



Jane D. Heron, RN, BSN, MBA, LNCC, is a Legal Nurse Consultant and Expert Witness with Med League Support Services, Inc., 260 Route 202/31, Suite 200, Flemington, NJ 08822. She can be reached at (908) 788-8227 or www.medleague.com.



Meghan C. Lewallen is an associate at Mellino Robenalt LLC. She can be reached at 440.333.3800 or mlewallen@mellinorobenalt.com.

1006 Summary Witness: The Nurse as a Summary Provider

by Jane D. Heron, RN, BSN, MBA, LNCC
and Meghan C. Lewallen

Would you like to give your clients a voice without having them testify about their own care and treatment? Do you want to bring their story to life? Do you want to avoid adding to your clients' pain and suffering by making them relive a terrible experience? Perhaps they don't remember what happened to them, are unable to communicate, or are not alive to tell their story. Do you want a jury to decide against your client simply because they did not understand what your client went through?

As an Evidence Rule 1006 summary witness, a professional registered nurse can give your clients the voice they need to share their story. Unlike an expert witness, 1006 summary witnesses are not called to testify about liability issues in a case. They do not offer opinions on standard of care, causation, or even what injuries the plaintiff sustained as a result of malpractice or negligence. Instead, the 1006 summary witness provides a clear, unbiased explanation of what your client endured. The idea is for the jury to fully comprehend how your client's life was affected by his or her injuries, medical conditions, complications, or treatment.

1006 summary witnesses are generally retained in medical malpractice or personal injury cases where it is important for the client's story to be told. This includes cases involving: (1) delay in diagnosis, (2) delay in treatment, (3) motor vehicle accidents, (4) burns, (5) spinal cord

injuries, (6) workplace injuries, (7) medication errors, (8) surgical errors, and (9) drug reactions. These types of cases often involve thousands of pages of medical records that the jury would be forced to read and comprehend on their own. Because a nurse has specialized knowledge, skill, experience, training and education, he or she is able to explain information in your client's medical record in a way that is easy for the jury to understand. It is unrealistic to expect that a jury will go through thousands of pages of medical records and fully comprehend the information, particularly if the records are complex. Medical records are often filled with technical medical terminology, abbreviations, symbols, and notes and reports that are difficult to decipher.

1006 summaries can be presented to a jury in two forms: (1) a written report and (2) trial testimony. In the report, the witness may use a variety of methods to explain your client's complex care and describe procedures performed. It is important for reports to accurately reflect the underlying medical records; however, they may be comprised of a combination of narrative summaries, exhibits of symptoms, illustrations to explain procedures, charts, graphs, quotes, illustrations from the medical records, and photographs.¹ At trial, the 1006 witness can then walk the jury through your client's medical records by testifying about the information contained in his or her report.

Because of their unique role, summary witnesses offer value to your case that experts and clients

cannot provide. Expert witnesses typically provide a brief summary about your client's care and then focus on deviations from the standard of care. They do not provide a detailed summary of what your client went through. The expert focuses on his or her area of expertise and not on the full scope of your client's experience. Often times, medical experts find it difficult to clearly explain complex care and terminology to lay people. Think about the last time you visited your doctor's office. Did you leave fully understanding everything your doctor said? Were all your questions answered? Put yourself in the shoes of a jury trying to follow and remember complicated expert testimony about your client's course. Would it be helpful to have a nurse add clarity to your client's story? Likewise, when clients testify about their experience, they usually lack the skill, knowledge, and understanding necessary to explain the care they received in a clear manner. Additionally, a number of other benefits to retaining a summary provider include:

- Summarizing thousands of medical records in a report of moderate length;
- More cost effective and *efficient* than calling all of your client's healthcare providers to testify in court;
- More understandable and compelling than a piecemeal presentation by each treating or examining provider;
- The nurse serves as a surrogate to convey information to the jury;
- The nurse possesses technical and specialized knowledge to assist the trier of fact in understanding the evidence;
- The nurse provides a better understanding of voluminous records that cannot be conveniently examined and understood by a

jury unfamiliar with the medical terminology, abbreviations, and symbols found in medical records;

- The nurse provides a clear, unbiased voice for your client, which allows you to focus on the legal aspects of your case.

When a 1006 summary provider is properly utilized the impact of the witness's report and testimony can be very powerful. Because few attorneys have encountered this type of witness, as trial approaches opposing counsel will likely try to exclude the witness's report and testimony with a motion *in limine*. In an effort to exclude such evidence defense counsel will suggest the summary report goes beyond what is permissible in Evidence Rule 1006. In order to overcome this argument, it is important to have a strong grasp on the rule itself as well as its underlying purpose.

