



## Expert Testimony

By Christian H. Staples

**A** review of some of the cases addressing the admissibility of nurses' medical causation opinions and an analysis of the underlying rationales that dictated the cases' outcomes.

# Can Nurses Provide Medical Causation Opinions?

In the vast majority of medical malpractice actions, plaintiffs' attorneys must offer expert testimony to establish the applicable standard of care and whether a defendant's alleged breach was the proximate cause of a plaintiff's inju-

ries and damages. Health care providers rely on the courts to govern expert testimony admissibility on these issues fairly.

The applicable standard of care is usually defined by a statute and most commonly requires that health care providers will do what other similarly trained professionals would do under the same or similar circumstances. In principle, at least, this is an apple-to-apple comparison.

Causation, on the other hand, is a much more amorphous concept. Most states do not have statutes that directly address the admissibility of medical causation opinions. Instead, practitioners must craft their arguments for or against admissibility based on the nature of the specific medical causation opinion at issue, the witness's qualifications for offering such an opinion, and whether the opinion will help a jury to determine a matter at issue. The starting point for this analysis is usually a combination of Rule 702 of the Federal Rules of Evidence or the relevant state law counter-

part and the applicable case law interpreting the rule.

Generally speaking, a court will consider any licensed physician qualified to offer a medical causation opinion. Linger- ing doubts about a physician's qualifications to testify in this regard frequently factor into deciding how much weight to assign that physician's opinion but not the opinion's admissibility.

However, when a nurse enters the causation arena, red flags go up. Although plaintiffs, defendants, and the lawyers who represent them all recognize the critical role that nurses play in providing modern medical services, a diligent practitioner rightfully will question whether even the most experienced nurse is qualified to offer a medical causation opinion in a court of law.

For purposes of this article, the term "medical causation opinion" is defined as testimony in the form of an opinion regarding the proximate cause of an individual's injury, illness, or death, or opinion testimony regarding an individual's medical diagnosis. Excluded from this definition is a "nursing diagnosis" which, unfortunately, must be left for discussion on another day.

This article will explore whether courts consider nurses qualified to offer medical causation opinions in modern medical



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malpractice actions. Reviewing the relevant case law on this issue reveals a jurisdictional split of authority that defies easy reconciliation. Nonetheless, this article will attempt to present a workable classification of the case law in this area.

The article will examine those cases holding that nurses are not qualified to offer medical causation opinions, emphasizing

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the Supreme Court of Mississippi’s decision in *Vaughn v. Mississippi Baptist Med. Ctr.*, 20 So. 3d 645 (Miss. 2009). Next, the article will explore those cases holding that nurses may be qualified to offer medical causation opinions, focusing on the Supreme Court of Pennsylvania’s decision in *Freed v. Geisinger Med. Ctr.*, 601 Pa. 233, 971 A.2d 1202 (Pa. 2009). We will consider the rationale behind these decisions and will discuss the pros and cons of each. Finally, the article will offer a few practice pointers that defense practitioners can apply to future cases.

### **Cases Holding That Nurses Are Not Qualified to Offer Medical Causation Opinions**

One of the more recent decisions holding that nurses are not qualified to testify on medical causation is *Vaughn v. Mississippi Baptist Med. Ctr.*, 20 So. 3d 645 (Miss. 2009). The facts of *Vaughn* are as follows: the plaintiff, Paula Vaughn, was admitted to the hospital for double artery bypass surgery and repair of two heart valves. *Id.* at 647. Additionally, the plaintiff had arteries removed from the upper insides of both of her thighs, resulting in bilateral, open wounds. *Id.* at 647–48. As a result of these procedures, she was temporarily unable to ambulate or use the bathroom without assistance from the hospital staff. *Id.* at 648. The plaintiff alleged that the hospital

staff’s failure to assist her to the bathroom caused her to involuntarily urinate and defecate on herself, thereby contaminating her leg wounds and ultimately causing a staph infection to develop. *Id.* The hospital denied that the plaintiff developed a staph infection during her hospitalization. *Id.*

The plaintiff designated Crystal Keller, RN, as an expert witness to testify regarding the causal nexus between the alleged negligence of hospital staff and the plaintiff’s staph infection. 20 So. 3d at 648. The trial court granted the hospital’s motion to strike Keller as an expert as well as the accompanying motion for summary judgment, and the plaintiff appealed. *Id.* at 649.

