Legal aspects of anesthesia charting

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To the anesthesia practitioner, the possibility of malpractice claims constitutes a very real and ever-present problem for it lies within the risks inherent in the administration of anesthesia. Since the areas of anesthesia which may be subject to suit are legion, the problem of malpractice becomes too complex to afford easy answers. Clearly, though, it is a problem all too serious to ignore. This article examines one aspect of the problem: the importance of good documentation in anesthesia.

JCAH Standard Number I for Medical Record Service states as follows: “An adequate medical record shall be maintained for every person admitted as an inpatient, outpatient or an emergency patient.”

Interpreting this, the purposes of the medical record are:

1. To serve as a basis for planning continuity of care;
2. To provide a means of communicating with the physician and other professionals contributing to the patient’s care;
3. To furnish documentary evidence of the course of the patient’s illness and treatment during each hospital stay;
4. To serve as a basis for review, study and evaluation of the care rendered to the patient;
5. To assist in protecting the legal interests of the patient, hospital and responsible practitioner; and
6. To provide data for use in research and education.

Medical professionals can readily appreciate the significance and utility of the patient’s record in delivering quality care. Anesthetists frequently rely upon the medical record for information about the patient’s condition. Often, when communication with the patient is impaired, the chart forms the entire basis for a choice of anesthetic technique.

The significance of legibility, accuracy, and informative documentation in medical records can easily be recognized as an essential factor in promoting quality care. In an AANA Journal article entitled “Medical Records—A Tale of Two Patients,” William R. Kucera relates: “The medical and anesthesia records are mainly intended to provide a complete description of the method and type of anesthesia used. In addition, the chart serves as a basis for further anesthesia evaluation regarding possible reactions. In the event that subsequent operations are needed, the medical records should provide the necessary information which will serve to guide the conduct of these procedures.”

There can be no dispute as to this use of the anesthesia record as it pertains to medical professionals.
Pursuit of information

Medical professionals are not alone in their pursuit of "necessary information" in the medical record. Lawyers, medical consultants, and juries are becoming increasingly interested in record contents. Their interest, perhaps, is not totally unrelated to a statement from the National Association of Insurance Commissioners indicating that its member companies "paid close to $35 million for claims made against hospitals, between June 1975 and July 1976, to say nothing of investigative costs and attorneys' fees." Ostensibly, the public is aware that malpractice judgments can be lucrative and that lawyers are available to secure patients' rights.

While it may be true that legal recourse is a necessary and just safeguard, it is also true that its indiscriminate use is increasingly threatening to conscientious practitioners. Moreover, malpractice premiums have risen sharply, dissuading some from continuing to carry liability insurance and others from even continuing to practice. Clearly, claims of malpractice have victimized some medical professionals.

Improve documentation

One way to discourage claims of malpractice may be to improve documentation. In this respect, the JCAI’s fifth purpose of the medical record, i.e., "to assist in protecting the legal interests of the patient, hospital and responsible practitioner," acquires increased significance. Here, a comment made by an experienced trial lawyer while preparing defense for a case of alleged malpractice bears repeating. The comment was: "If you were ever given the chance to have a choice between good records and a malpractice insurance policy, take the records. The insurance policy can be cancelled, the records cannot." Bernard Horn, MD, has also commented that claims of malpractice can be won or lost on the basis of inaccurate or inadequate charts.5

Nonetheless, there are some who do not agree with the premise that there is a need to practice defensive measures in the delivery of health care services. In an article entitled "An Anesthesiologist’s View of the Anesthesia Chart" appearing in the AANA Journal, author Dr. Allen Shepard stated: "Records, of any type, have the potential to assume legal significance, and the anesthetic chart is not an exception. Its ultimate value is not as a legal document, but as a summary of the care rendered by the anesthetist. The law expects one thing from you: care for your patient in a manner that meets the accepted and recognized standards of care within your specialty. Place the anesthetic record in its proper perspective."6

Irrespective of this viewpoint, the fact that the jury may favor what has been documented at the time of the incident, as opposed to other types of evidence, has also been stated.

