Dynamic Chiropractic

Liar

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The risk associated with treating a patient is inversely proportional to the honesty of the history presented. While dishonest patients may occasionally visit the private office, they commonly present to the emergency department (ED). Working in the ED provides an excellent opportunity to be exposed to a variety of patients with difficult behaviors. The risk associated with treating a, "truth-shading patient" is related primarily to assessing severity. The greater the truth-shading behavior, the more difficult the diagnostic and treatment planning. The practitioner is also at risk of suffering vicarious disrepute by virtue of association with a dishonest individual. On occasion, the patient's dishonest answers can contribute to a life-threatening situation.

The most common form of dishonesty is obviously the magnifying patient. It is difficult to imagine too many patients who do not magnify at least a little. There is almost always some secondary gain to being in pain. The fringe benefits range from monetary gain through litigation, missed work days, and not having to take out the garbage, to extra hugs from a loved one. At the risk of being politically incorrect, some magnification appears to be either cultural or related to poor communication skills. Large numbers of non-English-speaking patients present to the ED. It follows common sense that an individual who does not speak English well will need to use pantomime. If the patient is a poor actor, it may appear that he or she is magnifying or malingering.

Outright malingering is less common than magnification. As long as caution is employed, it is reasonably easy to handle the malingering individual. Waddel's signs are a good predictor of malingering and can help the practitioner assign the proper disposition. However, one must be careful not to allow the label of malingerer to encourage prejudice. A patient may be a very bad actor or possibly even a true malingerer, and simultaneously, be suffering from a serious, but hidden medical condition. I evaluated a 25-year-old man who whined like a child as he described his sensory deficit. Ignoring his crybaby mannerisms and taking his complaints seriously, I ordered a MRI that demonstrated a significant syrinx positioned in his cervical spinal cord. It would have been just as easy to dismiss him due to his annoying behavior.

Some very serious conditions (e.g., brain tumor) will generate a nonphysiological history. Dr. Boston Martin, a retired brain surgeon, advised, "The more bizarre-sounding the symptoms, the more important it is to obtain imaging studies of the brain." He spoke of several patients who had been labeled as either malingering or neurotic. Upon proper evaluation, they were all found to suffer from serious organic brain pathology.

In the extreme converse, some cultures or personality types tend to belittle their complaints. I am always afraid of the patient who presents with a "church lady" personality. This type of patient appears almost embarrassed to admit to being injured due to another's negligence. Perhaps feeling guilty for not completely forgiving the offender prevents this person from admitting to the full extent of the injury.

Drug seekers search out the ED. It is not uncommon for the local hospitals to be flooded by drug seekers, when the carnival is in town. These patients typically present complaining of severe lower back pain. They claim to have a private physician back home who prescribed strong narcotic pills,

but unfortunately, the bottle was left behind in Kansas.

They stereotypically complain of being allergic to acetaminophen, aspirin, ibuprofen and Toradol. The only medications left are narcotic. A clever ED physician may use the on-call chiropractor as a secret weapon against drug seekers. Most people who present to the ED with back pain are willing to give chiropractic a try. Drug seekers lose their patience quickly and head for the door. They have no interest in a viable alternative treatment that does not include intravenous morphine or Demerol.

Once I evaluated a woman who wore a bathing suit under her clothing. She explained that she was planning a trip to the beach. She apparently thought some narcotics would make the trip more enjoyable. The woman complained of not being taken seriously before I was even able to ask my first question. She was quick to refuse treatment and asked to be discharged immediately. The attending ED physician eagerly granted her request.

One of the best fakers presented with a winged scapula. He claimed that he fell while climbing a tree. He complained that his rope abruptly stopped his fall by snagging his shoulder blade. Unfortunate for him, there was no bruise or abrasion to confirm his story. Before he left, he admitted to having the winged scapula since birth.

The patient I fear the most is the one who doesn't see the chiropractor as a general diagnostician. One patient denied any medical history. I did a complete systems review, leaving nothing to chance. He answered "no" to all my questions, just as he had done with the triage nurse and the attending ED physician. He followed up in my office three weeks later. When I questioned the delay in follow-up, he replied that he had needed to see his oncologist for a regularly scheduled surgery to remove more of the slow-growing bladder cancer. As he was unaware that cancer could spread from the bladder to the spine, he felt it was unnecessary to tell me. Even though I asked all the right questions, the patient erroneously believed it was only important to answer questions he believed were related to his lower back complaint.

Another ED patient told me he had no complaints other than neck pain. He claimed to be otherwise in great general physical condition. He advised that he had been to four other hospitals without satisfaction. He complained that he had only been given medication that temporarily covered his pain. I was gratified at his proclamation that he had finally received real treatment for his problem. Upon visiting my office two weeks later, he appeared to be limping. He now complained of hip pain. Palpation revealed inguinal lymph nodes the size of large grapes. He was apparently hoping that if he ignored this rapidly growing problem, it would go away. A review of his previous medical records revealed that he had been urged by a medical physician, almost one year earlier, to go to specialist for evaluation and treatment of a suspected abdominal tumor. I referred him to the appropriate hospital clinic, but unfortunately, I suspect it is too late for him to begin meaningful treatment.

Experience in the ED clearly illustrates that we cannot accept a patient's casual response to our important questions. I now ask about medication by questioning, "Are you taking any medication for any condition, not just for your back?" If I sense resistance, I will give the example of the woman with leg pain who is a smoker and taking birth control, who may be suffering from a blood clot. I stress to the patient that they need to answer every question truthfully and completely - even if they do not believe it relates to their presenting complaint. If they still do not seem to understand, I will give them further examples. I might tell them that a patient may not realize their skin condition can be related to joint pain (e.g., psoriatic arthritis). I also try to make them understand that I need to know about conditions which slow healing (e.g., diabetes, and that is why I would ask about excessive thirst, hunger and urination as well).

The ED provides a wider variety and greater severity of presentations than the private office. This establishes the ED an excellent and challenging source of continuing education. Working in the ED offers a constant reminder that we cannot trust the first response of some patients, and that the information we seek may need to be extracted forcefully from the patient.

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