Charting

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The Scope and Standards for Nurse Anesthesia Practice, adopted by the American Association of Nurse Anesthetists (AANA), provides: “There shall be complete, accurate, and timely documentation of pertinent information on the patient’s medical record. ”1(p4) The interpretation of this standard provides the justification: “Document all anesthetic interventions and patient responses. Accurate documentation facilitates comprehensive patient care, provides information for retrospective review and research data, and establishes a medical-legal record. ”1(p4) For many years, I have known that charting was significant for “medical-legal” purposes, but could I show why? I have searched for cases involving nurse anesthetists that explain the significance, from a legal standpoint, of charting. The literature has been surprisingly bare. It recently occurred to me that I was simply looking in the wrong place.

In this issue, I will discuss a number of cases involving anesthesia and charting. As we will see, although all but 1 of the cases involves anesthesiologists, the courts view charting in exactly the way the AANA Scope and Standards for Nurse Anesthesia Practice imply that they do.1 Charting is important for the legal record. Not surprisingly, the cases bear out the wisdom of that old saying: “If it’s not recorded on the chart, it didn’t happen.”

Vuletich v Bolgla

In Vuletich v Bolgla (85 Ill. App. 3d, 810, 407 N.E. 2d 566, Illinois, 1980), a patient had sued an anesthesiologist for injuries sustained during corrective eye surgery. The jury had rendered a verdict in favor of the anesthesiologist, and the patient was appealing because of errors that he thought had occurred during trial. The appellate court sent the case back for a new trial. The patient’s claim was that the anesthesiologist had failed to watch and record the patient’s breathing. The patient’s theory of the case was incorporated in the testimony of an anesthesiologist testifying as an expert witness. The expert testified that the patient’s symptoms were the result of asphyxial brain damage that probably occurred over a 5- to 12-minute period. Key to the expert’s theory was the fact that the anesthesiologist failed to chart the patient’s respiration during the operation. The expert testified that the anesthesiologist’s failure to chart the patient’s respiration during the operation suggested that the anesthesiologist could have been casual in his observation of the patient’s breathing. The defendant anesthesiologist introduced experts who testified that the anesthesiologist’s performance met the standards of good practice. The anesthesiologist’s defense depended on the testimony of a scrub nurse who testified that the anesthesiologist had a particular practice and method of monitoring respiration, a practice which he usually followed and, to her knowledge, followed during the plaintiff’s surgery.

Most of what goes on during a trial is easily understood whether you have a legal background or not. An exception is the lengthy and intricate rules that have developed as to the acceptance of evidence. Courts will only accept evidence that their experience shows is reliable. In general, the courts do not permit evidence to be introduced unless it relates to the procedure being questioned. The fact that an anesthesiologist did or did not monitor breathing in another case does not mean that the anesthesiologist did or did not monitor breathing in this case. There is, however, a very important exception. When there is no direct evidence of what actually occurred in the present case, a person will be allowed to introduce evidence of what he or she customarily did. Thus, the admissibility of the scrub nurse’s testimony as to the procedures normally followed by the anesthesiologist depended on there being no eyewitness to the actual corrective eye surgery.

The court found that there were, in fact, 2 eyewitnesses to the corrective eye surgery. This was sufficient to exclude the scrub nurse’s testimony of the anesthesiologist’s habit. The first eyewitness was the scrub nurse, herself, who testified that she observed the patient breathing when he moved during the operation. The second “eyewitness” was the anesthesia chart. Even though the interpretation of the chart was in dispute (one expert claiming that it showed a failure to monitor and the other that it showed the anes-
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The anesthesiologist met the standard of care, it provided the most direct compelling testimony as to what had happened and was sufficient to exclude the admission of "habit testimony."

Whether or not the chart condemned or exonerated the anesthesiologist in this particular case, is not as important as the fact that it had the capacity to do so. Standards of practice followed by practitioners and incorporated into standards adopted by the AANA require a chart and require that blood pressure and heart rate be recorded at least every 5 minutes. 1(p3) Note that the AANA Scope and Standards for Nurse Anesthesia Practice requires recording as well as monitoring. 1 Failure to record the ongoing monitoring of the patient's signs permits others to argue that they were not recorded because they were not taken. Recording vital signs permits the practitioner to observe trends and to catch and anticipate problems before they become significant and life threatening, as well as to prove that vital signs were monitored.

