Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Olfaction: A Primeval Legacy -- Part II

Let us now move our discussion to the healing arts. In every facility, public or private, discernible scents and smells are present. Health care professionals (doctors, nurses, technicians, volunteers), all emit their own unique olfactory signature. Some odors are derived from the materials with which they are obliged to work, others from personal cosmetic sources such as: colognes, perfumes, hair spray, toilet water, mouthwashes, lotions, soaps, etc. Superadded to these variegated fragrances are those emanating from their patients. In all, a virtual bouquet of aromas which, if properly interpreted, carry valuable information.

In private practice, the moment patients enter your office, especially for the very first time, all of their senses are peeked. They visually peruse the office layout, experience waiting room furniture through their sense of touch, acoustically attend environmental sounds, and more importantly, decode incoming odors with their sense of smell. If all else in your office is perfect, but there is an offensive odor present, the entire experience may be seriously jeopardized.

Assuming your office has gotten a passing grade for smell, the next hurdle involves either you, your receptionist, or your nurse. If any of you are guilty of having bad breath, body odor, or wearing an overwhelming cologne or perfume, patients may be offended.

Then, there is the question of patient gowns. Are they freshly laundered? Does the covering on your adjusting table give off an unpleasant odor? If pillows are used, are they freshly scented? Of special importance is the doctor's uniform. Because we come into such close physical contact with our patients, and what we do often causes some perspiration, body and uniform odors must be judiciously guarded against.

While palpating patients' cervical spine in the supine position, our face comes very close to theirs. In consequence, as we instruct them to relax, or turn in a particular direction, we often breathe directly into their face. The risk of offending in this situation is extremely high.

Offensive odor emanating from a patient is equally unpleasant for the treating doctor. This occurs when we ask patients to take a deep breath and, upon exhalation, they send forth a putrid smelling breath. Irrespective of whether the malodorous breath comes from the doctor or the patient, it is woefully inexcusable.

Odor residue from certain patients may also contaminate your treatment table. Despite the fact that you cover your table with a towel, or conscientiously replace the headpiece tissues, the leather or Naugahyde often retains some memory of a noxious odor.

I am reminded of the war that took place on Eastern Airlines between smoking and nonsmoking passengers. Both wanted their rights to the air. Is smoking permitted in your office? Nonsmoking patients are quick to detect doctors that smoke. Despite not smoking in their office, their clothing betrays them. Smoke permeates everything with which a smoker comes into contact. What we need to

remember is that patients do not prefer the same scents. Surely you have encountered pipe smokers who cannot understand why everyone doesn't like the smell of tobacco smoke. Cigar smokers are a breed unto themselves. While they insist that not smoking while treating patients gets them off the hook, the cigar odor never leaves them.

Think of the patients you are currently treating. Would you agree that you prefer not touching those who smell unattractive, unpleasant, and foul? Or, even more disgusting, a patient who flatulates during an adjustment. People approach more readily attractive things and persons. If patients look unpleasant or has bad breath or body odor, it is unlikely that we will want to touch them. Attractive people in society receive more touch because attractiveness is related to scent. Since chiropractic is a highly specialized profession involving touch, it is essential that we become sensitized to how intimately touch and scent interface.

In any responsible discussion of odor, diet must be taken into consideration. I am referring to people who eat such things as garlic, onions, and fermented cabbage. They, too, contribute to one's olfactory signature. Do you, or any member of your staff, qualify as one of the aforementioned eaters? While it may be embarrassing, encourage your nurse or receptionist to check your breath every morning and, if it is suspect, pop a breath mint or use a breath spray.

Reflect for a moment upon how people judge the food placed before them. Some are turned off by how it looks, others by how it tastes or smells. The latter is undoubtedly the most primitive approach to food. Perhaps it is because the rhinencephalon (which controls smell) is the oldest and most primitive part of the human brain. Interestingly, when one researcher gave students long lists of paired words, those paired with odors were remembered best. Odor remains in our memory longer than what we see or hear.

Patients, when presented an odor, may fail to identify exactly what they smell, but will decide upon some type of label, usually responding that the label is "on the tip of the tongue."

Let me close by urging you to rekindle your interest in the role olfactory communication plays in your professional life. Patients adapt to how both you and your office smells. In time, those odors will become psychologically associated with a pleasant or unpleasant experience; i.e., the odor is the message. Heighten your awareness of how odors impact upon you and those whom you treat. Appreciate the fact that a successful practice or a successful practitioner might well be contingent upon something as simple as scent or odor. "The nose knows."

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Editor's Note:

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