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Copyright Compliance: Photocopying and Fair Use

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I would like to take this opportunity to thank Leroy and Diane Ellenberger and Rose Clifford for allowing us to publish their article.

Many legal nurse consultants and attorneys believe that their use of copyrighted medical literature constitutes "fair use" and is therefore exempt from (1) copyright law (U.S. Code, Title 17) and (2) the need to pay copyright permission fees for photocopies of copyrighted material. "Fair use" applies only to use for "private study, scholarship, or research," with emphasis on "private". Although the interpretation of this definition is debatable, it has not been fully adjudicated. This common belief is wrong because the "fair use" exemption from the copyright laws does not apply to commercial users of copyrighted literature photocopying entire articles, which includes attorneys, law firms, and legal nurse consultants, as well as document delivery services. Some also believe that "fair use" allows anyone to make one photocopy of an article without permission. Whatever the validity of this belief, it does not apply to the commercial, for-profit sector.

Copyright fees generally run from $9.00 to $30.00 per article or chapter plus $3.00 handling fee per item. Large volume users can avoid per item fees by acquiring an annual internal license from the Copyright Clearance Center (CCC) and also including a document delivery service as "Other Parties" on the license, as needed. The cost of an annual license is based on the nature of the business and the number of professional staff.

The CCC in concert with major publishers has been aggressively encouraging compliance with payment of copyright permission fees through sting operations and law suits. In 2003 a legal nurse consulting practice in Texas, which also provided document delivery for attorneys, was sued by the CCC and five major scientific publishers for copyright cont on p 3

Inside this issue:

VTE: Prevention and Timely Treatment Factors in Malpractice Claims-Part 2

Maggie Driscoll BSN RN CCRN CLNC

There are two main methods for preventing VTE (venous thromboembolism): **mechanical methods and pharmacological medication.**

Mechanical methods of helping to prevent VTE include: early ambulation, graded compression stockings and intermittent sequential compression devices. A Sequential Compression Device (SCD) is applied to the legs. This consists of an air pump connected to a disposable sleeve by a series of air tubes. The sleeve is placed around the patient's leg. Air is then forced into different parts of the sleeve in sequence, creating pressure around the calves and improving venous return. The intermittent sequential compression device is particularly useful in patients at high risk of bleeding, such as those undergoing neurosurgery, or major knee surgery.

Graded compression stockings must be fitted properly to be maximally effective (graded highest at the ankle and decreasing in a proximal direction). The stockings are inexpensive and should be considered in all at-risk surgical patients.

Pharmacological Agents used to prevent VTE include unfractionated heparin (low-dose and adjusted-dose), low-molecular-weight heparins (LMWH's such as enoxaparin) and heparinoids, warfarin (also known as coumadin) and dextran. These agents prevent, to varying degrees, clot formation by interfering with blood coagulation (heparin, warfarin) or blood flow and fibrin stability (dextran).

Bleeding is the major side effect of the pharmacological agents used to prevent VTE, however major studies and clinical trials, have found LMWH's to be a highly effective and safe form of prophylaxis in patients undergoing orthopaedic and general surgery, and in stroke patients. They are considered the most effective form of prophylaxis in hip surgery, knee surgery and following major trauma.

Guidelines:

The type of preventative methods, duration and frequency, are based on a patient's risk factors, and the potential benefits and associated complication these methods could potentially create. In 2001 the American College of Chest Physicians published recommendations for the prevention of VTE based on the results of pooled data as well as major randomized trials and/or formal, published meta-analyses. These recommendations were evidence-based, where possible, but practical suggestions for prophylaxis were also provided, cont on p 3

Obstetrical Hemorrhage Questions and Answers

Jan Aken RN IBCLC LNC

1. What is the incident of direct obstetrical death owing to hemorrhage?
   a. 1-5% of cases
   b. 25- 30% of cases.

The answer is b. **25-30 %.(** Williams 2001, p 620)