...a jury of lay persons will believe a black and white copy of a record over a person’s memory for several reasons. First, they may feel that someone testifying as to events which occurred several years ago may not fully remember them. Second, the jury may believe that a record made when the events occurred might be more accurate than someone’s recollection of the past. Therefore, it is clear that the medical record plays an extremely important role before and during a trial.7

The question in the minds of the jury may not be the credibility of the witness, but the accuracy of his or her memory. The probability of total recall of any situation over several years duration is remote, especially when it involves a daily routine. While it is true that there may be difficulty in admitting entire medical records to the courtroom, portions of the record may be admissible if they offer proof of the nature and extent of the injury, the extent of pain and suffering, or the mental status of the individual.8 In the case of a claim
against an anesthetist, the potential admission of the anesthetic chart as well as pre- and postanesthetic notes must be considered a very real possibility. Thus, the importance of concise, informative, legible documentation of anesthetic procedures assumes legal
import.

The initial documentation done by the anesthetist is usually the preanesthetic note. If it is omitted, and no explanatory remarks are given, the consequences could become severe in the hands of a plaintiff’s skilled counsel. The following quotation from Dornette exemplifies such a situation:

It may be inferred that the anesthesiologist (using the term loosely) has so little regard for the seriousness of an anesthetic that he feels he need not see a patient to determine what type of anesthetic is most suitable for that patient, or even worse, that he is too lazy to do so. In cases where the anesthesiologist claims that he has seen the patient, but no note has been made, it has been my uniform experience that the complainant will either deny the visit completely, or at least deny the point in challenge.9

The preanesthetic visit not only enables the anesthetist to evaluate the patient’s physical and mental status, but it also enables the patient to evaluate the anesthetist. The outcome of the latter evaluation may be a determining factor in whether or not a suit evolves when a complication occurs. It is common knowledge that a patient who has good rapport with his physician rarely sues him. The same may be said about nurses who care for patients on a long-term basis. Nurses and doctors in anesthesia, however, have limited contact with their patients prior to rendering them unconscious for surgery. Few patients realize or even want to know exactly what an anesthetist does for them. Many believe that a single injection of Pentothal® “anesthetizes” them. Thus, insufficient patient knowledge combined with limited patient-anesthetist contact may establish anesthesia personnel as prime candidates for claims of malpractice. Moreover, failure to make and document preanesthetic visits invites trouble.

**Demonstrate proper precautions**

Conversely, Dornette stresses, “If an anesthetist can demonstrate that he followed proper precautions in examining the patient before the administration of an anesthetic, he is a long way to a verdict in his favor, in the event of a death or serious injury during anesthesia.”10

Even the seemingly insignificant notations such as the FS classification and notations of height and weight in the preanesthetic note may not escape scrutiny. The following passage is taken from an article entitled “As a Lawyer Views Your Chart” by George F. Gore:

The problem that we have encountered most often in this regard is the failure to designate the patient as class E or 1-E, or to designate in some way that this is an emergency procedure from the anesthetic point of view. To the lawyer reviewing your chart, whether or not you have classified this as an emergency anesthetic case can have significance regarding: claims of informed consent to the particular anesthetic technique, your choice of anesthetic technique and agents (rapid vs slow induction) and the need for and availability of time for administration of preoperative fluids and/or blood.11

Gore also relates a situation in which the height and weight of the patient had not been documented. The case involved the administration of a hyperbaric spinal anesthetic where the patient suffered a cardiac arrest intraoperatively with subsequent brain damage. The entire medical record did not contain a single notation of the patient’s height or weight.12 Accordingly, an “expert witness” might go a long way in convincing the jury regarding the significance of such an omission.
Dosage, route and duration of medications may be cited by medical consultants as important factors in respiratory depression and/or hypotension. Gore relates a case involving a patient with a 17-year history of bleeding ulcers who had undergone a subtotal gastrectomy. The patient's lawyer claimed that the patient was hypovolemic and anemic on admission to the operating room and that preoperative anticholinergic and sedative medications given intramuscularly had remained in the patient's muscles, not properly absorbed nor circulating. The attorney claimed further that despite intraoperative administration of blood and fluids, the premedication was suddenly released into the circulation and was contributory to a precipitous hypotension. The anesthesiologist's notation made at the onset of surgery indicated that the patient had arrived in the OR 'calm and dry' and thus evidenced that the preoperative medication had indeed been absorbed and was not lurking in the muscle tissue.

