THE PROBLEM-ORIENTED APPROACH IN PSYCHIATRY

H. D. CHOPRA, M.D., M.R.C.Psych., M.R.A. N.Z.G.P., D.P.M., F.A.P.A.

SUMMARY

The problem-oriented approach to record keeping developed by Lawrence Weed is having a significant impact on the practice of Psychiatry. In this system, the physician is required to identify list and number all the patient’s psychiatric, social and physical problems. The problem list is kept at the front of the record, much like a table of contents. All subsequent data including the clinician’s plans and progress notes are cross-indexed to the numbered problems. A plan for approaching each problem is constructed with the help of the list of assets and resources which include patient’s existing or potential characterological strengths, vocational skills and talents, as well as resources and supportive factors within the family and community. At regular intervals progress notes are made which may be classified as subjective, objective or related to the treatment plan.

This system is aimed at effective patient-care because the information can be easily retrievable and thus can be thoroughly analysed, correlated and synthesized into an ongoing treatment plan. Some problems posed by the system are discussed and the author offers a simple practical mode of recording.

THE NEED FOR CHANGE

The traditional method of collecting, storing, and using the information about the patient, his illness and its treatment has got its own problems.

(a) The hospital record oftenly contains comprehensive data covering the patient’s present illness, past history, family background, demographic information, etc. but effective and efficient utilisation of data is impeded by its sheer volume and ‘often by’ poor legibility.

(b) The traditional routine of piling up reports from various sources, recording observations and documenting treatment procedures by various people in separate progress-notes results in an accumulation of bulky records which can make it difficult to locate any pertinent information when required. Moreover, many patients suffer from multiple problems, yet a systematic and up-to-date list of their problems is rarely available.

THE PROBLEM-ORIENTED APPROACH

For effective patient care, information must be easily retrievable so that it can be analysed, correlated and synthesized into an ongoing treatment plan. This is accomplished by the problem-oriented-method of codifying medical data, developed by Lawrence WEED (1970), Professor of Medicine at the University of Vermont in Burlington.

Recent studies by Grant and Maletzky (1972), Gilandas (1973), Mazur (1974), Ryback (1974) and others show that this system is applicable to psychiatry and in fact may be a major contribution to this discipline.

Essentially, the problem oriented record (P.O.R.) requires the physician to identify, list and number all the patient’s psychiatric and social problems, as well as past and current physical ones. The problem list is placed at the front of the record, much like a table of contents. All subsequent data, including the clinician’s plans, orders and progress notes and even the discharge summary are cross-indexed to the numbered problems. Th list is then modified as problems change; those which are resolved are marked accordingly and their corresponding numbers left unused thereafter. New problems are coded as they occur. The problem list functions as an index
and allows the clinician to efficiently retrieve desired information. Moreover, the record serves as a repository for information about the course of treatment and outcome for each of the patient’s problems.

*Comparison between the Traditional Psychiatric Record and Problem-Oriented Record (Ryback, 1974):—*

**The Traditional Record**

1. **Data Base** discipline oriented.
2. Patient's problems not well defined.
3. When entered in record, treatment stated in general purpose terms.
4. Patient's condition not systematically routinely assessed.
5. Treatments not routinely entered.
6. Important variables within given treatment usually not specified.
7. In discharge summary: —
   a) course of treatment not adequately reported.
   b) after-care not spelled out.
8. The recording of events lags far behind events.
9. Different elements of treatments not routinely entered or interrelated.

**The Problem-Oriented Record (P.O.R.)**

1. **Data Base** content oriented.
2. Patient's problem well defined.
3. Treatment indicated for specific problems.
4. Patient's condition routinely assessed for each problem.
5. Treatments routinely entered for each problem.
6. Important variables within a treatment specified.
7. In discharge summary: —
   a) each problem separately reviewed and assessed.
   b) after-care of each problem spelled out.
8. The recording of all important events follows closely after the event.
9. All problems listed. All goals with regard to each problem listed. All treatments for each problem listed. Patient's response to treatment for each specific problem listed. Must be able to identify problems to be entered on the Problem-list.

