26| Neuropsych Essentials: Commentary on Clinical Report Writing

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NAVIGATING NEUROPSYCHOLOGY

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Speakers: John Bellone, Ryan Van Patten

Intro Music 00:00

John Bellone 00:17
Welcome, everyone, to Navigating Neuropsychology: A voyage into the depths of the brain and behavior. I'm John Bellone...

Ryan Van Patten 00:23

...and I'm Ryan Van Patten. Today we provide a commentary on our previous episode, which was the discussion with Jacobus Donders on neuropsychological report writing. He's a board certified neuropsychologist and wrote a very well regarded book on the topic. We do link to the book on our website, which is navneuro.com/26. We highly recommend that everyone listen to the previous episode before listening to this one, as we will expand on the discussion that we started with Jacobus.

So before we get into the weeds today, I'd like to give a few caveats about this topic of neuropsych report writing. First and foremost, there's no one absolute right way to write a neuropsych report. There's no one truth here. We can contrast that with other topics that we talk about, such as the neuropathology of Alzheimer's disease, where scientists are trying to figure out what is the upstream cause of Alzheimer's disease. We may not know, but there are facts and there is ultimate knowledge. Neuropsych report writing is truly a matter of preference. We can use logic here and try to find the best way to do it, but I think it's helpful that we say this is all opinion based, it's all subjective. So John and I will be offering our opinions on this topic today. Feel free to have a different perspective and share that with us. We're always open to it. But realize we are not claiming to be the ultimate authorities on this topic.

John Bellone 02:05

Ultimately, we would like to get a discussion going more broadly than just the two of us. You can do that on Twitter or on our website, we can start a commentary on that as well. Get more people involved. That would be great.

Ryan Van Patten 02:18

Yeah, I like that idea. So that's the first caveat. The second one is that this topic in particular, neuropsych report writing, is difficult to talk about in a broad strokes manner, as we usually do on NavNeuro, because it's so very context dependent. As neuropsychologists, we can work in different settings, see different populations, different referral sources, and all of those factors and many others will impact what our reports should and do look like. So if I asked John a question like, “What should my background section look like?” You know, it depends. What is my patient's age and history? What setting do I work in? So, for that reason, it's hard to give broad strokes answers in a lot of these areas. They may not apply to everyone, but we'll do our best to be as helpful as we can and acknowledge the different settings that everyone works in.

John Bellone 03:16
We'll probably stick more with what we're familiar with and what we're doing right now on a day to day basis. We're both working in outpatient practice, essentially. So we'll be talking more about that. But, hopefully, we can try to make it more broadly applicable as well.

Ryan Van Patten 03:32
Yep, for sure. So, the upcoming content we have in the rest of the episode, we can divide it into two different topics. First, we're going to review a recent paper on neuropsych report writing. It's very relevant. It's the 2018 stakeholders paper that was published in The Clinical Neuropsychologist.

John Bellone 03:54
Karen Postal was the lead author of that study.

Ryan Van Patten 03:57
Yep. After that, we're going to use that data and leverage it and integrate it with our conversation with Jacobus as well as our own thoughts, experiences, interactions with neuropsychologists and have a broad discussion about several of these areas. So we hope that that's helpful for you.

John Bellone 04:17
Basically, Ryan and I, after we recorded that episode, we hung up the phone with Jacobus and we had like an hour-long discussion. We're like, "Oh my gosh, we should be recording this" because we had a lot of commentary on it and questions and thoughts. So here we are today trying to do that.

Ryan Van Patten 04:32
And hopefully we don't sound like bumbling fools. [laughs]

John Bellone 04:35
[laughs] Yeah, well, one of us will.

Ryan Van Patten 04:37
Well, we won't mention who that might be.

John Bellone 04:40
[laughs]

Ryan Van Patten 04:41
Speaking of which, John, why don't you articulate the stakeholders project and tell us all about it using your highfalutin language? [laughs]

John Bellone 04:48
Oh, yeah. Well, thank you. So glad you finally admitted that on air. We're going to briefly summarize the findings of that study. So we only selected some results that we thought were best to highlight. Listeners should really look at the full manuscript for all the findings. You can find those on the show notes. We have them linked. Again, that's navneuro.com/26.

So the first place really to start is why we write the reports the way we do with the length and level of depth that we do because, obviously, if you listen to the previous episode, Jacobus is strongly advocating for a much briefer, more concise report. And that is not the standard right now in the field. The standard is to write quite lengthy reports. We're going to get into the data from this study, in terms of the report length and time to turn around and things like that, but what's the historical context on this? And really, it's that as Karen Postal stated in her previous episode with us, and this actually comes from Applebaum, 1970, in the past, the referring provider gave the feedback for the psychological testing. It was not as common that neuropsychologists gave the feedback. At that time, we needed to, or the neuropsychologist felt like they needed to justify their diagnoses and recommendations to that referral source and provide the context for them, so that they could pass along the results to the patient and convince that provider about the validity of our conclusions. And, although we now provide feedback and don't really need to write that lengthy of a report, that report writing culture has not caught up to the times and we still, on average, write quite a lengthy report. So why don't we get in some of the data from the study? You want to start off?

