PSYCHOLOGICAL TREATMENT RECORDS in MALPRACTICE CLAIMS

Albert M. Drukteinis, M.D., J.D.

It is almost axiomatic today that adequate records are necessary for proper tracking of psychological treatment and as a defense for potential malpractice claims. Although the quality of records may vary, psychologists are paying increased attention to them. In institutions such as psychiatric hospitals or psychiatric units in general hospitals, formalized documentation systems have been established through internal policy or pressure from regulatory agencies like the Joint Commission of Accreditation of Hospitals (JCAH), the Health Care Finance Administration (HCFA), and private third-party insurance payers. Similar formats for psychological records have made their way into community mental health centers and other psychological care facilities. Initial psychological records will include background and historical information regarding the patient, mental status and observational assessments, psychological testing results, physical examinations where indicated, diagnostic formulations, treatment recommendations, estimated lengths of stay, and legal documents for consent to accept treatment, release of information, and a patient's bill of rights. Because institutional psychological treatment has moved to a multidisciplinary approach, various professionals can participate, and may even be required to participate in the treatment: psychiatrists, psychologists, social workers, case managers, nurses, mental health workers, etc. Typically, each will provide their own individual assessments from which a multidisciplinary treatment plan is formulated and recorded, and then signed by each of the disciplines' representatives. During the course of treatment, progress notes are kept, again by each of the disciplines independently, with periodic treatment plan review by the team at a frequency established, again, by internal policy or regulatory agencies. Records of medication administration, safety and suicide checks, levels of restrictions and passes, unusual incidents, family meetings, discharge planning, follow-up recommendations, contact with outpatient treatment providers or other care facilities, all contribute to create a substantial mass of documented information. There is no question that documentation helps provide accountability for treatment and forces reflection on the treatment direction. It is not clear, however, whether this extraordinary time commitment has led to proportional improvement in patient care and, contrary to what might be assumed, whether it has led to improved protection against malpractice claims.

The size and complexity of psychological treatment records are a phenomenon only of the last couple of decades. While psychoanalysts of the early part of this century might have kept records of their psychoanalytical explorations through the patient's unconscious, these so-called *process notes* were not considered an official record of care; official records were sparse. The process notes often contained very intimate, free association ramblings, symbolic references, descriptions of deep sexual and aggressive urges, which were loosely related to the context of everyday conscious life. They were more for heuristic value than a log of the patient's actual progress in treatment. To the non-analytically trained observer, those notes could appear sordid and shocking - for example, references to sexual fantasies toward one's mother may be a benign exploration of the Oedipal complex to an analyst, but appear as a perverted, sexual deviancy to anyone else. Even today, process notes from insight-oriented psychotherapy or formal psychoanalysis are frequently kept out of the patient's record for that reason, and erroneously presumed to not be legally discoverable. The fact is that most lawyers do not know that those process notes exist and, with routine requests for medical records, will not obtain them. Obviously, there is potentially damaging information in those notes for any litigation, especially malpractice claims, and they will require a great deal of sophisticated explanation to neutralize.

Psychiatric institutions during the same era, both state and private, were the places where most psychiatric treatment of the mentally ill occurred. Records from these institutions would

typically include some historical information, mental status and physical examinations a diagnostic formulation, necessary legal forms, and treatment recommendations. Treatment progress might be contained in brief notes written every few days initially and then monthly, or less, later. Because many patients, prior to deinstitutionalization and discovery of the hewer psychotropic medications, might spend years at the institution, it would not be unusual for one or two notes per year to be the only psychological treatment record. Of course, today, we may be surprised by the paucity of treatment records for these patients compared to our modern documentation. Yet, just as in all of medicine, the extensive focus on documentation has taken away from personal contact with patients. Furthermore, while attempting to protect mental health providers from unwarranted malpractice claims, it may have inadvertently given those claims more ammunition.

