Examining SOAP Notes Written by Internal Medicine Practitioners from Patient Encounters in the Hospital Setting

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Abstract

This study examines SOAP notes as used by internal medicine practitioners in the hospital setting, reviewing the main sections of the acronym SOAP, as well as any physician problems and solutions to problems that are seen. The study uses SOAP note guides specific to hospitals as a means of creating generalizable ideas and sample SOAP notes from internal medicine to supplement the general ideas with specific observations. Furthermore, the study considers tip guides and a video as a means of researching issues physicians face when writing the notes. The four main sections of SOAP notes – Subjective, Objective, Assessment, and Plan – were considered in their entirety. Before each section was elaborated on, SOAP notes were considered in general for possible flaws. Each section's purpose was stated, and key parts or components of the sections were explained, as well as any significant role the section played in internal medicine. Any issues physicians face when writing each section were outlined, and solutions for the issues were given.

Key Words/phrases: SOAP notes, progress note, internal medicine, hospital, physician notes

Introduction

When an internal medicine physician encounters a patient in a hospital setting, the practitioner will write SOAP notes as a part of the required charting. The term "SOAP" arrives from the four distinct sections of the notes: Subjective analysis, Objective analysis, Assessment, and treatment Plan. This paper will be structured in accordance with these sections, sections that can be readily identified on many patients' charts. SOAP notes are often found on charts because they are valuable in their ability to facilitate smooth communication between physicians, give reminders to physicians of important events during the encounter, and provide a legal safeguard to the physician's practice. In internal medicine especially, notes are important as oftentimes general practitioners are those who first receive and refer patients to specialists.

This paper is an overview of SOAP notes as a whole, breaking down the extent of information and writing done in each section by an internal medicine practitioner in a hospital setting. While undoubtedly an important part of an internal medicine practitioners toolkit, the extent of formal training during medical school varies, and oftentimes prospective interns must turn to explanatory documents and samples from education hospitals. The focus of this paper will be to grow a premed's understanding of SOAP notes in what each section consists of the amount/type of writing done, and the potential difficulties internal medicine practitioners face in writing the document.

Methods

In order to develop knowledge of SOAP notes, the writing done within and issues faced while writing them, several types of sources were used. Below are each of the sources that were used:

How-To Guides

First, general "How-To" guides were selected as a means of gaining general information as to what SOAP notes do, what each section accomplishes, and key conventions or parts to be emphasized in each section. Examples of these guides are sources (1), (2), (3), and (4). The criteria for the "How-To" guides were general, as these kinds of guides tend not to focus on a particular discipline of medicine; in other words, there were no major guides on SOAP notes for internal medicine specifically. However, all of these guides do come from established teaching hospitals, like (1) and (4) or medical education organizations, like (2) and (3). (5) is a special case of a document that provided both a how-to guide as well as a sample.

Sample Documents

Second, sample documents were selected due to their ability to provide detailed examples of what SOAP notes would look like in the field. Examples of samples are documents (5), (6), (7), and (8). Samples also provided examples of how errors commonly made could be mitigated. The samples were more specifically selected, starting by being filtered twice. First, all of the sample documents were written by either teaching hospitals, like (8), or medical educational organizations for hospitals, like (5), (6), and (7), thus fitting the first specification of the study. Secondly, the samples all are written within internal medicine, fitting the second specification of the study. As stated before, (5) was a special case, containing both a sample and a how-to guide.

Tip Guides

Third, two sources were "tip guides" that were selected for their ability to explicitly call out issues that physicians had when writing SOAP notes. Examples of these documents are (9) and (10). These two documents came up with the key words "SOAP note", "hospital", and "internal medicine". They also came from websites focused on medical education.

Video Source

Finally, a video, source (11), is used throughout the paper as a whole, filling in gaps and expanding on how to write effective SOAP notes. This video also helps to directly give a physicians perspective into this project. It was selected because of the internal medicine practitioner who is in the video, as not only does he practice internal medicine, but he does so at an academic university's affiliated hospital, which fits the constraints of the study.