The gist of the hospital’s argument was that because Keller was not qualified to diagnose an infection, she was not qualified to render an opinion regarding the medical cause of the plaintiff’s infection. *Id.* at 650. In response, the plaintiff argued “that, as a nurse, Keller was trained to recognize the signs and symptoms of an infection” and that her opinions in this regard were “within a nurse’s area of practice.” *Id.*

Curiously, both sides cited the same case to support their arguments: *Richardson v. Methodist Hospital of Hattiesburg, Inc.*, 807 So. 2d 1244 (Miss. 2002). *Vaughn*, 20 So. 3d at 651. In *Richardson*, the very same nursing expert, Keller, was permitted to offer an opinion on whether the alleged negligence of the nursing staff proximately caused the patient’s physical pain and suffering, but Keller was precluded from testifying regarding the cause of the patient’s death. *Id.* (citing *Richardson*, 807 So. 2d at 1245 and 1248).

The Supreme Court of Mississippi easily distinguished *Richardson* from the *Vaughn* case: Keller was not testifying about the cause of Vaughn’s pain and suffering, but instead she was to testify about the signs, symptoms, development, and progression of the plaintiff’s staph infection. *Id.* n1. This distinction would prove fatal to the plaintiff’s case. According to the *Vaughn* court, [w]hile *Richardson* explicitly held that a nurse cannot testify as to cause of death, we agree with [the defendant] that *Richardson* should be interpreted as having made impermissible any testimony from a nursing expert on diagnostic impressions, because nurses are not qualified to make medical diagnoses or attest to the cause of illnesses.

*Id.* at 651–52 (citing *Richardson*, 807 So. 2d at 1247–48).

Following this interpretation of *Richardson*, the *Vaughn* court declared, “We now explicitly hold that nurses cannot testify as to medical causation.” *Id.* at 652. According to the *Vaughn* court, this holding “is in keeping with the majority rule that nursing experts cannot opine as to medical causation and are unable to establish the necessary element of proximate cause.” 20 So. 3d at 652 (citing *Richberger v. West Clinic, P.C.*, 152 S.W.3d 505 (Tenn. Ct. App. 2004); *Elswick v. Nichols*, 144 F. Supp. 2d 758 (E.D. Ky. 2001); *Colwell v. Holy Family Hosp.*, 15 P.3d 210 (Wash. Ct. App. 2001); *Long v. Methodist Hosp. of Indiana, Inc.*, 699 N.E.2d 1164 (Ind. Ct. App. 1998); *Phillips v. Alamed Co., Inc.*, 588 So. 2d 463 (Ala. 1991)).

After announcing its holding, the *Vaughn* court noted that under the Mississippi Nursing Practice Law the practice of professional nursing does not include acts of medical diagnosis. *Id.* at 652 n.2. This likely explains why the *Vaughn* court extended *Richardson* in the *Vaughn* case to prohibit nurses from testifying regarding “diagnostic impressions” and likewise concluded that in that jurisdiction courts should preclude nurses from testifying on “medical causation.” *Id.* at 652. As we will discuss below, whether nursing practice laws actually compel such a conclusion remains open for debate. Nonetheless, in other cases courts have prevented nurses from offering medical causation testimony because those other states had nursing practice laws prohibiting nurses from making medical diagnoses. *See, e.g., Richberger*, 152 S.W.3d at 511 (“According to [Tennessee law defining the practice of nursing], a registered nurse is prohibited from making a medical diagnosis and is therefore not competent to offer opinions on medical causation in a medical malpractice action.”); *Stryczek v. Methodist Hosps., Inc.*, 694 N.E.2d 1186, 1189 (Ind. Ct. App. 1998) (comparing and contrasting the scope of physician and nursing diagnostic and treatment authority under the Indiana practice laws and concluding that a nurse is not qualified to testify regarding the cause of cardiac damage); *Costello v. Christus Santa Rosa Health Care Corp.*, 141 S.W.3d 245, 248–49 (Tex. Ct. App. 2004) (holding that a nurse is precluded under

the Texas Nursing Practice Act from testifying regarding cause of death); *Robertson v. Mount Carmel East Hosp.*, 2011 WL 1632128, at \* 6 (Ohio Ct. App. Apr. 28, 2011) (holding that the Ohio nursing practice law precludes a nurse from testifying regarding issues of proximate cause).