Between the years 1979 through 1992, Chichakli 1999, found after looking at 4915 maternal deaths that hemorrhage was found to be a direct cause in 30% of maternal deaths. The major causes of death from hemorrhage are respectively in this order

a. Abruptio placenta
b. Lacerated/uterine rupture
c Uterine atony
d Coagulopathies
e Placenta previa
f Placenta accreda /increta/percreta
g Uterine bleeding and
h Retained placenta

2. Which of the following is most commonly associated with placental abruption?

a. trauma
b. hypertension

The answer is b some type of **hypertension** (Williams 2001,p 624)

The separation of the placenta from the uterine wall before delivery is called placental abruption. The primary cause is unknown; however, abruption is associated with several conditions. The most common conditions associated with placental abruption are:

a. Hypertension
b. Preeclampsia
c. Gestational hypertension/chronic hypertension

3. What is the average frequency of placental abruption?

a. 1 in 60
b. 1 in 200

The answer is b. **1 in 200** (Williams 2001, p 622)

As one would suspect, placenta abruption with concealed hemorrhage carries a high maternal mortality rate.

4. What is the incidence of abruption severe enough to kill the fetus?

a. 1 in 350
b. 1 in 1550

The answer is b **1 in 1550** (Williams 2001, p 623)

The incidence of fetal deaths from abruption continuers to decrease. The reason being physicians are seeing and taking care of fewer women with high-parity, the readily availability of medical care along with improved transportation to "high tech" maternal care centers

5. What is the most common presenting sign in women with an abruption?

a. Back pain
b. Bleeding with abdominal pain

The answer is b. **Bleeding with abdominal pain.** (Williams 2001, p. 626.)

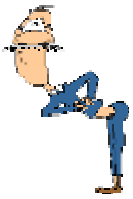
Other signs associated with an abruption include

a. Back pain
b. Fetal distress(e.g. bradycardia seen on the monitor strip)
c. Contractions less than 2 minutes apart
d. Uterine hypertonus (a uterus that does not relax between contractions)
e. Preterm labor
f. Dead fetus

Reference:
Williams Obstetrics 21st Ed. 2001
Chapter 25 Obstetrical Hemorrhage

The Red Flags of Acute Low Back Pain ….*are they a clue?*

Jeannine Lurie RN, BSN, CLNC



Acute Low back pain is one of the top ten reasons why patients seek medical care. Acute low back pain (ALBP) is commonly referred to as back pain symptoms of less than 3 months in duration. Most all of us between the ages of 45 to 60 years will experience some form of "back pain". In general back pain is not considered life threatening. Back pain can arise from many causes. It can range from dull annoying ache to absolute agony. Approximately 80-90% of back pain, in adults is related to mechanical injuries. Most of these will resolve within 3-4 weeks and require only conservative medical measures, such as, non-steroidal anti-inflammatory medications and a program of rest with gradual return to the activities of daily living. A small percent of these patients will experience continual chronic symptoms without any explanation of organic pathology and some will have an underlying disease.

Back pain can also be an indicator of further complications. Health Care providers, both medical and nursing are continually on alert for signs and symptoms that could indicate complications of ALBP. Medical providers concentrate on a detailed history and physical examination in order to rule out these symptoms. Nursing personnel focus interviews and assessments promptly reporting any key or suspicious findings. Acute Low back pain has become so prevalent that the Agency for Health Care Policy and Research (AHRQ) along with the Washington D.C Department of Veterans Affairs has published guidelines establishing a framework for evaluation of Acute Low Back Pain. Red Flag indicators such as trauma, numbness and tingling, sudden loss of bowel and bladder, unexplained fever or weight loss are valuable "clues" that could indicate an underlying complications.

Cauda Equina Syndrome

Continued back pain complaints quite often unveil a lumbar disc herniation. Again, conservative measures, time medications or even surgical interventions may relieve the symptoms. However, lurking in the back ground lays the potential for a serious, devastating complication – the *Cauda Equina Syndrome.* Unlike the herniated disc, Cauda Equina Syndrome cont on p. 4

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infringement. In discovery the plaintiffs requested the defendant's client list. Document retrievers in San Francisco, Sacramento, and Davis, CA, have also been sued by the CCC and major publishers for not paying the respective copyright fees.