Ryan Van Patten 06:50

Sure. So we'll summarize methods and results as John had mentioned. Between 2012 and 2016, the authors of the stakeholders paper surveyed 726 neuropsychologists, slightly over half were board certified. They also surveyed 434 medical providers, primarily physicians about neuropsych report writing.

John Bellone 07:13
It's quite a good sample.

Ryan Van Patten 07:14
Yeah, I like to see those numbers. It is a sample of convenience. But, importantly, there was diversity in terms of US geographic region, setting, and clinical populations served. So, hopefully, that leads to pretty good generalizability. A few initial results - the mean report length for adult and geriatric patients was about 6 to 8 pages, while the mean report length for pediatric patients was close to 12 pages.

John Bellone 07:44
Just the pause there. I don't think they specified whether or not that included a table of results, but I'm assuming that's the full report with the table.

Ryan Van Patten 07:53
Right. Yeah, I believe that also includes the table. But that's a good point, right? Because the data summary sheet, the table, can take several pages on its own. Time spent writing reports varies, but it's often over two hours and sometimes over five hours, with pediatric and forensic reports taking longer than adult and geriatric reports. That number, five hours for one report is beefy, for sure.

John Bellone 08:22
Welcome to my life, Ryan. [laughs]

Ryan Van Patten 08:25
That's probably low for you.

John Bellone 08:26
It's really low. You're right. [laughs]

Ryan Van Patten 08:28
Actually, that five hour number sounds familiar. I think that's how long it takes you to edit a single episode of NavNeuro.

John Bellone 08:34
It's…yeah.

Ryan Van Patten 08:35
How long does it take you to brush your teeth in the morning? 45 minutes?

John Bellone 08:38
I have to edit out all your idiosyncrasies and…

Ryan Van Patten 08:43
[laughs] Inappropriate comments.

John Bellone 08:44
comments. Yeah, exactly.

Ryan Van Patten 08:45
Yeah. Back to the data.

John Bellone 08:46
[laughs]

Ryan Van Patten 08:48
Referral sources claimed that it takes two weeks to a month to receive most reports. Importantly, 73% of referral sources stated that long turnaround times for neuropsych reports negatively impacts patient care. So, really, our referral sources are looking to get our reports sooner if possible, as soon as possible. This timeline of two weeks to a month, for them, feels like a long time. Most referral sources prefer bulleted diagnosis and recommendation sections, and they find it valuable to have scores such as the results table included in the report. Additionally, about half of referral sources said that they prefer that we reduce jargon in our reports. These referral sources read the diagnosis and impression section most frequently, which probably won't be a surprise to anyone - I think we've known that for quite some time. Moving on, the data were equivocal with respect to whether or not neuropsychologists say that the report is written for the patient him- or herself to read. However, most neuropsychologists say that they give the entire report to the patient.

John Bellone 10:05
Some said that they only send a summary sheet to the patient, but most do share the entire report, which I prefer as well.

Ryan Van Patten 10:13
And, of course, if a patient requests the report, it's part of their medical record, so they legally have a right to it. But I think it makes sense to give them a copy whether they've requested it or not.

John Bellone 10:21
Yeah.

Ryan Van Patten 10:22

And finally, referral sources use the report for diagnostic purposes, to identify a cognitive profile and inform treatment planning, and to track cognitive functioning over time. Over 80% of the referral sources rate our reports as moderately to very effective in communicating results to them. So this is certainly good to hear. We can think about that in the context of our recent episode where we talked about the neuropsychology outcome satisfaction initiative that Neil Pliskin spearheaded. So the stakeholders paper provides more data to support the overall utility of neuropsych.

John Bellone 11:01
Yeah. We have several different papers now, several different converging studies showing the usefulness to our referral sources and patients.

Ryan Van Patten 11:08

Right. I think these resources are helpful for us to accumulate. I know, myself, I'll create a folder in my Dropbox and just have all those there. Be aware of them in case someone asks me, at some point, as Neil had mentioned, at some point, you might be asked, “How do you know that neuropsych is beneficial?”

John Bellone 11:24
Yeah, “Show me the data.”

Ryan Van Patten 11:25

Right. Right. So it'd be helpful that we can just easily access it as opposed to feeling like we're caught with our pants down.

John Bellone 11:32
Yeah. So those were a lot of numbers and bulleted points. But the take home is that we're writing fairly lengthy reports, much longer than any other profession, really, in

terms of the medical community. And it takes us a long time to write those. And per the referral sources, that time that it takes us to turn those around negatively impacts care. So that's kind of the take home that I extracted from that.

Ryan Van Patten 12:00

Those are some definitely big picture takeaways. Why don't we use that as a launching off point for a deeper discussion on some of these issues? I think first and foremost, going off of our discussion with Jacobus, why should we shorten our reports? We're going to talk about how next but first let's give a few more reasons for why this is really important. What Jacobus would say, and I would agree with, is that, really, the most important thing here is to talk to your referral source about what he or she wants. They are asking the question, it is our job to answer it. So depending on who the referring provider is, if it's a neurosurgeon in an epilepsy unit, as Jacobus had mentioned, used that example, they're generally looking for a really brief, to the point, letter - lateralizing, language, is there a risk for postoperative cognitive decline, that sort of thing. That might differ from a pediatrician, who is also very interested in knowing a bit more about background, mental health, psychiatric history, those sorts of things.

