant to answer questions about the injury or illness
- ☐ Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- ☐ Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
- ☐ Demonstrates fearful or nervous behavior or avoids eye contact
- ☐ Is resistant to assistance or demonstrates hostile behavior
- ☐ Is unable to provide his/her address
- ☐ Is not aware of his/her location, the current date, or time
- ☐ Is not in possession of his/her identification documents
- ☐ Is not in control of his or her own money
- ☐ Is not being paid or wages are withheld

RED FLAGS AND INDICATORS

Labor Trafficking Indicators

- ☐ Has been abused at work or threatened with harm by an employer or supervisor
- ☐ Is not allowed to take adequate breaks, food, or water while at work
- ☐ Is not provided with adequate personal protective equipment for hazardous work
- ☐ Was recruited for different work than he/she is currently doing
- ☐ Is required to live in housing provided by employer
- ☐ Has a debt to employer or recruiter that he/she cannot pay off

Sex Trafficking Indicators

- ☐ Patient is under the age of 18 and is involved in the commercial sex industry
- ☐ Has tattoos or other forms of branding, such as tattoos that say, "Daddy," "Property of…," "For sale," etc.
- ☐ Reports an unusually high numbers of sexual partners
- ☐ Does not have appropriate clothing for the weather or venue
- ☐ Uses language common in the commercial sex industry

This publication was made possible in part through Grant Number 90ZV0102 from the Office on Trafficking in Persons, Administration for Children and Families, U.S. Department of Health and Human Services (HHS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office on Trafficking in Persons, Administration for Children and Families, or HHS.

HEALTH INDICATORS AND CONSEQUENCES OF HUMAN TRAFFICKING*[i]

Physical Health Indicators

- ☐ Signs of physical abuse or unexplained injuries
  - Bruising
  - Burns
  - Cuts or wounds
  - Blunt force trauma
  - Fractures
  - Broken teeth
  - Signs of torture
- ☐ Neurological conditions
  - Traumatic brain injury
  - Headaches or migraines
  - Unexplained memory loss
  - Vertigo of unknown etiology
  - Insomnia
  - Difficulty concentrating
- ☐ Cardiovascular[ii]/respiratory[iii] conditions that appear to be caused or worsened by stress, such as:
  - Arrhythmia
  - High blood pressure
  - Acute Respiratory Distress
- ☐ Gastrointestinal conditions that appear to be caused or worsened by stress[iv], such as:
  - Constipation
  - Irritable bowel syndrome
- ☐ Dietary health issues
  - Severe weight loss
  - Malnutrition
  - Loss of appetite
- ☐ Reproductive issues
  - Sexually-transmitted infections
  - Genitourinary issues
  - Repeated unwanted pregnancies
  - Forced or pressured abortions
  - Genital trauma
  - Sexual dysfunction
  - Retained foreign body
- ☐ Substance use disorders
- ☐ Other health issues
  - Effects of prolonged exposure to extreme temperatures
  - Effects of prolonged exposure to industrial or agricultural chemicals
  - Somatic complaints

Mental Health Indicators

- ☐ Depression
- ☐ Suicidal ideation
- ☐ Self-harming behaviors
- ☐ Anxiety
- ☐ Post-traumatic stress disorder
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Lack of emotional responsiveness
- ☐ Feelings of shame or guilt
- ☐ Hyper-vigilance
- ☐ Hostility
- ☐ Attachment disorders[v]
  - Lack of or difficulty in engaging in social interactions
  - Signs of withdrawal, fear, sadness, or irritability
- ☐ Depersonalization or derealization[vi]
  - Feeling like an outside observer of themselves, as if watching themselves in a movie
  - Emotional or physical numbness of senses
  - Feeling alienated from or unfamiliar with their surroundings
  - Distortions in perception of time
- ☐ Dissociation disorders[vii]
  - Memory loss
  - A sense of being detached from themselves
  - A lack of a sense of self-identity, or switching between alternate identities
  - A perception of the people and things around them as distorted or unreal

HEALTH INDICATORS AND CONSEQUENCES OF HUMAN TRAFFICKING*[i] (continued)

Social or Developmental Indicators

- ☐ Increased engagement in high risk behaviors, such as running away or early sexual initiation if a minor
- ☐ Trauma bonding with trafficker or other victims (e.g. Stockholm syndrome)
- ☐ Difficulty establishing or maintaining healthy relationships
- ☐ Delayed physical or cognitive development
- ☐ Impaired social skills

**This list of physical and mental health indicators of human trafficking is not exhaustive. Trafficking survivors may experience one or more of these indicators, none of these indicators, or health indicators not on this list. This list is intended to help you assess if a patient's condition may be a result of a trafficking-related trauma and should be considered in context.*

VICTIM IDENTIFICATION AND RESPONSE

HOW DO I CONDUCT AN ASSESSMENT OR EXAM WITH A POTENTIAL VICTIM OF HUMAN TRAFFICKING?

