

# A Winning Record: Exploring the Role of Medical Records in Litigation

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# Educational Objectives

1. Differentiate the use of medical records in preliminary injunction, depositions, and dispositive motions;
2. Recognize common legal pitfalls of generic or vague documentation; and
3. Identify tools to effectively document encounters beyond the medical aspect.

# Understanding the Claims

- Pretrial Detainees and Prisoners/Inmates bring their lawsuits under 42 U.S.C. § 1983
  - For a deprivation of rights, privileges, or immunities secured by the Constitution and laws.
- Prisoners/Inmates – 8<sup>th</sup> Amendment
- Pretrial detainees – 14<sup>th</sup> Amendment
- Occasionally, state law claim – Medical Negligence

# Deliberate Indifference

- Prison officials violate the Eighth Amendment's proscription against cruel and unusual punishment when they display “**deliberate indifference to serious medical needs of prisoners.**” *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976).
- A claim of deliberate indifference to a serious medical need contains **both an objective and a subjective component.** *Farmer v. Brennan*, 511 U.S. 825, 834, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994)
- To satisfy the objective component, a prisoner must demonstrate that his medical condition is “**objectively, sufficiently serious.**” A **serious medical condition** is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would perceive the need for a doctor's attention. *Foelker v. Outagamie County*, 394 F.3d 510, 512–13 (7th Cir.2005).
- To satisfy the **subjective component**, a prisoner must demonstrate that prison officials acted with a “**sufficiently culpable state of mind.**” *Farmer*, 511 U.S. at 834, 114 S.Ct. 1970 (quoting *Wilson v. Seiter*, 501 U.S. 294, 297, 111 S.Ct. 2321, 115 L.Ed.2d 271 (1991)).

# Deliberate Indifference: Subjective Element

- The officials must **know of** and **disregard** an excessive risk to inmate health
- They must “both **be aware of** facts from which the inference could be drawn that a **substantial risk of serious harm exists**” and “must also draw the inference.” *Farmer*, 511 U.S. at 837, 114 S.Ct. 1970.
- This is not to say that a prisoner must establish that officials intended or desired the harm that transpired. Instead, it is enough to show that the defendants **knew of a substantial risk** of harm to the inmate **and disregarded the risk**.
- Additionally, a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious. *Farmer*, 511 U.S. at 842, 114 S.Ct. 1970.
- Under the deliberate indifference standard, you have the right to be wrong as long as your wrong was based upon sound medical reasoning and judgment.

# Medical Negligence

- To make a submissible case, Plaintiff must show the healthcare provider's actions
  - Violated the applicable standard of care;
  - Were performed negligently; and
  - Injured the Plaintiff.
  
- Medical negligence is “the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by members of the defendant's profession.” MAI 11.06; *McLaughlin v. Griffith*, 220 S.W.3d 319, 320 (Mo. Ct. App. 2007).
  - This standard of care generally must be established by expert testimony.
  - An adverse result raises no presumption of negligence.

# Purpose of Medical Records:

## Medical

- Communicate patient health information among health care professionals;
- List subjective complaints;
- List objective findings;
- Medical assessment, condition, and diagnosis;
- Continuity and plan of care.



# Purpose of Medical Records:

## Legal

- Evidence.
- Defensive documentation:
  - "Documentation that's undertaken with the sensitivity that individuals on the outside may be reviewing the records looking for fault at a later date."
- Keep in mind the audience.
  - The Plaintiff.
  - The Defense.
  - Experts.
  - The Judge.
  - A Jury.

# A Note From Two Perspectives

## ■ Medical

- ✓ Subjective notes
- ✓ Objective notes
- ✓ Appropriate analysis
- ✓ Plan of action

**Evidence that patient received appropriate exam for injured finger, right?**

Subjective, Objective, Assessment	Plans
NP NOTE	1) Exam Rt hand
S) 1+ FO 4+ Rt hand swelling	Rt wrist
& pain	2) Tylenol 325mg
o) Rt hand (dorsal edema)	(2) PO BID PRN
bruising, edema of dorsum	(x2 cardio grinds)
& fingers, good blanching	3) F/U x1 wk
Sharp/dull sensation	Rt hand MD/ND
appropriate — grip normal	CL. —
Warm & blanching —	
A) Rt edema / pain	
<u>Additional note</u>	4) Day in & out
<u>Consulted with Dr.</u>	X1 wk
regarding Fx Rt hand —	5) Wound suture
	Rt hand
	(Applied)
	6) F/U Dr
	on Monday 4/21

## ■ Legal

- ✓ Subjective – swelling and pain
- ✓ Objective notes – further evidence of serious injury
- ✓ Analysis – demonstrates knowledge of serious injury
- ✓ Plan of action – no referral for additional care.

