

02 - 5.2 The Psychiatric Report and Medical Record

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reasons. Some are motivated by secondary gain (e.g., for financial resources, absence from work, or for a supply of medication). Some patients may deceive, not for an external advantage, but for the psychological benefits of assuming a sick role. As noted above, unconscious processes may result in events or feelings being outside the patient's awareness. There are no current biological markers to definitively validate a patient's symptoms. Psychiatrists are dependent on the patient's self-report. Given these limitations, it may be useful, especially when there is a question about the patient's reliability (possibly related to inconsistencies in the patient's report), to gather collateral information regarding the patient. This allows the psychiatrist to have a more broad understanding of the patient outside the interview setting, and discrepancies in symptom severity between self-report and collateral information may suggest deception. There are also some psychological tests that can help in further evaluating the reliability of the patient.

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5.2 The Psychiatric Report and Medical Record PSYCHIATRIC REPORT This section complements the previous section, "Psychiatric Interview, History, and Mental Status Examination," in that it provides a comprehensive outline on how to write the psychiatric

report (see Table 5.2-1). The need to follow some sort of outline in gathering data about a person in order to make a psychiatric diagnosis is universally recognized. The one that follows calls for including a tremendous amount of potential information about the patient, not all of which need be obtained, depending on the

circumstances in the case. Beginning clinicians are advised to get as much information as possible; more experienced clinicians can pick and choose among the series of questions they might ask. In all cases, however, the person is best understood within the context of his or her life events. Table 5.2-1 Psychiatric Report

The psychiatric report covers both the psychiatric history and the mental status. The

history, or anamnesis (from the Greek meaning “to remember”), describes life events within the framework of the life cycle, from infancy to old age, and the clinician should attempt to elicit the emotional reaction to each event as remembered by the patient. The mental status examination covers what the patient is thinking and feeling at the moment and how he or she responds to specific questions from the examiner. Sometimes it may be necessary to report, in detail, the questions asked and the answers received; but this should be kept to a minimum, so that the report does not read like a verbatim transcript. Nevertheless, the clinician should try to use the patient’s own words as much as possible, especially when describing certain symptoms such as hallucinations or delusions. Finally, the psychiatric report includes more than the psychiatric history and mental status. It also includes a summary of positive and negative findings and an interpretation of the data. It has more than descriptive value; it has meaning that helps provide an understanding of the case. The examiner addresses critical questions in the report: Are future diagnostic studies needed, and, if so, which ones? Is a consultant needed? Is a comprehensive neurological workup, including an electroencephalogram (EEG) or computed tomography (CT) scan, needed? Are psychological tests indicated? Are psychodynamic factors relevant? Has the cultural context of the patient’s illness been considered? The report includes a diagnosis made according to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). A prognosis is also discussed in the report, with good and bad prognostic factors listed. The report concludes with a discussion of a treatment plan and makes firm recommendations about management of the case.

MEDICAL RECORD The psychiatric report is a part of the medical record; however, the medical record is more than the psychiatric report. It is a narrative that documents all events that occur during the course of treatment, most often referring to the patient’s stay in the hospital. Progress notes record every interaction between doctor and patient; reports of all special studies, including laboratory tests; and prescriptions and orders for all medications. Nurses’ notes help describe the patient’s course: Is the patient beginning to respond to treatment? Are there times during the day or night when symptoms get worse or remit? Are there adverse effects or complaints by the patient about prescribed medication? Are there signs of agitation, violence, or mention of suicide? If the patient requires restraints or seclusion, are the proper supervisory procedures being followed? Taken as a whole, the medical record tells what happened to the patient since first making contact with the health care system. It concludes with a discharge summary that provides a concise overview of the patient’s course with recommendations for future treatment, if necessary. Evidence of contact with a referral agency should be documented in the medical record to establish continuity of care if further intervention is necessary.

Use of the Record The medical record is not only used by physicians, but is also used by regulatory agencies and managed care companies to determine length of stay, quality of care, and reimbursement to doctors and hospitals. In theory, the inpatient medical record is accessible to authorized persons only and is safeguarded for confidentiality. In practice, however, absolute confidentiality cannot be guaranteed. Guidelines for what material needs to be incorporated into the medical record are provided in Table 5.2-2.

Table 5.2-2 Medical Record The medical record is also crucial in malpractice litigation. Robert I. Simon summarized the liability issues as follows: Properly kept medical records can be the psychiatrist's best ally in malpractice litigation. If no record is kept, numerous questions will be raised regarding the psychiatrist's competence and credibility. This failure to keep medical records may also violate state statutes or licensing provisions. Failure to keep medical records may arise out of the psychiatrist's concern that patient treatment information be totally protected. Although this is an admirable ideal, in real life the psychiatrist may be legally compelled under certain circumstances to testify directly about confidential treatment matters.

Outpatient records are also subject to scrutiny by third parties under certain circumstances, and psychiatrists in private practice are under the same obligation to maintain a record of the patient in treatment as the hospital psychiatrist. Table 5.2-3 lists documentation issues of concern to third-party payers.