The *Vaughn* opinion has several flaws. First, while the court expressly ruled that nurses cannot testify on “medical causation,” it never defined that term. Because of this shortcoming, it is unclear whether *Vaughn* overrules *Richardson’s* exception to inadmissibility for a nurse’s testimony on the proximate cause of physical pain and suffering. The dissent in *Vaughn* would have allowed Keller to testify about the proximate cause of the plaintiff’s “pain and suffering, depression, mental anguish, emotional distress, and loss of dignity.” 20 So. 3d at 658 (Kitchens, J., dissenting). According to the majority, however, Keller’s affidavit did not state or even imply that she would offer an opinion regarding the cause of those injuries and related damages. *Id.* at 651 n.1. It remains to be seen whether Mississippi courts would still permit a nurse to offer an opinion regarding the proximate cause of a plaintiff’s pain and suffering and related damages under the right set of facts.

The second and perhaps the most obvious flaw in *Vaughn* is that it establishes a hard-and-fast rule that courts will have to apply in all future cases. The dissent in *Vaughn* clearly raised this point, despite agreeing with the majority’s conclusion that Keller was not qualified to discuss the proximate cause of the plaintiff’s staph infection. As the dissent so eloquently stated: the issue of whether a particular nurse, by virtue of his or her knowledge, skill, experience, training or education, possesses such ability is better determined by a case-by-case inquiry than by a broad, ‘one-size-fits-all’ judicial pontification to the effect that no nurse in the world will ever be allowed to testify as to medical causation in any Mississippi court case.

*Id.* at 657 (Kitchens, J., dissenting). The dissent makes a good point given that each case presents a unique set of facts and circumstances and, similarly, each nurse possesses a different level of education, training, knowledge, skill, and experience.

### Cases Holding That Nurses May Be Qualified to Offer Medical Causation Opinions

One of the more recent cases holding that nurses may be qualified to offer medical causation opinions is *Freed v. Geisinger Med. Ctr.*, 971 A.2d 1202 (Pa. 2009). *Freed* is an interesting case because it caused the Pennsylvania Supreme Court to overturn its earlier decision in *Flanagan v. Labe*, 690 A.2d 183 (Pa. 1997), which had prohibited nurses from offering medical causation opinions.

The facts of *Freed* are as follows: the plaintiff, Roger Freed, was involved in an automobile accident during which he suffered severe spinal cord injuries resulting in paraplegia. 971 A.2d at 1204. He developed bedsores on his buttocks and sacrum when he was hospitalized. *Id.* at 1204–05. The bedsores ultimately became infected and required surgical debridement. *Id.* at 1205. The plaintiff alleged that the medical center nursing staff negligently failed to prevent and treat his bedsores. *Id.* During the trial, the plaintiff presented the testimony of Linda D. Pershall, RN, as an expert witness on the standard of care and on causation. *Id.* During direct examination, when Pershall was asked for her opinion on the cause of the plaintiff’s bedsores, the trial court sustained the defense attorney’s objection on the basis that Pershall “was not a medical doctor and, therefore, was not qualified to give a medical diagnosis.” 971 A.2d at 1205. Accordingly, the trial court granted a compulsory nonsuit in favor of the defendants. *Id.*

The plaintiff appealed to the superior court, which reversed the trial court holding and held that Pershall was competent to offer expert testimony on medical causation. *Id.* at 1206. The intermediate appellate court was apparently persuaded partly because the parties had stipulated that the relevant medical diagnosis was bedsores and that, by definition, the cause of bedsores is unrelieved pressure on that part of the body where the bedsores develop. *Id.* at 1207. Therefore, according to the superior court, the only dispute was “whether a breach of the standard of nursing care for an immobilized patient proximately caused the unrelieved pressure that in turn caused [the plaintiff’s] pressure wounds to develop and/or worsen.” *Id.* The superior court con-

cluded that the trial court should not have precluded Pershall from testifying on this issue. 971 A.2d at 1207.