Two large intellectual property law firms in New York and Washington, D.C., were both sued by CCC and major publishers because employees of the firms were violating the publishers' copyright by photocopying articles without an internal license. They settled with the publishers for an undisclosed amount and agreed to purchase a multi-year in-house license. Texaco was sued for one scientist photocopying copyrighted material without paying the necessary fees (American Geophysical Union v. Texaco). Using a "fair use" defense, they lost at trial and again on appeal. This is the only suit by the CCC to come to trial as all of the rest of the suits have had out of court, undisclosed settlements.

The copyright law is strict liability law. The penalties for copyright infringement are substantial and may be up to $150,000 per infringement, but may be judicially reduced if the defendant can show having had no knowledge of infringement. Furthermore, under the Digital Millennium Copyright Act of 1998, the electronic transmission of copyrighted material, e.g., via PDF files as opposed to fax, requires an additional permission and may also be subject to penalty.

FURTHER READING

Copyright Clearance Center
<http://www.copyright.com>
Copyright & Fair Use: Settlement of the Texaco Case
<http://fairuse.stanford.edu/primary_materials/cases/texaco/settlement.html>
James S. Heller, "Where have you gone, fair use: Document delivery in the For-Profit Sector"
<http://www.unc.edu/~unclng/copy-corner17.htm>

CORRECTION: The article above incorrectly reports that the CCC and major publishers sued intellectual property law firms in New York and Washington, D.C. In the latter case, the D.C. law firm was sued by a publisher whose content was reprinted without permission. In the former case, the New York firm was threatened by the CCC and major publishers with a suit for illegal in-house photocopying whereupon they settled and purchased a multi-year in-house license to avoid the suit. [This correction will appear in the next issue of OnPoint.]

Note: Users of photocopies of copyrighted materials should also be advised that according to the law the copyright permission fee should be paid for every copy of an article made from the first copy provided by the document delivery service. This requirement does not apply if the firm possesses an annual license from the Copyright Clearance Center. However, it needs to be kept in mind that while the CCC has responsibility for the vast majority of publications available in the United States, some publications are outside their purview and permissions would need to be sought separately from these non-participating entities.

VTE: Prevention and Timely Treatment Factors in Malpractice Claims-Part 2

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particularly in situations where the evidence was considered to be inadequate. These guidelines can be accessed online at: http://www.chestjournal.org/cgi/content/full/119/1_suppl/132S

Treatment:

Many studies have demonstrated that preventing VTE is more cost-effective than treating its devastating consequences such as pulmonary embolism and chronic venous insufficiency. If a VTE is identified or suspected, anticoagulation therapy (such as heparin and coumadin), will likely begin unless contraindicated (such as in active bleeding).
Massive DVT's and symptomatic PE's are typically treated with fibrinolytic agents (intravenous medication that dissolves the clot) unless contraindicated (patients with recent surgery or trauma, malignant disease, recent stroke, uncontrolled high blood pressure, intracranial disease, active peptic ulcer disease, recent liver or renal biopsy, and recent arterial puncture).

For patient's who cannot undergo fibrinolytic therapy, other methods of preventing fatal VTE can be considered such as embolectomy (clot removal) and/or the placement of a vena cava filter (a filter placed to trap blood clots before they travel to the heart and lungs) or thoracotomy.

Medical Malpractice Claims:

The most common medical malpractice claims involving VTE center around the failure to prevent PE by addressing the likelihood of DVT, and the failure to react to clinical findings in a timely manner. Healthcare professionals who do not provide appropriate VTE prophylaxis in at-risk patient populations, fail to perform an adequate history and physical assessment, fail to complete the correct diagnostic testing to identify VTE in patients with symptoms of VTE and fail to adequately treat these patients in a timely manner are most at risk for legal action.

When investigating claims where VTE is the cause of death or injury, it is vital to review the patient's risk factors, the healthcare professional's assessment and identification of these risk factors through history and physical. Also identify whether the appropriate preventative measures where taken in a timely and effective manner, whether the appropriate diagnostic testing was completed in response to patient symptoms and whether any complications were identified and treated appropriately.