Table 5.2-3 Documentation Issues

Personal Notes and Observations

According to laws relating to access to medical records, some jurisdictions (such as in the Public Health Law of New York State) have a provision that applies to a physician's personal notes and observations. Personal notes are defined as "a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders." The data are maintained only by the clinician and cannot be disclosed to any other person, including the patient. Psychiatrists concerned about material that may prove damaging or otherwise hurtful to the patient if released to a third party may consider using this provision to maintain doctor-patient confidentiality.

Psychotherapy Notes Psychotherapy notes include details of transference, fantasies, dreams, personal information about persons with whom the patient interacts, and other intimate details of the patient's life. They may also include the psychiatrist's comments on his or her countertransference and feelings toward the patient. Psychotherapy notes should be kept separate from the rest of the medical records.

Patient Access to Records Patients have a legal right to access their medical records. This right represents society's belief that the responsibility for medical care has become a collaborative process between doctor and patient. Patients see many different physicians, and they can be more effective historians and coordinators of their own care with such information. Psychiatrists must be careful in releasing their records to the patient if, in their judgment, the patient can be harmed emotionally as a result. Under these circumstances, the psychiatrist may choose to prepare a summary of the patient's course of treatment, holding back material that might be hurtful—especially if it were to get into the hands of third parties. In malpractice cases, however, it may not be possible to do so. When litigation occurs, the entire medical record is subject to discovery. Psychotherapy notes are usually protected, but not always. If psychotherapy notes are ordered to be produced, the judge would probably review them privately and select what is relevant to the case in question.

Blogs Blogs or web logs are used by persons who wish to record their day-to-day experiences or to express their thoughts and feelings about events. Physicians

should be especially cautious about such activities because they are subject to discovery in lawsuits. Pseudonyms and aliases offer no protection because they can be traced. Writing about patients on blogs is a breach in confidentiality. In one case a doctor detailed his thoughts about a lawsuit that included hostile comments about the plaintiff and his attorney. His blog was discovered inadvertently and was used against him in court. Physicians are advised not to use blogs to vent emotions and to write nothing that they would not write for attribution even if their identity were discovered.

E-Mail E-mail is increasingly being used by physicians as a quick and efficient way to communicate not only with patients but also with other doctors about their patients; however, it is a public document and should be treated as such. The dictum of not diagnosing or prescribing medication over the telephone to a patient one has not examined should also apply to e-mail. It is not only dangerous but also unethical. All email messages should be printed to include with the paper chart unless electronic archives are regularly backed up and secure. Ethical Issues and the Medical Record Psychiatrists continually make judgments about what is appropriate material to include in the psychiatric report, the medical record, the case report, and other written communications about a patient. Such judgments often involve ethical issues. In a case report, for example, the patient should not be identifiable, a position made clear in the American Psychiatric Association's (APA's) Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, which states that published case reports must be suitably disguised to safeguard patient confidentiality without altering material to provide a less-than-complete portrayal of the patient's actual condition. In some instances, obtaining a written release from the patient that allows the psychiatrist to publish the case may also be advisable, even if the patient is appropriately disguised. Psychiatrists sometimes include material in the medical record that is specifically directed toward warding off future culpability if liability issues are ever raised. This may include having advised the patient about specific adverse effects of medication to be prescribed. Health Insurance Portability and Accountability Act (HIPAA) The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to address the medical delivery system's mounting complexity and its rising dependence on electronic communication. The act orders that the federal Department of Health and Human Services (HHS) develop rules protecting the transmission and confidentiality of patient information, and all units under HIPAA must comply with such rules. Two rules were finalized in February 2003: the Transaction Rule and the Privacy Rule (see Tables 5.2-4 and 5.2-5). The Transaction Rule facilitates transferring health information effectively and efficiently by means of regulations created by the HHS that established a uniform set of formats, code sets, and data requirements. The Privacy Rule, administered by the Office of Civil Rights (OCR) at HHS, protects the confidentiality of patient information. This means that a patient's medical information belongs to the patient and that the patient has the right to access it, with the exception of psychotherapy notes, which are deemed as property of the psychotherapist who wrote them.

Table 5.2-4 Transaction Rule Code Sets Table 5.2-5 Patient's Rights under the Privacy Rule

In 2003, the Privacy Rule was executed. Under the Privacy Rule, there are certain guidelines by which every practice must abide:

1. Every practice must establish written privacy procedures. These include administrative, physical, and technical safeguards that establish who has access to the patient's information, how this information is used within the facility, and when the information will

and will not be disclosed to others.

2. Every practice must take steps to make sure that its business associates protect the privacy of medical records and other health information.
3. Every practice must train employees to comply with the rule.
4. Every practice must have a designated person to serve as a privacy officer. If it is an individual practice or private practice, this person can be the physician.
5. Every practice must establish complaint procedures for patients who wish to ask or to complain about the privacy of their records. The OCR at HHS is responsible for making sure that Privacy Rule is enforced; however, it is not clear as to how it will be done. One method expressed by the

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