John Bellone 13:10

In the discussion of the stakeholders paper, they note that the vast majority of neuropsychologists say that they would like to change the report. So there's clearly something that we're aware of, wanting to do something about it. So why haven't we shortened our reports yet as a field? There are potentially a few reasons for that. They say that it reduces the thoroughness of the document. Some neuropsychologists received some pushback from institutions and from the field itself, from other neuropsychologists. Another roadblock might be the erroneous assumption among neuropsychologists that referral sources want that level of detail. However, this is a direct quote from the stakeholders paper, "most referring physicians preferred shorter reports, less jargon, bulleted diagnosis sections, and quicker turnaround time." So that is in contrast to some of those fears that neuropsychologists have that we're not being as detailed or that we're not being as thorough. That's clear evidence that the referral sources do not want us to be that thorough.

Ryan Van Patten 14:18

Yeah. That idea that people are endorsing, the experience where institutions that they work for and even our field itself pushes back against writing shorter reports is

interesting. I myself, I'm a second year fellow, and so I haven't yet risen to the point of being an independent practitioner.

John Bellone 14:38
He's just a baby. [laughs]

Ryan Van Patten 14:42
Risen to the point of being an adult who can take care of himself and write his own reports.

John Bellone 14:49
[laughs]

Ryan Van Patten 14:50
So I've always been under the supervision of a licensed psychologist at this point, of course. But I'm trying to imagine what that exactly would look like or feel like to receive push back from your institution or from the field of neuropsychology. John, you're an early career professional, supposedly competent.

John Bellone 15:08
[laughs] Debatable.

Ryan Van Patten 15:09
Yeah. Almost for a year now, you've been working at a private practice and writing your own reports. So I'm curious, from your perspective, we had this conversation with Jacobus, you also, as far as I know, really value shorter reports. Do you feel pressure of one sort or another to write long reports so as to be perceived as competent?

John Bellone 15:35
Yeah, it is an interesting question. I have several thoughts about that. Well, first of all, when I joined a group practice of other neuropsychologists, there was kind of a template that I was expected to follow to some degree. I had a license to make it my own. Luckily, they were already producing the kind of report that I wanted to write - much shorter. We can talk more specifically about the length of my reports. I feel some pressure, probably more - and I mentioned this in the episode - more just as an early career neuropsychologist, when I'm writing to not omit anything. There are times where I probably add more details, just because I don't want to be

perceived as someone who misses something. That the referral source is thinking, "Oh my gosh, he didn't say that there weren't any manic symptoms", or "there wasn't any behavioral variant FTD symptoms", when really based on my previous sections, it should be assumed that there weren't. When I said, "Psychiatric history was unremarkable", or, you know, "There weren't any personality changes or behavioral changes." But I feel like I have to specify all those details. That's more of a pressure I put on myself. I also think that I'm getting referrals from a number of different sources, so it's not just where I'm working in a facility where the neurologist sends me a ton of cases. I'm getting them from a lot of different types of physicians and referral sources, so it's hard to know what each of them want. But no one has ever said that the report was not long enough or not detailed enough. It is so far and above what those neurologists write, because I get their reports, too. [laughs]

Ryan Van Patten 17:22
Yeah.

John Bellone 17:23

So it's definitely self imposed that fear and that sense, I think, where it's kind of beat into us in our training that we have to include the kitchen sink into every report. It's something that we have to shed, I think, and I'm trying to work through that.

Ryan Van Patten 17:40

Yeah, I really agree with what you just said. Imagine a trainee such as you or me who has gone through 5, 6, 7 years of grad school, 2 years of postdoc with a dozen or more supervisors. If in each of those scenarios, we're writing 12 page reports, then it's only natural that it's going to become embedded in our style. We think it's necessary and we may not have the wherewithal to question that and look for how to become more efficient. I think what you're talking about now makes sense. As early career professionals, there's a need to prove ourselves to prove competency. We just became licensed recently. We don't want to do something wrong. We don't want to mess up. So it seems safer to include the kitchen sink, as opposed to potentially the danger, I think, is that we leave something out. Right? I didn't mention this, it was relevant, the referral source or another neuropsychologist catches it, and I look bad, right? The way I'm thinking about it now is that it's certainly important that we don't miss something, but that doesn't need to be spelled out in the report. You mentioned manic symptoms earlier. So if in the report, if you had said psychiatric history is clean, that includes manic symptoms. So you have covered it. And being a competent neuropsychologist, that potential behavioral variant FTD case where someone might question if that's the case, you

have thought through that. And in your impressions, in summary, whatever your conclusion was, that conclusion takes into consideration the possibility that FTD is a contributor. I'm guessing that it wasn't so you didn't say that. So in my view, you've written a sound report. It's just maybe how we need to think about this that more of the logic and rationale can go on behind the scenes in our heads, you know, in the conceptualization and it doesn't have to be on paper.