**What is a problem?**

The problem should be stated at the healthcare provider’s level of understanding.

a) The problem can be aetologic, diagnostic, or dynamic; abnormal laboratory findings; physiologic; social or demographic; behavioural; mental status; or symptoms (refer Table I).

b) A problem may also be “incomplete data-base” if the information defined as necessary is missing, thus making evaluation and/or treatment a problem for both the therapist and patient.

c) The problem defined may often need to be validated with the patient, for example: the problem of being separated from mental status and physical examinations, preliminary reports of laboratory and psychological tests and observations of the patient’s behaviour.

2. **Problem Formulation**

The first step is to define and isolate problems. All the team-members involved...
PROBLEM—ORIENTED APPROACH IN PSYCHIATRY

Table 1—An outline of the four basic sections of the problem-oriented medical record: data base, problem list, plans, and follow-up. (Ryback, 1974)

Chief Complaint
Present Illness
Psychosocial History
Family History
Physical Exam, Past Medical Hx., Review of Systems
Mental Status Exam
Psychological Testing
Laboratory Studies

PROBLEMS (To be stated at the physician’s level of understanding)
Etiologic, diagnostic, dynamic—e.g., schizophrenia
Abnormal laboratory finding—e.g., abnormal EEG
Physiologic—intention tremor
Social, demographic—separated
Behavioural—temper tantrums
Mental status—thought disorder, hallucinations
Symptoms—insomnia

The problems are numbered and the number is constant throughout the records, the list of problems become an Index to one patient’s record.

Specifically State:

(a) The protocol for ‘Working-up’ each problem, the differential diagnosis, exactly what additional information is needed, how it is to be obtained, in what order.

(b) The treatment, e.g. psychotherapy, behaviour therapy, ECT, psychopharmacology. What parameters necessary to judge efficacy.

(c) What the patient is to be told.

Progress Notes. (Numbered and titled.
Organised into subjective or symptomatic data, objective data, assessment and plan).

Flow Sheets (where applicable).

or divorced may be considered a problem by the mental health care provider, but the patient may feel it is the resolution or a problem for him.

(d) From an operational view point, a problem may be defined as “anything important enough to do something about or for which something has been done”.

(e) A problem can also be defined as something that concerns the patient, or the physician or both.

(f) Diagnosis may be used as a problem but not without further definition as the diagnostic-nomenclature is often sufficiently broad to be useless for treatment purposes.

The higher level of abstraction involved in a diagnosis may on occasion be extremely useful as a problem. Without it, the same problem list may be defined for a thought disorder as for an organic brain syndrome. For example: thought blocking, loose associations and bizarre behaviour, are evident in both schizophrenia and tertiary syphilis; yet one would not treat schizophrenia with Penicillin.

(g) The problem identified with fall into various categories. From the viewpoint of need of action or readiness for solution, all problems will fall into two categories:

(i) Active Problem (present, current, re-
quiring-action, needing immediate and ongoing management or investigation).

(ii) *Inactive Problems* (past, solved, dormant, requiring awareness because of a possibility of reactivation or interproblem relationship and interaction).

(a) The problems may also be classified according to the disciplines and realms of expertise, such as:

(i) *Medical* (biological, organic, physical, somatic, constitutional, anatomic, physiological, and clinical pathological laboratory findings).

(ii) *Psychological* (intellectual, emotional, behavioural, sensorial, psychiatric, endopsychic, intrapersonal, psychosomatic, and motivational).

(iii) *Sociological* (interpersonal, demographic, social, economic, cultural, legal, vocational-educational and racial).

**What is a problem list?**

Weed (1970) suggests that the "first page of a patient record should consist of a numbered problem list. It is a 'table of contents' and an 'index' combined, and the care with which it is constructed determines the quality of the whole record. Inherent in the problem-oriented approach to data organisation in the medical record is the necessity for completeness in the formulation of the problem-list and careful analysis and follow through on each problem, as revealed in the titled progress notes".

Different workers have described their own comprehensive ways of preparing the 'problem-list'.

