Several decades ago in my residency training at University Hospitals of Cleveland we kept two charts on every patient in the outpatient clinic. The official medical record circulated throughout the general hospital and slept in Medical Records when not in use. The other folder was in a locked filing cabinet in the Adult Psychiatry clinic. Into the official record went all the information another clinician seeing the patient would need to know, including a simple statement that psychotherapy took place.

The confidential chart was another story. Since we were learning psychotherapy, we wrote detailed notes describing what went on in treatment sessions. Sensitive factual details about the patient and significant others went there also. We even ventured some thoughts about our own reactions to the patient’s thoughts and behavior, and how to understand and respond. We went over this information regularly with our supervisors, most of whom were psychoanalysts.

We worried about those confidential charts. Would they be called into court some day when the patient got into a custody battle or made a claim for pain and suffering in a liability suit? Could we use them if we were sued by the patient? Would unauthorized people get into those filing cabinets? The legal status of the confidential records was uncertain. We knew they could be subject to a subpoena, but maybe we could get the hospital to fight it. We were told that this had never happened, so we shrugged off our worries. Nonetheless, we were careful not to be flippant or irresponsible in what we wrote.

Along came managed care, the dangers of retrospective review by insurance companies and dreaded Medicare, and, more recently, central computerized records. The plot got even thicker. One had to be very careful not to put too much or too little in the medical record, because so many eyes could view it. The idea of patients’ rights to review their own charts was catching on. There had to be enough clinical data to justify a diagnosis and a rationale for the treatment plan. That meant a factual history of the present illness and relevant past and family history, a good mental status exam, lab results, and records from other sources. Medications and their aftermath belonged there. When coding for Psychotherapy with Medical Evaluation and Management (E&M), a psychiatrist had to include at least some elements of assessment, medical decision-making, and management. The “SOAP” formula came in very handy.

But what about the psychotherapy? In the medical record, should one get into the specific details and the emotions and damaged lives of the protagonists, let alone the therapist’s reactions? Certainly not, I felt. I settled for a statement of the type of psychotherapy (e.g., psychodynamic, CBT, IPT, group) and the length in minutes of the session (usually “with Medical E&M”) and maybe a word or two about a salient theme of the session (“discussed marital issues,” “work with assertiveness and self-control,” “body image and self-esteem,” and the like.) I worried if that would be enough for Medicare, but anything more would betray my patient’s confidentiality to a potential, unanticipated reader of the record. If I wanted to discuss the patient with colleagues in consultation or a study group, I wrote detailed process notes from time to time with nothing on them that identified the patient.

A few years ago, when I was drafting an APA resource document on Documentation of Psychotherapy by Psychiatrists,1 the toughest section concerned the psychiatrist’s personal working notes. The drafts were circulated to many components of the APA. Legal eagles expressed strong reservations about saying anything...
about personal working notes, and the malpractice carrier’s attorneys were even more opposed to sanctioning them. Such notes would create a “shadow record” that the patient did not know about and that could be problematic in court proceedings.

I was reminded that any demand for records during the discovery phase of a lawsuit would include all notes in any form. The personal notes would have to be produced, and any effort to hide or destroy them after receiving a subpoena would be disastrous. The subpoena could be fought, but a judge might wind up reviewing the notes in chambers and selecting what was relevant to the trial. On the other hand, how could I have had the superb education I received in that residency and in later psychoanalytic training without using process notes of therapy sessions? How would I have remembered important details of the material to write up the case for research or certification as an analyst? Personal working notes are a time-tested custom of psychotherapists for study purposes. The final resource document described the dilemma and the caveats, and gave an injunction to destroy the notes systematically as soon as their purpose had been served, but the section on personal working notes stayed in.

**Jaffee v. Redmond**

In 1996, the U.S. Supreme Court decision in *Jaffee v. Redmond* protected the contents of psychotherapy from discovery under an absolute privilege comparable to the attorney-client privilege.

**The new privacy rule promulgated in December, 2000 by the Department of Health and Human Services at the direction of the 1997 Health Insurance Portability and Accountability Act (HIPAA) brought fresh clarity and heightened protection for psychotherapy notes. It acknowledges the direct influence of the *Jaffee* decision and carries it into the regulatory realm. It will not become operative until 2003, but its effect on documentation will begin as soon as practitioners are familiar with its complexities. Whatever problems it poses in other respects, it is a great boon to psychotherapy.

Whereas a general consent of the patient will be required for use of records for treatment, payment, and healthcare oversight purposes, a higher level of authorization will be required for disclosure of psychotherapy.
notes. Authorization must specify the recipient, the duration of the authorization, and the nature of the material to be released. The extent of disclosure is limited to what is necessary to serve the purpose. Psychotherapy material may be used for supervision and consultation within the ambit of confidentiality. It may be disclosed without authorization only to the extent necessary to prevent imminent harm to the patient or others, to a medical examiner to determine cause of a patient's death, for a therapist's defense in a malpractice suit, or for health care oversight (investigation of the therapist). The privacy of the notes continues after the patient's death. Authorization may not be a required condition to obtain health insurance.

In order to qualify for the higher level of protection, psychotherapy material must be maintained in a portion of the record separate from the general medical record. The rule describes psychotherapy notes as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session." The definition excludes "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis and progress." (The material excluded from psychotherapy notes belongs in the general medical record.) Furthermore, "to meet the definition of psychotherapy notes, the information must be separated from the rest of the individual's medical record." Notably, it is still part of the identifiable record.

While keeping a separate part of the record is an inconvenience, it is no more so than I experienced back in my residency. The relief of knowing that the material is protected makes it well worthwhile. As medical records in an institutional setting are increasingly computerized and hence accessible despite rigorous safeguards, the option of maintaining a safe haven of psychotherapy notes outside the system is even more appealing.

Importantly, keeping separate notes is not required, but the special protection applies only to separate notes. Since the rule applies only to identifiable medical information, a therapist's personal working notes without any patient identification are neither covered nor prohibited by the HIPAA privacy rule.

The rule does not link psychotherapy notes to any particular type of psychiatric service code, only to a "counseling" session. Since a psychotherapeutic relationship with a psychiatrist is broadly viewed as beginning the moment one meets the patient and may continue throughout any kind of psychiatric care, it would appear to be appropriate to put sensitive material from an initial evaluation or a medication management visit into protected psychotherapy notes. Patients certainly appear on our thresholds expecting to trust us with their most intimate secrets, and it is our obligation to uphold that confidence no matter what CPT code we use. HIPAA goes a long way towards supporting us in so doing.

Postscript

As this issue goes to press, the status of the HIPAA privacy rule is provisional because it is being reviewed by Congress and because the incoming Bush administration has opened it to further comment. The author is unaware of any challenges that have been raised to the provisions concerning psychotherapy notes. However, healthcare professionals should be attentive to any changes that emerge. Barring major deviation from the Congressionally mandated process, the HIPAA rule will become final in April, 2001, for implementation 2 years later.

References