Psychological treatment presents unique problems for documentation and record keeping which are not faced in other types of medical treatment. In the first instance, when multidisciplinary treatment is involved, each of the disciplines provides its own formulation of the problem, treatment plan, observations, and record of progress. Automatically, this compounds the amount of information in the records by the number of professionals who provide that input. Second, treatment is longer for the same psychological condition than for a more circumscribed medical malady. Weeks or months of hospitalization in serious psychological disorder s is not unusual, and months or years of outpatient treatment is commonplace. Therefore, the size of the treatment record grows exponentially; hundreds or even thousands of pages, especially in chronic cases, are frequently seen. Regardless of how coordinated a multidisciplinary treatment team is, or how much joint discussion takes place in treatment planning, individual members of the team still retain their own perspective. Their observations and opinions will differ based on the theoretical framework of their discipline, the context of their observations, and other personal variables. They will often differ on what aspects of the patient's progress they emphasize or ignore. The vague nature of psychiatric diagnoses, with overlapping criteria and lack of laboratory or tissue pathology, also contribute to the various types of opinions which are generated in the same case. In addition, over the course of time, there is turnover in most treatment facilities, so that new people within the same discipline are added, bringing their own unique perspectives. As a consequence, it is almost impossible to find a psychological treatment record which does not regularly have contradictions, inconsistencies, or mistakes. If the patient has been to more than one facility, contradictions are expected. In the courtroom under cross examination, those contradictions can appear more egregious than they actually are, given the massive record which may have accumulated.

A number of specific areas in psychological treatment records are particularly troublesome, and are often isolated as evidence of psychological malpractice. One of these, which is also the frequent subject of malpractice claims, is the prevention of violence to self or others. Suicide is still one of the leading causes of death in this country and mental health providers are now often being sued for failing to prevent it. Recording a patient's suicidal fantasies or wishes, as well as steps taken in response, are part of necessary documentation. But, once recorded, this information appears to establish foreseeability of suicide for which control is now required. Yet, thousands of patients describe similar feelings which they never act upon, and knowing which patients are genuine risks may often be impossible to determine. When a patient is found to still be cooperating with treatment, recording within the record of a *contract* in which the patient agrees to notify the therapist if the urges become stronger, is a popular technique. Unfortunately, it may not have much realistic value, since patients break these imaginary contracts all the time. Similarly, recording *suicide checks* on a psychiatric unit is a routine procedure that may be limited in its value. While it appears to represent a safeguard for suicidal patients, and in some instances may disclose a despondent or actively suicidal individual, in practice it tends to be a perfunctory procedure. Considering that fifteen-

minute checks, for example, would involve almost a hundred documentations per day, it is doubtful that much serious assessment can take place other than an eyeball of the patient. How much can be ascertained in this cursory observation? Even if some conversation takes place each time, by the fiftieth or so check of the day, does the question "Are you feeling suicidal?" have any value? Still, recording of these checks has assumed a prominent status in psychiatric units as well as in courtrooms where the presence or absence of checks is scrutinized closely.

Recording that a patient is dangerous to someone else either because of a general propensity or because a specific individual has been identified, is also a standard practice. The same issue of foreseeability is here as well, since a record of violent thoughts appears to establish foreseeability. However, part of psychological treatment is to allow patients to discuss their aggressive and hostile feelings, most of which may be only figurative and never materialized. The mental health provider, therefore, faces a serious dilemma in whether to record these thoughts or not, since that may imply a duty to warn a potential victim or to move for involuntary commitment. If patients are aware that their most Private violent thoughts, fanciful or otherwise, are being recorded, is it likely that they will ever share them with their therapist? Hock will they then learn to deal with them?

Confidentiality in general is a major concern in psychological treatment records. Although no absolute therapist-patient privilege exists most patients still assume that the treatment relationship is confidential. Even while they see a therapist recording information, they do not believe it is for distribution. indeed, psychological therapy does not work unless patients are willing to be candid about their most personal matters. It should be well known, though, that psychological treatment records are discoverable. They are almost always discoverable when the patient has raised his or her mental state at issue in litigation. In addition, the patient's mental state is sometimes raised at issue by other family members in a divorce or child custody proceeding, so that the court may have a legitimate interest in the patient's mental condition. There are situations where psychological treatment records are also discoverable by a defendant in a criminal proceeding and the f ill extent of this is now in heated debate throughout the country. Finally, the era of managed care has gutted confidentiality substantially. Treatment reviewers have access to detailed psychological histories of patients and computer files of insurance companies may be accessible to unknown numbers of people. Patients have little say in the matter, since reimbursement for services depends on adequate documentation of need for treatment and requires sufficient psychological data to establish that need. For mental health providers, therefore, to record or not record - that is the question? Recording may jeopardize the patient's interests; not recording may jeopardize the providers; recording too much, may jeopardize both. The psychological treatment record may have mushroomed to become a curse While clearly, good documentation should assist the treatment effort and protect providers, in many instances it does neither. Instead, voluminous information by individual or team providers allows more room for attack especially in malpractice claims where the larger the record, the more likely the assumed error.