# The oblique view

**We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he looks at how to decipher patient's notes.**

## Making a note

**"You shouldn't do that!"**

This helpful piece of advice entered my left ear as I was poised to commit some thoughts on a patient's clinical state onto a page in the case notes.

"Do what?" I queried. (Admittedly, writing in the notes was a fairly rare event for me anyway, but I was nevertheless keen to learn of the latest element of healthcare protocol that I was just about to breach).

"Use blue ink; you're meant to write in black". . . And that was how this particular article started.

I do recall one colleague who sported at least three fountain pens: blue ink dealt with routine day-to-day entries (e.g. "angina no better"), whilst green related to tasks awaiting completion (e.g. "chase up old ECGs"). Red, however, as one might imagine, was employed to highlight issues of major concern (e.g. "no pulses – ?radial" or "aspirin intolerant – documented anaphylaxis with clopidogrel").

We accept that all the documentation related to our patients' hospital stay is contained in an ever burgeoning mass of paperwork enclosed in folders which grow steadily in volume – and volumes. All items of data are contained therein: correspondence, medical notes, nursing reports, anaesthetic records, contributions from dietitians, physiotherapists and occupational therapy. ECGs, EEGs, lung function tests and pathology results are interspersed with occasional glossy coloured prints of gastric mucosa or large bowel polyps.

Faded, royal blue, fountain pen entries recording out-patient visits in the 1950s and carbon copies typed letters to general practitioners, are now seen as just quaint rather than of major clinical value. Surgical operation notes, traditionally in red ink and which describe the "incision, findings, procedure and closure", are far more difficult to find as one wades through page after page. As our post-CABG patient lays waiting on the cath lab table for reinvestigation, we desperately search through this morass for the account of just which saphenous vein grafts were anastomosed to which coronary arteries.

Each department has tried to make their own contribution easier to identify. So ophthalmology, orthopaedics and vascular surgery attempt to make their pages stand out by having blue, red, or blue and red-striped edges, whilst gastroenterology and haematology use green (thankfully, not brown) and pink pages, respectively. It is only a matter of time before some department chances on white script on black paper.

Understandably, medico-legal concerns require such 'bumf' to remain available for years but the impact on the day-to-day handling of case notes is considerable. Indeed, a colleague actually published a paper in this very journal demonstrating that the notes of patients with chronic heart failure were significantly heavier than those from patients with other chronic conditions. Thus, the true burden of this disease could be properly quantified.

The "note trolleys" that accompany ward rounds have never been adequately designed to accommodate the reams of paperwork that they attempt to transport. As for the angled tables that sit at the end of every ITU bed, they are simply "not fit for purpose". The fiddle (a nautical term as it happens, which describes the raised rim on its lower edge) has never been made high enough to actually stop notes, pens – indeed anything – falling onto the floor.

**Decoding the pathway**

But now, a new and innovative supplement has crept into our bulging A4 folder. As if it was not big enough already, its straining seams have been further stressed by that unwieldy and unweadable (sorry, unreadable) document – namely, the care pathway. With the best of intentions, this committee-designed 'tool' plots the management of the more common conditions or procedures, in order that all the required, evidence-based steps can be monitored, checked and accounted for. If a specific element is missed, a blood test result ignored or a signature omitted, such "variance" can be traced and analysed.

Sounds great, yes? But in my experience such paperwork is not particularly easy on the eye and is far removed from the more traditional accounts detailing the presenting complaint, history of the presenting complaint, past medical history, etc. Surely the advantage of such a wad is that it ensures uniform care and

provides checks at appropriate points so that crucial decisions are not missed. But how often do we actually audit these tomes?

Doctors know full well that they are not top of the league when it comes to medical note keeping. Being renowned for illegible scrawl is all very well but it only takes an afternoon in a coroner's court (not me, by the way) to bring home just how bad we are at even the basic elements of documentation. No time, no date, no patient's name, no signature, no idea who has written what, let alone what was actually written. Bizarre acronyms like TLOC and FOOH ('transient loss of consciousness' and 'fell on outstretched hand'), sit alongside familiar examples like PERLA and NAD.

**'Post-it' clues**

I am constantly surprised by how often vital pieces of clinical information are scribbled on a 'post-it' and simply adhered to the front of the notes, rather than being documented within the folder at the appropriate place. More than once a little yellow or pink square has escaped from between the jungle of pages and fluttered innocently to the floor. It is only then that you notice a platelet count of 10, a potassium level of 6.5 or the fact that all but one of the patient's first degree relatives are interventional cardiologists in the US – phone numbers supplied – and are keen to discuss the patient's angiogram with you at your earliest convenience. And the other one is a lawyer.

Perhaps we feel so pressurised by our many and various commitments that we cannot donate the time required to sit down, unscrew the top of our Mont Blanc and scribe thoughtfully in the notes.

I have to confess that, in my occasional out-patient clinic, I never write in the notes – but that is not because of time pressure. I prefer to sit and listen (call me old fashioned) and then consolidate my thoughts in a dictated letter once the patient has left. This approach also avoids the sort of Pavlovian response that occurs when the patient notices that everything said is immediately followed by the attentive doctor scribbling furiously. This apparent "reward" results in the patient naturally assuming that you want to hear more. (A note of caution here – if you are trying this approach: don't lose the tape!).

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**● The complete collection of these and other articles will soon be available in a book 'The Oblique View'. Further details can be obtained from Nikki@tfmpublishing.com**