**Kearl v Board of Medical Quality Assurance**

The requirement of recording, as well as monitoring vital signs, was underscored by *Kearl v Board of Medical Quality Assurance* (189 Cal. App. 3d, 1040, 236 Cal. Rptr. 526, 1986). The case involved the revocation or suspension of an anesthesiologist's medical license due to gross negligence or incompetence. One of the incidents that gave rise to the proceedings was that of a 37-year-old woman undergoing back surgery. During surgery her blood pressure and pulse rate dropped. Although resuscitative measures were taken, she remained unconscious and died 12 days later of a cardiac arrest.

The question in the proceeding for revocation of the anesthesiologist's medical license was whether he had constantly monitored the patient's vital signs. According to the anesthesiologist, some hospitals provided anesthesia charts with space for recordation only at 15-minute intervals. He claimed it was common to monitor vital signs every 5 minutes but to record only those at the 15-minute intervals. Thus, argued the anesthesiologist, the fact that he recorded the vital signs at 15-minute intervals did not mean that he was not taking them at 5-minute intervals. Another anesthesiologist supported the defendant's position by testifying that it was acceptable to record vital signs every 10 to 15 minutes as long as the anesthesiologist took the patient's blood pressure more frequently and monitored the pulse continuously. On the other hand, another expert anesthesiologist testified that the failure to record vital signs every 5 minutes was an extreme departure from community standards because it takes only 3 to 4 minutes for irreversible brain damage to occur.

Recording is important not only because it documents trends in the patient but also because it shows that the vital signs were in fact taken every 5 minutes. The expert testified that the failure to take and record vital signs was evidence of gross negligence and supported the decision of the licensing board to revoke or suspend the license. The problem with recording vital signs only every 15 minutes is that it does not leave any evidence that they were monitored every 5 minutes. The reviewing court concluded that recording was not a technical-
unclear exactly how long the cardiac arrest lasted, it was probably less than 5 minutes. Nonetheless, the patient suffered permanent brain damage. Not surprising, the patient’s lawyer asked to examine the hospital’s records. When the anesthesiologist learned that the patient’s lawyer wanted to see his anesthesia chart, he went to the hospital record room and worked on the chart until the record room clerk told him that this was improper.

The plaintiff’s theory of the case was that the patient had not been properly ventilated and that although the heart may not have stopped beating, it had to have been beating very weakly. The anesthesiologist’s failure to detect the weak blood pressure was negligence. The anesthesiologist testified that this theory could not have been correct because he checked blood pressure at least every 5 minutes and pulse at least every 2 minutes. As indicated by his anesthesia chart, there were no signs that the patient had any difficulty until he suddenly failed to detect the pulse. During the trial, the patient’s attorney used the fact that the anesthesiologist had altered the chart after the operation and prior to trial to infer that the chart showed something that did not support the anesthesiologist before it had been changed. The trial court, for some reason, sided with the anesthesiologist and indicated from the bench that if there was evidence that the chart was changed, then maybe it could not be used to support the anesthesiologist’s position that a weak pulse had not come to his attention. However, said the judge, the chart could not be used to support the plaintiff’s case since there was nothing in the chart, revised or not, to show declining blood pressure. The Supreme Court of Kentucky disagreed. The patient’s expert witness testified that the information presented in the chart was too regular to be believed because fluctuations in blood pressure had to have occurred yet were not present on the chart. The Supreme Court of Kentucky sided with the patient. The regularity of blood pressure and the evidence that the anesthesiologist had altered the chart in preparation for trial were sufficient to allow the plaintiff to make inferences as to what happened during the operation. And, the plaintiff should be able to make these inferences without the derogatory comments of the trial judge. Interestingly, the court says:

It is not for us [the court] to draw inferences from this unusual conduct. The jury was entitled to place great significance, or no significance at all, or all the gradations in between on the additions; and it is improper for the trial court to advise the jury, as was done here, that the changes were not material in determining the cause of the cardiac arrest. This [the trial court’s statement that the changes were not material] misses the point, and, in effect, directs the jury not to consider...[the anesthesiologist’s]...conduct in this respect at all. (573 S.W. 2d 337)

The anesthesia chart is only valuable when it is a neutral observer. Improving what it says is likely to have the opposite effect.