**Evidence that provider deliberately ignored the need to refer to an orthopedic surgeon.**

# What is a Motion for Preliminary Injunction

- A request for immediate relief absent which the plaintiff will suffer irreparable harm.
- Seeks a specific course of treatment (that you did not give).
- Preliminary injunctions seek extraordinary relief, such as consultations with a specialist or surgery, and not for routine medical care.
- Plaintiff's medical history, and therefore the medical records, will become the subject of scrutiny by the Court (which has no medical training).

# **Motion for Preliminary Injunction: Plaintiff's Burden of Proof**

- The underlying case has a likelihood of success on the merits;
- No adequate remedy at law exists; and
- Plaintiff will suffer irreparable harm without the relief.

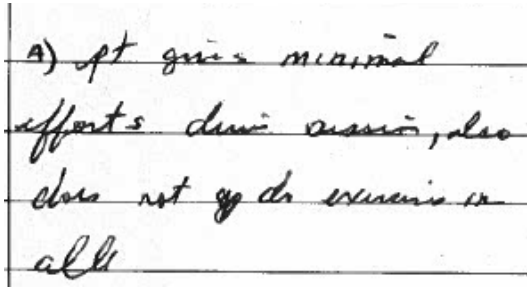
# Use of Medical Records at the Preliminary Injunction Stage

- Demonstrate the plaintiff's current condition.
- Provide the treatment rendered to date.
- Explain the clinical basis for the current course of treatment.
- Demonstrate that plaintiff will not suffer from irreparable harm
- Support the lack of medical indication for the plaintiff's requested treatment.
  - This is a necessary element to defeat the plaintiff's motion.

**You may be called to a hearing to testify regarding medical care provided and the medical reasoning.**

# Example: Records Reflect Reasoning

- Motion filed alleging that medical staff refused to provide him any treatment related to chronic back pain.
- Physical therapy *was* ordered, but was discontinued.
- Medical records notes:
  - “poor compliance”
  - “compliance minimal”
  - “Minimal efforts during session, also does not do exercises at all.”



a) pt gives minimal  
efforts during session, also  
does not do exercises at  
all

**Without these additional notes, it would have appeared that physical therapy was discontinued without reason.**

# What is a Deposition?

- The taking of an oral statement out of court before trial
- Given under oath
- Two main purposes:
  - To find out what the witness knows; and
  - To preserve witness testimony
- Question and answer format
- Court reporter – creating the record
- Pre-Deposition Meeting with Counsel.
  - What are the allegations?
  - Review the medical records.

# Use of Medical Records at a Deposition

- Plaintiff's counsel
  - To show the plaintiff's condition.
  - To demonstrate additional treatment was necessary.
  - To demonstrate a different course of treatment was necessary.
  - Example: "persisting in a course of treatment known to be ineffective"
- Defense counsel
  - The treatment was consistent with the subjective complaints and the objective findings.
  - To explain the reasoning for a particular course of treatment.
  - Ultimately, that the plan of care was within acceptable medical judgment.



# Deposition Tips and Traps

- How do records help you?
  - Clear, consistent, easy to read (if handwritten)
  - Contains sufficient detail to an outsider unfamiliar with this patient.
  - Helps avoid ambiguity.
    - I don't know. I don't recall. I don't remember.
- Not charted means it never happened.
- Policies and procedures are only guidelines. Don't be convinced otherwise.
- NCCHC Recommendations are also only guidelines and do not determine the standard of care.
- Poor communication does not equal poor care.

# What is a Dispositive Motion?

- When counsel requests disposition of a case without need for further trial court proceedings.
- There must be no dispute of material fact.
  - A fact that is central to the underlying claim.
- This is the put up or shut up stage.

# Use of Medical Records at the Dispositive Motion Stage

- Medical records are one of the most persuasive pieces of evidence. Ideally, the medical record alone should prove the provider's decisions were within accepted professional judgment.
- Thorough records can undermine the plaintiff's arguments by providing critical insight into the extent of the medical condition, ability, and needs.
- Since most medical records are drafted before litigation, records tend to carry more weight than affidavits or testimony which could be deemed "self-serving."

