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Reading this review as a psychiatrist, I cannot help but focus on the human layer beneath what is presented as a technical problem. The authors catalog how mandatory fields, templates, and algorithmic aids can enhance completeness and correctness of documentation, but what they are really describing is the constant negotiation between cognitive workload, system constraints, and clinical reality. Psychiatrists know this tension well: rich, nuanced narratives are often flattened into checkboxes or drop-downs, and the quality of those data then becomes the “truth” that drives decisions, research, and reimbursement.

I was struck by how little attention has been given to “currency.” Timeliness is the one dimension of data quality that truly defines clinical utility in psychiatry, where context can shift rapidly and meaning is embedded in chronology. Yet only three of the reviewed studies looked at it. This gap highlights what I often observe in my own work: the barrier is rarely the interface alone, but the clinical environment in which the interface is used. A 60-minute intake compressed into 30 minutes will never yield current, accurate data, no matter how refined the UI design.

The review rightly notes the promise of predictive algorithms, autocomplete, and structured ontologies. These tools can ease burden and guide clinicians toward standardized categories, but they also risk subtly redefining what is “documentable” and, by extension, what is real. In psychiatry, where patient experience resists neat categorization, this is not a trivial concern. Automation can improve correctness as defined by concordance with a model, but it may simultaneously erase clinically relevant complexity.

The larger issue, in my view, is that we continue to treat data quality as a UI optimization problem rather than a sociotechnical one. If incentives reward throughput, or if staffing shortages make timely documentation impossible, no clever autocomplete will fix the resulting data gaps. As in clinical psychiatry, where symptoms are best understood within context rather than isolation, so too must we approach data quality within the broader context of workflow, incentives, and care environments.

This is why I resonate less with the optimism around adaptive interfaces and more with the idea of subtraction and simplification. Before layering on new predictive aids or adaptive UIs, perhaps the more radical innovation would be to remove the clutter, paring back to what is truly essential, ensuring it is documented well and in time. The promise of this article is real, but I worry we are once again asking interfaces to solve structural problems they cannot resolve on their own.