Victims of trafficking do not often disclose their trafficking situation in clinical settings.[viii] Therefore, it is critical for medical practitioners to be thoughtful about engaging patients, employing trauma-informed practices, and creating a space that is conducive for discussing human trafficking. Before beginning any conversation with a patient, assess the potential safety risks that may result from asking sensitive questions of the patient. Recognize that the goal of your interaction is not disclosure or rescue, but rather to create a safe, nonjudgmental place that will help you identify trafficking indicators and assist the patient.

Recommendations for Assessments:

- Allow the patient to decide if they would feel more comfortable speaking with a male or female practitioner.
- If the patient requires interpretation, always utilize professional interpreters who are unrelated to the patient or situation.
- If the patient is accompanied by others, find a time and place to speak with the patient privately.
- Take time to build rapport with potential victims, or if you do not have the time yourself, find someone else on staff who can develop rapport with the patient.
- Ensure that the patient understands confidentiality policies and practices, including mandatory reporting laws.
- Use multidisciplinary resources, such as social workers, where available
- Refer to existing institutional protocols for victims of abuse/sexual abuse.
- You may contact the National Human Trafficking Resource Center (NHTRC) hotline for assistance in conducting an assessment and determining next steps if you have not already developed a protocol to respond to victims of human trafficking.

WHAT SHOULD I DO IF I BELIEVE I HAVE IDENTIFIED A VICTIM OF HUMAN TRAFFICKING?

Every situation of human trafficking is unique; it is important to use a victim-centered response. Not all victims of trafficking will be comfortable disclosing their situation, nor will all victims be ready to seek assistance from service providers, law enforcement, or even medical providers. Medical providers, however, have a unique opportunity to provide potential trafficking victims with information and options, while supporting them through the process of connecting with advocates or service providers if they are ready to report their situation.

If a patient has disclosed that they have been trafficked:

- Provide the patient with the NHTRC hotline number and encourage him/her to call if he/she wants help or wants to talk to someone. If the patient feels it is dangerous to have something with the number written on it you can have them memorize the number.

i Caring for Trafficked Persons: Guidance for Health Providers, International Organization for Migration (IOM)
ii Conditions, American Heart Association
iii All Diseases, American Lung Association
iv Diseases and Conditions, Cleveland Clinic
v Reactive Attachment Disorder: Symptoms, Mayo Clinic
vi Depersonalization-derealization Disorder: Symptoms, Mayo Clinic
vii Dissociative disorders: Symptoms, Mayo Clinic; Dissociative Disorders, National Alliance on Mental Illness
viii Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting, Massachusetts General and Massachusetts Medical Society

- In situations of immediate, life-threatening danger, follow your institutional policies for reporting to law enforcement. Whenever possible, make an effort to partner with the patient in the decision to contact law enforcement.
- Provide the patient with options for services, reporting, and resources. Ensure that safety planning is included in the discharge planning process.
- If the patient is a minor, follow mandatory state reporting laws and institutional policies for child abuse or serving unaccompanied youth.
- Ensure that any information regarding the patient's injuries or treatment is accurately documented in the patient's records. While documentation of abuse may be helpful in building a case against a trafficker, information about the victim can also be used against them in a court proceeding.

AM I OBLIGATED TO REPORT SITUATIONS OF HUMAN TRAFFICKING? IF SO, WHO SHOULD I CONTACT?

Legal requirements regarding mandatory reporting of human trafficking may differ from state to state, and situations may require mandatory reporting under related statutes even if the situation is not human trafficking (e.g. child abuse or domestic violence). Refer to your local or state requirements regarding mandatory reporting. While contacting the NHTRC will not fulfill mandatory reporting requirements, the NHTRC can facilitate a report to specialized law enforcement trained to handle human trafficking cases.