Results

Organized into four distinct sections, SOAP notes grant internal medicine practitioners a clear and efficient way to summarize patient visits, providing future specialists with an important base to work with. Each section comes with a distinct purpose, distinct elements, and differing challenges that must be mitigated by practitioners.

Subjective Section

The first section of SOAP notes is the subjective section. (1) and (3) state that the aim of the subjective section is to provide a place for the concerns of patients' to be taken down. This section acts as a record of the personal experiences and feelings of the patient, and the physician in (11) notes that he was taught that this section is meant to convey the patient's story as a doctor understands it. All samples had distinctly separated subjective sections; however, the section within each sample varied in length and format, demonstrating the inconsistent way medical students are taught documentation, as explained by (11).

Seen in (5), the subjective section is of particular importance in internal medicine, as internal medicine practitioners will often refer patients with more specific issues to specialists, and it is important that the notes clearly reflect the patient's issue. Thus, internal medicine subjective sections tend to be much longer than in other specialties; sources (5), (7), and (8) all had subjective sections that were longer than similar notes from other specialties.

A common element of this section is the patient's "Chief Complaint" which is, as outlined by (1), (2) and (4), is the primary reason for the patient's visit. All samples had a common complaint, and the physician in (11) suggested that such a complaint be clear and directly quoted. In internal medicine the chief complaint manifests itself as a variety of issues, examples of which are chest pain in (7) and an arthritis follow up in (6). Another common element of this section is a brief medical history, as stated in (1), (4), and (11). While not all of the guides had references to this patient history, all of the samples had some form of medical history that generally went on for a sentence or more. Source (4) specifically adds that the history section should only have the information pertinent to the specific case.

Both (2), (9) and (11) elaborate that an issue physicians face when writing this section is that of bias. Oftentimes physicians will have patients that act in a difficult or inappropriate manner, which will cause physician bias to permeate the SOAP notes that are meant to be objective documentation. (9), (10), and (11) all explain that the most effective way to mitigate bias surrounding a patient is to provide direct patient quotes. The physician in (11) even elaborates that he utilizes patient quotes heavily in the subjective section; however, none of the samples found use direct quotes themselves.

Alongside bias, (2) and (9) examine another issue faced with this section: vague or unprofessional phrasing. This issue can be remedied by, as stated before, taking direct

quotes from patients in addition to avoiding overly wordy phrasing in favor of concise sentences and maintaining a professional tone.

Objective Section

The second section of SOAP notes is the objective section. (1), (3), and (4) have the aim of the objective section being to record physician observations and tests and/or measurements taken by the physician. This section is a log of the objective data collected by the physician during the encounter with the patient. All samples have distinctly laid out objective sections, either laid out in a paragraph style or a bulleted list. The data in (5) was laid out in a paragraph style, whereas the data in (6) was typed in a bulleted list. (7) and (8) both had a mix of these styles, which the physician in (11) states as typical for internal medicine doctors to do.

In internal medicine, (4) advises, objective sections are strongly encouraged to include measurements and tests that are repeatable. This is because specialists down the line from the general practitioners will likely rerun these tests, thus requiring repeatable tests that are laid out clearly. In addition, (10) emphasizes that all staff that were present during or who ran the tests be specifically documented for the potential legal implications. None of the samples reflected this, but that is likely because, due to HIPAA restrictions, the samples are fabricated, and no real staff appeared during the tests.

An issue encountered in the objective section, as revealed by (1), is the failure of physicians to differentiate between signs and symptoms. Simply, symptoms are the feelings of patients, which belong in the subjective section, whereas signs are the objective measurements and observations done by physicians, which belong in the objective section. Oftentimes, as (11) and (10) note, physicians will write information in the objective section that belongs to the subjective section. Thus, it is important to keep in mind that only tests, observations, and measurements taken by the healthcare provider make it into the objective section.

