# Chart Warfare

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"No worries. Feel free to page if anything else comes up."

I hang up the phone and return to typing my notes. Someone from the emergency department had called to cancel a request for psychiatry consultation. There had been some earlier concern that a patient was hearing voices, but this worry turned out to be unfounded. As the on-call psychiatry resident, I find myself relieved to have extra time to catch up on work.

Later that night, curiosity is nagging, and I log back into the patient's chart to see what happened regarding treatment. A sentence toward the end of the emergency department note irritates me: "Consulted psychiatry, who did not feel patient warranted evaluation." This phrasing suggests that I did not want to see the patient, that I have shirked my responsibilities, that I am to blame if anything bad happens from a psychiatric standpoint. I know I should call the emergency department — or, ideally, go in person, chat with the team, and clear up any confusion. But I do not have that kind of time while on call, and I need my side of the story in the chart. Gritting my teeth, I open a note, chronicling the cancelled consultation request, my prior chart review and conversations with emergency department staff, and my availability for any consultation needs. I click sign.

I have just committed a cardinal sin in medicine: chart warfare.

Chart warfare is the practice of health professionals documenting in medical records their disputes related to clinical care, typically in ways that are not helpful to patients. Although this practice has not been well studied, the medical literature has long acknowledged the conduct of chart wars.[1,2] Some chart warfare is obvious, including outright refusals to assume care for patients with complicated medical needs, heated arguments over the evidence supporting specific diagnoses or treatments, and clashes about whether inpatients are ready for discharge. For example, a 1994 article on physician communication described a case in which an attending physician and an intern disagreed about the appropriate duration of antimicrobial therapy for a patient: "When the attending insisted on discharge home with an oral antimicrobial, the intern wrote in the chart that there were no good controlled clinical trials indicating that short-term parenteral therapy gave results comparable to conservative management with ten-day parenteral therapy. The ensuing 'chart battle' resulted in a two-day delay in the patient's discharge home."[1]

Yet many clinicians appear to be students of Sun Tzu, the military strategist who advised, "Be extremely subtle, even to the point of formlessness."[3] A great deal of chart warfare is conducted in subtle tones, using words or phrases that infuse medical documentation with judgment. Annoyed by a request to admit a patient, a consultant might write that a patient would be "best served" on another inpatient service. After paging a physician about a patient's insomnia, a frustrated nurse who wants to offer sleep medications to the patient might document, "MD aware, no orders received." Irked that a specialist has not returned phone calls about a referral, a primary care physician might write that she will "continue to wait" for a callback.

Digital technologies have further weaponized medical records. When scribbling broadsides in paper charts, health professionals are often limited to variations in handwriting, such as capitalization or underlining. With electronic medical records, clinicians can easily boldface text, italicize words, change fonts, adjust colors, and deploy previously prepared templates in airing grievances. I have seen clinical recommendations capitalized in bright red text, multiple abstracts from academic journals copied and pasted into assessments, and even the insertion of digital images in notes as part of modern click-to-click combat in medical documentation.

Chart warfare may feel vindicating in the moment, but health professionals should recognize its long-term harms. First, it tends to divide, rather than unite, health professionals, pitting us against one another in our work. When disputes arise in medicine, clinicians should strive to talk with one another, to understand opposing perspectives and to reconcile our differences. Criticizing each other from afar at separate computers, workrooms, and offices serves only to reinforce disagreements and to distance ourselves further from our colleagues.

Second, chart warfare leaves potentially unwanted trails of

medicolegal information. Given initiatives to expand patients' access to medical notes, patients may become privy to these clashes, which could affect their relationships with their caregivers. Patients can also request their medical records weeks, months, or even years after treatment, and what they find there could shape their retrospective understanding of their care. Although clinicians may participate in chart wars with the goal of protecting themselves against legal liability, unnecessary arguments between clinicians in charts, especially comments insinuating blame, could be misunderstood or taken out of context during any future legal proceedings.

Third, chart warfare shifts the focus of care away from the patient. Clinicians may use strong wording, adjust text font or color, or cite medical literature in charts in appropriate efforts to advocate for patients; but when they do so strictly to score points against colleagues or to cover themselves against all hypothetical liability, it is unclear how these practices help patients. A 2009 single-site study of 227 inpatient charts raised concern about how physicians "employ intergroup communication in a written form to win conflicts," noting that "patient care and satisfaction become secondary concerns" in these situations.[2]

Patients can benefit greatly when health professionals bring diverse views and backgrounds to clinical decision making. Still, amid ever-growing burdens of medical documentation, are there ways to capture these benefits while minimizing chart warfare?

When professional disputes occur, clinicians should avoid managing conflicts solely through medical records. As modeled by Rennecker and Godwin, workers can communicate synchronously (transmitting information in real time) and asynchronously (passively leaving information for each other).[4] Delays inherent to asynchronous communication, such as writing a note in a chart for someone to read later, can introduce barriers and foster misunderstandings between coworkers, particularly when disagreements already exist. In my experience, turning to more personal and synchronous forms of communication — face-to-face discussions,

meetings between teams, or even brief phone calls — during disputes can help us see that our colleagues are not faceless opponents but rather caring people who typically have good intentions.

Medical institutions can also take steps to curb chart warfare. For instance, a study published in 1996 showed that 32 residents reported 127 ethical disagreements with attending physicians in the previous year, but just 11 of those residents (34%) had discussed these disagreements with their attendings; 17 of 24 responding residents (71%) desired formal mechanisms for resolving ethical disagreements with attendings.[5] If clinicians lack outlets for resolving disputes and spend hours each day documenting care in medical records, chart warfare may be unavoidable. Some outlets for navigating disputes, such as grand rounds and morbidity and mortality conferences, have long existed in academic settings, yet more can be created. Training clinicians in conflict management, including raising awareness about the harms of chart warfare, might prevent disagreements from spilling over inappropriately into medical records. Exploring ways to encourage real-time conversations between clinicians during disputes might mitigate tendencies to assign blame or to deflect liability in chart notes to colleagues whom we've never met.

Lately, if I run into disagreements with colleagues, I try to think twice before reacting as I did that night on call and firing off a note to prove a point. Speaking with one another has become increasingly vital, as more clinical care is completed and documented electronically. Disagreements are part of the practice of medicine, but inscribing our gripes with one another into patients' charts need not be.

Disclosure forms provided by the author are available at NEJM.org.

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