The use of preprinted anesthetic charts with blanks to be checked for appropriate information is becoming increasingly common. Problems can occur when blanks are not completed or are labeled as inapplicable. Dornette suggests that "negative information should be recorded as such, not left blank. Blank spaces suggest that the chart is incomplete and imply that care has been incomplete. If the anesthesiologist or nurse does not routinely fill out all blocks, squares, or spaces on the anesthesia record form, it may be desirable to make a note explaining the absence of some data."14

Care must also be taken when preprinted symbols are used to indicate patient position. In one situation involving respiratory difficulties, an anesthesiologist circled such a symbol indicating a head-up position of 25-45°. Those in the operating room at the time of the incident in question testified that the head of the table could not have been elevated more than 5°, if at all. Although this was the only symbol which indicated a head-up position, it did not reflect the patient's actual position as revealed through testimony.15 Despite the fact that the patient's actual position may not have been a significant factor in causing his respiratory difficulties, the fact that an inaccurate entry had been made could not be disputed. The logical conclusion of such evidence may be to question the accuracy of other entries on the chart as well. Dornette writes:

The following partial report involves an abdomino-pelvic operation on a 37-year-old woman who was never aroused following anesthesia. The surgeon, during the operation, noticed four episodes that could be related to the anesthetic. Twice he saw dark blood, and on both occasions he brought this to the attention of the anesthesiologist, who by increasing the percent of oxygen and ventilation, relieved the hypoxia immediately. On two other occasions, the surgeon discovered that the stomach was distended, indicating that the anesthetic gases were being forced into it. Each time, this was brought to the attention of the anesthesiologist, and the surgeon emptied the stomach with manual pressure. It should be emphasized that there was no evidence that cardiac arrest ever occurred. Nor was there any evidence that respiratory arrest ever occurred. Yet it appears that this patient did suffer diffuse brain damage. Because she had adequate blood volume and hemoglobin before the operation, it must be assumed that ventilation was inadequate especially because the anesthesiologist stated there was no obstruction.16

Respiratory depression may be the most frequent side effect or problem encountered in anesthesia. Nearly all types of anesthesia can be implicated. Dornette states that "respiratory depth, not rate" is of prime importance, and that
often "charts are totally silent regarding these points." Using 'AR' and 'CR' to indicate assisted or controlled respirations may be advisable to indicate proper management of a patient, as opposed to mere observation of rate without regard to depth. According to Dornette, "Not all complications can be avoided, but written evidence that they were anticipated and that efforts, even though unsuccessful, were made to prevent and treat them will do much to provide better courtroom defense."

The legal aspects of spinal anesthetics have been recognized for some time. Assurances for sterile techniques, as well as documentation of injection site and level of anesthesia reached are absolute necessities. The level must be charted clearly. Recordings such as "T-9+" should never be used as they suggest doubt and cannot insure credibility even for the most convincing witness. Respiratory rate and depth should also be documented to verify proper management.

Legal suicide

Failure to chart a problem that has occurred is legal suicide. No amount of skill or knowledge can prevent problems or complications from occurring 100% of the time. Dornette emphasizes, "The immediate notation of difficulties and complications is the best evidence of carefully considered management rather than the converse." A problem or complication of any sort is bound to be in the spotlight of scrutiny.

As Gore notes, "Whatever the problem is, it must be charted, and it must be charted timely, clearly, and accurately . . . you cannot afford to subject yourself to even a hint of any 'cover-up.'" In a case discussed by Gore, the accidental disconnection of an oxygen hose from the anesthesia machine was revealed in court. It was cited as the primary cause of cardiopulmonary problems presented in the case. The medical and anesthesia records did not give any indication that the event had occurred. "The failure to record it is absolutely legally indefensible," states Gore. It is doubtful that even the most skilled attorney could discredit the importance of such evidence. Jack L. Mumme, president of a firm that investigates hospital malpractice claims, concurs:

Malpractice claims are won or lost on the basis of patients' charts, where it's not so much what you've written, but what you haven't that counts. In addition to vital signs, abnormalities and notable changes in the patient's condition are the key items to be charted. Making note of them shows that you are doing your job. What constitutes an abnormality depends on the case involved, but whatever it is, be sure to describe it thoroughly.

