

I. Conflicting Principles and Priorities

The issues considered in the following paragraphs highlight an irreconcilable conflict between two important principles. On the one hand, medical-legal principles indicate that the medical record should be complete, factual, and accurate. On the other, the growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record lest this expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in every individual clinical situation must be free to use their judgment in facing this dilemma. What follows is a consideration of the issues involved; it is not a standard and is not binding on members of the APA.

Documentation of any medical procedure serves multiple purposes and is generally required by state statute, case law, and/or the bylaws of health care organizations. Documentation is a medical and legal record of assessment, decision-making, general management, and specific medical treatment. It should be factual, legible and accurate. The record traditionally serves to provide clinical care, supporting continuity in the care of the patient by the treating psychiatrist or successors. Secondly, with the patient's specific, delimited, written, informed consent, the medical record can also be referenced to verify that services actually took place or to evaluate "medical necessity" of services rendered for purposes of claiming third party payment. (This usage of a record of psychotherapy is, however, considered by many practitioners to be incompatible with the practice of psychotherapy; it is illegal in the District of Columbia.) Furthermore, the medical record may become evidence in litigation for a variety of purposes, including professional liability, where documentation may make a significant difference in the exposure of the treating psychiatrist to risk (Psychiatrists' Purchasing Group, 1994).

Despite ethical standards and varying degrees of legal protection of confidentiality of the doctor-patient relationship, medical records may be open to disclosure in unanticipated ways that are beyond the control of the patient or the psychiatrist, as in the case of mandated reporting laws or other statutory exceptions to confidentiality. Such potential intrusions present risks to the integrity of psychotherapeutic treatments. The psychiatrist should use all available legal means to protect the confidentiality of any record of psychotherapy

Psychiatric treatment, and especially psychotherapy, involve sensitive, personal information about the patient and other people in the patient's life. The patient reveals this information to the psychiatrist in the faith and trust that it will be used to advance the treatment and that no information from that treatment will be revealed to any other person without informed consent for disclosure. In a landmark ruling pertaining to the admissibility of evidence in Federal courts, the U.S. Supreme Court has explicitly acknowledged the absolute privilege of any information pertaining to a psychotherapy (*Jaffee vs. Redmond, 1996*) as being essential to

effective treatment.

Data regarding the diagnosis and treatment of substance abuse are also protected at a higher standard than other medical records by Federal law; this protection comes through a different legal pathway and thus cannot be quantitatively compared with the protection of psychotherapy by the Supreme Court. The American Psychiatric Association is committed to seeking maximum protection of the confidentiality of psychiatric records.

The fact that it is now technically feasible to computerize medical records and transmit them electronically presents a greatly increased vulnerability to unauthorized access that may compromise confidentiality and could significantly harm to the patient. There is no consensus that any security system exists that absolutely protects electronic records in data banks from human error or malice. Although the same risks pertain to paper records, access to electronic records may be easier to accomplish and more difficult to detect. Recording psychotherapy content or process in electronic systems beyond the direct control of the practitioner (and professionals in an organized setting who are collaborating in the patient's care) would place a patient's private thoughts and acts at such grave risk of unauthorized disclosure as to make treatment impossible.

Psychotherapy is a crucial part of the training of psychiatric residents. As a part of this training, residents must learn how to document psychotherapy in the medical record while maintaining confidentiality. They need to understand those instances when documentation conflicts with and potentially jeopardizes the confidentiality upon which the effectiveness of the psychotherapy is based. The same emphasis on maintaining confidentiality in documentation should also be addressed in the continuing education of practicing psychiatrists.

What follows is a suggested format, not a standard of practice, for documentation of psychotherapy by psychiatrists. It does not address issues involved in the process of releasing information to third parties², but it considers how the possibility of such release may affect documentation procedures. This discussion does not necessarily reflect current practice of documentation of psychotherapy throughout the profession. Variations occur because of state law and the requirements of individual clinical situations. The extent of documentation may vary from session to session and depends on the treatment method and intensity. A patient and/or a psychotherapist may prefer that there be no documentation, although this can pose significant risks to the practitioner because of the absence of contemporaneous documentation that can serve as evidence to support the standard of care provided. It is not unethical for the psychiatrist to refrain from keeping a written record of the psychotherapy, and this may be regarded as the clinically appropriate course of action. In some states, however, documentation is explicitly required under law.

APA's ethical principles state that "Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient." And, "Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact." The psychiatrist should be mindful of the cautions stated in these

principles when writing medical records in general, considering how likely it is that the records might be viewed by others and thus become a vehicle for disclosure. Entering any notation of psychotherapy process or content requires even greater circumspection.