**Tabora v Gottlieb Memorial Hospital**

Charting also played a role in a very curious case involving discrimination against an anesthesiologist of Asian background. While he never got along with the chief of medicine, the anesthesiologist had been a member of the hospital’s medical staff for approximately 17 years. In 1990, 2 incidents occurred, following which he was suspended from the medical staff. In the first incident, there had been an emergency call for medical assistance during open-heart surgery. The anesthesiologist reported to the surgical suite where he was informed that the surgeon required anesthetic assistance. Because he was not qualified to administer anesthesia during a cardiac operation, he did not believe he could render appropriate assistance and did not enter the room. It turned out that the assistance required was someone to pump blood, a procedure that the anesthesiologist could have easily performed. There was a second incident where the anesthesiologist and an assisting nurse claimed that the anesthesiologist had urged an obstetrician to replace a patient’s blood loss. The patient suffered complications and died 2 weeks later. After her death, the anesthesiologist added a comment to the medical chart of his disagreement with the surgeons over the replacement of blood. The anesthesiologist was suspended. He brought suit, claiming that the suspension was a result of discrimination because of national origin and race made illegal by the Civil Rights Act of 1964.

The trial court wrote 2 decisions in the course of this dispute. In the first, on February 15, 1995, the district court ruled on efforts by the defendants to dismiss the suit against them (Tabora v Gottlieb Memorial Hospital (1995, W.L. 121567 (N.D. Ill.)). The defendants (the hospital and its medical chief of staff) had tried to have the suit dismissed on the grounds that the suspension had gone through a medical peer review committee, the Civil Rights Act did not apply to a physician who was not technically an employee of the hospital, the 2 incidents that occurred in 1990 justified termination, and various
other points. The court held that there were too many disputes about the evidence for summary judgment and denied the defendants’ motion. After a trial, the court issued its verdict on September 30, 1996 (1996 W.L. 563709 (N.D. Ill.)). The court found little evidence justifying the dismissal of the anesthesiologist on clinical grounds but a great deal of evidence that there was, in fact, prejudice against him as a result of his national origin. With regard to changing the chart after the operation, the anesthesiologist testified that the hospital had never enforced rules prohibiting physicians from completing notes after an operation was complete. In fact, if a doctor did not complete his notes on time, he received a notice from the records office telling him to return and complete the paperwork.

While the court does not comment on the practices followed regarding the completion of charts, the court makes it clear that it did not believe that the anesthesiologist’s firing had anything to do with the way he completed his charts. Why does the court ignore the subsequent changes to the chart in Tabora while condemning them in Seaton v Rosenberg? First, Dr Tabora had corroborating testimony that what he put in the chart actually happened. Second, while his entry may have criticized another physician, it was not entered to remove blame from the author.

**Armijo v Albuquerque Anesthesia Services, Ltd.**

To this point we have noted that proper charting facilitates comprehensive patient care, provides information for retrospective review and research data, and that the failure to record accurate information creates the negative inference that proper monitoring did not occur. But there is another benefit of proper charting. Proper charting may, in fact, protect the practitioner. This protection can be seen in a 1984 case that arose in New Mexico (Armijo v Albuquerque Anesthesia Services, Ltd., 101 N.M. 129, 679 P.2d 271, 1984). The plaintiff had been admitted to a hospital for a knee operation. Anesthesia was administered by a nurse anesthetist. Although the patient died, the case gives no reason why, other than the patient had been classified as an ASA Class II risk because of obesity. There was no allegation of any specific act of negligence in the complaint. Instead, the plaintiff’s suit claimed that the ratio of anesthesiologists to nurse anesthetists was “dangerously low.” The only testimony before the court on this absurd claim was the testimony of 1 of the anesthesiologists that he had checked the anesthesia record to make sure the nurse anesthetist had done nothing wrong and, in fact, saw nothing wrong with the anesthesia. Since this was the only evidence as to the question of the anesthesia care, the trial court issued summary judgment in favor of the nurse anesthetists and other defendants. The dismissal of the case for summary judgment was appealed, and the appellate court affirmed. Interestingly, as a kind of last ditch argument as to why the trial court’s grant of summary judgment should be overturned, the plaintiff had argued that the grant of summary judgment in favor of the defendants was a product of confusion, error, and haste. The appellate court stated that the plaintiff’s contention was “frivolous,” the ultimate in judicial dismissals.

**Conclusion**

Even though all but one of these cases involved an anesthesiologist rather than a nurse anesthetist, the lesson and implications for nurse anesthesia are clear. Accurate and timely documentation of pertinent information on a patient’s medical record will enable CRNAs to see trends and to learn from experience, improving patient care. Accurate and timely charting also can prevent negative inferences that could otherwise be made in the absence of accurate information and can protect CRNAs when something has gone wrong and people are looking for someone to blame.

**REFERENCE**