How to Write a Medical Note for the Foundations of Doctoring Course and Beyond: Demystifying the Focused (SOAP) Note and the Comprehensive (H&P) Note

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Overview of the Medical Note

Medical notes, a written summary of a physician's interaction with a patient, are a hallmark of medical communication. While much of the care of a patient involves direct verbal communication with the patient and any health professions team members involved on the medical care of the patient, medical notes are an essential means of transmitting information to other health care team members, of providing a log or record of what occurred during the patient encounter, but also to display important aspects of decision making by the provider and to detail diagnostic and treatment plans or recommendations. Medical notes are not necessarily for the patient to read as they are generally written with standard medical language that uses precise medical terms and descriptors and commonly accepted abbreviations. In the American health care system, medical notes are also the cornerstone of how billing occurs and they provide the justification of charges to the patient in a written

form. The level of sophistication and the details recorded in the medical note along with other factors such as the clinical setting, level of severity, and complexity of decision making all impact billing for the patient for the care received. Lastly, a medical note also serves the purpose of providing medico-legal protection against medical liability suits; therefore, the creation of a medical note is a professional activity that must be held to the highest standards.

Figure 1: Purposes of Medical Notes

Purposes of a Medical Note:

1) *Provides communication* with other health professions team members using standard medical language and abbreviations.

2) *Serves as a record* of the doctor-patient encounter, history and physical examination in addition to diagnostic and treatment plans.

3) *Demonstrates medical decision making* for the provider to other health professionals.

4) *Provides a template for billing purposes* that documents the complexity of the visit.

5) *Serves as medico-legal protection* from medical liability cases.

Medical notes has several qualities that are essential to maintain these high standards: *completeness, accuracy conciseness, and organization*. A medical note must be complete to capture those elements that are needed to assure a good understanding of the interaction between the patient and the plan of care without superfluous information. As medical students, all information may at first seem

possibly relevant to the patients' presenting complaints but eventually with more experience you will have a better understanding of what is most relevant to include in your written communications. When starting out it is best to first be accurate and complete then work on being concise. One of the biggest ways to achieve conciseness is through proper organization of your written communications so as to avoid duplication and to meet the expectations of others health professionals reading your notes. Following a template of how to write a note is one of the best ways to create a note that is complete, accurate, concise, and organized. Foundations of Doctoring will be providing you with several templates for your medical notes for use throughout medical school.

Types of Medical Notes

The first and most important type of note that you will be exposed to is the SOAP note that follows the acronym for S-subjective, O-objective, A-assessment, and P-plan. The SOAP note was first used in the late 1960's and has become a common template for outpatient office visits with patients (acute presentations or follow-up appointments) and certain inpatient visits. SOAP notes are the prototypical example of a "***focused***" note that you will write for follow-up visits for an established patient. This is commonly done on follow-up clinic visits for an established patient with a known problem in the outpatient setting or on an admitted patient as a daily progress note of a known patient who has a straight forward problem being addressed during the hospital stay. SOAP notes are

important as they serve as the foundational template for all other medical notes as all notes that the four parts: S-Subjective, O-Objective, A-Assessment, and P-Plan.

The Subjective or "S" section captures what the patient is reporting to you as the provider; this section is used to identify the patient's current status and agenda for seeking medical attention. In general, you can use the patient's own words, but more typically you will use medical terms that capture the patient's presenting complaints and symptoms. The Objective or "O" section includes the data that you have collected about the patient that includes vital signs, the physical examination, and any relevant diagnostic tests, radiologic studies or laboratory results performed. As you might suspect, the objective section typically contains much more medical vocabulary than the subjective section as you must list out all the essential physical examination maneuvers that you performed on the patient using medical terminology.