Assessment Section

The third section of SOAP notes is the assessment section. As (1), (3), and (11) outline, the goal of this section is to summarize the findings of the already written objective and subjective sections and arrive at a conclusion. The physician in (11) explains how oftentimes this conclusion is a diagnosis; however, physicians may not be able to reach a diagnosis and may provide a differential diagnosis or a general judgement based on the findings they have. Samples (6), (7), and (8) all have diagnoses given, but sample (5) filled the assessment section with a summary of the current status of the patient. All samples had a section for the assessment.

Even in internal medicine, the assessment section is the shortest part of the notes. Sample (5) and template (4) both had a suggested format for a sentence write up of the patient's problem and presentation. Samples (6) and (7) adopted a brief bullet point style structure, with no complete sentences. Sample (8) had a mix of both styles, having both a bulleted

format with sentences echoing the format explained in (4) and (5). However, (4) explains that both a bulleted list and a sentence are sufficient ways to approach the assessment section.

(2) and (10) explain that a common issue physicians face when writing this section is implying false certainty in their assessment. In internal medicine, this has even larger implications as specialists down the line may shift their thought process to accommodate any certain diagnosis provided by the physician. Source (9) states that by keeping the assessment brief by avoiding unnecessary wording, physicians can mitigate that issue. Furthermore, as explained by the physician in (11), a hard diagnosis need not be given if the information does not support it, and temporary answer or differential diagnosis can be appropriate.

Plan Section

The final section of SOAP notes is the plan section. As (1), (2), and (3) all claim, the plan section is meant to address any future testing, referrals, or treatment recommended by the physician. The physician in (11) explains how this section refers to a variety of different topics, including changes in patient's behaviors, future physician tests/investigations, treatment options, and any possible consultations.

A common element of the plan section, as mentioned in (2), are predictions of expected outcomes if the patient adheres to the plan. Samples (6) and (8) included these expectations in the plan; none of the other samples nor guides had reference to this section. (11) had a brief reference to expectations, but nothing that seemed to warrant it being a necessity in the notes.

All samples had a plan outlined in the notes, however only some of the samples had a different section written out for the plan. Samples (7) and (8) as well as the template (4) had distinctly separate plan sections of varying length. The lengths themselves did not have anything to do with the field being internal medicine, the length varies from patient to patient, as mentioned in (1). Samples (5) and (6) both had a plan section combined with an assessment section. None of the guide documents nor the video, (11), elaborated on this type of structure.

A common issue found in the plan section, as explained by (2) is that the plan is oftentimes vague and/or not present. (10) emphasizes the importance of physicians having an open conversation with patients and their plan routes to create better quality healthcare. (10) further elaborates the importance of adding something such as "Patient knows to call any time if an emergency arises" can help protect doctors from legal issues that may arise as a result of a patient being unclear on the plan. However, none of the samples had any references like this in them.

A common critic of SOAP notes in general that sources (1), (3), (5), and (11) elaborate on is the idea that SOAP notes are not fitting for every situation. Oftentimes, SOAP notes are either too expansive or too narrow to properly address certain patient issues. Thus, (3) provides alternative

formats for brief note taking and more in depth note styles. However, because there are not SOAP notes, they will not be elaborated on; but it is important to consider that SOAP notes are not a perfect nor isolated medical documents.

Furthermore, (1) specifically addresses how SOAP notes do not oftentimes provide great detail to change over time. Thus, other documentation styles are sought out for their abilities to depict clear change over time. Like above, these documents were not elaborated upon in this study.

Conclusion

SOAP notes are a common charting method used by internal medicine physicians when recording patient encounters in hospitals. While important to all fields of medical practice, SOAP notes are especially important to general practitioners, as their documentation efforts will impact specialists down the line from them. While conventions within sample documents may vary, there is a generally agreed-upon structure to SOAP notes that is adhered to in internal medicine. Based on the findings in this study, prospective medical students and future residents would find it informative to understand SOAP notes, their structure, issues associated, and how physicians go about mitigating those issues.

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