# Defensive Documentation: In Practice

- Include in your note what you offered to address patient's complaints.
  - Many cases allege that certain treatment options were not available, even though they were offered and the patient refused at the time.

# **EXAMPLE OF DEFENSIVE DOCUMENTATION**

# The Best Defense is a Good Offense

## Subjective/Objective

I am not getting my medications.

Patient continues on segregation.

Patient states that he is not getting his effexor.

Patient was advice about this situation and he refuse to titrate down his medications.

Patient states that his remeron is not working also.

Patient reports depression, anhedonia, poor concentration, poor energy and poor sleep.

Patient states that he would like to be put back on effexor.

Patient denies suicidal and homicidal ideations

Patient denies AH and VH

Patient denies side effect from his medication.

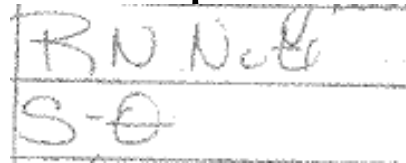
# ... MUCH LESS DEFENSIVE

7/6/16	<u>MD note</u>	
	SOA 7th reportedly correct ambulate.	
	Stable.	PI
)		Observe, Evaluate

# Reducing Ambiguities in Records

- Plaintiff alleged that while in the infirmary his complaints of pain were ignored and or he was not given the opportunity to complain.

- Every nursing entry –



A handwritten note in a box, divided into two sections. The top section contains the text "BN Note" and the bottom section contains "S-O".

- No complaint = nurses never asked

- Next line in each entry –



A handwritten note on lined paper that reads "O-Sick call offered -".



**DEFENSIVE  
DOCUMENTATION:  
CONSISTENCY BETWEEN  
PROVIDERS**

# "The Shoe Investigation"

9/9/14	LPN Note
AK	S/O: shoes ordered per MD issued this date and fit well.
	A: medical supplies

12(29/14)	PA Note
1pm	S/O) Trn reports Reold wrong orthopedic shoes (size 11 1/2) & needed size 10.

4/12-15	LPN Note
1220pm	S/O) Trn seen on NSC noted his new diabetic shoes. Trn was issued S/R wrong size he got 11 1/2 and needs size 10.
	A: diabetic shoes

to Arons on my feet. New shoes are same size as shoes issued 9/14 sz 11.5 woman's sz 10 men. pt educated that shoes issued on 9/14 are in good condition no need for some day of Arons negative and

# The Shoe Investigation Continues

Date	Time	Subjective, Objective, Assessment
4/24/15	9 PM	<p>Client Name</p> <p>96) I'm continuing to request multiple shoes for his Diabetes and have the belief that he is on the take issued new shoes at his convenience. On 1/31/14, Dr. Coe ordered shoes for him, for bunion and mild hammie toes. On 3/8/14, I wrote him educated the special shoes were not approved. 4/7/14, I'm received diabetic shoes. Dr. Coe said offender 4/14 and the offender went wearing his shoes issued 7 days prior. 8/18/14, offender decided to put off a foot lesion removal w/ Dr. Coe after it was addressed multiple times. It was excused 9/25/14 by Dr. Coe. He ordered 12/9/14 his shoes were the</p>

Subjective, Objective, Assessment
<p>wrong size. They are 11 1/2 women's size 10 men. He came to USC 4/10/15 for new shoes. On 4/21/15, he came going to issue the new shoes but his other ones are the same size &amp; fit well. He wants gym shoes. His sugars aren't well controlled, he frequently skips an insulin. He needs to purchase shoes, he's lost 4 commissary tickets show he has spent \$95.46 since 3/2/15, mostly on food. He is not indigent, some medications not reordered during last clinic. He can buy gym shoes if he wants them.</p> <p>A) shoe investigation, need to reveal</p>

# The Shoe Investigation: The End

POC: Mr. also was noted  
on yard wearing a new  
pair of Nike Tennis shoes  
- walking around yard  
5 different.  
4/1/10

der's Medical Record

Printed on Recycled Paper

LPN Note: I/m also was  
noted on yard wearing  
a new pair of Nike tennis  
shoes and walking  
around yard  
without difficulty.