II. Suggested format for documentation of psychotherapy by psychiatrists

1. *Clinical judgment.* The growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record in order not to expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in each individual clinical situation must be free to use their judgment in coming to terms with this dilemma.

2. *Variation in documentation procedures.* Variations in documentation procedures may necessarily occur because of state law or the requirements of individual clinical situations. The latter may include a patient's request or the clinician's judgment that there be no identifiable documentation. It is not considered to be a violation of professional ethics to keep only administrative records and no therapy notes. Possible legal ramifications may vary based on geographic location.

3. *Initial evaluation.* The record of the patient's initial evaluation should accord with generally accepted procedures for conducting and documenting an initial psychiatric evaluation, which are beyond the scope of these recommendations. It is important that the individual clinician use judgment in regard to what information is included in the evaluation report so as not to jeopardize the patient's privacy or confidentiality. An initial evaluation may be done and documented by another psychiatrist.

4. *Concise, factual documentation of psychotherapy while respecting the privacy of the patient's mental life.* Characteristically, psychotherapy notes should concisely record only factual, administrative material regarding the psychotherapy itself, such as the date, duration of the session (some Medicare carriers want documentation of the clock time of starting and ending the session), procedure code, and/or category of psychotherapeutic intervention (e.g., psychodynamic therapy, supportive therapy, cognitive restructuring, relaxation or behavioral modification techniques, etc.). Depending on the security of the patient record in the particular treatment setting, some practitioners may also include a brief listing of major themes or topic(s) addressed, whereas others would consider this an unacceptable risk to the confidentiality of privileged communications.

5. *Documentation of psychiatric management.* Records may include other descriptive and factual information, not related to the process or content of psychotherapy, which may provide a record of responsible, diligent psychiatric management and be valuable both to patient care and to the psychiatrist in case of untoward developments. Examples of such information are: notable events in the treatment setting or the patient's life, clinical observations of the patient's mental and physical status, documentation of the psychiatrist's efforts to obtain relevant information from other sources, psychological test findings, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic

procedure, or other pertinent data. Reporting requirements may necessitate factual documentation in cases involving activities dangerous to the patient's self or others, such as suicidal ideation with intention to act, child abuse, credible threats of harm to others, etc. Collaboration with other clinicians should also be noted. The record would generally include basic management information that could enable other clinicians to maintain continuity of care if necessary. However, a responsible professional approach in today's world is to consider and justify the necessity of recording each item.

6. Exclusion of mental content from the formal record. Intimate personal content, details of fantasies and dreams, process interactions, sensitive information about other individuals in the patient's life, or the psychiatrist's personal reactions, hypotheses, or speculations are not necessary in a formal medical record. Before charting such material the clinician should carefully consider the potential vulnerability of the record to disclosure and misinterpretation.

7. Information systems considerations. Information entered into a computerized system that goes beyond the direct and immediate control of the treating psychiatrist (and, in an organized treatment setting, of the professionals who are collaborating in the patient's care) should be stringently restricted to protect patient privacy and confidentiality. It must be limited to the minimum requirements of the system for administrative and basic clinical data and not jeopardize the essential privacy of psychotherapy material. As with any disclosure of medical records, paper or electronic, transmission of clinical data to information systems outside the treatment setting must not occur without the awareness and specific, voluntary, delimited, written consent of the patient; such consent must not be mandated as a precondition for third party payment for treatment. Psychiatrists, along with their patients, should have the right to decide together to keep information from psychotherapy out of any computerized system.

8. Psychotherapy with Medical Evaluation and Management. The APA and the Commission of Psychotherapy by Psychiatrists affirm that psychiatrists' medical training, experience, and assessment and management skills are integral to their ongoing psychotherapeutic work. However, certain CPT codes in the 908xx series specifying "Psychotherapy with Medical Evaluation and Management (E&M)" have been interpreted by APA's experts on coding to require specific documentation that in each session thus coded the physician 1) *assessed* the patient's condition through *history-taking and examination* and/or 2) carried out *medical decision-making* and/or 3) provided *management services*. The medical E&M service(s) may optionally be described under a separate heading from the psychotherapy service. Writing a prescription is only one of many possible actions fulfilling this requirement. Documentation may include mental status or physical observations or findings, laboratory test results, prescriptions written (dates, dosages, quantities, refills, phone number of pharmacy, etc.), side effects or rationale for changes of medication, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic procedure, compliance with medication regimen and clinical response, etc. A minimal number of E&M activities may suffice. At this time, it appears that the medical evaluation and management service (as distinct from the psychotherapy service) rendered under the "Psychotherapy with Medical E&M" codes is comparable to a Level One service under the general E&M codes (992xx) available for use by all physicians. Level One assessment could consist of one element

of the mental status examination, a vital sign, or an observation of musculoskeletal status.