John Bellone 19:51

Right. Or we can put a sentence in the summary, which I think I did the in summary impressions, that although some of the symptoms could potentially look similar to behavioral variant FTD, that doesn't fit with the rest of the data. So just a sentence of those impressions could do that work as well. I also find that I just maybe put too much detail into the background. That when the patient goes off on this tangent about all these things, I try to incorporate that, but it's just too much. I think it's irrelevant for the most part.

Ryan Van Patten 20:24

Right, right. So I think this is a good launching point for us to start to get into how to shorten reports. To summarize this conversation, I think what I'm getting at here is that this is particularly directed towards early career professionals, which is to say, have confidence in your training, be thorough and do a good job. But don't feel like every thought you have in your head about the case must go down on paper. You can be brief and summarize and be confident that you've considered all the angles without having to prove that to someone.

John Bellone 20:55

Yeah, and not just really great professionals, but also established professionals who are used to the old system. I would encourage them to take a second look at the reports, really think about how they could maybe summarize more or cut certain things or just streamline it a little bit more. I think everyone could benefit from that to some degree.

Ryan Van Patten 21:14

Yep. Perfect. So let's get into some specific ideas and recommendations in this regard. So…

John Bellone 21:20

Did you want to talk about, Ryan, I know you brought up in the interview that the report can be thought of as a one stop shop. Have you got any quick thoughts about that?

Ryan Van Patten 21:31

Yeah, yeah, definitely. So as we've gone through this process of these two episodes, I've been thinking about the perspective of shorter reports versus longer reports. As we mentioned, there's no one right way, but John and I are advocating to shorten [them]. And as I compare Jacobus and his perspective to other supervisors I've had, other approaches to writing longer reports, a big difference that I've noticed is when we write long neuropsych reports, often the mindset is that the report is a one stop shop for this patient. In other words, we're including everything that might be relevant from developmental history all the way to now. We're covering all medical history, we might include labs, all neuroimaging, anything brain, mental health, neurology related should go in this one document, which is this all inclusive narrative of the patient's brain behavior functioning. So I

think that's the approach that often leads to really long reports. If we're taking that approach, we include all that information from the EMR, maybe every or many notes from mental health and social work, long narratives about timelines. In contrast, what Jacobus would argue, I think, is that we don't need to think about our reports as being self contained. He really railed against the idea of redundancy. I think he was referring to redundancy within the report. But it also seems like he is pushing back against redundancy with respect to the medical record, meaning that we don't need to regurgitate all of the notes from other specialists. Maybe this person had neuroimaging five times and has had seven neurology appointments. That could take up a page and a half of our report, just to summarize. And if we are not quoting, but putting this into our own words, that might be an hour just to do that. Rather than that, I think we are empowered to refer the reader to these other experts, these other professionals notes. We could certainly provide really brief summaries of imaging...

John Bellone 24:04

Overarching summary, even, of all the imaging would be helpful.

Ryan Van Patten 24:08

Right. That drastically shortens our reports, and importantly, increases our efficiency because we're not spending so much time copy, pasting, and quoting, summarizing in our own words, all these things that take a really long time and really aren't necessary. That idea of avoiding redundancy is really helpful, I think.

So I think about those two ways - do we need to be a one stop shop or not? In my opinion, we don't need to be.

John Bellone 24:33
Right. That's a lot of burden on us.

Ryan Van Patten 24:35
Right.

John Bellone 24:36
I don't know why we're the ones who shoulder that burden all by ourselves to put this heavenly document together.

Ryan Van Patten 24:44
[laughs]

John Bellone 24:44
This immaculate document.

Ryan Van Patten 24:46
Perfect consolidation of someone's brain behavior functioning over their 75 years.

John Bellone 24:52
It doesn't mean that we should be sloppy or that we should not include things but it should be directly relevant to the referral question. That's what Jacobus kept going back to.

Ryan Van Patten 25:02
Quality, right? We're advocating for shortening, but that doesn't mean reducing quality. Actually, it can mean enhancing quality, often. So, yeah, thanks for bringing it up, John. So how to shorten reports? Something else to think about is focusing on the essential information. It may sound obvious, but if you're working on trying to shorten the reports that you're writing, what you can do is go through them and think, each statement, each paragraph, how is this relevant to the referral question and my ultimate conclusions? If it really starts to deviate, even moderately, from the central focus of this report - you know, it's an mTBI case, the referral source wants to know PCS or not. Then a lengthy timeline of this person's recent marital distress

and conflict with family, or ongoing lawsuit over an estate? Be brief and just think, does the psychosocial sphere directly impact PCS or not?

John Bellone 26:17

I think maybe one way we can do this is to not start writing, which is what Jacobus had advocated for, not start writing or dictating the report until you've already thought about how everything works together and what the main pillars are. What do you really want to communicate to this referral source? And how do you answer this question as best you can? That might help limit yourself from going too far into the weeds or deviating from that main objective. I also liked what he said about approaching it like a tweet, where you are confined to a certain number of characters, or a very brief email or a voicemail, or an elevator pitch, I think you said in the episode. If you had 30 seconds to communicate the results to that referring provider as they're walking down the hall to see the patient, what would you tell them? That would really help also to constrain your report to just the essentials. We can add a little bit more context to it, but having that be the focus when you're writing I think helps us stay on target.

