The article by Raff and James on record keeping by anaesthetists portrays a shocking sample of the standard of care delivered by our discipline, and confirms what many in the medical profession have long suspected. The profile of the anaesthesiologist as a perioperative physician is rendered ridiculous and the perception that we are merely technicians rather than true medical practitioners is given substance in the eyes of our medical colleagues and the general public.

Maintaining an anaesthetic record is part of the lore of anaesthetic practice. It reputedly serves several purposes:

* It is a prescription record for drugs administered during anaesthesia.
* It satisfies the clinical requirement of providing a record necessary for ongoing care.
* It alerts the anaesthetist to adverse trends in vital signs.

Why then are we so cavalier with regard to maintaining a record of this highly intrusive and dangerous medical procedure? While the record does serve as the anaesthetist’s prescription record, I am less convinced of its usefulness as either a record for later reference by medical staff or as a monitor of trends. On those few occasions when an anaesthetic record is available in the patient’s medical file, it is usually only the anaesthetist who has to give a subsequent anaesthetic who gives it a cursory reference, looking mainly for entries in the “Difficulties” section.

With regard to its usefulness as a trend monitor, the period of care during an anaesthetic is relatively short. Changes in vital signs fall within the range of even ageing short-term memory, and, more importantly, anaesthetists use targets, e.g., specific pulse and blood pressure values, as triggers for intervention, and thus respond to absolute values as and when they occur. So apart from ensuring that the anaesthetist is constantly in attendance, a trend record does not add much value to the quality of anaesthetic care.

When it comes to being used as evidence in court, the record can be of inestimable value. But it can also be detrimental to the anaesthetist’s cause. Because evidence is often given years after the event under scrutiny, it is usually the most reliable record of what happened, and it is not unusual for it to serve as a foil to nursing and surgical opinions based on subjective snapshots which reflect poorly on the vigilance and attentiveness of the anaesthetist. I have been involved in many cases where the surgeon has said in evidence “I told the anaesthetist that the blood was dark”. When a written record indicating prior intervention cannot contextualise this type of statement, the impression is created that the anaesthetist was inattentive and needed to be prompted into action.

There are those who keep minimal or no record of their anaesthetic, preferring to remain secretive about this for fear that the record will be used as a rod to beat them with at a later time. Under the spotlight of a legal investigation the inability to produce an anaesthetic record reflects very poorly on their level of care. The defense that it is only necessary to record abnormal events is a precarious one, and the failure to record the normal is prone to fall prey to the axiom “If you didn’t write it down, it didn’t happen”.

But when a crisis occurs priorities shift from mere vigilance and record keeping to the execution of the rescue operation, and no-one expects the anaesthetist to maintain an accurate record during such a time. But it is well to remember that nursing protocols often call for a dedicated nurse-scribe to record observations of vital signs and drug administration during a collapse, and it is not unusual for the resulting document produced by a non-anaesthetist (who is relatively unformed as to technical aspects of the rescue), to be embarrassing to the anaesthetist. In order to complete the record after the event anaesthetists sometimes retrospectively reconstruct the process and make recordings from memory. Once written down these are difficult to later dispute. Herein lies the trap – records of the sequence of events and vital signs may not be accurate when they are made retrospectively. They may introduce contradictions that tax the credibility of the anaesthetist when he or she is called to give evidence and present him/herself as a reliable witness. Anaesthetists should not therefore attempt to record precise values of vital signs and times retrospectively from memory; such detail should only be transcribed directly from the monitor’s electronic trend record.

Of course it is even better to make a hard copy of this digital trend record, but even this may need annotation of artifacts and incorrect recordings. Even in the everyday circumstances of uneventful anaesthetics, printouts of electronic trends paint a more realistic picture of events than the often optimistic “tram-lines” portraying what we would have liked to have happened rather than what actually occurred.

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