Documentation requirements for the general E&M (992xx) codes are still in flux. Third parties, such as Medicare, insurance companies, and HMO's are still in the process of developing policies on the kind of documentation they may require to reimburse patients and/or pay practitioners for CPT codes for "Psychotherapy with Medical E&M" (908xx). The APA will work hard to ensure that these new standards conform with APA recommendations for documentation of psychotherapy by psychiatrists³.

9. Consideration of patient access to records. Psychiatrists should be cognizant of and sensitive to the fact that patients have access to their medical records in many jurisdictions. State law may require release of the record to another physician or health care professional caring for the patient or to the patient's attorney, pursuant to valid written authorization by the patient.

10. Psychiatrist's personal working notes: an unresolved dilemma. In keeping with the APA Guidelines on Confidentiality (1987) and some authorities on psychiatry and the law (Appelbaum and Gutheil, 1991), the psychiatrist may make personal working notes, kept physically apart from the medical record, containing intimate details of the patient's mental phenomena, observations of other people in the patient's life, the psychiatrist's reflections and self-observations, hypotheses, predictions, etc. Such personal working notes are often used as a memory aid, as a guide to future work, for training, supervision or consultation, or for scientific research that would not identify the patient. Many psychiatrists consider such uses to be crucial to the clinical care they provide. *If such notes are written, every effort should be made to exclude information that would reveal the identity of the patient to anyone but the treating psychiatrist.* If there is any risk of disclosure, patients should be informed in a general way about the use of notes for teaching and research and the ways in which identifiable disclosures will be avoided, and the patient's consent should be obtained for such uses.

Except for a few jurisdictions there is no statutory assurance that such notes are exempt from discovery in litigation, and even in protective jurisdictions the definition of personal working notes may be challenged and the notes subject to judicial review. It is possible for a psychiatrist to resist a subpoena of such material, but the likely outcome is that the judge would review it *in camera* and select what is relevant to the case at hand. *Destroying such notes after a subpoena arrives opens the psychiatrist to extreme legal risk and should never be done. Personal working notes should be destroyed as soon as their purpose has been served, and this should be done in a systematic, routine way for all cases that clearly is not designed to avoid discovery in a specific case.* Psychiatrists should acquaint themselves with the prevailing law on personal working notes in their state. The absence of notes does not assure that a psychiatrist would not be required to testify from memory regarding the content of treatment.

11. Final clinical note. A final clinical note at the end of treatment may summarize the psychotherapy concisely from a technical standpoint without divulging intimate personal information, and document the patient's status and prognosis, reasons for termination, and any recommendations made to the patient regarding further treatment and/or follow-up. It is important that the individual clinician use judgment in regard to what information is included in

the final report so as not to jeopardize the patient's privacy or confidentiality. An exit evaluation may be done and documented by another psychiatrist.

12. Special situations. Special documentation requirements established by reputable professional organizations for use by members of those organizations may apply to specified treatment methods or clinical situations. An example is The American Psychoanalytic Association's Practice Bulletin on "Charting Psychoanalysis" (American Psychoanalytic Association, 1997.)

Footnotes

¹. *This resource document incorporates valuable comments and suggestions made by members of many components of the APA. These include the Commission on Psychotherapy by Psychiatrists, the Council on Psychiatry and the Law and its Committee on Confidentiality, the Consortium on Treatment Issues of the Council on Psychiatric Services, the Council on Health Care Systems and Financing and its Committee on Private Practice, the Work Group on Codes and Reimbursements, the Joint Commission on Government Relations, the Committee on Ethics, JoAnn E. Macbeth, J.D. (APA's legal counsel), and APA's liability insurance carrier. As the primary author, Norman A. Clemens, M.D., chair of the Commission on Psychotherapy by Psychiatrists, integrated the contributions of the above components with the assistance of members of the Commission. The Commission is most grateful for the thoughtful work that went into these contributions.*

². *Recommendations for actual third-party review procedures and the individual psychiatrist's response to a request for review or disclosure are beyond the scope of this paper. Psychiatrists should be alert to APA statements on these important and complex matters.*

³. *Individual psychiatrists and their patients should be able to exercise the right, if they believe that it is essential to the integrity of psychotherapy, to insist that any review of the psychotherapy (beyond administrative review of such matters as date and duration of service, CPT code, charge, etc.) be conducted in a professional, confidential setting. All personal data, including the content of psychotherapy, must remain confidential, and only the medical opinion (as to whether the treatment in question is or is not medically indicated) would be sent to a third party.*

REFERENCES

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