The defendants then appealed to the Supreme Court of Pennsylvania, arguing that the superior court holding conflicted with the supreme court’s prior decision in *Flanagan*, 690 A.2d 183, and therefore the court should vacate the superior court holding. *Id.* at 1206. Naturally, the Supreme Court of Pennsylvania began to analyze the issue by thoroughly reviewing the *Flanagan* decision. *See id.* at 1206–07.

*Flanagan* was a medical malpractice case in which the plaintiff alleged that he received substandard nursing care in connection with treatment for a collapsed lung. 690 A.2d 183, 184 (Pa. 1997). Specifically, the hospital inserted a tube into the plaintiff’s chest wall to treat the collapsed lung, and the plaintiff subsequently developed subcutaneous emphysema. *Id.* The plaintiff alleged that the nursing staff’s negligent care prevented an early diagnosis and caused his condition to worsen. *Id.* The plaintiff proffered the testimony of a registered nurse to establish that the nursing staff’s breach of the applicable standard of care was “a substantial contributing factor in his progressively worsening subcutaneous emphysema.” *Id.* at 184–85. The *Flanagan* court held that the trial court had excluded this testimony properly because “the normal test of competency is constrained by [the Professional Nursing Law] limiting the deemed competency of nurses.” *Id.* at 185. In other words, because the Pennsylvania Professional Nursing Law prevented nurses from making medical diagnoses, the trial court properly excluded the nurse’s testimony regarding “the identity and cause” of the plaintiff’s condition. 690 A.2d at 186.

In overturning *Flanagan*, four controlling principles guided the *Freed* court: (1) the holding in *Flanagan* conflicted with the general standards governing the admissibility of expert testimony; (2) *Flanagan* did not offer support for applying the Professional Nursing Law to the rules governing the admissibility of expert testimony in a court of law; (3) the lower courts had unsuccessfully attempted to both distinguish *Flanagan* from other cases and to carve out exceptions to the rule that it had announced; and (4) because *Flanagan*



involved an evidentiary issue and resolving it, similar to resolving a procedural issue, would “not favor one class of litigants over another,” maintaining *stare decisis* due to policy considerations became “less compelling.” 971 A.2d at 1212 (quoting *Hohn v. United States*, 524 U.S. 236 (1998)).

In analyzing the first principle, the *Freed* court recited the rule that “in order to qual-

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ify as an expert witness in a given field, a witness need only possess greater expertise than is within the ordinary range of training, knowledge, intelligence, or experience.” *Id.* at 1208 (quoting the superior court decision in *Freed*’s case). The *Freed* court emphasized that this standard for admissibility was “a liberal one.” *Id.* at 1209 (citing and quoting *Miller v. Brass Rail Tavern*, 664 A.2d 525, 528 (Pa. 1995)). According to the *Freed* court, *Flanagan* had improperly “narrowed the well-established liberal standard for expert testimony in those cases involving nurses offered as experts.” *Id.*

With respect to the second principle, the *Freed* court determined that the *Flanagan* court did not offer “support for its [the *Flanagan* court’s] conclusion that the restrictions contained in the Professional Nursing Law apply in a court of law.” *Id.* at 1210. According to the *Freed* court, “there is no language whatsoever in [the Professional Nursing Law] to suggest that the principles governing the actual *practice* of nursing are applicable in the distinct *legal arena* of malpractice or negligence actions, which is governed by the Rules of Evidence and the Rules of Civil Procedure.” 971 A.2d at 1210

(emphasis in original). This is an important point because *Freed* appears to be one of the few cases to interpret the nursing practice principles codified in laws as separate and distinct from rules of evidence or rules of civil procedure. *But see Velazquez v. Commonwealth of Virginia*, 557 S.E.2d 213, 218 (Va. 2002) (“We are of the opinion that the testimony of a [sexual assault nurse examiner] regarding the causation of physical injuries to a victim of a sexual assault is not the practice of medicine....”).