Another area of charting that frequently escapes documentation is the relief of the initial anesthetist by another. Often times, it does not require the skill of a handwriting analyst to observe that this has taken place when the chart is reviewed. The change of anesthetists, while essential and common in many instances, should be clearly recorded. It serves to protect both persons involved in the event of an untoward complication. The following account is a case in point. It describes the case of a perfectly healthy 10-year-old girl who underwent removal of a femoral osteochondroma:

The plaintiff's attorney was arguing that this girl was not properly monitored and attended to during a 15-minute period, and in fact, was claiming that she had been abandoned for at least part of that time. Dr. A, the anesthesiologist who started the case, was the chief of anesthesiology, a highly respected and very experienced physician. He testified that at some time during the 15-minute period in question, he was called to assist a second anesthesiologist, Dr. B, in another room. Dr. A testified further that before leaving this girl he was relieved by Dr. C., another
Board Certified anesthesiologist. Unfortunately, Dr. C testified that while he did come into the girl's operating room and attend to her for a few minutes, he did not recall seeing Dr. A. in the room when he entered, and he could not testify that, in fact, Dr. A. was in the room when he entered. Further difficulty was presented by the fact that Dr. B. testified that he did not recall needing any help during his operation and did not recall Dr. A. ever coming into his room to assist him. Moreover, Dr. B.'s anesthesia record did not reflect any particular difficulty or any notation whatsoever that Dr. A. had ever been in his room.

Despite some degree of mental impairment due to the hypoxia, the girl was able to recognize her handicap. The settlement involved nearly a million dollars.

Certainly, there are instances when documentation is neither timely nor feasible. For example, there is no excuse for neglecting a patient in order to document what is being done. The primary objective must be total devotion to the patient at all times. However, failure to document when time and circumstances allow must be viewed as a potential legal hazard. Why? Because the lawyer's purpose is to discover and embellish any errors or omissions that may substantiate a claim of malpractice. "The traditional concept that the anesthetic record portrays the moment-to-moment physiologic responses of the anesthetized patient" can readily be seen as both foolish and impossible, notes Allen Shepard. He comments further on the origin of this concept:

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 the disastrous effects of such attacks upon charts compiled with the greatest of 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 counselors about the anesthetic chart and its function. What does the anesthetic chart actually represent? It is a summary of the monitoring of physiologic responses to anesthesia and surgery and of the pharmacologic and supportive therapy. The chart cannot portray continuous monitoring, but furnishes evidence of periodic assessment of certain parameters.

Until this misconception is clarified and/or methods of documentation improve, successful claims of malpractice can be expected to flourish. Documentation must demonstrate the quality of care given. Poor and illegible records do not suggest quality care. Errors, omissions and discrepancies merely serve to fuel the fires of malpractice. Conversely, honest, thorough and complete documentation may help to dampen the flames.

Human fallibility suggests that errors in documentation will periodically occur. When they do, their corrections must be made clearly, credibly, and without obliteration of the erroneous information. "Deletion or destruction of information is called spoilation at law," writes Dornette. In the courtroom, it is usually construed as favorable to the person seeking the information and unfavorable to the person responsible for the record.

Thus, corrections must be made in such a way that spoilation is avoided. Drawing a single line through the erroneous material, circling it, and writing "error" to designate it as such, are acceptable methods. A notation indicating the reason for the change has also been suggested by Dornette who claims that "...different handwritings, erasures, 'write-overs,' inserts or obliterations can strongly infer negligence." Handwriting analysts and
methods for chemically dating ink are capable of proving back-dated records or changes made after-the-fact. Both can understandably have disastrous effects in court. Therefore, any error should be corrected as soon as it is discovered. It should also be noted that erasures or obliterations will intensify suspicion regardless of the innocence with which they were made.