The Assessment or "A" section is an interpretation of the subjective and objective information gathered that displays the provider's clinical decision making about the patient's presentation. The assessment has three parts in general: the summary statement, the problem list, and a differential diagnosis discussion with comparing or contrasting (if applicable) or an impression of what you think the diagnosis is. The summary statement is a one or two sentence synopsis of the case highlighting major symptom(s) and physical examination features. The Plan or "P" details additional diagnostic workup, treatment plans and follow-up for the patient for each

problem that the patient's problem list. We will provide more specific details about the assessment and plans later in this chapter but also in another chapter in the Clinical Reasoning Handbook.

Progress notes, which are another variant of a SOAP note, that is much more streamlined as you would be typically seeing the patient on a regular basis, such as a patient who is hospitalized in an inpatient ward and you are seeing on a daily basis. Progress notes often follow the SOAP note template but can be even more condensed if the follow-up is relatively straightforward. Problem list notes also can be formatted like a SOAP note with subjective, objective, assessment and plan sections, but they would typically have several active problem that need to be carefully followed, assessment, and treated. Problem list notes are commonplace in intensive care units as a single patient will likely have multiple complex problems that may require discussion of a differential diagnosis, require detailed plans and affect several organ systems.

Another type of note that is based in part from the SOAP note format is a comprehensive History and Physical (H&P) note. Comprehensive H&P notes are more complete notes appropriate for admissions to the hospital, emergency department visits, and for pre-operative assessments for surgical cases. H&P notes are useful when a complete or comprehensive visit with a patients is needed that covers the patient's complete medical history and requires a very through physical exam prior to coming up with an assessment and plan.

Figure 2: Types of Medical Notes

Types of a Medical Note
1) SOAP Note
2) History and Physical Note
3) Progress Note
4) Problem List Note

The Subjective Portion of a Medical Note

The subjective portions of your notes will need to contain two essential elements: the chief complaint and a history of present illness. Classically, the chief complaint is the main reason (which is very often a symptom such as pain) that the patient is seeking medical care and is captured in the patient's own words. As examples, "I'm here to find out the cause of my knee pain," or "I'm in need of a refill of medications," would be typical chief complaints. The history of present illness (HPI) is connected to the chief complaint in that it captures the details of the chief complaint, especially if it a symptom.

With regards to the style and prose, the subjective portion of the note is typically written in the present tense about the chief complaint. As an example, you might record, "The pain is sharp, located in the upper abdomen and worse with meals." You could also write, "The patient describes that pain as sharp, located in the upper abdomen, and associated with meals," but you would not have to repeatedly

mention that the "Patient reports . . ." or the "Patient describes . . ." as readers would assume that the information in the Subjective portion of the note is coming from the patient.

For completeness and accuracy, the HPI should be a chronological story of the chief complaint that identifies the seven attributes of a symptom. The seven attributes of a symptom are onset, location, quality, severity, timing/frequency, alleviating factors, and aggravating factors. An acronym, OPQRST, can be used to help remember to cover many of the attributes of a symptom. These are O-onset, P-palliation and provocation, Q-quality, R-radiation, S-severity, and T-timing. Your Bates physical examination textbook chapters provide additional details of how to capture these seven attributes of a symptom. Other details may be important to include in the HPI such as other associated symptoms and the response to any attempted treatments.

Figure 3: Attributes of a Symptom

Attributes of a Symptom

1) Onset

2) Location

3) Severity

4) Quality

5) Timing and Frequency

6) Alleviating factors

7) Aggravating factors

The subjective section of a note can also include additional elements that you deem pertinent to why the patient is seeking medical care. Some of these elements one might see in the more comprehensive H&P note such as pertinent positive and negatives from a review of systems (ROS). The ROS is a detailed exploration of multiple organ systems to assess for other symptoms that may be present in a patient and may help to inform you as to why the patient is coming to see you. Other component of the H&P note such as relevant past medical and surgical history and social risk factors, such as smoking or alcohol use, can also be included. Documentation of over-the-counter and prescriptions medications and any medication allergies are commonly included in the subjective section of the more comprehensive note, such as an H&P note (and as needed for other types of notes), for a new patient.

