Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Case History as Meta-Message, Part II

During an exchange of information across your desk, you must take into consideration how things are said, i.e., paralanguage, which encompasses such variables as speech speed, volume, pitch, emphasis, and accent. Each has the capability of altering either the doctor or patient's perception of the intake.

Consider first the doctor or patient's speech speed. If the doctor speaks rapidly, the patient could easily get the impression of being rushed; a fast-talking patient could give the impression of being high strung or apprehensive. Voice volume is another issue: The loud doctor or patient always runs the risk of being regarded as coarse or unpolished. Voice pitch, likewise, has the reputation of inviting a misconception. Because movies have created a stereotypical image of a doctor, patients expect their personal physician to "sound like a doctor." A high-pitched squeaky voice does not instill confidence.

Emphasizing certain words can be misleading. Because the majority of patients are unfamiliar with chiropractic terminology, asking patients in a firm and emphatic voice if they have ever been told of having scoliosis could be frightening.

The proliferation of foreign doctors in the health care profession has markedly increased in recent years; consequently there are more doctors with strong accents. The number of patients with accents has also increased. Hence, an accent coming from either side of the desk can easily put undue strain on the intelligibility of a case history. As if this were not enough, variations of word pronunciation in the English language can also create difficulty. A patient once came into a doctor's office complaining of a "risin." The doctor could not make head nor tail of the word "risin." Finally, after some probing and pointing, it was determined that the patient had a raised area on her neck.

Another aspect of case history taking involves the seating arrangement (proxemics). As a rule, patients sit at one end of the doctor's desk, at a right angle to the doctor. This means that the patient's head must be turned slightly to face the doctor. It would be much better if the patient's chair were positioned to face the doctor more directly, thereby facilitating direct eye contact. The better the eye contact, the better the communication.

The case history process should also be free of interruptions. Although the occasional telephone call or passing question by a nurse is understandable, an excess in either instance should be discouraged.

A great many chiropractic offices either have piped-in music or a radio playing in the background. Although this is fundamentally a good idea, it could be a distraction, especially if it is the kind of music the doctor likes and the patient dislikes. The first visit to a doctor's office is taken seriously by a great many patients. Having to listen to the doctor while some disquieting music is playing in the background is counterproductive. While gentle and relaxing music is certainly acceptable in the waiting and treatment rooms, it should not be played during the case history. The doctor and patient should give undivided attention to one another.

Consideration should also be extended to how doctors and patients are dressed. This falls under the heading of sartorial communication. It derives from the Latin sartor, meaning a tailor. Colorado psychiatrist Dr. Jean Rosenbaum suggests, "When you're selecting clothes, you're choosing a kind of substitute body." Indeed, the clothes people wear does advertise something about the people inside them. In a previous column on credibility, I indicated that the doctor who "looks like a doctor" instills more confidence in a patient than one who does not.

In reverse, the way a patient is groomed could also influence the doctor. Compare your reaction to a handsomely dressed new patient and one who is slovenly dressed. Will you talk differently? Will you subconsciously make inferences about economic, educational, or intellectual status? Both patient and doctor usually have a mental picture of how the other should look; the extent top which either fails to conform to that image will be reflected in the attitudes displayed during a case history.

Next, there is the matter of how patients should be addressed. Initially, a formal approach is recommended: Mr., Miss, Ms., Mrs. or if warranted, any professional title. Calling new patients by their first name is not only presumptuous but unprofessional. Patients have been known to take offense but not register vocal objection. The doctors who take such a liberty contend that it helps establish a friendlier and less apprehensive doctor-patient relationship. While this may be true in certain cases, it is wiser to wait until the patient has been under your care for a while and then, after asking the patient's permission ("May I call you Mary?" or "May I call you John?"), take such a liberty.

Beware! Once you begin to call patients by their first name, some will do the same with you. Patients have been known to call in for an appointment and ask the receptionist or nurse, "Can John see me around 4:30 on Wednesday?" For some reason, once doctor and patient are on a first name basis, something changes. It should be said, however, that with certain special patients, such an arrangement works well. To repeat: While taking a case history on that first visit, address your patient properly.

Don't put words in a patient's mouth. Once you have asked a question, say nothing until the patient has had an opportunity to answer. Some will require a little more time to formulate their ideas, especially when their complaint is charged with emotion. Doctors are frequently impatient. Example: "Tell me about the pain." Before the patient has had a chance to answer, the doctor adds, "Is it sharp and stabbing or dull and aching?" Don't lead them unless they appear to be totally unable to grasp your meaning. Permit them to use their own words, enabling them to recognize their complaint if it is ever fed back to them. If a patient complains of pain in the tailbone and you record them saying coccyx, it may cause some confusion later on.

An excellent communication technique to employ during a case history is something called, "tagging." It consists of taking the essence of what a patient has just said and use it as a preface to your response. For example, if your patient has just said, "Doctor, lately I have had a great deal of trouble sleeping. I get up five and six times a night." To reassure your patient that you were listening, and that you understood them, begin your reply, "Regarding your difficulty sleeping ..." Naturally, this is not done with everything they say, just use it periodically.

Few things are more counter-productive in a case history than overkill; that is, saying or explaining too much. Unfortunately, doctors frequently fall into an either/or category -- they either say too much or too little. A happy medium is the exception rather than the rule. The best policy is to take your lead from your patient. As you speak, watch carefully for any facial signs of confusion. If necessary, ask if the patient understood what you said. Generously invite questions.

Where a case history is taken deserves some attention. Although most take place in the doctor's private office, some do not. Depending upon available space and office routine, a case history may sometime occur in an examination or treatment room. Though the site may not seem relevant, it is. Health care contexts actually have a great influence on the communication between doctor and patient, particularly a new one. The setting alone gives off different signals.

Let us consider the doctor's private office first. The patient is usually seated on some kind of chair, not an examining or treatment table. Second, the patient is fully dressed, not wearing a treatment gown. And lastly, the patient is surrounded by various diplomas, citations, and awards extolling the doctor's professional reputation and accomplishments. All of these accoutrements serve to create an entirely different climate in which to be asked and to answer health-related questions. Obviously, the doctor's private office is the best place to take a case history.

In concluding a case history, the doctor is obliged to summarize. Consolidate what you have gleaned from the patient and put it into a clear and concise perspective. Say things such as: "I understand you correctly, your problem is mainly at the base of your skull on the right side, and it hurts you most when you turn your head to the right. Is that correct?" Having said that, have the patient confirm your assessment of his problem. Emphasize the fact that "getting well" is a cooperative effort. It is essential that your patient appreciate your understanding of the problem and what you plan to do about it. Communication is the means, chiropractic is the method.

In closing, I would like to mention something of paramount importance. Patients are never to be treated as if they were children. Many are more educated, more successful, more worldly, and more intelligent than we are. Simply because we are dealing with their health, and any serious malady could shorten or compromise their life or life style, we have no right to adopt a holier-than-thou attitude. It is common knowledge that, no matter how important a person is by society's standards, sickness or disease has an uncanny way of humbling the best of us. Hence, as healers, we must not lose sight of our humanity. When taking your next case history, assume a more egalitarian manner, become more sensitive to meta-messages and by doing so, extend those less fortunate a gentle hand, a kind word, and a sympathetic ear.

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Editor's Note:

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