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Acute Low Back Pain

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is a medical emergency.

Cauda Equina, Latin for *"horse's tail"* is actually an apt physical description. The Cauda Equina is a sack of nerve roots, with a common covering at the base of the spinal cord. These individual nerve roots provide motor and sensory function to the lower extremities and the bladder.

Cauda Equina Syndrome is rare. Etiologies often reveal a ruptured midline intervertebral disc usually causing compression of nerve roots below the L-1 level however tumors and other compressive masses have also been found to be responsible for this devastating condition. The symptoms can mimic those of many other conditions. They may vary in intensity and evolve slowly over time. Most often, a standard plain film radiograph is not helpful in detecting the problem. MRI, sometimes CT or Myelogram have proven to be valuable tools is detecting the defect.

A thorough, detailed medical examination will often discover "red flag" findings such as continued low back pain *(which may or may not be present),* urinary or bowel incontinence, motor weakness or sensory loss and/or saddle anesthesia *(loss of sensations, in areas that would sit on a saddle).* Diminished reflexes or sensory abnormalities in the legs, bladder or rectum and muscle weakness or wasting in the lower extremities and sometimes male sexual dysfunction can also be key findings. Anal tone examination might reveal weakness deficits in the external anal sphincter. The literature supports urinary retention as the most consistent finding. A post void residual catheterization revealing greater than 200 cc is suggestive of urinary retention. Exploring patient's history may also reveal significant "red flags". Many times a recent trauma, cancer or severe infection might predispose a Cauda Equina Syndrome.

Treatment of Cauda Equina is necessary to restore bowel and bladder function, prevent further weakness of the lower extremities and to avoid further complications such as paraplegia. Prompt surgical consultation, is paramount as the window of opportunity is narrow. Studies have shown that early emergent neurosurgical intervention, optimally within 24-48 hours of the onset of the syndrome has proved to be advantageous to the outcome by improving sensory and motor deficits and restoring bowel and bladder functions.

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Whiplash, Neck Pain or Pain in the Neck?

Pattie Patterson RN, LNCC, CLCP

Whiplash is a soft tissue injury to the neck, also called neck sprain or neck strain. It is caused by the head being jerked forward and backward suddenly. Imagine if you will, you are driving down the road when the car behind you rear-ends your car, pushing your car forward. Your shoulders travel forward until they are under your head, and your neck extends forward as your head tilting downward toward your steering wheel. You step on the brakes, brining your car to an abrupt halt, throwing your head and neck backward bouncing against the headrest. In a matter of a few seconds, you have experienced whiplash. (Be advised, this same jarring movement can and often does cause more severe injuries, we are only speaking to whiplash here.)

Approximately 20 percent of people involved in rear-end collisions later experience symptoms that center in the neck region. Although most of these people recover quickly, a smaller number develop chronic conditions that result in severe pain and sometimes disability.

Signs and Symptoms

People who experience whiplash may develop one or more of these symptoms, usually within the first two days after the accident.

- Neck pain and stiffness
- Headaches
- Pain in the shoulder or between shoulder blades
- Low back pain
- Pain or numbness in the arm and/or hand
- Dizziness
- Ringing in the ears
- Difficulty concentrating or remembering
- Irritability, sleep disturbances. Fatigue

Diagnosis and Treatment

Since whiplash injuries are to soft tissues, diagnosis is usually by exclusion. A CT scan or MRI can usually exclude other types of injuries.

Early movement is the key to recovery of whiplash injuries. Exercises, pain meds, physical therapy, traction, massage, ultrasound and injections may be prescribed. Ice may be applied for the first 24 hrs, after which heat may be applied to the affected area. A soft cervical collar may be used for short-term intermittently.

The Independent Medical Exam Has Many Uses

Robert Morrison, RN BSN

In the past we have looked at the Functional Capacity Evaluation (FCE), traditionally used in Worker's Compensation cases, and how it can be useful to the personal injury attorney. Like the FCE, the Independent Medical Exam (IME) is a time-honored tool used by claims managers and defense attorneys when evaluating and defending against Worker's Compensation claims. For this reason, it is often termed DME, for Defense Medical Exam. At ANC, we have found that it can also be useful in our medical malpractice or personal injury analyses, for both the plaintiff and the defense.

