

8) M. Shepherd, B. Cooper, A. C. Brown, *et al.*, "Minor Mental Illness in London: Some Aspects of a General Practice Survey," *British Medical Journal*, Vol. 11, November 28, 1964, pp. 1359-1363.

9) J. Marmor, P. L. Scheideman, and C. K. Kanno, *Psychiatrists and Their Patients: A National Study of Private Office Practice*, Joint Information Service, Washington, D.C., 1975.

10) E. M. Heiman and M. W. Kahn, "Mental Health Patients in a Barrio Health Center," *International Journal of Social Psychiatry*, Vol. 21, Autumn 1975, 197-204.

11) B. A. Udell and R. K. Hornstra, "A Comparative Study of Neurotics Seen in a Community Mental Health Center and in Private Practice," *Hospital & Community Psychiatry*, Vol. 27, April 1976, pp. 269-271.

12) E. M. Heiman and M. W. Kahn, "Mexican American and European American Psychopathology and Hospital Course," *Archives of*

*General Psychiatry*, Vol. 34, February 1977, pp. 167-170.

13) M. Schwartzburg and A. Schwartz, "A Five-Year Study of Brief Hospitalization," *American Journal of Psychiatry*, Vol. 133, August 1976, pp. 922-924.

14) H. R. Spiro, I. Siassi, and G. Crocetti, "Cost-Financed Mental Health Facility: III. Economic Issues and Implications for Future Patterns of Health Care," *Journal of Nervous and Mental Disease*, Vol. 160, April 1975, pp. 249-254.

15) J. Grad and P. Sainsbury, "Evaluating the Community Psychiatric Service in Chichester: Results," in *Evaluating the Effectiveness of Community Mental Health Services*, E. M. Gruenberg, editor, Milbank Memorial Fund, New York City, 1966, pp. 246-287.

16) Ad Hoc Committee on Professional Standards Review Organizations, *Model Criteria Sets*, American Psychiatric Association, Washington, D.C., 1976.

## Paranoia and Progress Notes: A Guide to Forensically Informed Psychiatric Recordkeeping

**THOMAS G. GUTHEIL, M.D.**  
*Acting Director, Adult Inpatient Services  
Massachusetts Mental Health Center  
Boston, Massachusetts*

*Trainees in the mental health professions, and their teachers, might well use paranoia as a motivating force to make psychiatric records effective for forensic purposes, utilization review, and sound treatment planning. The utilization reviewer maintains a highly quantitative view, as if all forms of treatment were like poultices of a predetermined size and predetermined rate of application. The utilization perspective is, If it isn't written, it didn't happen. It is also important not to confuse progress with process notes; process material and conscious and unconscious content belong in a private set of notes, while the public records contain the facts. The author outlines other considerations, such as what to do at the realization that a significant detail was omitted from an earlier note and how to document a situation in which a clinically based calculated risk was taken.*

■ The subject of records and recordkeeping in psychiatry (as in any other medical field) is usually considered so boring as to represent an opiate more soporific than Mandragora. This view usually prevails until one's first appearance in a court of law with a case record as the subject of contention, and—in a near-miraculous metamorphosis—the boredom is instantly transformed into

terror. From this and other experiences emerges the conviction that we professionals could take a leaf from our patients' books and employ paranoia as a motivating force to stimulate ourselves to make our records effective for forensic purposes, utilization review, and—above all—sound treatment planning.

The following systematic approach is presented as a guide to trainees in mental health fields and their teachers; the goals are the raising of consciousness, the rude shattering of denial, and the inculcation of a proven approach and its attendant useful attitudes. A mock set of progress notes on a depressed married woman will serve as an ongoing example for consideration.

• *Paranoia as the reality principle.* We mental health professionals should face, with dispassionate resoluteness, the cold fact that certain people are out to get us. These people are called "lawyers," and the reason they are out to get us is simple: they are paid to do so. The plot is variously termed "malpractice litigation," "contemporary narcissistic entitlement," or "the American disease." The practice of suing thy neighbor for almost anything has become a serious contender for the title of the country's second favorite indoor sport.

These facts are familiar to anyone able to read a

Dr. Gutheil also is assistant professor of psychiatry at Harvard Medical School (Massachusetts Mental Health Center). His address at the center is 74 Fenwood Road, Boston, Massachusetts 02115.

newspaper and need not be belabored, but it is this reality-based paranoia that may serve as our stimulus in attempting to achieve records unassailable from the viewpoints of utilization review, forensic considerations, and treatment.