3. *Treatment Plan*:

A plan for approaching each problem is constructed and cross-indexed by number to the problem. The plan may call for collection of further data to clarify ambiguous phenomena; somatic pharmacological, psychological, activity or milieu therapy; environmental manipulation; or educating the patient to the management of his problems. Table II shows a sample of problem list and treatment plan.

| Problem number | Active and inactive problems | Date first noted | Date resolved | Treatment Plan |
|----------------|----------------------------|------------------|---------------|----------------|
| 1              | Depression (crying, not socialising) | 4-13-72          |               | Problems 1, 2, 3—Medication: Largactil 50 mg. q.i.d. Elavil 25 mg. b.i.d. (psychiatrist). Notes due each week. |
| 2              | Paranoid ideation (people wish to harm her, threatens others) | 4-13-72          |               | Problems 1, 2—group therapy one hour per week (psychologist). Notes due every two weeks. |
| 3              | Auditory hallucinations (voices of parents abusing her) | 4-13-72          |               | Problems 1—industrial therapy. Serving meals in the cafeteria three hours a day. Notes due every two weeks. |
| 4              | Vocational (lacks employment) | 4-13-72          |               | Problems 1—recreational therapy. Bowling twice a week and regular evening hospital activities. Notes due each week. |
|                |                            |                  |               | Problems 4—vocational counselling one hour per week (rehabilitation counselor). Notes due every two weeks. |
4. Progress Notes:

At regular intervals notes are inserted on the patient's progress. The notes are cross-indexed to the numbered problems and may be structured according to whether they are subjective (the patient's view of his problem), objective (actual clinical findings and other aspects noticed by the clinician), or related to the treatment plan (modifications or additions to the initial plan). Table III shows a sample of progress record.

Table IV gives the format of the "Problem Sheet" used in a author's unit at Royal Park Psychiatric Hospital, Melbourne, Australia. The medical officer presents the detailed history of the patient at the Team-meeting (team comprises of the Consultant Psychiatrist, Medical Officers, Nursing Staff, Psychologist, Social Worker and Occupational Therapist) and the "Problem-list" is prepared which is reviewed every week. Action planned for each problem is assigned to the member of the team concerned who takes action and reports back at the next team-meeting. The "Problem-sheet" is always kept in the front of the case-record and is used as a reference. No patient is considered for discharge until all the problems have been explored and appropriate actions have been taken.

**Table III—Sample Progress Record (GILANDAS, 1973)**

| Date   | Problem number | Problem title          | Notes (S, subjective. O, objective. P, plan) |
|--------|----------------|------------------------|---------------------------------------------|
| 4-20-72| 1              | Depression             | (S) States she is depressed.                |
|        |                |                        | (O) Inappropriate affect and poor self concept. |
|        |                |                        | (P) Increase antidepressant medication if there is no change in the immediate future. |
| 1-20-72| 2              | Paranoid ideation      | (S) Does not verbalise paranoid ideas.      |
|        |                |                        | (O) Remission                              |
| 4-20-72| 3              | Auditory hallucinations| (S) Denial of any hallucinations.           |
|        |                |                        | (O) Remission —Psychiatrist.                |
| 1-20-72| 1              | Depression             | (S) Attends occupational therapy regularly but cries a lot. (O) Patient feels worthless and sorry for herself. (P) Needs constant instruction and supervision while doing crafts.—Occupational therapist. |
|        |                |                        |                                            |
| 4-27-72| 1              | Depression             | (S) Verbalises feelings of depression. (O) Psychomotor retardation, flat affect with repressed hostility. (P) Encouraged to be more expressive in group therapy. |
|        |                |                        |                                            |
| 1-27-72| 2              | Paranoid ideation      | (S) No longer believes people are against her. (O) Problem has been resolved.—Psychologist. |
|        | 4              | Vocational             | (S) Feels incapable of working. (O) Presently too depressed to make realistic vocational plans. (P) Vocational tests to be given when patient stabilises.—Vocational Rehabilitation counsellor. |
| 4-27-72| 1              | Depression             | (S) Says she enjoys working in the canteen. (P) She should continue present work assignment. (O) This activity seems to diminish her depression.—Industrial therapist. |
Table IV
Osler Ward
Name: Mrs. O. W.  Age: 57  Sex: F.  Marital Status: Married

