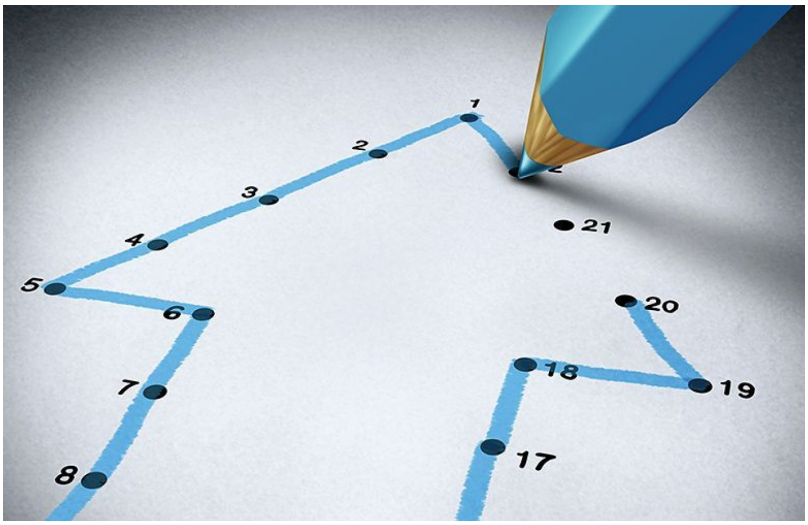
Dynamic Chiropractic



CHIROPRACTIC (GENERAL)

The Rest of the Story: Let the Patient Tell Their Story (Part 2)

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

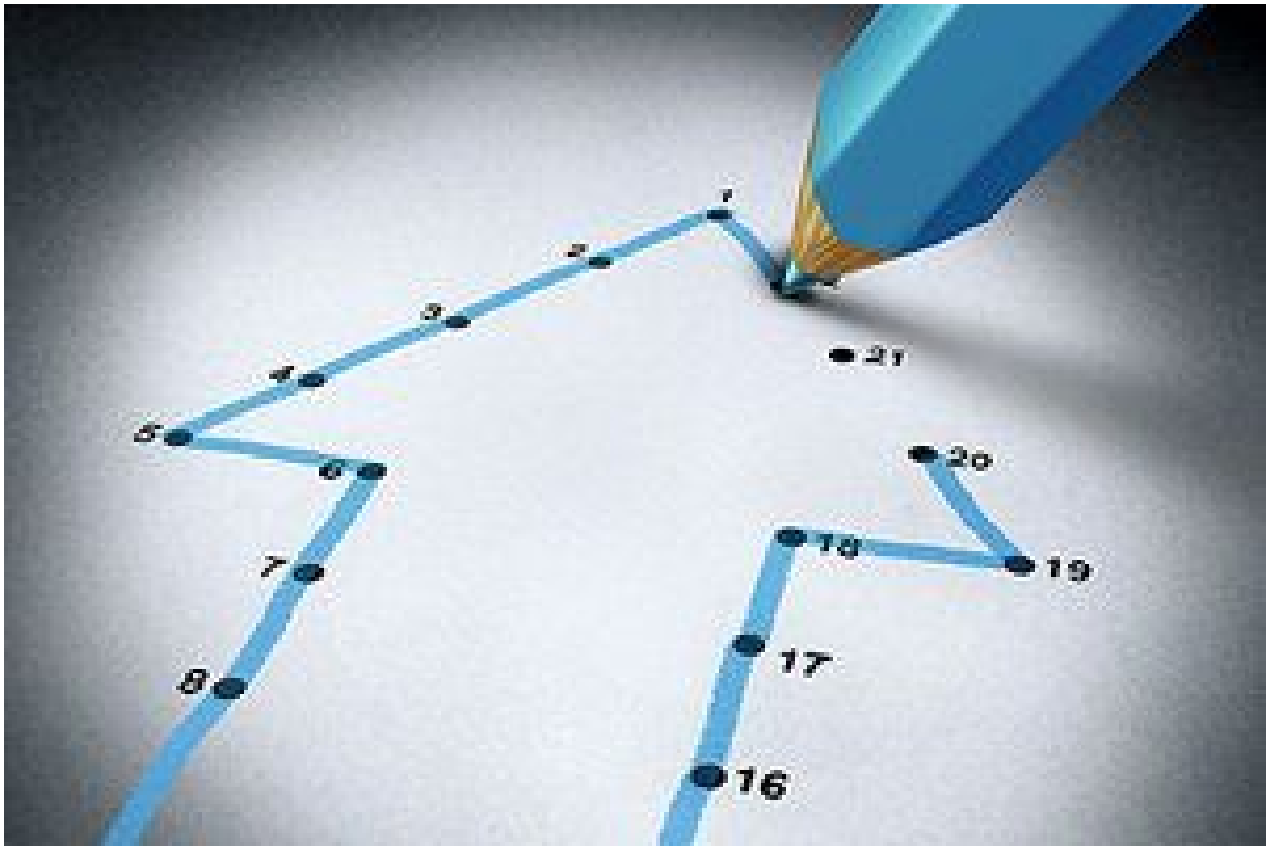
Back in 2014, I wrote about allowing a patient to tell you their story – about taking the time to listen and engage all the aspects of their case history, the injury in question and the related issues. I also discussed aspects of symptom magnification and malingering. Most patients come in with legitimate complaints seeking your help – but you have to have a clear picture of what is going on if you are going to give them the care they need.