Turning to the third and fourth principles, the *Freed* court appears to have concluded that the various exceptions that the lower courts, including the superior court below, had attempted to carve out from *Flanagan* did not establish a clear precedent for future cases. Despite concluding that *Flanagan* was “inherently flawed,” the *Freed* court was “loath to reverse [its] own prior decisions, as such action necessarily implicates the great principle of *stare decisis*.” 971 A.2d at 1211. Nonetheless, the *Freed* court found a solution by analogizing the admissibility of expert testimony as an evidentiary issue to a question of procedure, as noted above, and on that basis concluded that “the role of *stare decisis* is diminished.” *Id.* at 1212 (citing *Hohn v. United States*, 524 U.S. 236 (1998)).

Finally, the *Freed* court had to decide whether to apply its decision retroactively or prospectively, noting that it had discretion to do either. *Id.* at 1213. The *Freed* court found that it could apply its decision to overturn *Flanagan* retroactively to *Freed*’s case. *Id.* at 1213–14. So the *Freed* court affirmed the superior court’s order reversing the trial court’s entry of a compulsory nonsuit in favor of the defendants, remanded the case for a trial, and instructed the trial court to assess the competence of all the expert witnesses, including Pershall’s, based on the witness’ training, knowledge, intelligence, and experience. *Id.* at 1214.

As a side note to conclude the discussion of *Freed*, the Pennsylvania legislature enacted the Medical Care Availability and Reduction of Error Act (the MCARE Act) before the Supreme Court of Pennsylvania issued the opinion in the *Freed* case appeal. The MCARE Act made substantial changes to the requirements for qualifying as an expert witness in medi-

cal malpractice actions. As the *Freed* court recognized, “our decision to overrule *Flanagan* may have limited impact in light of the legislature’s enactment of the MCARE Act....” *Id.* at 1212 n. 8. However, because the purpose of this article is to examine the analysis in *Freed* and that court’s reasons for overturning *Flanagan* rather than the specific requirements for the admissibility of expert testimony in the state of Pennsylvania, discussing the MCARE Act is beyond the scope of this article. However, for those interested in learning more about the MCARE Act, see 40 Pa. Stat. Ann. §§1303.101–1303.910.

One criticism of *Freed* is that, as a bedsores case, the causation issue was relatively basic when compared with, say, the cause of certain cardiac or neurologic conditions, or the cause of an individual’s death. In fact, the overwhelming weight of authority in this country holds that nurses are qualified to testify regarding the development and prevention of bedsores. See *Gaines v. Comanche Co. Med. Hosp.*, 143 P.3d 203, 206 n.10 (Okla. 2006) (citing other cases). According to the *Gaines* court, “[r]esearch reveals no decision, turning on the issue of whether a nurse may offer expert testimony relating to bedsores, which has disallowed such evidence.” *Id.* at 207.

Because bedsores cases typically involve allegations of *nursing* negligence, rather than physician negligence, because nurses typically identify and care for bedsores, bedsores are primarily an issue for which nurses have unique expertise. It logically follows that nurses more likely than not can competently testify regarding the proximate cause of bedsores. But the *Gaines* court carefully limited that holding to the facts of the case. See *id.* at 206 (“Today’s decision cannot be determined to have ‘opened the floodgates’ for nurses to testify as experts in malpractice cases brought against physicians. It is limited to its facts and expresses no opinion on whether the patient should prevail.”). *Freed* did not contain a similar disclaimer, and therefore other courts could interpret it as *carte blanche* authority for admitting nursing testimony on a wide variety of medical causation topics.

The Supreme Court of Pennsylvania has not been the only court to permit a nurse to testify on medical causation.

Courts in other states have similarly held that nursing experts are qualified to offer medical causation opinions provided that they have the requisite knowledge, training, and experience in the subject area to which their testimony relates. For example, in North Carolina, a long line of cases holds that nurses are qualified to testify on medical causation. See, e.g., *Maloney v. Wake Hosp. Sys., Inc.*, 262 S.E.2d 680 (N.C. Ct. App. 1980) (holding that the trial court erred in excluding a nurse's opinion that the burn suffered by the plaintiff was caused by an undiluted bolus of potassium chloride that was administered into the tissue of the plaintiff's hand); *State v. Tyler*, 485 S.E.2d 599 (N.C. 1997) (upholding the admission of a nurse's trial testimony regarding the cause of the victim's death and the effects of the sedative medication Versed, which was administered to the victim); *Diggs v. Novant Health, Inc.*, 628 S.E.2d 851 (N.C. Ct. App. 2006) (holding that the nurse was improperly precluded from testifying that the defendant nursing staff's failure to report the plaintiff's troubled breathing and sharp throat pain following gall bladder surgery would have led to an earlier identification of the plaintiff's punctured esophagus and would have lessened the seriousness of the plaintiff's injuries resulting from that perforation).