Ryan Van Patten 27:30

Relatedly, and John, I think would be helpful - there was a discussion last episode about the inverted pyramid approach. I think it would be helpful for our listeners, if you just briefly described what that is and how to use it.

John Bellone 27:42

Yeah, that's not mine. This is from journalism. It's a very common approach to writing where you basically start the inverted pyramid. So the biggest part is at the very top and that's where you spend the most time and that's the most important part. So, basically, you spend the most time on the "need to know" topic, the need to know details. And then progressively less time as you get further and further into the weeds, less time both just in terms of your time writing it and less space on the page. So, “need to know” at the top, and then it goes less and less and less down into like the "nice to know" things down into details.

Ryan Van Patten 28:22

Yeah. In our report writing, we might think of the "nice to know" part as actually not even existing. Right? The report could just be "need to know". So if it feels like it falls more under the "nice to know" category you might consider cutting it. We've hinted at this, but something I want to make a little more explicit is what I found in my own reports often takes up a lot of time for me, and words / space on the page

are timelines. I think certainly timelines can be very necessary, need to know, useful, if they directly pertain to the presenting problem. So often working with older adults, they may come in with memory loss, subjective cognitive complaints that they've noticed for the last year or two. So it's important for us to state how long they and their spouse or their close family members have noted this decline. And then we often look for precipitating events, like was there a primary stressor that happened right around that time? If there was, of course that's relevant. But if there are other things going on in their lives, like relationships, moves from one place to another, kids graduating college, etc. I think as opposed to providing detailed timelines, maybe primarily around psychosocial or even physical health issues - like colonoscopy on this day - we can really summarize that stuff. If it correlates with their cognitive decline as directly relevant to what they've noticed, their subjective symptoms, then have at it and be detailed. Otherwise, a sentence is probably sufficient.

John Bellone 30:09

I think a general principle to keep in mind is we should be spending more of our time with our patients and spend less time on the writing. Spending less time on the writing and the reason why we're doing this shortening our reports is one because we're not getting paid for an unlimited amount of hours doing this. And number two, is that I would much rather spend an extra 30 minutes in the room with my patients answering their questions and talking about brain health, than using that half hour to write up minutiae from that interview.

Ryan Van Patten 30:42

Right. You would prefer that and I strongly believe that most of your patients would prefer that. As a patient myself, if I see a doctor, I'd rather him or her spend more time with me, educating me, learning about my symptoms, than writing some note that I'm probably not interested in. The referring provider doesn't need our long report. So the referring provider probably would prefer that we spend more time with a patient. The patient will be better educated about their symptoms, it will be easier for that person to interact with the patient later. So it seems like a win win win. I think about it from a humanitarian perspective, sort of utilitarian or effective altruism, where we are in psychology to help people so we should try to maximize our time that we spend professionally to help as many people as we can as much as possible. I think that the task of writing reports, at its core, is essential and very important. But spending hours upon hours on that task takes away from other things we can be doing that are a much better use of our time - spending more time with people in the room seeing more patients. If you shave off even 30 to 45

minutes per report, that'll add up and you'll be able to see more people or you could use your time pro bono or you could volunteer. There's many other ways that we would be using the skills that we've learned in a much better way if we can be a little more efficient here.

John Bellone 32:20
Or you can take up, you know, tap dancing classes like you've been doing on the side. [laughs]

Ryan Van Patten 32:25
[laughs] I told you that in confidence, John. I didn't realize this is no holds barred and we're telling secrets.

John Bellone 32:31
I think it is great. It's good exercise.

Ryan Van Patten 32:33
Okay, I'll remember that next time you tell me something.

John Bellone 32:37
I'll make sure to post the picture of Ryan and his leotard on the website. [laughs]

Ryan Van Patten 32:41

[laughs] Okay, so I think now it makes sense for us to transition and talk a bit more about the specific situation where we have trainees writing reports. We had gotten into this with Jacobus a little bit and I think it's a really helpful area to explore.

John Bellone 33:01

We both had the experience where, as a trainee, we feel like we can't make changes, even if we wanted to. We have to stick with our supervisor's template. We both have that experience, right?

Ryan Van Patten 33:14

Right. Yeah, I think that's ubiquitous for all trainees. And that's appropriate. Trainees should use the style and template of their supervisors. What I'm thinking about here is from the perspective of the supervisor. I'm still of the opinion that it could be helpful to use a lengthy neuropsych report as a tool for training. Jacobus

agreed and said that could work. He then highlighted the issue of like, do we have to burden the referral source with that lengthy report? Which is valid. Then he followed it up to say that he prefers to spend more time in supervision in the room with people in verbally talking through these issues. I respect that and I generally agree. At the same time, I think that the written format of a report is so different from a conversation. That it will allow us more detail, more room, as a supervisor, to really understand how our supervisees are thinking. If I'm having a conversation with you, we're talking about the battery, I'm not going to ask you to go through every test and give me the one sentence description of the Stroop Color Word measures inhibitory control, etc. But in a report you would actually get to see - and I think the process of doing that for a trainee and then being able to receive feedback via track changes from a supervisor on all those details early on in your training [is helpful]. This actually piggybacks off of our conversation with Neil Pliskin about the importance of technical aspects, that detail early on in training when we really need to get that groundwork solidified. I think using a long report to provide us detailed feedback on all of the nuts and bolts and specifics about a neuropsych eval could be helpful.