When working with adults who have been trafficked, it is important to gain permission and consent from the patient before disclosing any personal information about the patient to others, including service providers.

Furthermore, medical providers should be aware of how HIPAA regulations impact the ability to report potential trafficking situations on behalf of a patient. When contacting the NHTRC or connecting with local service providers, keep in mind any confidentiality obligations.

HOW CAN I UTILIZE THE NATIONAL HUMAN TRAFFICKING RESOURCE CENTER HOTLINE TO ASSIST VICTIMS OF TRAFFICKING?

The NHTRC offers confidential round-the-clock access to a safe space to report tips, seek services, and ask for help. The NHTRC is operated 24/7 and has access to over 200 languages through a tele-interpreting service. All communications with the NHTRC are strictly confidential to the extent permitted by law and callers need not disclose personal information in order to access services through the NHTRC. The NHTRC is also an excellent resource for healthcare institutions to help identify and connect with existing resources in their area as they begin the process of developing a response protocol for victims of human trafficking. Healthcare professionals can access the NHTRC for the following services:

Service Referrals: The NHTRC has a referral network of over 3,200 referral contacts, including antitrafficking organizations, legal service providers, shelters, law enforcement, and local social service agencies that can assist victims of human trafficking.

Tip Reporting: The NHTRC has specialized local and national response protocols across the country for law enforcement and service providers. The NTHRC can facilitate a report to law enforcement contacts who are trained on trafficking and designated to respond to NHTRC hotline.

Training and Technical Assistance: The NHTRC also provides training and technical assistance on a wide range of human trafficking topics through calling the hotline and visiting the NHTRC's website. The NHTRC can also guide clinicians through an assessment with a potential victim.

The National Human Trafficking Resource Center (NHTRC) maintains a database of service providers and resources throughout the United States, along with extensive training resources on a variety of topics related to human trafficking.

REPORT ONLINE OR ACCESS RESOURCES & REFERRALS:

www.traffickingresourcecenter.org
Call: 1-888-373-7888 (24/7)
Email: nhtrc@polarisproject.org

ADDITIONAL RESOURCES

SOAR to Health and Wellness, U.S. Department of Health and Human Services

HEAL Trafficking, Health Professional Education, Advocacy, and Linkage

Understanding & Combating Human Trafficking as a Health, Social, & Economic Issue, Child Family Health International

Child Sex Trafficking Webinar Series for Healthcare Professionals, Children's Healthcare of Atlanta

Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the U.S., Institute of Medicine/National Research Council Report

Human Trafficking: Guidebook on Identification, Assessment, and Response in the Healthcare Setting, Massachusetts General and Massachusetts Medical Society

Caring for Trafficked Persons: A Guide for Health Providers, The International Organization for Migration and UN Global Initiative to Fight Human Trafficking

The Role of the Nurse in Combatting Human Trafficking, Donna Sabella in the American Journal of Nursing

Online Educational Modules for Healthcare Professionals: Christian Medical Dental Associations

Transgender Care

GLOSSARY OF TRANSGENDER TERMS

Reprinted with permission from The Teaching Transgender Toolkit

This is a glossary of some of the more common terms that are used when discussing transgender identities and experiences. Definitions and preferred terms will vary by location and group.

Affirming:
The unequivocal support for an individual person's gender identity or expression, regardless of the biological sex they were assigned at birth; the systematic support to ensure that transgender people and communities are fully represented, included, valued and honored.

Affirming Pronouns:
Refers to the most respectful and accurate pronouns for a person, as defined by that person. This is also sometimes referred to as "preferred gender pronouns," although this phrasing is increasingly outdated. To ascertain someone's affirming pronouns, ask: "What are your pronouns?"

Agender:
A person who does not identify as having a gender identity that can be categorized as male or female, and sometimes indicates identifying as not having a gender identity.

AG/ Aggressive:
A term used to describe a female-bodied and identified person who prefers presenting as masculine. This term is most commonly used in urban communities of color.

Biological Sex:
A person's combination of genitals, chromosomes and hormones, usually categorized as "male" or "female" based on visual inspection of genitals via ultrasound or at birth. Many assume that a person's gender identity will be congruent with their sex assignment. Everyone has a biological sex.

