

# The Psychiatric Note in the Era of Electronic Communication

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The electronic medical record (EMR) is a central component of health care reform and is already implemented in many settings (Blumenthal, 2009). Some clinicians may find this a desirable and others an undesirable development (Baron, 2007; Garg et al., 2005; Mangalmurti et al., 2010; Sittig and Classen, 2010); however, increasing numbers of mental health clinicians now face the challenge of using the EMR wisely and therapeutically in settings in which such systems are now, or soon will be, operative (Mojtabai, 2007). This article illustrates how the EMR can be used to benefit patients and providers while understanding that as with all change there are potential anticipated and unanticipated problems.

In most ways, the psychiatric note in the EMR is not radically different from traditional notes in paper medical records. The EMR note continues to address the tasks of documenting the psychiatric assessment, current treatment regimens, outcomes, and future treatment steps. However, the legibility and accessibility of EMR notes greatly increase the degree of “sharedness” of treatment assessment and planning with cotreaters and patients. The increased degree of “sharedness” of the EMR can foster treatment continuity and effective communication between a team of providers. To reap these benefits, the EMR requires us to produce clear, comprehensive but relatively brief notes. Although clear concise notes were desirable in the paper-based medical record, the EMR makes such notes essential.

The EMR will be more readily available to the patients and other clinicians, potentially posing issues for the patient clinician alliance but also potentially increasing the opportunities for greater clinician-patient collaboration. While the paper charts were always “permanent,” the new accessibility of an EMR results in notes that are also more easily retrieved. This raises concerns regarding potentially “sensitive” information discussed during mental health treatment.

We illustrate the potential benefits and clinical concerns using 2 clinical vignettes in 2 different treatment settings.

Dr. A and Dr. H work in settings in which the EMR is being introduced. Dr. A works in a tertiary care academic medical center and treats Mr. J for depression and narcissistic personality disorder with combined medication and psychotherapy. An EMR would make the diagnosis of narcissistic personality disorder more transparent and result in a discussion between Dr. A and his patient that may enhance or threaten their working alliance. Dr. H works at the local community mental health center and treats Mr. B for schizophrenia. Mr. B has ongoing delusions regarding a computer chip in his head, and may react poorly to the news that his notes are now available in electronic format.

## “SHAREDNESS” NECESSITATES INCREASED CLARITY

EMR notes benefit from “built in” legibility but clarity is also required to promote therapeutic and treatment objectives. Clarity requires the use of common language, effective organization of thoughts, and conciseness that highlights the key information from a visit. Dr. A and Dr. H first considered the need to produce clear notes that would communicate important treatment details not only for their own use, but also for colleagues making treatment decisions for shared patients, and for patients who might now want to review their records as part of their treatment.

One way to enhance the clarity of a widely shared note is to use a template, more commonly used in the EMR than in paper records. Templates are structured notes that specify information to be documented using a variety of automated methods (i.e., drop down boxes, text fields, or prefilled domains). Templates may contribute to the organization of medical information and also remind the clinician to gather and document essential elements of a clinical encounter (i.e., automatically remind when a lithium level is needed). However, if they are not thoughtfully designed or used, templates can result in generic “cut and paste” notes in which important details of the treatment are omitted and therefore likely to be forgotten (Thielke et al., 2007; Wrenn et al., 2010). Including both

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free text and fixed choice options can facilitate appropriate documentation of thought processes and clinical information (LoConte et al., 2008; Payne et al., 2006; Plovnick, 2010).

### USING THE EMR IN TREATMENT

Dr. A and Dr. H also wondered if EMR documentation could make the medical record a therapeutic tool. Potentially, sharing data on medications, laboratory results, symptom severity scales, and assessment could turn the EMR into a new opportunity for patient engagement and collaborative decision making (Blumenthal, 2010; Plovnick, 2010).