John Bellone 35:05

Yeah, I don't think the report has to change too much or be too lengthy. I think what you're advocating for, I agree could be helpful. Maybe that just might look like the trainee adding another section, elaborating on the results in prose. I don't do that. I put the summary table and then, in the summary, I give a very high level summary of the results. I know some neuropsychologists go through each cognitive domain and summarize, and then, again, summarize it in the summary section and the impression section. Jacobus doesn't do this and I prefer not to do it either. But that might be one way for trainees to get more of that feedback from us, from supervisors. But that doesn't affect the report too much.

Ryan Van Patten 35:54

Right. I like that. So we could have the succinct report that is the official report that is going to the referral source. And then we could have a few of these added sections to that report that are trainee specific, which might be the test list and descriptions - what each test measures, a summary of the results. Is there anything else? As I think about this, at the moment, the background section could probably be pretty similar. I think the background is an area where it would make more sense for us to talk through it verbally, as opposed to a test list, right?

John Bellone 36:31
Yeah.

Ryan Van Patten 36:32
In that case, the trainee could write a brief background section, but in supervision, could expand on all of his or her thought processes that went into - you know, what information did you ask about the clinical interview? Why didn't you ask this? What led you to think that, for example, poor balance and urinary frequency and cognitive impairment might hang together? What diagnosis are you thinking of here?

John Bellone 37:01
Think about how, if we're writing shorter reports to begin with, there's going to be much less to edit as a supervisor and that's going to free us up, time wise, to spend that time with our supervisees and go through all those “what ifs?” - what if this person had a 7th grade education? How would this be different? What would you do differently? Or if English was a second language? It really frees us up to dive into those nuances more in our supervision If we're not slogging through the edits of this report.

Ryan Van Patten 37:40
Right. Yeah. Related to what you're saying now, and a slight tangent from report writing, is in the domain of supervision, an area that I think we could have a lot of room for improvement is supervisors explicitly talking to supervisees about test selection and rationale for why each test is selected. In my experience, that's an area where I feel like we may lean more on convention in how we were trained and less on the literature and a specific rationale for one test over another. Of course, I'm not trying to paint with a broad brush, everyone's different. This has been my experience. So the point being, that's an example of an area in which we would have more time to talk with our trainees through the nuance of why we select each test if we're not spending so much time writing such long reports.

John Bellone 37:41
Yeah, it frees us up for a lot of different things. Yeah, absolutely. I agree with that.

Ryan Van Patten 38:39
Another relevant topic here is whether or not we should include the report itself as part of the feedback session. And, if so, to what extent should we do that? To caveat this, neuropsychologists vary in whether or not they prefer to have feedback

on the same day of testing. For example, Jacobus explicitly stated that he does prefer feedback on the same day of testing, whereas Karen Postal prefers a separate appointment for feedback. Once again, there's no one right way to do this. Obviously, if feedback is on the same day as testing, we won't have the report written. So for the sake of this discussion, let's assume the situation where feedback is on a different day. So, John, I'll ask you, to what extent do you make the report a focal point in feedback or not? And what's your rationale?

John Bellone 39:36

There's lots of different ways you can do this and I've seen different supervisors approach this differently. My preference, what I'm doing now might evolve, but I have the report written. Usually I turn it around in about a week for my geriatric patients especially. So I'll see them and then we'll schedule feedback in a week. That'll give me time to score and write the report and then I'll have that report in my hand when I'm sitting across from them a week from the evaluation. I'll use that as my guide, as I'm going through the feedback. So I'll have the table, the score summary right in front of me and I'll go through each score. I go through a high level of how they performed in different cognitive domains, what that means, functionally, and how that maps onto their symptoms. Then I have my etiology section right there and the diagnosis. So I just use it as a guide. Basically, I don't rehash everything in there. I'm assuming if they took that home - so at the end of my feedback, I give it to them. I like for them to have something to take home. I feel like that really helps. Then, right there, they have my contact information, they have my phone number, my email, on that report, in case they have any questions afterwards. A lot of my patients have memory problems, it's the most common reason why they come to see me. So I'm giving them all this information and it feels wrong to send them home empty handed basically.

Ryan Van Patten 41:05

Don't forget, by the way, these 12 recommendations. Each one.

John Bellone 41:08

Exactly. Right. [laughs] So I tell them, “The first two pages, that's the summary. And the recommendations are on page two. I'm going to give you all this information, but it's all written right there.” I try to limit the jargon. I know it's mainly written for the referral source, for the neurologist, but I tried to make it accessible for everyone. So I hand that to them to go home with, and I like that model. That's probably 90% of the cases I do. Sometimes, if they come from far away, or it's going to be a burden for them to come back or to get their caregiver to bring them, then I either give them

feedback right then or I give them preliminary feedback and we do we schedule a phone feedback later when I've had a chance to write the report and I'm essentially doing the same thing over the phone as I'm going through the results. That's not the ideal case, but that's typically how I do it.