Additionally, when considering patients with more chronic problems or an acute exacerbation of a chronic illness instead of an acute or new problem there are some subtleties that you may wish to consider. For chronic problems, you may wish to quickly revisit the history of the chronic medical problem and confirm your understanding of the patients experience with the disease. You may also touch up and report compliance with any medications or medication side effects, any current symptoms or complications related to the chronic illness, any end organ affects from the chronic illness, and any health maintenance needs related to the chronic illness.

Depending upon the exact setting in which your preceptor practices, there may also be site-specific information subjective information that you may need to include. Examples of this may include specific historical information related to pediatric history for a pediatric patient, obstetric history and gynecologic history for an OB/GYN clinic visit, or details about a recent surgery if you are precepting in a surgery clinic. Some information can be very specific to a clinic, such as a details related to the family history for genetic counseling clinic or mental health history for a psychiatric clinic. Finally, any specific information related to the patient's agenda for seeking medical care or personal situations that impact the patient's ability to compliance with the any recommended diagnostic or treatment plans may be included in the subjective portion of the SOAP note.

The Objective Portion of the Medical Note

The objective section of the medical note includes what we can observe or measure during our interaction with the patient. The objective portion of the medical note should be written using standard medical language or commonly accepted abbreviations and should not include any quotes from the patient or common language to describe the physical examination. In the objective portion of the note, you would describe the physical examination maneuvers that you performed using standard medical terminology; your readers will expect this so you should use it. You would NOT write, "There is belly pain in the upper stomach." Instead you would write, "Abdomen: Epigastric tenderness to light and deep palpation."

The objective section typically includes vital signs, general appearance, the physical examination, and any laboratory or radiology testing results. Maintaining the order of vitals signs, physical examination, and test results helps to maximize your organization through adherence to the typical note template whether it's a focused note, such as a SOAP note, or a more comprehensive note, such as a H&P note.

In general, one should document what was actually performed during patient encounter. Recording your physical examination is very important and you should provide details of exactly what you performed during the encounter. In phase I, you learned about six clustered body systems: HEENT, Cardiac, Pulmonary, Abdomen, Upper and Lower Musculoskeletal, but in phase II, you will gain other systems, such as the neurologic exam and eye exams in addition to the core physical examination checklist. When recording the physical exam you should NOT state the HEENT exam is "normal" or "WNL" meaning "within normal limits." You should document exactly what you performed and wish to become part of the patient's medical record. You should use precise terms or commonly accepted abbreviations in writing out exactly what you did during the physical examination. In the objective portion of the note the adage, "if you didn't document it, then you didn't do it" certainly applies! To create a complete and accurate medical note, you will need to be through and contentious with your physical examination documentation. If by chance you have access to laboratory or radiologic studies during the visit, the

results of these studies can be included at the end of the objective portion of the medical note.

The Assessment Section of the Medical Note

The assessment section of the SOAP note is one of the most important parts of the note as it displays your medical decision-making and clinical reasoning about the patient's presentation. Once you have entered into the assessment portion of the medical note, you have moved from the reporting or recording portion of the note where you are documenting the relevant historical information and data that you have gathered from the patient, into the portion of the note where you will be documenting your thoughts or decision making about the patient. In the assessment section of the medical note, you are discussing *what you think* may be going on with the patient and *why you think* what you are thinking. This is the essence of medical decision-making! For established or stable problems the medical decision-making may be very straightforward, but for acute or complex problems the medical decision-making may be very nuanced. To keep the assessment portion of your medical note concise and organized it is helpful to break the assessment section into its component parts: the summary statement, the problem list, and the differential diagnosis discussion.