Ohio Evidence Rule 1006 governs the use of summary evidence. Ohio courts have recognized the purpose of Rule 1006 "is to permit summary documents prepared by witnesses, not lawyers, to enhance or clarify their testimony and aid the jury in understanding complicated or voluminous data."² Specifically, Rule 1006 states "[t]he content of voluminous writings, recordings, or photographs which cannot conveniently be examined in court may be presented in the form of a chart, summary, or calculation."³

Importantly, under Rule 1006, an individual must establish five requirements before the admission of summary evidence: (1) the underlying documents are so voluminous that they cannot be conveniently examined in court; (2) the proponent of the summary must have made the documents available for examination or copying at a reasonable time and place; (3) the underlying documents must be admissible in evidence; (4) the summary must be accurate and non-prejudicial;

and (5) the summary must be properly introduced through the testimony of a witness who supervised its preparation.⁴

Most hospital inpatient admission charts fulfill the first three criteria. Issues generally arise with the fourth requirement that the summary be accurate and non-prejudicial. Opposing counsel will likely attack the witness's report if he or she does not limit the summary to a list of dates, times, and events set forth in the medical records. However, the records themselves are not limited to lists of dates, times, and events. Instead, every medical chart includes documentation about the reasons for procedures and tests; and Operative Reports or Procedure Notes contain descriptions of procedures. If the medical records are not limited to dates, times, and events, there is no justification for limiting the 1006 report to those items.

Opposing counsel may also suggest that the use of charts and photographs within the report is unfairly prejudicial. However, Rule 1006 expressly permits the use of "charts, summaries, and calculations." As previously stated, ultimately, the purpose of summary evidence is to present information in a way that is easy for the jury to understand. In essence, a 1006 summary report is nothing more than a summarization of the client's medical records, supported by admissible demonstrative evidence used to help illustrate unfamiliar medical procedures and equipment.⁵

Jane Heron, RN was recently retained as a 1006 summary witness in a case involving a woman that sustained a hypoxic brain injury. In that case, the patient went to the hospital for an elective procedure. As part of anesthesia for this surgery, the patient was given a drug in the same family of drugs as the drug to which the patient was allergic. When the drug was administered the patient went into anaphylactic shock, stopped

breathing, and could not be resuscitated without extraordinary measures. The patient was transferred to another hospital. Over the next fifteen days the patient was placed on ventilation support, blood transfusions, and an ECMO machine. During this time she also underwent extensive medical procedures, including ECMO removal of both cannulas; intra aortic balloon pump insertion via the left femoral artery; open repair of right common femoral artery; placement of two chest tubes; and placement of left internal jugular Swan Ganz catheter. The medical chart from this hospitalization was about 1500 pages.

Ms. Heron prepared a summary report that illustrated and explained contents of the client's hospital records during her fifteen-day admission. Importantly, the report was written in terms that individuals without medical training would be able to understand. Most lay jurors are not familiar with what anaphylactic shock entails, what an ECMO machine is or does or how a person is placed on such a machine, nor are they familiar with many of the other procedures that were performed on the patient at the hospitals where treatment occurred. Ms. Heron later testified at trial as to the contents of her report. Without her testimony, it would have been virtually impossible for the jury to truly understand what the client experienced.

Now that almost every hospital has switched to electronic medical records it makes even more sense to have a nurse summarize these records which are essentially unintelligible to most jurors.■

Additional Resources

1. Judge Sabatino, Superior Court of New Jersey Law Division, Mercer County, 5/9/2002 regarding the Heinzerling case 359 NJ Superior 1 Appellate Division.
2. Patricia Iyer, The Expert Fact Witness, in Patricia Iyer (Editor) Medical Legal Aspects of Pain and Suffering, Lawyers and Judges Publishing Co. Tucson 2003.

End Notes

1. See *United States v. Bray*, 139 F.3d 1104, 1110 (6th Cir. 1998) (Reports must summarize the information contained in the "underlying documents accurately, correctly, and in a non-misleading manner.").
2. *In re Estate of Lucitte*, 6th Dist. No. L-10-1136, 2012-Ohio-390, ¶ 71.
3. OHIO EVID. R. 1006.
4. *United States v. Moon*, 513 F.3d 527, 545 (6th Cir. 2008).
5. See *Moretz v. Muakkassa*, 9th Dist. No. 25602, 2012-Ohio-1177, ¶ 21 ("This Court has held that demonstrative evidence is admissible to illustrate a witness's testimony."), rev'd on other grounds at 137 Ohio St.3d 171, 2013-Ohio-4656, 998 N.E.2d 479.

[Editor's Note: In *Moretz*, the Supreme Court held that "[i]llustrations from medical textbooks are subject to the learned-treatise hearsay exception set forth in Evid. R. 803(18) and therefore shall not be admitted into evidence as an exhibit over the objection of a party." *Id.* at syllabus 1. *Moretz*, however, did not overrule the more general proposition that demonstrative evidence is admissible to illustrate the testimony of a witness.]