Problems in correcting errors

Gore cites three examples of problems with corrections of errors in his article, “As a Lawyer Views Your Chart.” The first case involved a 21-year-old primipara who suffered a questionable cardiac arrest with resultant brain damage. At the critical point of the record, an obvious erasure had been made with “BP and a descending arrow” written in. A handwriting expert proved that the original notation had been “No BP.” Despite the fact that no one could testify with certainty that the blood pressure was actually absent, the evidence was undeniably incriminatory.

The second example also included the testimony of a handwriting analyst. In this case, a 28-year-old apprehensive, obese patient was given a spinal anesthetic for a laminectomy. The factor in question was whether or not the patient had been given a hyper- or hypobaric spinal anesthetic for the surgery, performed in the prone jackknife position. The chart in this case was not only difficult to read, but also contained an over-write. The handwriting analyst demonstrated that the original notation had been “PED,” indicating Pontocaine®, ephedrine and dextrose—a hyperbaric solution. The last two letters of this notation had been changed to “H₂O” followed by a plus sign and “...the word ephedrine written partially over the next word on that line.”

In view of such evidence, a decision as to which type of solution had actually been administered would be difficult at best.

The third example entailed charting inaccuracies in a case of severe hypotension which resulted in patient brain damage. The chart in this case had listed drugs and other resuscitative measures taken, but the order of these measures had been changed, and, subsequently, renumbered. According to Gore, “Apparently, someone later realized that he (the anesthesiologist) had forgotten to record the only vasopressor administered subsequent to the hypotensive episode. Thus, the name and dosage of that drug were squeezed in between notations, and all of the notations thereafter had to be renumbered.”

Innocent as the correction may have been, the question of tainted records must emerge. When, in fact, was the record changed? By whom? And for what reason?

Perhaps, a more legally defensible way to correct the previously mentioned or similar type of charting error would be to write an addendum to the record in the progress notes, reporting the omission and recording the fact that it had been given. Such an honest disclosure could have cleared the confusion resulting from the method of correction used by the anesthesiologist.

Mumme advises:

Never back-date or tamper with records. If that’s detected—and it can be, through a change in penmanship or the color of the ink used or sophisticated chemical analysis that dates the ink—you’ve lost your case right there. Remember, the medical chart is something jurors take into the jury room. It’s the only complete document available in malpractice cases, so it has to be as good as gold.

The development of “golden” records may seem superfluous, time-consuming and idealistic, but, in court, they may provide better assistance than the best defense counselor, not to mention the fact that they may discourage litigation altogether. Clearly then, recognition of potential situations for suit, as well as special attention to problem areas of charting, should become routine.
A final word of caution: If, for some reason, a record must be recopied, the fact that the record is a copy should be clearly noted, and the reason for it stated. Keeping the original record on file for future reference has also been advised by Dornette.88 Until quality of care is reflected in documentation, the notion that “if it’s not charted, it’s not done” will continue to vindicate claims of malpractice, warranted or not. Improved documentation may provide one of the means by which claims of malpractice may be curbed.

The medical profession can avoid many legal pitfalls through proper documentation. Together with a heightened legal consciousness, complete, clear and conclusive charting in medical records can support the credibility and defense of claims of malpractice in addition to reflecting the true quality of care rendered by nurses and doctors practicing anesthesia.

REFERENCES
(3) Mumme, Jack L. 1977. Seven Surefire Ways to Lose a Malpractice Case. RN Magazine. 40:60 (November).
(4) Dornette, Clinical Anesthesia, op cit, p. 208.
(7) Dornette, Clinical Anesthesia, op cit, p. 414.
(12) Ibid.
(13) Ibid.
(14) Clinical Anesthesia, op cit, p. 196.
(15) Gore, op cit, p. 593.
(19) Gore, op cit, p. 593.
(20) Dornette, Anesthesiology, op cit, p. 372.
(21) Gore, op cit, p. 596.
(22) Ibid, p. 596-597.
(23) Mumme, op cit, p. 61.
(25) Shepard, op cit, p. 304.
(26) Ibid.
(27) Clinical Anesthesia, op cit, p. 204.
(29) Gore, op cit, p. 591.
(31) Ibid, p. 596.

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