• *The utilization poultice.* To enter into the proper mind-set for effective recordkeeping, one must grasp the differences between the clinical and the utilization points of view. To the clinician, a number of phenomena may have therapeutic force: verbal interventions; empathic relationships; art, music, drama, and other modes of expression; and so on. The therapeutic effect of these modalities and their means of operation in the fluid, ongoing process are notoriously hard even to articulate, much less quantify.

In stark contrast to the clinician, the utilization reviewer maintains a highly quantitative view of treatment. It is very much as though all forms of treatment were like poultices of a predetermined size and a predetermined rate of application; thus psychotherapy poultices would be applied for one hour, twice a week, occupational therapy poultices would be applied for an hour a day, and so on. Clearly such a poulticed view permits rapid utilization review: one merely counts poultices. But this technique, in turn, requires clear listing and identification of the poultices to be counted.

It should go without saying that laments about the Philistine impact of such a view on the art of clinical psychiatry are utterly beside the point at issue. A host of trends presses us to point proudly to our poultices as unambiguous indexes of the smooth flow of treatment going on; these trends are not limited to negligence suits but include reimbursement by insurance companies and other third-party payers as well.

• *What you see is what you've got.* Much of clinical psychiatry, being more art than science, is ineffable; this truism might delude the novice into believing that one need not reduce the ephemera of treatment to the mere written word. Shifting to the utilization perspective, however, one perceives a more nearly fundamental truism: if you didn't write it, it didn't happen. This simple consideration is often hard to grasp in the here-and-now. One reasons, "I know what I'm doing" or "My colleagues know I would (or wouldn't) do that!" We are prone to assume, unconsciously and parochially, that a malpractice jury would be composed of friends, colleagues, well-wishers, and sympathizers who would intuitively assume we're the kind of folks who would never omit getting skull x-rays for anyone who hit his head in our hospital.

A moment's thought reveals the whole cloth of which this fantasy is woven. Consider this progress note:

"2/18/79—After a big fight in the OT room with sewing room occupational therapist, Mrs. Melancholicos entered a prolonged phase of negative mother transference to me; this may require more aggressive intervention, perhaps dream interpretation? Eating markedly less."

The note mentions occupational therapy, but there is no indication that OT is occurring as part of *treatment*.

While that might be inferred by an astute clinician, the utilization reviewer does not see the poultice and would thus feel no conflict about refusing to reimburse.

What is more, it is unclear if the patient was in the OT room by accident, oversight, or prescription of OT as treatment; each of these conditions would have its own criteria for assessment of the clinical care and judgment involved. The reason for the patient's presence would be of paramount importance if the fight involved injury, a fact also not recorded.

In addition, "eating markedly less" is a phrase masquerading as a poultice of the "medical evaluation" type. This masquerade is easily penetrated by its lack of quantification: input-output, daily weights, specific meals skipped, and, at very least, a *plan* to determine such quantities as the foregoing are clearly lacking. It is futile to protest that one did (or thought of) these things since, to the utilization reviewer or lawyer, it didn't happen because it wasn't written down. The limits of what is written down constitutes our fourth point.

• *The Books-of-the Month Club.* A progress note provides an illustration:

"3/10/79—Mrs. Melancholicos is beginning to realize in therapy that her Oedipal longings for her stepfather coupled with the incestuous gratifications by her biological father place her fragile defensive structure under great strain as the transference to me heats up. Her unconscious polymorphous perverse fantasies are emerging as latent homosexual conflicts in dreams."

The point can be succinctly stated: the writer has confused process notes with progress notes. As a solid rule of thumb: there is no room for unconscious fantasies in a public record. (And—because of the subpoena—all records are potentially public). The Solomonic solution is two sets of books. While that is a bad approach to public funding, accounting, and embezzling, it is forensically sound recordkeeping. Pragmatically it means that process material, conscious and unconscious content, and the like belong in a private set of notes. Some experienced practitioners use an idiosyncratic code, shorthand, personal abbreviations, or crypticisms; others avoid putting the patient's name explicitly on these records to further ensure confidentiality. If these practices seem excessive, a brief consultation with Mr. Daniel Ellsberg's psychiatrist—the doctor whose personal files were burglarized during the Watergate scandal—is recommended.

Note that no kinds of records are proof against subpoena. However, a "front set," organized from a utilization viewpoint, will serve the overwhelming majority of purposes of referral, consultation, reimbursement, and peer review.