Renovating History

One aspect of patient care not previously discussed is what I call the "renovated history" – when the patient honestly gives you what they think is a correct history, but it is not. This is typically when a patient has experienced other care or is under other care for a condition and no longer considers it a health issue.

A good example is blood pressure – I routinely ask about blood pressure as part of my history consult. A patient may have excellent blood pressure and deny any issues, but later in the consult will tell you they are taking Avapro, Coreg or Lopressor. If you ask them why they are taking the medication, they will readily tell you, "It controls my blood pressure." They assume that since the med is in their system and all is well, they no longer have the problem.

The point here is not to get into an argument about the appropriateness of medications – blood pressure or otherwise – or to open an opportunity to berate the patient on the evils of allopathic medicine. The point is that patients often think if their symptoms have been treated with medications, there is no longer an active issue. As physicians, it is our responsibility to fully and completely understand the scope of our patient's health history – even if they don't.



Surgery or No Surgery?

Beyond medications, surgeries are another aspect of the health history that patients often fumble. This past week, I had an older woman come to my office for a long-standing history of back pain, heart irregularities and breathing problems. While talking through her history, I inquired about her surgical history.

Initially, she denied any surgeries, but then made a side comment that she had not had any "that would affect anything I [meaning me, the DC] was interested in." (*Note* – this is often the time you should be *very* interested). Only after I inquired again and told her I wanted to be as complete as possible in my understanding of her history did she admit she had undergone a complete hysterectomy – with both transverse and lateral incisions. What's more, that surgery was performed just months before her current complaints began.

When the Story Changes

Another good example of the urgency of a complete history came up in a recent EMT training class. On being called to a patient's residence, you are given a chief complaint of severe headache. He had been working on his car when the symptoms started – he went into his kitchen and sat down, but the headache got worse, to the point of nausea and lightheadedness.

Initially, most people think of migraine, but if you take the time to ask other questions, the story changes: *Where were you working on the car ?* "In the garage." *Was it running?* "Yes."

Also note it is January – it is cold outside, so the garage door is closed. Now the situation changes dramatically. This is not just a sudden-onset migraine; it is an urgent issue of carbon monoxide poisoning. But the story is not over yet.

Where is the patient? In his kitchen. *Where is the garage?* "Through that open door right there."

Now there is a legitimate issue of your health and safety, as well as the patient's and that of anyone else in the home. It becomes imperative to keep asking questions until you have a crystal-clear understanding of every aspect of what you are dealing with.

The Perils of an Incomplete Picture

If you don't have a good understanding of what is happening with your patient, be extremely careful. When I was in my preceptorship, we had a patient come into the clinic. He complained of back pain and headache, and he denied any significant history on consultation. But when the attending touched him for palpation examination, he was hot to the touch – not warm, *hot*.

I recall my teacher stepping back and commenting that he was hot and something else was going on. Did he have a fever? At that point, the patient became angry and said it was nothing to be worried about. My teacher asked again and the patient refused to give any other information.

At that time, I watched my instructor tell the patient he was sorry, but if the patient could not tell him what was going on, we would not be able to accept him as a patient. The patient left angry. We were contacted by the local hospital later that week and informed that he had passed away due to immunocompromise and multiple organ system failure. He also had several spinal fractures.

Had my teacher not drawn the line and refused treatment based on an incomplete history, we could very well have been implicated in that patient's death. (Please note – we didn't just choose to refuse to treat the patient; care was refused because the patient would not provide a complete history of their problem and associated symptoms. You can't provide the right care if you don't know what you are dealing with.)

Record the Full Picture

As I emphasized in part 1: Pay attention. Listen to the story. Observe the patient. And *ask questions.* I recently encountered a case in which the doctor stated under oath that he had released the patient to return to light-duty work with lifting restrictions – but counsel then produced a document signed by the doctor showing he had released the patient to return to work full-time, full-duty, with no restrictions. What you "think" or "remember" is not credible – if it is not written down, it is not part of the record.

APRIL 2016