Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Let the Patient Tell Their Story

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

Often when a patient presents with an injury, they want to tell their story. People by nature like to talk about themselves, particularly when they're worried about their health. Your job when doing the patient interview is to ask open-ended questions so the person will tell you their story – all the gory details: which way they were looking when rear-ended, how they twisted when falling down the steps, how hot the weather was when they were injured doing yard work. Those details help to fill in the narrative and validate the patient's complaints.

The Value of a Good Story

If a patient were looking to the side during a rear-end collision, there will likely be a rotation / torsion component to the hyperflexion / hyperextension injury. This would create greater soft-tissue and joint injury in multiple planes, and can be a factor in how quickly the patient responds to care.

If a patient slipped on the steps, they could have twisted their ankle, sat down hard on their coccyx and tried to stop their fall – wrenching their shoulder all at the same time. So, the fall is more than just a back injury – but a complex of different injuries, each of which requires specific care. (Not to mention in this case that trying to walk on a sprained ankle can aggravate a lower back and again be a limiting factor in the healing response.)

Again, patients like to talk – let them. The patient will often tell you exactly what is wrong with them in the first 50 words if you let them. A good narrative consultation should give you a pretty clear clinical impression of the patient. At that point, your exam and diagnostics should really be to confirm what you already suspect is going on. Listen to the story. Then record it in your notes.

Story Embellishment

Some patients, especially those with chronic pain complaints, will often "overtell" the story. This does not mean they are malingering. More often than not, they are trying to convince you of the legitimacy of their complaints. Sometimes they will embellish their complaints. This is understandable: The patient does not feel others believe they have legitimate complaints – nothing

broken, no casts or scars – just the vague complaint of pain. These patients have been dealing with their issues for so long that they feel a need to validate.

While this can be viewed as "symptom magnification," it does not mean the patient is intentionally trying to be misleading – they are legitimately trying to convince you that they have a real pain complaint. Again, listen to the story – the patient will tell you what is going on.

Signs of True Malingering

Knowing patients want to tell their story should help you recognize a red flag when a patient is vague or on guard. According to *Evans' Illustrated Essentials in Orthopedic Physical Assessment,* a true malingerer will often be quarrelsome, nervous or ill at ease. Often they will avoid eye contact, sometimes even wearing dark glasses.

These should be clues to dig deeper. Ask leading questions. Watch them. See if how the patient moves matches their pain complaints.

For example, I recently had a patient who reported severe, debilitating pain – he staggered around

my office with his cane – but would pick up his cane and run across the street to the bus once he left my office.

His complaints did not match his behavior. This gets into the realm of malingering. Such an observation should be noted in the record – at least stating that "the patient's subjective complaints do not correlate with their objective presentation."

On the flip side, I had a young man come in for evaluation after getting blitzed in football practice – he was hunched and limping getting out of the car, but expressed minimal complaints during my consult. He did not want to miss out on playing, and he knew his coach would pull him from the game if he were injured.

Determining legitimate malingering, or fraud, is difficult. You have to be careful and complete in your consultation and examination. Multiple similar tests should be used to define and localize complaints. Waddell's testing is an expected tool. Careful correlation of your findings with other case records is also important.

Observe how they move when you are not testing, or when they come into or leave the office. Casually talking about what their plans are for the weekend can cue comments about activities they would otherwise not be able to pursue. Someone with an acute lumbar disc and sciatica probably should not be planning a tennis match later that afternoon.

Story Details and Documentation

Pay attention. Listen to the story. Observe the patient. As physicians, we are responsible for collecting and assimilating all of this data to present a clear and accurate clinical profile. I have said before that we should expect our records will be reviewed by others – insurance adjusters, attorneys and other doctors. The more complete and accurate the records are, the more opportunity you have to validate your treatment and support your care plan.

Think of these notes like a fire extinguisher: you don't want to have to deal with it, but when you need it, you are happy to have it there. During a deposition, an attorney can ask you just about anything about your care of the patient, whether or not you wrote it down. What you "think" or "remember" is not credible – if it is not written down, it is not part of the record!

If you are ever called upon to justify the care you provided a patient, the notes in your file will be the only tool you have at your disposal. Make sure you take the time to complete your documentation. As I've said before and will say again, it's good practice and good patient care!

OCTOBER 2014