The author indicates that it is time to look at the anesthetic chart in a new light—one that places more emphasis on the chart as a measure of patient care, rather than as a reference piece in the courtroom. The author draws from his experience as a medical consultant and expert witness in malpractice litigation, as well as that of a practicing anesthesiologist.

The traditional concept that the anesthetic record portrays the moment-to-moment physiologic responses of the anesthetized patient needs revision. Unless this concept is revised, we will continue to expose ourselves to unnecessary legal attack, and we will continue to function under suboptimal conditions. In the final analysis, it is the patient who will suffer on both points.

Anesthesia training programs, from their inception, have stressed the importance of accurate, neat, and detailed anesthetic charts. Defense attorneys have taken up this banner in the face of attacks made upon the chart by plaintiffs’ attorneys. I have witnessed in courtrooms the disastrous effect of such attacks upon charts compiled with the greatest care and attention to detail. This is our own fault. We have perpetrated a misconception of what the anesthetic record represents and have failed to enlighten our defense coun-

celors about the anesthetic chart and its function.

What does the chart represent? What does the chart actually represent? It is a summary of the monitoring of physiologic responses to anesthesia and surgery and of pharmacologic and supportive therapy. The demands made upon the anesthetist in continually observing the patient, providing support, and maintaining the anesthetized state for the patient preclude distractions of the magnitude required to keep a “neat, accurate, timely” record. The chart cannot portray continuous monitoring, but instead, furnishes evidence of periodic assessment of certain parameters. Since moment-to-moment changes occur in vital organ systems (such as, the cardiovascular system), it would be impossible to record in writing such a multitude of changes even with continuous electronic monitoring.

While we accept the monitoring of the patient’s physiology and his support as equally important to the maintenance of the anesthetic, we continue to accept unquestionably the dictum that a “timely” anesthetic record must be kept. While we do this with both eyes and a hand, who is caring for our patient? This inappropriate accent on record-keeping during anesthesia results in a frequently observed scene as one peers into the operating room: the anesthetist is making notations on the chart with great care while the cardioscope, ven-
tilation, and state of perfusion go unobserved.

Is there a happy medium where one can do intraoperative charting without jeopardizing the patient? Of course, there is. However, if the demands of the situation can place your patient in jeopardy, rather than indulging in any distractions, simply wait until the case is safely terminated to complete your record. Place significant events in sequence and summarize your monitoring of the patient. If you can make notes safely during the case, use them. Indicate on the record that it was completed after termination of the case. There is no successful arguing with total devotion to patient care.

If you feel that a detailed narrative account of unusual events during anesthesia or recovery is necessary, write an “addendum to the anesthesia record” on a separate sheet and attach it to the anesthetic chart, placing the date and your signature on it.

I am in favor of complete honesty in reporting. At times, anesthetists are reluctant to report such things as difficulty in intubating a patient, hypotensive episodes, or slow arousal. It is illogical to expect all anesthetic procedures to be free of problems. If they were, anesthetists would have to be specialists. Much of our training is aimed at problem control—prevention, if possible, and treatment, if necessary.

The combined effects of surgical stress and anesthesia produce complex physiological changes that are unpredictable. In addition, many patients today are coming to surgery with a variety of potent drugs “on board,” so to speak. The possible interaction of these drugs with anesthetic agents may not be known. In anesthesia, as well as in medicine in general, we are frequently confronted with “unknowns,” for there is much that we do not know. If a patient’s response to a drug or maneuver is unanticipated, don’t be afraid to say so. Despite attempts to make it otherwise, the practice of anesthesiology remains more art than science.

Records and the law

Records of any type have the potential to assume legal significance, and the anesthetic chart is not an exception. However, its ultimate value is not as a legal document but as a summary of the care rendered by the anesthetist. As such, it may be utilized in teaching or for reference during postoperative care or when the patient requires subsequent anesthetics.

The law expects one thing of you: care for your patient in a manner that meets the accepted and recognized standard of care within your specialty. When the standard of care rendered by you is questioned, your anesthetic chart will be scrutinized; but no conclusions will be drawn from such scrutiny alone. It will be entered into “evidence.” Your testimony will be taken by all attorneys involved. If your testimony is not in conflict with your record of the case, and if you have not deviated from the accepted standard of care, you will not be vulnerable.

Anesthesiology, a relatively young specialty, has matured tremendously in recent years. As anesthetists, we should demonstrate professional maturity in recognizing the need for a change in concept of the anesthetic chart. Your patient has waited all his life for the anesthetic you are going to administer to him. Let the brief period of your life which you devote to him be free of distraction. Place the anesthetic record in its proper perspective.

AUTHOR

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