Ryan Van Patten 42:05
Yeah, that makes sense. That's quite consistent with what I would be biased towards doing. I've noticed in my training that there's been a progression in feedback for spending more and more time on impressions, diagnosis, recommendations, and less and less time on background, specific test scores, etc. So early on in my training, there were points where, as part of the model I was in, we would hand the report to the individual and step through the entire report with them. But when we do that, we're really just regurgitating what they've already told us. If we're going through, especially if it's a long report, “You told me this about your psychiatric functioning”, “You told me that about a stroke you had 10 years ago”, right? The person is sitting there in feedback waiting for the bottom line.

John Bellone 42:56
Totally.

Ryan Van Patten 42:57
Right.

John Bellone 42:58
Like Karen Postal said, "Just tell me, is it Alzheimer's disease? Is it ADHD?”

Ryan Van Patten 43:04
Right. They're just sitting there waiting to hear something that they really find relevant.

John Bellone 43:08

I've also learned from just trial and error that if you hand them anything to look at, they are not listening to you anymore. So I stopped doing that. I am the sole holder of a report and I don't give them that till the very end.

Ryan Van Patten 43:21
I like that a lot because, yeah, it can be it, especially if it's long, but even if it's not, flipping through, there's all these scores that don't make sense. What is relevant to

me? Or trying to divide their attention between you and the report. As a neuropsychologist, it's not a good way to use their cognitive resources. So similar to you, I like having a copy of the report for the person in the room. And then certainly referencing it frequently, but having a conversation with them.

John Bellone 43:51
Absolutely.

Ryan Van Patten 43:51
Like you, I'll say, “The recommendations are here written out for you to review later. All this information is in this document. But let's talk about it.” And most of the feedback session is answering their questions, providing psychoeducation. Really what I think are the most important clinical tasks that we engage in using our therapeutic skills.

John Bellone 44:10
Yeah, checking in very frequently after each section. After [each] round of information, I always ask them,”Any questions? Does that make sense? What do you think about that? How are you reacting?” The report is really just a guide for me in case they had any specific questions. I can look back, "Oh, yeah. You are taking this medication.” It's just to help jog my memory as well.

Ryan Van Patten 44:31
Perfect. Yeah. An anchor, a guide, that is under the surface or that is in our hand until the very end is how I see it. Okay, great. Now we also have a few suggestions that we got from Jacobus' book, on neuropsych report writing. These are just tips that he gives us, areas where we might improve. The first one is referring to the impressions section. What sometimes we might find is that this section is essentially just a laundry list of individual test findings without any clear integration of different components. Really, in this part of the report, we need to be pulling all the information together to make a concerted point. This is where our primary case conceptualization should reside. So, as far as I'm concerned, we don't need to be restating test scores or going into a lot of minutiae that the reader could find elsewhere. I think the referral source will likely read this section more than any other and will benefit from knowing what our takeaway is. If the person has Alzheimer's disease, if we conclude that a child has ADHD, or that someone's test findings are not valid, then this is where we're putting it all together - the most important information from the background, with behavioral obs, with test results in a very concise way.

John Bellone 46:08

I think by laundry lists he really means that we should avoid the tendency to just say how they performed on this test and in this test and this test and this test. The referring provider doesn't care about the Trail Making Test, they care about what the performance on that test means for their patients. That's really what we should be doing. We should be integrating, obviously, with all of the results in context with the background and then talking at a much higher level about all the results rather than just listing the different tests. I even had a supervisor, I think it was - I'm going to put a shout out to her - I think it was Karen Miller at UCLA who said she didn't like to see a test name in the summary section, in the impression section. It had its place, but not there. Because you should really take a much higher level approach to that impression section.

Ryan Van Patten 47:06

Yeah, this brings up a question that I'll pose to you, John, to see what you think related to the impression section, specifically the etiology of cognitive impairment. The approach that I usually use is simply to list the different potential ideologies for cognitive impairment in an ordinal fashion - like, here are this person's risk factors for cognitive impairment, first and foremost, family history of Alzheimer's disease, second, a few concussions, third, poor sleep, fourth, depression, anxiety, done. I found that to work pretty well. In the past, I've had discussions with people who use different methods who think that that doesn't work as well. In my mind, having it listed, boom, boom, boom, it's sort of like you could just take that and use bullet points. It just seems like the referring provider could look at that to get a sense as to the most important potential etiology for cognitive impairment and then sequentially go down the list and present a pretty succinct fashion. What do you think? What's your approach?

John Bellone 48:13

Yeah, that's very similar to my approach. I think that could also tend to look like a laundry list of etiologies, right? It could be this, could be this, could be this, could be this. But, I mean, sometimes that's the best we can do. And it really does - you know, chronic pain and poor sleep and vascular, they all contribute to these cognitive impairments that we're seeing. Another supervisor of mine, Tim Belliveau, used to say, "Tell them first what you really think it is." Give your primary - like, if you had to put money down on what the etiology was, you should list that first and be most confident in that. Then give your secondary and tertiary potential etiologies. I like that approach, too.