In the public record—the ward record, the clinic file, or the "front" file for the private office—go the "facts": an aggregation of observable data, poultice-rich, that indicates attention to the problems at hand and shows (documents, actually) the progress of the case. The Weed system or other problem-oriented approach fits more uneasily into psychiatry than into the rest of medicine, but such utilization-review-based operational ap-

**In writing progress notes, trainees are urged to hallucinate on their shoulder the image of a hostile prosecuting attorney who might preside at the trial in which their records are subpoenaed.**

proaches can be very helpful in keeping a poulitced perspective.

Part of the issue here is the fact that, while minimum standards and requirements for recordkeeping exist and are supported by statute and accreditation guidelines, there is no maximum standard; there is a floor, but no ceiling, on what to write. This realization may help to curb excessive prolixity.

We now turn to approaches to the question of how one monitors or selects what goes into the public record.

• *A lawyer on my shoulder is a monkey on my back.* Consider this note:

"4/15/79—Mrs. Melancholicos describes unusually heavy menstrual bleeding for eight days, shortly following my interpretation that her husband's phone call was like unshed tears; out of spite she stubbornly refuses the interpretation at the conscious level."

In addition to the process-progress confusion mentioned earlier, there are two points to note. First, the description of menstrual bleeding (for whatever reason it may occur) screams for a "medical evaluation" poultice (gynecologic consult, blood studies, and the like), and there is no sign from the record that the occurrence was noted (much less responded to) as other than a dynamic issue.

Second, the writer attributes the patient's rejection of an interpretation to spite. While "out of spite" may represent an assessment of the patient's mental state that is almost telepathically accurate, it would sound to the lawyer (who may, let us recall, read it aloud in court someday) judgmental, prejudicial, and hostile. And, related to a claim of possible negligence toward this patient, it would become rather more difficult to convince a jury that, in all other parts of the patient's treatment, the doctor maintained a dispassionate, Hippocratic, and conscientious scrupulousness.

As prophylaxis against such a regrettable denouement, I recommend to my trainees that they deliberately hallucinate upon their right shoulder the image of a hostile prosecuting attorney who might preside at their trial, and that to this visual hallucination they append the auditory impression of the voice most suited to it. It is the kind of voice that might well declaim, "Now then, Doctor—you *are* a doctor, aren't you?—what are we to make of this three-word remark lifted

out of context from volume 2 of this record?"

Having achieved this goal-directed transient psychotic state, the trainee should then mentally test out in that context the sound of what he or she is about to write. This atmosphere is very different from the forgiving, heuristic, supportive, and clinically centered milieu of peers and colleagues in which much of psychiatry is carried out. As the title of this section hints, this practice can rapidly become addictive, and a very useful addiction it is, too.

One should also keep solidly in mind the need for sound documentation for such possible future events as a hearing. Such forensic events often stand or fall on the clarity and specificity of documentation. Another possibility should be anticipated: a possible felony in relation to the patient would require carefully recorded distinction between allegation without observation ("the alleged crime" should always be so described) and observation proper ("The patient assaulted a staff member at 3 p.m.").

• *The mill that grinds meds.* Psychiatric outpatients and inpatients are commonly on medications for long periods of time, often on unchanged regimens. While the regimen may be clinically appropriate, its repetitiveness may breed an inappropriate tendency not to review same. A highly useful habit to develop—not only for ease of utilization review or consultation but for the optimal planning of treatment—is, at each appointment, listing the medications in a standard place (start or end of note). This practice encourages review as well as documentation of prescription refills, side-effects, and other pharmacologic data.

• *Here come de fudge.* There is a potential pitfall in the lawyer-on-shoulder approach; the novice may be tempted to apply it retrospectively and plug into previous notes the significant but forgotten details. This is occasionally referred to as "fudging" and is as self-defeating as it is useless. Clearly the best approach is to note the details the first time around, but, even for the best of clinicians, omissions may occur. The soundest approach then is candor. Noting the present date, one states something like: "Reviewing the notes of August-September, I find no mention of. . . ." Such brief updates, made when the omission is noted and—one hopes—before the subpoena arrives, can fill in gaps while preserving integrity and forensic validity.

One should also avoid the temptation of excessive optimism in forecasting the future lest it be seen as a promise that one is expected to keep, regardless.

• *Time and tidings wait for no man.* Despite the timelessness of the unconscious and the lengthy time course of therapeutic change, certain events evolve at an accelerated pace that should be reflected in their recorded account. If a patient falls out of bed, if a phone call comes with particular news about a patient or from a patient, if a patient escapes from a hospital or when the absence is first noted, these events have an hour-and-minute precision that is not shared by the lifting of a depression or a psychosis. Malpractice suits, it must be obvious, have been won or lost on matters of timing

such as the above. For this reason alone, as well as for the clinical need to reconstruct events with accuracy, the use of time notations (as well as dates) is a useful habit to develop.