Bigender:
A person who experiences gender identity as two genders at the same time, or whose gender identity may vary between two genders. These may be masculine and feminine, or could also include nonbinary identities.

Butch:
A term used to describe a masculine person or gender expression.

Cisgender: (pronounced /sis-gender/):
An adjective to describe a person whose gender identity is congruent with (or "matches") the biological sex they were assigned at birth. (Some people abbreviate this as "cis").

Coming Out:
The process through which a transgender person acknowledges and explains their gender identity to themselves and others.

(Anti-Transgender) Discrimination:
Any of a broad range of actions taken to deny transgender people access to situations/places or to inflict harm upon transgender people. Examples of discrimination include: not hiring a transgender person, threatening a gender non-conforming person's physical safety, denying a transgender person access to services, or reporting someone for using the "wrong" bathroom.

Gender Binary:
The idea that gender is strictly an either/or option of male/men/masculine or female/woman/feminine based on sex assigned at birth, rather than a continuum or spectrum of gender identities and expressions. The gender binary is often considered to be limiting and problematic for all people, and especially for those who do not fit neatly into the either/or categories.

Femme:
A term used to describe a feminine person or gender expression.

Femme Queen:
A term used to describe someone who is male bodied but identifies as and expresses feminine gender. Used primarily in urban communities, particularly in communities of color and ballroom communities.

Gender Conforming:
A person whose gender expression is perceived as being consistent with cultural norms expected for that gender. According to these norms, boys/men are or should be masculine, and girls/women are or should be feminine. Not all cisgender people are gender conforming and not all transgender people are gender non-conforming. (For example, a transgender woman may have a very feminine gender expression).

Gender Dysphoria (GD):
The formal diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM 5), used by psychologists and physicians to indicate that a person meets the diagnostic criteria to engage in medical transition. In other words, the medical diagnosis for being transgender. Formerly known as Gender Identity Disorder (GID). The inclusion of Gender Dysphoria as a diagnosis in the DSM 5 is controversial in transgender communities because it implies that being transgender is a mental illness rather than a valid identity. On the other hand, since a formal diagnosis is generally required in order to receive or provide treatment in the US, it does provide access to medical care for some people who wouldn't ordinarily be eligible to receive it.

Gender Expression:
A person's outward gender presentation, usually comprised of personal style, clothing, hairstyle, makeup, jewelry, vocal inflection and body language. Gender expression is typically categorized as masculine or feminine, less commonly as androgynous. All people express a gender. Gender expression can be congruent with a person's gender identity, but it can also be incongruent if a person does not feel safe or supported, or does not have the resources needed to engage in gender expression that authentically reflects their gender identity.

Genderfluid:
A person whose gender identity or expression shifts between masculine and feminine, or falls somewhere along this spectrum.

Gender Identity:
A person's deep-seated, internal sense of who they are as a gendered being—specifically, the gender with which they identify themselves. All people have a gender identity.

Gender Marker:
The marker (male or female) that appears on a person's identity documents (e.g., birth certificate, driver's license, passport, travel or work visas, green cards, etc.). The gender marker on a transgender person's identity documents will be their sex assigned at birth until they undergo a legal and logistical process to change it, where possible.

Gender Neutral:
A term that describes something (sometimes a space, such as a bathroom; or an item, such as a piece of clothing) that is not segregated by sex/gender.

Gender Neutral Language:
Language that does not assume or confer gender. For example "person" instead of " man" or " woman."

Gender Non-Conforming:
A person whose gender expression is perceived as being inconsistent with cultural norms expected for that gender. Specifically, boys/men are not masculine enough or are feminine, while girls/women are not feminine enough or are masculine. Not all transgender people are gender non-conforming, and not all gender non-conforming people identify as transgender. Cisgender people may also be gender non-conforming. Gender non-conformity is often inaccurately confused with sexual orientation.

Genderqueer:
A person whose gender identity is neither male nor female, is between or beyond genders, or is some combination of genders.

Intersex:
An umbrella term that describes a person born with sex characteristics (e.g. genetic, genital, sexual/ reproductive or hormonal configurations) that do not fit typical binary notions of male or female bodies. The term describes a wide range of natural variations in human bodies. Intersex is frequently confused with transgender, but the two are completely distinct and generally unconnected. A more familiar term, hermaphrodite, is considered outdated and offensive.