The summary statement is a written sentence or two that captures the patient's agenda for seeking medical care using abstract descriptors while highlighting a few of the most significant elements of the subjective and objective portions of the

medical note. Traditionally, the summary statement would contain the patient's age, demographic information (such as age and gender), and those pieces of information from the subjective and objective sections that helps to inform you and the readers of your note what you think may be going on with the patient. Often, the process of writing up your summary statement, problem list, and differential diagnosis helps to clarify your thinking about the patient and organize your thoughts about the patient's presentation. There are several ways to approach your medical decision-making in the assessment, but the Foundations of Doctoring Course will show a few take-way points in the chapter "Displaying Clinical Reasoning in Medical Notes." Please review this chapter as you are working on writing your own medical notes as well as this chapter and additional readings in your Bates' physical examination textbook.

The next part of the assessment is the problem list. You should always have at least one problem listed in your medical note but many notes will have more than one problem that would need to be listed and discussed in the assessment and plan. The problem captured by the patient's chief complaint is typically the first problem listed in the problem list as it is likely the most pressing issue on the patient's agenda for seeking medical care. Other acute problems are listed next on the problem list followed by any stable or chronic medical problems. Ultimately, the exact ordering of the problem list is up to you and the clinical setting in which you are working. You should normally have a discussion of a plausible differential diagnosis for each acute problem on your problem list and you may not need a

differential diagnosis for a chronic or stable problem for which a diagnosis is already known.

Figure 4: Parts of the Assessment Section of a Medical Note

Parts of the Assessment Section of a Medical Note
1) Summary Statement
2) Problem List
3) Discussion of Differential Diagnosis

The Plan Section of the Medical Note

The plan section of the medical note is where you list out the plan of action for the patient. There are typically three domains that should be touched upon for each plan section: diagnostic recommendations, treatment options, and follow-up plans. Diagnostic recommendations could be laboratory test, radiologic tests, or more sophisticated examinations such as an ECG, sleep study, or a procedure, such as endoscopy. Treatment recommendations are often medications which should state the type of medication, dosing, frequency of administration, route, and length of treatment. Other treatments such as occupational therapy, stress management, or continued observation of a problem might be some examples of reasonable treatments. Finally, you should always consider follow-up plans to close the loop of the efficacy of your proposed treatments, follow-up on diagnostic tests, or return precautions if symptoms or problems worsen. It is always important to check with the patient on what their understanding of the plans are and what their ability to

have follow-up is as it greatly impacts the implementation of the plans that you are able to come up with for your patient!

Figure 5: Parts of the Plan Section of a Medical Note

Parts of the Plan Section of a Medical Note

1) Diagnostic Studies

2) Treatment Plans

3) Follow-up Plans and Return Precautions

Formatting the Assessment and Plan Section of the Medical Note

The assessment and plan section of the Medical note is often combined into a single section of a medical note. In the Foundations of Doctoring course, we suggest that you used a combined assessment and plan where there is an overall summary statement and problem list, but the plans for each problem are listed directly below the comparing and contrasting of the differential diagnosis for each particular problem. Variations include side-by-side listing of assessment and plans and completely separate assessments and plans. The format with a combined assessment and plan that we prefer is noted in Figure 6. Your clinical setting and specialty will ultimately dictate the format and structure of your medical note. When preparing your medical note for the Foundations of Doctoring sessions, look to use the provided template as much as possible but feel free to modify it to suit

your needs your preceptor's practice. A summary of the general purposes of each section of a medical note is listed in Figure 7.

Figure 6: Combined Assessment and Plans for a Medical Note

Assessment/Plan:

Summary Statement

1.Assessment: Problem #1 – Differential Diagnosis Discussion

Plan:

2. Assessment: Problem #2 - Differential Diagnosis Discussion

Plan:

3. Assessment: Problem #3 - Differential Diagnosis Discussion

Plan:

Figure 7: Summary of Sections in a Medical Note

S – Subjective

–Reports the historical information of why a patient is coming to see you.

O – Objective

–Details the data and physical evidence demonstrated by the patient and any known diagnostic studies.

A – Assessment

–Demonstrates medical decision-making of the provider

P - Plan

–Proposes diagnostic, treatment, and follow-up recommendations