• *Multidisciplinary denial.* The naive reader of the foregoing may assume that only physicians need to be concerned with this level of meticulousness. That is, of course, utter denial. Reality dictates unequivocally otherwise as increasing numbers of psychologists, social workers, nurses, and aides are named as defendants or co-defendants in suits. Though I know of no specific example, I could envision even an occupational therapist's being cited for negligence in connection with a patient's using a craft tool for self-injury. Thus being a nonphysician is no protection against litigation. However, sound recordkeeping may well be partial protection.

• *Non-Schneiderian thought broadcasting.* The usual notes on patient care, then, should be austere but complete, factual, anticipatory, and well-poulticed. There are certain situations, however, whose very nature requires a modification of the basic approach, a modification perhaps best characterized as "thinking out loud for the record." These problem situations have in common the factors of uncertainty, the taking of clinically based calculated risks, trial-and-error empiricism, and the like.

A typical example might be the decision not to hospitalize a suicidal patient. Not hospitalizing the patient is often clinically wise but, after a given patient commits suicide, even the soundest decision may appear dubious in hindsight. And, we must recall, it is with hindsight that the evidence at the trial is presented. It is unfortunate that juries often have difficulty seeing that for a treatment to be 80 per cent effective, two people out of ten must succumb to dismal failure—and one of the two (or their next of kin) may be the plaintiff—without any aspersion being cast on the treatment itself.

There is no absolute defense against this problem, but "thinking for the record" stacks the deck heavily in favor of a finding of error in judgment rather than negligence. The following disguised composite example demonstrates how it might occur.<sup>1</sup> The critical issue is the decision not to petition for involuntary commitment for a chronically suicidal borderline patient who is signing out against medical advice (AMA).

"3/9/79, 3:50 p.m. Patient submitted AMA paper on 3/6/79. Filing for commitment was again (3/7) considered, given his recent assaultiveness and propensity for self-injury on 2/26. In reviewing the situation with Dr. Supervisor and staff, we agreed that commitment at this time would only produce further regression for the patient. Continuing hospitalization could not be expected to improve his ability to care for himself or, as per consultation on 3/8 from Dr. X [an outside consultant who conferenced the case], significantly protect the patient from suicide in the hospital. His history further

suggests he is capable of recompensating outside the hospital, and his inclination for self-injury appears to increase with on-going hospitalization (see progress notes December through February).

"We are also aware of the risks for this patient in regard to chronic suicidality; however, commitment at this time would only further erode his responsibility for his own life and might well produce intensified acting out on the ward with little reduction in seriousness of self-destructive behavior.

"At the suggestion of Dr. Attending, the patient was asked to negotiate a planned discharge; he consistently refused this offer. A day care program was offered, but again without acceptance. The patient understood that we could not fully support his discharge plan and therefore we consider the discharge AMA.

"The discharge plan involves [here follow specific details of the discharge plan, including the date and time of the first outpatient appointment, the precise doses of medication, and so forth]."

Several comments can be made about the example. Note, first, that specific dates and names are included, showing that the treating professional did not operate alone and unchecked in making this difficult but commonly encountered decision. Note the careful articulation of the pros and cons, including known risks and disadvantages and the reasons for overriding them. Note the demonstrated flexibility of options offered the patient, avoiding the image of "Do it my way or else."

Note, further, the details (only alluded to in the sample) of a treatment plan designed despite the fact that the patient isn't following the prescription. Note documentation that the against-advice situation has been discussed with the patient, an approach that goes beyond merely obtaining the patient's signature on an AMA form. And, finally, note how treatment planning builds explicitly on past observed (and recorded) data.

As a general rule, the more uncertainty there is, the more one should think out loud in the record.

Although the above illustration is a highly charged example of a particularly stressful clinical decision, we might underline the fact that, after all, the fundamental purpose of records is to aid treatment planning in general. Thus the paradigm of a plan built on observed, recorded, and repeatedly reviewed clinical data holds good across the board for clinical recordkeeping.

It is sobering to realize that while in theory honest error is separable from negligence, in practice juries often confound the distinction; there is no infallible protection against this fact of forensic life. The principles outlined in this review, however, set the records of clinical care on a solid footing that permits some freedom from trepidation, and in these paranoid times that is a significant freedom indeed. ■

<sup>1</sup> The author is indebted to Richard Kessler, Ph.D., for this clinical example.