LGBTQ:
An acronym commonly used to refer to Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning individuals and communities. LGBTQ is often erroneously used as a synonym for "non-heterosexual," which incorrectly implies that transgender is a sexual orientation.

Medical Transition:
A long-term series of medical interventions that utilizes hormonal treatments and/or surgical interventions to change a person's body to be more congruent with their gender identity. Medical transition is the approved medical treatment for Gender Dysphoria.

Microaggressions:
Small, individual acts of hostility or derision toward transgender or gender non-conforming people, which can sometimes be unintentional. Examples of microaggressions include: use of non-affirming name or pronouns, derogatory language, asking inappropriate or offensive questions, and exhibiting looks that reveal distaste or confusion.

Non-Binary:
A continuum or spectrum of gender identities and expressions, often based on the rejection of the gender binary's assumption that gender is strictly an either/or option of male/men/masculine or female/ woman/feminine based on sex assigned at birth. Words that people may use to express their nonbinary gender identity include "agender," "bigender," "genderqueer," "genderfluid," and "pangender."

Pangender:
A person who identifies as all genders.

(Anti-Transgender) Prejudice:
An individual's negative attitudes, beliefs, or reactions to transgender people. Examples of anti-transgender prejudice include: believing that transgender people are mentally disturbed, being uncomfortable sharing space with a transgender person, or thinking that transgender people should not be allowed to use public bathrooms.

Pubertal Suppression:
A low-risk medical process that "pauses" the hormonal changes that activate puberty in young adolescents. The result is a purposeful delay of the development of secondary sex characteristics (e.g. breast growth, testicular enlargement, facial hair, body fat redistribution, voice changes, etc.). Suppression allows more time to make decisions about hormonal interventions and can prevent the increased dysphoria that often accompanies puberty for transgender youth.

Questioning:
A person who is exploring or questioning their gender identity or expression. Some may later identify as transgender or gender non-conforming, while others may not. Can also refer to someone who is questioning or exploring their sexual orientation.

Same-Gender Loving:
A label sometimes used by members of the African-American/Black community to express an alternative sexual orientation without relying on terms and symbols of European descent. The term emerged in the early 1990's with the intention of offering Black women who love women and Black men who love men a voice, a way of identifying and being that resonated with the uniqueness of Black culture. (Sometimes abbreviated "SGL.")

Sex Assigned at Birth:
The determination of a person's sex based on the visual appearance of the genitals at birth. The sex someone is labeled at birth.

Green, E.R. & Maurer, L.M. (2015). The Teaching Transgender Toolkit: A Facilitator's Guide to Increasing Knowledge, Decreasing Prejudice & Building Skills. Ithaca NY: Planned Parenthood of Greater New York: Out for Health. ISBN: 978-0-9966783-0-8 Available at www.teachingtransgender.com

SPECIFIC ISSUES IN SCREENING FOR TRANSWOMEN AND TRANSMEN WITH PAST OR CURRENT HORMONE USE

	Transwomen (MTF)	Transmen (FTM)
Breast cancer	Discuss screening in patients >50 years with additional risk factors for breast cancer*	Intact breasts: Routine screening as for natal females
		Postmastectomy: Yearly chest wall and axillary exams¶
Cervical cancer	Vaginoplasty: No screening	Cervix intact: Routine screening as for natal females
		No cervix: No screening
Prostate cancer	Routine screening as for natal males	N/A
Cardiovascular disease	Screen for risk factors	Screen for risk factors
Diabetes mellitus	On estrogen: Increased risk	Routine screening$^{\Delta}$
Hyperlipidemia	On estrogen: Annual lipid screening	On testosterone: Annual lipid screening
Osteoporosis	Testes intact: Routine screening as for natal males	Screen all patients >65 years Screen patients age 50 to 65 if off hormones for >5 years
	Postorchiectomy: Screen all patients >65 years Screen patients age 50 to 65 years if off hormones for >5 years	

* Estrogen/progestin therapy for >5 years, family history, body mass index (BMI) >35.

¶ While there is no evidence to support clinical breast examinations in this population, we perform yearly chest wall and axillary exams and use this as an opportunity to examine scar tissue, examine any changes, and educate the patient about the small but possible risk of breast cancer.