The EMR forced Dr. A to reconsider his practice of avoiding discussion of certain issues. Previously, Dr. A documented diagnoses of personality disorders in the unshared record, but did not disclose these diagnoses with patients or other providers. Doing so would require a significant shift in his approach. Dr. A needed to consider whether to avoid documenting personality disorders in the EMR or to begin disclosing the diagnosis to patients and other providers. Because Dr. A felt this diagnosis was critical to the treatment, he elected to discuss it with Mr. J. Mr. J was first aghast at the label, but discussion ultimately facilitated greater awareness about how his personality style affected his relationships. These discussions of what would be documented in the EMR note became a part of the therapeutic process.

The treatment of Dr. H focused on daily activities of Mr. B, improving coping strategies and achieving mutually agreed upon goals. Although Mr. B's diagnosis of schizophrenia was mentioned at annual treatment plan reviews, it was not a focus, and after several years of treatment his delusion regarding the computer chip in his head was rarely discussed. Dr. H worried if Mr. B saw his medical record that this would adversely impact their therapeutic alliance. When the EMR was introduced, Dr. H thought that it was important to explain this new system for keeping medical records to all of her patients. Not surprisingly, Mr. B was very concerned about the use of a computer for storage of his information and communication between medical providers. Dr. H and Mr. B needed to spend considerable time processing diagnostic, treatment, and documentation issues. Both found it useful to have easy access to all of his somatic care, since Dr. H examined Mr. B more frequently than did his primary care physician. Dr. H was able to explain laboratory findings and provide additional education about his medical diagnoses and convey this to his primary care physician.

### PRIVACY

Another goal of the EMR is to develop a life-long patient record for current and future providers. Such records raise important questions such as: "Who has access to what information?" "What should be included in the note?"

Mr. J insisted that the information related to his interpersonal functioning be in a private section of his record accessible only to himself and Dr. A, not to other providers. After discussion, Dr. A and Mr. J agreed that his depression diagnosis and antidepressant medication would be recorded in the EMR because of its potential importance for high-quality decision making by cotreating clinicians. Other information, including the diagnosis of narcissistic personality disorder, would not be recorded in the EMR. Dr. A consulted with his institution regarding whether or not a "shadow record" of other information that might be helpful for psychotherapy could be kept separately in his own files.

Mr. B had a history of violent decompensations when he stopped his medications, and he was worried that any provider with access to his record would think he was "a violent mental case." Mr. B's concerns were further heightened when his urologist insisted on speaking with Dr. H for an assessment of Mr. B's capacity to consent to a prostate

biopsy. Dr. H and Mr. B spent significant time discussing the EMR, the reason for the EMR to include information about Mr. B's relapses when off medication, and the fact that the urologist would consult this record. They then collaborated in writing a note that underscored Mr. B's current strengths, treatment adherence, and ability to make responsible decisions regarding his surgery.

### CONCLUSIONS

The EMR marks a significant change in both medical and psychiatric documentation. There will be no uniform national EMR standard, leading to variability in policies regarding both access and content of the psychiatric note. Clinicians who would like to wisely and skillfully write EMR notes must balance the potential benefits of transparency and access—which may promote better coordination among treatment providers and increased shared patient-provider decision making—with the drawbacks of difficult therapeutic discussions and concern about decreased patient privacy.

To date, there has been little research or teaching about the EMR note writing or how to meet these varied goals. Despite our concerns and anxieties, many mental health providers find themselves in a position where they must use the EMR and where the EMR clinical note forms the center point of communication with other providers and patients (Drake et al., 2010).

It is critical that we, mental health providers, think through the issues involved in writing EMR-based notes and retrain ourselves to write with clarity and brevity. We recommend that providers have discussions regarding EMR note content with their patients, balancing privacy and therapeutic benefit, and use the note to promote treatment collaboration. We must remember that with a shared EMR, information is more easily accessible. To take advantage of this new capability and to maximize benefits while minimizing drawbacks, notes should be written to facilitate shared decision making and strong working alliances and avoid content that will be counter therapeutic or misunderstood by patients and other providers.

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