Ryan Van Patten 48:56
Yeah, like that, too. I think having a laundry list of potential etiologies is more acceptable than having a laundry list of individual test findings.

John Bellone 49:04
Agreed. Absolutely. Yeah.

Ryan Van Patten 49:07
So the second little pearl that we'll take from the neuropsych report writing book is not offering any new information or insights. In other words, if our report doesn't offer anything new, after all this time, effort and energy, then obviously it wasn't worth it. So I think about this as a guiding principle. While we're writing these reports, keep in mind that you want to add incremental validity to what the referring provider already knows about the person. This could be tied in with the idea of a laundry list of individual test findings - just restating what we already know. We can be very descriptive and just get a bunch of information from someone and rehash it and there's this whole list of symptoms and test scores, but is that really adding anything above and beyond what was already there? In a neuropsych report we want to be sure that there's a takeaway, which goes to your previous point about what Tim Belliveau had told you. Make sure that your primary diagnosis, your primary case conceptualization, what you add to the understanding of this patient, the one thing you want in the mind of their physician, make sure that it's front and center. Of course, first and foremost, that it’s present, that it's in the report, and that it's worded in such a way that it will stick with them. This is another reason for us to write shorter reports. The longer the report is, the important stuff can drown out in all the other details. So I think that's a great recommendation.

John Bellone 50:43
Yeah. So, you know, obviously, this isn't the be all, end all of report writing. We'll be talking about this many more times and with different people. This is just our take on it, like we mentioned at the beginning. We talked a little bit about ways to shorten reports, and hopefully gave you some actionable steps to summarize more, cut extraneous details, and really, to focus on what the referring question is. But really, the main goal that we have is just to convince you, the listener and the field of neuropsychology generally, that we need to start tapering down our reports. Like the stakeholder’s project laid out, we are writing longer reports than we think is necessary, longer reports than the referring providers want. That increases the turnaround time, and that hurts patient care. Ultimately, patient care is what we really care about. That's why we're doing this. This should be a wake up call to us

that we need to make some minor adjustments and shorten our reports. So that was the main goal. We'll be talking about this more.

Ryan Van Patten 51:59
Agreed. Yeah. I want to mention that, of course, we want to provide a how-to guide as much as possible. So we're potentially opening up some people's purviews to the idea of shortening the reports. But then I hope that people are getting something from our discussion today in terms of how to do that. And we want to give that to you, but it's also really hard to do that because all reports are different, all patients are so different. So anything we say might apply to some situations and not others. So for us in this podcast format to provide really specific recommendations on what to cut is really difficult. Hence, I think our conversation today sounds big picture, conceptual, etc. I hope that was still relevant.

There are a few other things I want to mention that we haven't touched on yet today that are very relevant to report writing. One way to decrease report writing time is to use dictation software as opposed to typing out your reports. We haven't spent a lot of time on that because neither John or I use dictation software currently. So we just don't feel like we have the full technical know-how and the scope of knowledge to give you a lot of great insights there. But just be aware of that technology. My take away with dictating reports from what I've heard from a lot of people who do it is that initially, it increases the time to write the report because you're just not used to doing it that way. We're used to thinking and then typing and putting our thoughts on paper that way. This is a whole new modality. So give yourself time in the front end to be inefficient and figure out what works for you because once you get used to it, as I've heard, it drastically increases efficiency and reduces report writing time by dictating.

John Bellone 54:08
Yeah. We'll talk about that more with someone who has more skill. I do want to refer listeners to an online resource. It's from the Interorganizational Practice Committee, the IOPC. It's a committee of practice chairs from AACN and NAN and APA Div 40, and a few others. They have several templates of neuropsychologists who have offered templates of short reports. So you can model yours after that or just have a look and get more of a sense of what a 4 or 5 page neuropsych report might look like. We will directly link to that website. If you go to navneuro.com/26, we'll link to that page, in addition to the stakeholders projects and Jacobus Donders's report writing book as well. We're hoping that the old way of doing things, the lengthy report, is going to go what we're calling "the way the Donders." [laughs]

Ryan Van Patten 55:03
[laughs]

John Bellone 55:03
The lengthy reports are going the way of the dodo, the way of the Donders. So, hopefully we'll spark up some good conversation. Please find us on Twitter or on the website, the same link that I just gave you. We can have a back and forth about what you, our listeners, do and what you prefer. Hopefully we'll get a conversation going.

Ryan Van Patten 55:24
This is a great topic for conversation because, as we've stated multiple times, it's subjective. There are different opinions. This is all based on rationality and logic, how we might best accomplish our jobs. So we're very open to feedback and discussion. Well, we hope that this has been helpful and as interesting to you, our listeners, as it has been for us to go through ourselves. And, as always, join us next time as we continue to navigate the brain and behavior.

Exit Music 55:57

John Bellone 56:20
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Ryan Van Patten 56:32
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