Δ Transmen with polycystic ovary syndrome (PCOS) should be screened for diabetes as for natal females with PCOS. Refer to the UpToDate material on further evaluation after diagnosis of PCOS in adults.

Graphic 102596 Version 2.0

HORMONE REGIMENS FOR ADULT TRANSGENDER PERSONS

		Dose range	Comment
Transfeminine regimens (MTF transgender persons)*			
Estrogen	Oral: estradiol (17-beta-estradiol valerate)	2 to 4 mg/day	Some providers report giving higher doses.

HORMONE REGIMENS FOR ADULT TRANSGENDER PERSONS *(continued)*				
Estrogen *(continued)*	**Transdermal: estradiol patch**		0.025 to 0.2 mg per 24 hours, changed once or twice weekly, depending on specific preparation type	Lower risk of thromboembolism compared with oral estrogen options.
	Parenteral	Estradiol valerate	5 to 30 mg IM every two weeks	Prolonged time to onset of effect and steady state, greater risk of accumulation and overdose.
		Estradiol cypionate	2 to 10 mg IM every week	
Antiandrogens*	**Spironolactone**		100 to 300 mg/day oral	Monitor blood pressure and electrolytes.
	Cyproterone acetateΔ		25 to 50 mg/day oral	
GnRH agonists	**Leuprolide**		3.75 to 7.5 mg IM depot monthly OR 11.25 mg IM depot every 3 months	Inhibits gonadotropin secretion.
	Goserelin		3.6 mg SQ implant monthly	Expensive.
Transmasculine regimens (FTM transgender persons)				
Testosterone◊	**Parenteral**	Testosterone enanthate or cypionate	50 to 100 mg IM or SQ every week OR 100 to 200 mg IM every two weeks	Weekly injections produce less peak-trough variation in effect (eg, mood); injection site reaction may occur.
		Testosterone undecanoate	1000 mg IM every 10 to 12 weeks	Produces stable physiologic testosterone levels over 10 to 13 weeks.
	Transdermal	Testosterone gel 1% and 1.6%	2.5 to 10 grams of gel per day (equivalent to 25 to 100 mg/day testosterone)	Less variation in serum testosterone levels than injectable preparations; gel formulations can result in interpersonal transfer if contact occurs before fully dried (rare).
		Testosterone patch	2.5 to 7.5 mg/day transdermal	Transdermal patch may produce lower serum testosterone levels and more skin irritation compared with gels.
Suggestions shown in table are based upon case descriptions and experience. Regimen and dose must be carefully individualized based upon patient age, goals of therapy, whether pre- or postgonadectomy, and comorbid medical conditions and risks. Refer to UpToDate topics on transgender men and transgender females.				

MTF: male-to-female; IM: intramuscular; GnRH: gonadotropin-releasing hormone; SQ: subcutaneous; FTM: female-to-male.

* Dose of estrogen should be adjusted according to serum 17-beta-estradiol levels (ie, 100 to 200 pg/mL) and effect. Lower doses of estradiol are generally sufficient for feminization goals when combined with an antiandrogen, GnRH agonist, or after gonadectomy. Antiandrogen therapy is discontinued after gonadectomy.

¶ Synthetic estrogens (eg, ethinyl estradiol) are not recommended, due to elevated risk of thromboembolic disease, cardiovascular mortality, and inability to regulate dose by measurement of serum levels.

Δ Not available in the United States. Available widely elsewhere.

◊ Doses of testosterone should be adjusted according to serum testosterone levels (ie, normal male range 320 to 1000 ng/dL) and effect. Time to onset of effect of parenteral preparations may be less than with transdermal preparations. Supplemental agents such as depot medroxyprogesterone 150 mg every 3 months or oral medroxyprogesterone 5 to 10 mg/day or oral lynestrenol 5 to 10 mg/day (not available in the United States) have been used as an add-on option when starting testosterone therapy to induce cessation of menses.

§ 1000 mg initially, followed by an injection at 6 weeks, then at 12-week intervals.

Data from: 1. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 2017; 102:1.* *Graphic 69460 Version 8.0*

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Legal Nurse Consulting

Looking Ahead...

XXXI.4, Winter 2020 — Pediatrics and New Author Supplement

XXXII.1, Spring 2021 — LNC Practice Continuum, Niche Roles

XXXII.2, Summer 2021 — COVID-19

XXXII.3, Fall 2021 — Forensics

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