| No. | Problem with duration                                      | Date Defined | Assets and Resources                                      | Action Planned (Assigned Staff)                                      | Action taken and outcome                                      |
|-----|-----------------------------------------------------------|--------------|----------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------|
| 1   | Episodes of depression and elation for 2 1/2 years, more frequent in last 10 months. Present episode of Mania. | 15-11-77     | a. Complete remission and adequate functioning for 14 years in the community. | a. Use of a major tranquillizer. (Dr. P. P.)                        | Manic phase controlled with Haloperidol (40 mg. per day). Maintains improvement. |
|     |                                                           |              | b. Good work record.                                     |                                                                     |                                                                  |
| 2   | Thyrotoxicysis for 2 1/2 years.                          | 15-11-77     | Referral to General Hospital for assessment and management. (Dr. P. P.) | Put on Neomercazole and periodic follow-up at the General Hospital. |                                                                  |
| 3   | No social supports                                      | 15-11-77     | To arrange social support (S.W.)                         | Placement arranged in the community and to be followed up at Royal Park Out-patient Clinic after discharge. | Has been investigated, not suitable candidate for lithium carbonate. |
| 4   | Renal impairment                                         | 18-8-78      | Referred to Renal Unit (Dr. P. P.)                       |                                                                    |                                                                  |

Advantages of Problem oriented record
(Gilandas, 1973).

The research of different workers suggests that the P.O.R. has the following advantages:

(i) Problem oriented approach encourages the use of sound logic in the treatment of patients, thus enhancing continuing education. Medical schools using the system as the basis of their curriculum have found that it facilitates meaningful interaction between clinical theory and practice. According to Mayou (1978) the problem-solving methods are likely to be much more effective than conventional teaching of psychiatry.

(ii) Lot of valuable time can be saved when records are reviewed because information is easily retrieved.

(iii) Communication with others about the patient is improved.

(iv) Although the system doesn't require a computer, it anticipates and facilitates the computerisation of psychiatric records.

(v) Precise documentation allows more accurate clinical research.

(vi) Case management through structured documentation allows meaningful auditing and utilisation review. This is a significant advantage during a time when consumers increasingly demand accountability in terms of cost benefits from all supplying public services.
(vii) The P.O.R. functions as an excellent work sample of a physician which can be used by different examining bodies like Peer-review groups.

(viii) The system’s logic takes much of the “mystery” out of psychiatry and enables paraprofessionals to penetrate the rationale behind treatment and explore their own valuable contributions in the total management of the patient.

(ix) Most importantly, patient care is improved. To think quantitatively about the needs of patients has qualitative implications for them. The stress upon the patient’s involvement in his treatment together with education in the management of his problems is the basis for a viable therapeutic relationship.

Critical Evaluation (Gilandas, 1973).

The problem oriented system is not a panacea and as does every innovation, it has created some new problems.

(i) The P.O.R. accommodates itself to any theoretical interpretation of human dysfunction but difficulties may arise when clinicians of radically different schools appraise each other’s work.

*Communication can be improved if therapists briefly specify their orientation and how they assess the data.

(ii) Criticism has been experienced particularly by those committed to a Gestalt approach that the system fragments the patient and his problems.

*The record itself can’t fragment a person, only a clinician’s fallible behaviour can do so. The Therapist must use his skills to integrate the information recorded, assessing and treating each problem in the context of the other problems.

(iii) The philosophy of viewing the patient merely as a list of problems may result in ignoring his strengths.

*Mazur (1974) has added what he calls a vital balance approach to the system by including a patient’s Assetlist. “This integrates the catabolic vector of health promoting forces”. The list of Assets and Resources includes the salient points of the patient’s existing or potential characterologic strengths, vocational skills and talents, as well as resources and supportive factors within the family and community.

ACKNOWLEDGEMENTS

The author is grateful to Health Commission of Victoria for the permission to publish this paper. Special thanks to Dr. M. Wellstead for presenting this paper on author’s behalf at the Annual Conference of Indian Psychiatric Society held in Pune (January 1979).

REFERENCES

Gilandas, A. J. (1973). The Problem-Oriented Record in Psychiatry. A. N. Z. Journal of Psychiat., 7, 130.

Grant, R. & Maletzky, B. (1972). A Scientific Approach to Psychiatric Record Keeping. Psychiatry in Medicine, 3, 110.

Mazur, W. P. (1974). The Problem-Oriented System in the Psychiatric Hospital: A Manual for Mental Health Professionals. California: Trainex Press.

Mayou, R. (1970). Psychiatric Decision Making by Medical Students. Brit. J. Psychiat., 132, 191.

Ryback, R. S. (1974). The Problem Oriented Record in Psychiatry and Mental Health Care. New York: Grune & Stratton, Inc.

Weed, L. (1970). Medical Records, Medical Education and Patient Care. The Press of Case Western Reserve University, Cleveland, Ohio.