Medical records—A tale of two patients

Medical record charting procedures are extremely important from a legal, as well as a medical standpoint. This record is often the foundation for either proving or disproving an allegation that a nurse anesthetist acted in a negligent manner. Two simple illustrations will clearly demonstrate this.

The first example involves a young boy who injured his shoulder while playing football near his home. The following morning he was attended to in the emergency room where two physicians concluded that he had suffered a shoulder separation and prescribed surgery. At some point prior to the surgery, the boy received an intravenous solution containing sodium pentothal. The exact amount and method of administering were not recorded. The manufacturer's instructions provided that a small test dosage be administered with a reaction waiting time of 60 seconds, followed by full administration if the proper reaction was received. It was not recorded as to whether or not the nurse anesthetist followed this procedure.

The intravenous solution was exchanged for one containing dextrose and water. The nurse anesthetist proceeded to give the patient penthrane, nitrous oxide, and oxygen. She noted his respiration and pulse rate at various times. As time passed, the nurse anesthetist found she had to assist the boy's breathing. It soon became apparent that he could no longer breathe on his own. He was immediately taken out of the operating room (the operation having been successfully completed) and placed on a Bennett respirator in the recovery room. He soon expired.

The second example involves a child who was accidentally struck by an automobile, thereby fracturing her leg. She was brought to the emergency room where she was diagnosed as having a compound fracture. She was admitted and placed in traction. At various points, a nurse checked and recorded the condition of the patient's leg. On several occasions, the attending physician was called, at which times he adjusted the traction splints. A day later, the nurse reported that the leg looked "dusky" in color and once again summoned the physician. It was determined that the patient suffered ischemia of the leg, necessitating its amputation.

In the first illustration, the nurse anesthetist and the hospital were found liable, as they could not support their claim through notations on the medical record that they had acted properly. In the second example, the nurse and the hospital were found free of liability, as
it was shown through the medical records that they had acted in a professional manner.

Adequacy of charting
These illustrations raise several medical-legal problems concerning the adequacy of charting procedures. Initially, there are a number of medical reasons which are well known by most nurse anesthetists for preparing a well documented chart. The medical and anesthesia records are mainly intended to provide a complete description of the method and type of anesthesia used. It is obvious that this serves to provide information which will be helpful in the continued care and treatment of the patient during the postoperative recovery period.

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 necessary information which will serve to guide the conduct of these procedures. This information may be critical in the more distant future as well. It is possible that the patient may return to the hospital for continued treatment or some procedure which is totally different from the one recently performed. In that event, a new health care team may wish to review prior records. Therefore, from a medical standpoint, it is apparent that the records must be clear and accurate, containing no ambiguities.

On the other hand, a patient's medical records raise some serious legal problems as well. In most, if not all malpractice actions, a plaintiff's attorney will request a copy of his client's medical records. He, as well as the defense counsel, knows that information contained in these records may serve to aid or discourage their respective cases.

Trial evidence
In past columns, we have discussed some of the principles and concepts upon which professional liability is founded. However, it is not enough for the plaintiff merely to allege that a nurse anesthetist breached a standard of care, thereby causing injury. The law, in addition to filing a claim, requires the plaintiff to prove to the judge and jury that the nurse anesthetist actually conducted himself or herself in less than a professional manner. This proof may or may not be found in the medical records.

The medical record, in almost all cases, is the most important piece of information which is available to the opposing attorneys. This record will serve both the plaintiff and the defendant before and during the trial. Both attorneys and their respective experts on anesthesiology will review the medical record in an effort to find some improper act or conduct on the part of the nurse anesthetist or someone else during the surgical procedure.

Further, where possible, the attorneys will discuss the record with various persons, including the physicians, nurses, and so on, who were connected with the care and treatment of the patient. Often, these persons will be questioned in what is termed a deposition, regarding various facets of the case. Slowly and piece by piece, the two attorneys will fit together the various bits of information in an effort to understand how and why the patient suffered some further harm while in the hospital.

Once the reviews of the records are completed and statements from various persons are received and the attorneys have a general idea as to what happened, they may negotiate a settlement for an agreed amount of money. In the event they do not settle (compromise), the case will go to trial. Often, this period of detective work and negotiation lasts several years. From the time a case is filed, it may take three to five years before it reaches the trial stage.

Likewise, several years may elapse before the patient has even discovered he has been injured. In this instance, five to seven years may pass during which time many things may have occurred. For example, the patient may
have died, the physician and/or the nurse anesthetist may have taken up practice elsewhere, or other witnesses may be unavailable. Therefore, the medical records become increasingly important as possibly the sole source of what transpired almost seven years ago. Even if the various persons are available for questioning in depositions or at the trial stage, they may not remember the incident, much less the detail of the event which occurred at that time.

At the trial, each party will seek to present to the judge and jury their respective versions of what happened and why the patient may have been injured. Both the plaintiff and defendant will present various pieces of the puzzle, known as evidence, in an effort to persuade the jury as to whether or not someone was in error. In some states, the record itself may be introduced as evidence of what happened. However, in all states, someone, usually an expert, will testify as to what the record contains and what it means. Also, witnesses may have their memories refreshed by looking at their own notes and comments on the record in order that they may tell the court their own version of the story.

Finally, a jury of lay persons unfamiliar with medical practices 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 seven 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 the trial. The defense counsel and the nurse anesthetist, if he or she is the defendant, hope that the judge and jury will agree with their version of the story and decide in their favor, that is, that the anesthetist was not guilty of any wrong doing.

Conclusions drawn

The conclusions to be drawn are that the nurse anesthetist must provide detailed and complete records of his or her conduct regarding each and every case in which he or she becomes involved. The following are suggested guidelines to be followed in the preparation of a notation on medical records.

First, all notations should be made directly on the patient’s chart in the appropriate spaces provided. They should be made as soon after the observation as possible.

Second, the notes should be written as legibly as possible. Further, abbreviations should be avoided unless they are standard and used by others throughout the hospital.

Third, where an error in recording has been made, it should be documented directly on the chart in such a manner as to include the time at which the error was discovered. In so doing, the nurse anesthetist should not erase or obliterate the erroneous recording, as this will raise suspicions. Instead, one should draw a single line through the material or circle the material in question and comment as to its erroneous nature either below or in the margin. The error should be immediately corrected with the proper information as well as a comment to the effect that the error was in fact corrected.

Fourth, where an untoward anesthetic reaction develops, it should take priority over any charting procedure. However, a proper note should be drafted as soon as possible after the incident. This note should include a description of the reaction and the remedial procedures taken, as well as the patient’s reactions thereto.

Fifth, where a nurse anesthetist is relieved after the start of a surgical procedure, he or she should note the time and who relieved him or her. And finally, all charting should include complete, detailed descriptions of all activities and agents administered. Timeliness, completeness, clarity, and accuracy are the watch words. No hints of cover up should be provided on the patient’s medical records. The nurse anesthetist should strive to make all records and notations on paper as soon after the incident as possible. He or she may then, at his or her earliest convenience, record the notes directly onto the medical record.