During many years in case management and occupational risk management I have utilized the IME quite often. This exam can address many different issues involved in the Work Comp case, such as causal relationships between the injury and subsequent diagnoses, identification and quantification of damages, verification of the patient's current status and future medical needs, and the establishment of permanent impairment ratings.

After seeing the traditional uses for this type of exam, we have also recommended it to clients who are representing the plaintiff in both malpractice and personal injury claims. After all, if the findings from this exam serve the defense well in refuting medical injury claims, they can also serve to support and verify the plaintiff. We have also recommended this exam to clients who are evaluating the potential merits of a new claim before filing suit and committing extensive resources to the case. It can be a valuable part of our overall merit review and analysis.

In the personal injury arena we utilize this exam for two primary reasons. The first is to establish the medical relationship between the patient's current medical problems and the accident in question. In this situation we first perform a complete review of the patient's medical record, starting at least five years prior to the accident. This allowed us to establish the claimant's baseline medical status at the time of the injury. There may have been previous accidents or health problems that affected how they were able to recover from their injuries in the accident being litigated. These may be incident opposing counsel will be able to bring up in order to refute the claim of s that liability.

Once we have identified the claimant's status at the time of injury we review all of the medical information to identify and make a list all of the diagnoses made by the claimant's physicians following the accident. By cross-referencing the current diagnosis list against their baseline data we can identify those problems that would have required treatment if the accident had never happened. If the accident did not impact these problems then the plaintiff's attorney knows not to include them in the current settlement claim. If, on the other hand, our client is acting for the defense they are prepared to argue against these claims.

Now that we have a clear picture of the claimant's medical situation subsequent to the accident we can begin to explore the causal relationships. In many cases we can identify medical findings in the record that relate the diagnoses to the accident. If these findings are solid and secure (we prefer to have them made by more than one provider) then the attorney may not need any further medical review. If the relationship is not well established, then the IME can help confirm this. Permanent impairment ratings can also be obtained once the relationship is established.

The second primary reason we have used the IME is to establish future treatment needs for injuries that have not reached closure. Following a serious accident, it is not unusual to discover that there were multiple diagnoses made, and some of them simply fell through the cracks. The claimant and their providers focus on the most serious problems and forget to follow through on the less serious ones. We need to make sure that all of the problems associated with this accident have been treated to the maximum extent possible in order for the claim to be ready for settlement.

This exam has also served us well in medical malpractice reviews. In one instance we were reviewing a file on a claimant that suffered multiple injuries as a result of a fall. The surgeon correctly identified the area of damage, but on the day of surgery he operated on the wrong body part. As a result, the claimant had to have the original damage repaired, plus he suffered additional impairment due to the surgery done in the wrong area. The IME helped to quantify the total damage done to the patient as a result of the surgeon's error relative to the impairment due to the original injury, since both impairments had to be taken into account. The examiner was also charged with identifying the degree of liability of both injuries- the original fall and the surgical error- since they involved two different defendants.

The usefulness of this exam is virtually unlimited. The examiner has no prior or future relationship with the claimant, hence the term "independent." Thus, he does not stand to gain from continued treatment, nor does he lose if he finds that no further treatment is necessary. He is simply an objective witness and evaluator. This helps add credibility to the attorney's arguments.

We have always felt that our clients are best served by knowing everything there is to know about the claim, whether they are representing the plaintiff or defendant. The plaintiff's attorney needs to know if there are any weaknesses in their client's claims. This allows them to either bring in additional experts to bolster their claim, or to decline the case if it looks too difficult to prove. For our defense clients, knowing any potential mitigating factors can prevent them from inadvertently accepting liability for damages that were not caused by their client. Although we are usually able to establish these issues from the medical record, there will always be times when such an exam is useful. As we said in the beginning of this article, if the exam is useful to defense managers in one arena, it should be put to good use by both sides in other arenas as well. Sometimes the best tool to use is the one that has traditionally been used by the other side.

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