The "essential question" under North Carolina law is "whether the witness, through study or experience, has acquired such skill that he was better qualified than the jury to form an opinion on the subject matter to which his testimony applies." *Diggs*, 628 S.E.2d at 856 (quoting *Tyler*, 485 S.E.2d at 608). In answering this question, North Carolina has taken a liberal stance on the ability of nurses to act as expert witnesses in medical malpractice actions. See *Maloney*, 262 S.E.2d at 684 ("The role of the nurse is critical to providing a high standard of health care in modern medicine. Her expertise is different from, but no less exalted than, that of the physician."). The *Maloney* court went on to explain that "[t]he license, if any, held by a witness may properly be one fact for the court to take into account." *Id.* However, under *Maloney*, whether a witness possesses a license is separate and apart from "the controlling factors for the court's consideration," which "must be the education, knowledge,

information, skill and experience of the witness." *Id.*

### Conclusion

There are undoubtedly scores of other cases that have addressed whether nurses are qualified to present medical causation opinions. This article has merely showcased some of the decisions on this issue and analyzed the underlying rationales that have dictated the outcomes in those cases. Of course, each state is unique both in its laws regarding expert testimony admissibility and in its reported decisions applying those laws to specific case facts and circumstances. In medical malpractice cases that find their way into federal courts, those courts must address whether a nurse is qualified to offer medical causation opinions under Rule 702 of the Federal Rules of Evidence and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). See *Elswick v. Nichols*, 144 F. Supp. 2d 758, 765-66 (E.D. Ky. 2001).

Nonetheless, I can offer some overarching observations that apply on a nearly universal basis. For starters, it appears that the *Vaughn* court was right in stating that the majority of courts hold that nurses are not qualified, no matter their education, training, or experience, to present medical causation opinions. See 20 So. 3d at 652 (citing other cases). A majority of courts still require that a physician establish proximate cause. However, one exception exists: a nurse may testify regarding the proximate cause of a patient's bedsores. See *Gaines v. Comanche Co. Med. Hosp.*, 143 P.3d 203, 206 n.10 (Okla. 2006) (citing other cases). Furthermore, without a controlling precedent expressly prohibiting medical causation opinions from nurses, such as *Vaughn*, an appeals court generally will not reverse a trial court's ruling on the admissibility of expert testimony unless the trial court abused its discretion. See *General Electric Co. v. Joiner*, 522 U.S. 136, 139 (1997).

In terms of practical pointers that defense practitioners should consider when a nurse attempts to present a medical causation opinion, first, be sure to consider carefully the nature of the proffered opinion and examine the nurse's specific qualifications as they relate to that particular area of medicine. You can most eas-

ily accomplish this when taking a nurse's deposition, but you could also do it during a voir dire outside the presence of the jury. Second, do not become too enamored with the argument that a court should exclude a nurse's medical causation opinion simply because a nurse is not authorized to make medical diagnoses as part of his or her routine professional practice. As

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illustrated above, such arguments may fail with a court absent proof that the legislature intended for the relevant nursing practice laws to carry over and apply to a nurse's role as an expert witness. See *Freed*, 971 A.2d at 1210; *Velazquez v. Commonwealth of Virginia*, 557 S.E.2d 213, 218 (Va. 2002). Third, if you are constrained by your jurisdiction's prior rulings on the admissibility of a nurse's medical causation opinion, then you must examine those precedents closely and determine whether the underlying rationale for permitting or prohibiting such testimony is well supported. As noted in *Freed*, laws governing the admissibility of expert testimony are party-neutral, which diminishes the underlying purpose of maintaining *stare decisis*. 971 A.2d at 1212 (citing *Hohn v. United States*, 524 U.S. 236 (1998)). This argument may provide the additional boost that you need to convince a court to rule in your favor even if it means overturning an established precedent. 