



Henry A. Nasrallah, MD
Editor-in-Chief

Long overdue: Measurement-based psychiatric practice

Can you imagine an internist starting insulin for a patient with diabetes without obtaining a baseline glucose level? How would that internist know from visit to visit whether treatment was working and to what extent? How would he or she know how and when to adjust the dose to achieve hyperglycemia remission and a normal serum level?

Let's face it: many psychiatric charts are too general ('patient is doing better') or vague ('patient partially improved')

If our medical colleagues wouldn't dream of treating patients without measuring the symptoms of illness, why should psychiatric practice be different? Why aren't psychiatrists measuring patients' depression, anxiety, mania, or psychosis before and after starting psychopharmacologic agents?

Standardized tools unused

I recently surveyed a sample of CURRENT PSYCHIATRY readers, asking about their use of standard measurement instruments in clinical practice. I conducted this online survey as part of the needs assessment for a CME workshop I am planning at the University of Cincinnati. As I expected, most of the respondents indicated that they do not utilize any of 4 clinical rating scales routinely used in the evidence-based controlled trials required for FDA approval of psychiatric medications. These scales—which most said they had heard of or read about—include:

- Positive and Negative Syndrome Scale (PANSS) for schizophrenia
- Young Mania Rating Scale (YMRS) for bipolar mania
- Hamilton Depression Rating Scale (HAM-D) for unipolar depression
- Montgomery-Åsberg Depression Rating Scale (MADRS) for bipolar depression.

Lack of time was the most common reason respondents cited for not using these tools. Many preferred that their patients complete self-rating scales instead. Although I agree that patient self-ratings can be useful, they lack the objectivity and comprehensiveness of a clinician's observation.

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Many good reasons

One of the most important goals in modern psychiatric practice is to achieve remission, not just partial symptomatic response. Remission of depression, bipolar disorder, or schizophrenia is defined by a quantitative threshold measured on a standard rating scale. Therefore, we must use the pertinent rating scales if we wish to document that our patients achieve remission, which is the gateway to recovery and return to social and vocational functioning.

I believe psychiatrists should use standardized clinical rating scales because it is good medical practice that our patients need. Standardized measurements would enable all psychiatrists to use the same language relating to severity of illness, response, or remission. Then, when we read records of patients referred to us or cover while a colleague is on vacation, the numerical assessment combined with clinical impressions in the notes will facilitate continuity of care and guide ongoing treatment.

Let's face it: the contents of many psychiatric charts are too general ("patient is doing better") or vague ("patient partially improved"). Very few practitioners have time to cite whether or not every sign and symptom persists at a mild, moderate, or severe degree. By adopting standard rating scales, busy practitioners could do more (through better documentation) in less time (such as by circling the severity number corresponding to the symptoms listed on the scale).

Coming soon: Electronic medical records

The Obama administration's economic stimulus package includes \$19 billion to incentivize the adoption of universal electronic medical records (a 10-year goal set in 2004 by President Bush). Clinicians in facilities that have adopted e-medical records can enter clinical ratings with the click of a mouse. Issues beyond symptoms—such as functioning, quality of life, relationships, coping with stresses, etc.—can be addressed in the handwritten progress note text. (By the way, standard rating scales exist for those issues, too.)

Let us not wait for the time when reimbursement may become linked to documenting PANSS, YMRS, or MADRS scores at initial evaluations and follow-up visits. The time has come for psychiatrists—like our medical colleagues—to upgrade to objective, measurement-based practice and documentation. Improving the quality of inadequately informative or outright deficient medical records would be good for the patient and the practitioner. The quality of psychiatric treatment in the clinical setting should be no less rigorous than the controlled research trials that led to approval of the treatments.



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