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When the text takes control

INVITERT KOMMENTAR

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An analysis of ten patient records from the mental health service gives readers the sense of watching a postmodern collapse of documentation in slow motion.

Together with a group of researchers from the Norwegian health service, literary scholar Petter Aaslestad has conducted a study of the medical records of ten patients recruited upon admission to in-patient mental health services (1). The dataset comprised over 5500 pages. Analyses of the material revealed repetitive, voluminous copy-and-paste cascades of text and serious inconsistencies. The records were characterised by a defensive writing style, lacking reflective subjects. Possible diagnoses were repeatedly proposed. The researchers sought 'the patient's voice', but the patients' experiences and perspectives were not well represented and appeared to have little impact on the course of treatment.

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The situation described in the article is untenable and absurd. The authors interpret their findings as a possible sense of powerlessness but refrain from further causal analysis. Their conclusion is that clinicians must 'reclaim medical records'.

When I was asked to comment on the article, I felt the ground sway beneath me. What does the article actually mean? How did we end up here? It might be tempting to offer a trivialising excuse: ten records are too few on which to judge

an entire profession of record-keeping clinicians. However, qualitative findings need neither be representative nor generalisable to warrant interest from the field. Divergent or 'striking' findings can point to relevant phenomena and patterns that might otherwise be difficult to discern. Problems associated with bloated, incoherent and self-referential psychiatric records have also been described by other researchers (2). The overwhelming texts in these records can also be interpreted as an expression of a dehumanised and paternalistic clinical environment, because to be frank, a psychiatric medical record devoid of intellectual reflection and coherence constitutes an abuse of power: a betrayal of the patient. The responsibility ultimately rests with the clinicians.

Let me nevertheless seek additional perspectives, inspired by the article authors' reference to the medical record writers' possible powerlessness. To this end, I turn to a care ethics framework developed by Vosman and Niemeijer (3), recently applied by science theorist and psychiatrist Caroline Engen in her analysis of the online movement #legermåleve (#doctorsmust live) (4). The starting point is how the fundamental uncertainty of late modernity, characterised by unstable knowledge bases, pressure to standardise practices and institutional demands for control, makes it difficult to provide care in contemporary healthcare institutions. After all, good health care requires context-sensitive judgement, which cannot be standardised.

Vosman and Niemeijer invite a threefold reflection: first, acknowledge the participants' own accounts of their reality (think along). Next, seek additional perspectives on the matter (counter-think), and finally, develop new ways of working (re-think). In line with this approach, Engen gives serious consideration to her #doctorsmustlive colleagues' experiences of overwhelming workloads and time pressure (think along).

The most immediate solution at this level of reflection would be quantitative, i.e. that more doctors should manage fewer patients, but the analysis goes deeper than this. In the next step, attention is directed towards the qualities of the management systems that are increasingly shaping doctors' daily work. Have we reached a stage where late modernity's instrumental demands for documentation, categorisation, accountability, control and risk management threaten the identity, integrity and sense of meaning of doctors and patients alike? Is the institutional pressure on output not only quantitatively *high* but also qualitatively *inhumane?*

At the same analytical level, the path from overwhelmed clinician to inflated, defensive and depersonalised medical records is a short one. Perhaps these records are, therefore, better understood as a reflection of institutional pressures limiting clinicians' necessary professional autonomy rather than paternalism. The result is an erosion of spontaneous and creative human engagement. Does the analysis of ten patient records provide insight into a culture in which only the most independent-minded clinicians feel able – or perhaps dare – to assert themselves in the first person, sharing their own reflections, questions and uncertainties? Patients' rights to access, participation and shared decision-making have been strengthened. How realistic, however, is

recovery in an institutional climate in which clinicians dutifully document that the patient was given 'time and space to tell their story' (1) – without the shared narrative prompting any visible reflection or response.

> ***«How realistic is recovery in an institutional climate in which clinicians dutifully document that the patient was given 'time and space to tell their story' – without the shared narrative prompting any visible reflection or response»***

What about the final level (re-think)? Can the clinicians reclaim medical records? If so, they must do so within the framework of a future, reimagined mental health service that promotes health and is sustainable for patients as well as clinicians. Along the way, however, we will encounter more challenges than those posed by overarching late-modern managerial logic. Psychiatry is, after all, characterised by considerable epistemic instability and uncertainty. Controversies rage over its societal mandate and its possibilities (5), the validity and utility of diagnoses (6), and, not least, how we should fundamentally understand and respond to complex mental disorders (7). Amid all this, I reflect on the psychiatric field's recent contribution to the *Gjør kloke valg* (Choosing Wisely Norway) campaign. The first of four new recommendations reads as follows (8): 'Avoid reducing treatment to a single aspect of the patient'. Let us interpret this as a long-awaited new beginning rather than a tragic capitulation.

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