**THE OUTCOME:** "The record shows that, when the plaintiff complained about his shoes, the doctor and other medical staff ensured that his shoes fit and were the correct width and style for his condition."

# **EXAMPLE OF INCONSISTENCY**

# The Blister: What Blister?

4/28/18	RN Note	P: Cont as ordered
10 <sup>30</sup> am	S: Ø	
	O: (L) hand cleansed & NS.	
	Selenium sulfide applied.	
	(L) hand wrapped & gauze.	
	Compression stockings issued.	
	A: Tx	
4/29/18	RN Note	P: Cont as ordered
9 <sup>00</sup> am	S: Ø	
	O: (L) hand Cleansed & NS.	
	Selenium sulfide applied	
	et hand wrapped & gauze.	
	A: Tx	

4/30/18	LEN Note	P: cont. as needed
10am	S: Ø	
	O: I/m to HCU (L) hand	
	cleaned & NS. Selenium	
	sulfide applied, non-sterile	
	pad and coban applied.	
	No s/s of infection.	
	Improving.	
	A: am tx	
5/2/18	LEN Note	P: cont. as needed
9:45am	S: Ø	
	O: I/m to HCU old drug removed	
	and cleaned & NS. No s/s of	
	infection, no swelling. Burn on	
	(L) hand pink and healing, left	
	open to dry	
	A: am tx	

# The Blister Popped

5/4/8	- Cpn tx node -	$\Delta$
10 <sup>30</sup> 74	3" $\phi$	10
	0.3m. Quarter	
	Size blister busted	
	circumference	
	wrappe.	
	Arch center distance	

- Objective: "quarter size blister busted."

# Details Can Make A Difference

- Note the reason certain medication may or may not be used for the situation.

*IM seen today requesting to get back his Neurontin. Note IM has been crushing his med and snorting the Neurontin.*

- If waiting on off-site records or reports, note it.

*Awaiting urology records to review.*

- Document why a particular course of treatment is not recommended.

*Blood sugars will need to be under control before patient is a surgical candidate. ATP made to repeat Alc onsite and re-present with results.*



# BEYOND F.A.C.T. THINKING LIKE A LAWYER

Factual. Accurate. Complete. Timely.

- Encourage you to go beyond the pure facts.
- Is the offender being argumentative, abusive, violent?
  - Caution using "faking" or "malingering"
  - Instead, you could say, "offender's complaints are not consistent with this writer's observations and findings."
  - Carefully document your plan of care. (i.e., continued observation, additional testing, conservative treatment, such as physical therapy).
- Document noncompliance.
  - One step further: why is the noncompliance important?
  - Example: Offender is not a surgical candidate due to uncontrolled diabetes and thus concerns for wound closure.

# Observations and Knowledge

- **Remember: You are our eyes and ears of the facility.**
- Complaints of Pain (i.e., back, knee, shoulder, hernia)
  - Do you know his current activity level?
    - Is he the infirmary porter?
    - Do you often see him at gym or yard?
  - 10/10 pain but laughing and playing cards with cellies?
- Diabetic / Specialized Diets
  - Document his commissary records.
  - Is he refusing oral medications and/or insulin?
- Requesting Assistive Devices
  - Does he currently ambulate to the shower, dietary, yard, gym, job . . . ?
  - Does he kick the cell door when angry or to get attention?
  - Does he attempt to use his walker as a weapon?

# Lessons Learned

- Clear. Accurate. Complete. Detailed.
  - Keep in mind the "tone" of the record.
  - Document changes in condition – new symptoms, changes in size of hernia/cyst/wound
  - The better the note, the more deference you will receive.
- Avoid generic documentation.
  - Especially with electronic medical records as it looks like cut and paste
  - Subject: Ø; "fine"; "okay"
- Document the Reasoning and Clinical Judgment.
- Security Related Issues
  - Security did not bring. To be reschedule.
  - Unavailability of certain medical equipment/devices.
- Refusals, including reasoning.
  - Did not show up. Went to yard instead.
  - Refused direct observation medication.
  - Did not show for med line.

QUESTIONS?

# References

- CorrectCare, Fall 2022. Defensive Documentation for Nurses: Protect Yourself With a Strong Offense, by Nicole Walker, MSN, RN, CCHP
- *Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976)
- *Farmer v. Brennan*, 511 U.S. 825, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994)



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