Problem Oriented Medical Records: Some Reservations

Robert L. Spitzer, M.D.

Associate Professor of Clinical Psychiatry, Department of Psychiatry
Columbia University

Dr. Lipp performs a service by acquainting us with the latest idea as to how to improve the sorry state of quality control in the delivery of psychiatric care. It may be helpful to view his article as a problem oriented record with the patient as psychiatry. The chief complaint is the absence of techniques for evaluating the quality of the care given by psychiatrists to their patients. To continue the metaphor, Dr. Lipp provides an accurate patient profile and data base so that one can hardly dispute the nature of the problem, its seriousness and the need for treatment. Following his problem list he gives us with considerable enthusiasm and references to its inevitability, his “initial plan” which is the adoption of the problem oriented medical record system of Weed to psychiatric records.

Having written numerous traditional psychiatric case records as a psychiatric resident and analytic school candidate, and having tried in vain to use psychiatric hospital records for research purposes, I think the new problem oriented approach to the psychiatric case record will most likely be a distinct improvement. What does bother me are certain assumptions in Dr. Lipp’s article which should be questioned.

“Outcome research is expensive in time, money and staff effort. It is impractical on any but a research basis and certainly not useful in evaluating vast numbers of therapists and therapeutic contacts.” What would be the cost in time, money and staff effort to develop the kind of audit system presumably automated, that Dr. Lipp describes which would “evaluate vast numbers of therapists and therapeutic contacts.” My own experience with re
A fundamental assumption in Dr. Lipp’s article is that there is a relationship between the quality of care given to a patient and the ability of the therapist to document in a problem oriented medical record what he is doing, why he is doing it, and what progress he is making.

Problem oriented automated record keeping systems in psychiatry (Spitzer and Endicott, 1970; 1971), which, because of standardization of intake documents, are far simpler than a problem oriented automated system, leads me to conclude that such a system would be extremely expensive.

I would not agree that research studies can not be useful in evaluating vast numbers of therapists. The May study (1969) of the treatment of schizophrenia clearly showed that therapists who only administered psychotherapy to middle range prognosis first admission schizophrenics were far less effective than therapists who administered psychotropic medication, with or without psychotherapy. The results of that study, and of others (Bookhammer, et al, 1966; Grinspoon, et al, 1967; Hogarty, 1973), provides a sound basis for judging the efficacy of different treatment approaches to the specific type of patients studied. If a generally ineffective treatment, such as insight oriented psychotherapy with acute schizophrenia, were to be used by most psychiatrists, it is hard to see how any audit system would show that the treatment was in fact, ineffective, because of the effect of nonspecific factors and the variable outcome associated with all forms of treatment for this kind of patient.

A fundamental assumption in Dr. Lipp’s article is that there is a relationship between the quality of care given to a patient and the ability of the therapist to document in a problem oriented medical record what he is doing, why he is doing it, and what progress he is making. Since Dr. Lipp states that “the amount of time a therapist spends with a patient and the sophistication of the therapist’s training may have utterly no bearing on the quality of care received by any given patient” it does not seem unreasonable to wonder if it might not also be possible for very ineffective therapists applying ineffective treatments to produce very adequate appearing problem oriented records!

I suspect that with sufficient training, coercion and motivation, practitioners of psychoanalysis, drug therapy, behavior therapy, nude marathons, insulin coma, lobotomy and whatever else comes to your mind, could all produce acceptable problem oriented medical records.

What is clearly needed is a study investigating the relationship between

Problem-Oriented Medical Records: Some Reservations • 377
Can we really expect that the psychiatrist, faced with perhaps only minimal improvement in his patient, is not going to report some evidence of “significant” improvement which will justify his continued treatment and collection of his fee?

the adequacy of psychiatric records (traditional or problem oriented) and the outcome of patients, using a criterion other than the therapist’s assessment of progress. Are there any studies of this kind?

An implicit and crucial assumption in Dr. Lipp’s justification of the problem oriented psychiatric case record for the evaluation of individual therapists and third party payment is that the therapist’s assessment of the progress made by the patient will bear some relationship to the actual outcome. This would seem to ignore two obvious problems: first of all, there is considerable evidence that therapists administering demonstrably ineffective treatments will, even in the absence of external pressure, report progress which they will attribute to their own efforts. Secondly, and of even more importance, studies of different outcome measures in psychotherapy research consistently reveal low, zero, or even negative correlations between therapist and patient assessment of improvement (Bergin, 1971; Shapiro et al, 1973). This may be partly a function of generally ineffective treatment which will tend to reduce the variability and hence the correlations. In any case, one can hardly rely exclusively on the therapist’s judgment of the progress made in therapy.

Dr. Lipp’s article fails to mention potential dangers involved in the use of the problem oriented medical record to audit the quality of care given to psychiatric patients. There is no doubt that when records are scrutinized and the consequences of a “bad record” effect the therapist he will be under considerable pressure to modify what he puts in the record. This is sometimes referred to as “treating the record.” Can we really expect that the psychiatrist faced with perhaps only minimal improvement in his patient, is not going to report some evidence of “significant” improvement which will justify his continued treatment and collection of his fee? Is it not even possible that the most honest practitioner will have greater difficulty operating in such a system than his less scrupulous colleague?

Since I believe that the problem oriented record possesses so many advantages over the traditional record, why, with my usual sunny disposition, am I stressing its potential drawbacks? I believe the reason is that for many years I have participated in developing standardized recording forms as part of an automated record keeping in psychiatry. I have learned the hard way that it is far easier to design and impose systems on clinicians than it is to set...


