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Case History as Meta-Message, Part I

Patients and doctors use more than words to exchange ideas about what they feel and how they think; they employ such messages as time, space, gesture, facial expression, gender, posture, pronunciation, accent, dress, cosmetics, jewelry, jargon, context, etc., as signals (messages) of meaning. Metacommunication (meta, "beyond") is the technical term for the use of such signals. Put differently, metacommunication is a specialized form of feedback about the manner in which people communicate.

Every interaction (case history) has both a content and a relationship component. The physiological and psychological aspects of both verbal and nonverbal communication are inseparable. Hence, their interrelatedness is partially explained by metacommunication.

Communicologist Marshall McLuhan espoused, "The medium is the message." Using television as an example, he suggested that what appears on the television screen is not the real message, but rather, the fact that there is such a thing as television. Borrowing from such a mindset, what will be proposed here is the notion that the information actually revealed by a case history may be less telling than the information revealed by the process of taking it. For example, metacommunication can confirm, contradict, or substitute for words, i.e., a patient may say that he feels good but looks terrible. Which is the real message -- how the patient looks or how he says he feels? In this instance, how the patient claims to feel is the message; how he looks is the meta-message. Such cues as how the patient shakes hands, smiles, frowns, or sits in a chair may often transcend words.

Taking a comprehensive and reliable case history plays a significant role in any form of health care. The axiom, "A problem well-stated is half solved," tersely makes this point. I have been on the faculty of four chiropractic colleges and, to the best of my recollection, case history taking was either understressed or conspicuous by its absence. As my recall applies to chiropractic college curricula many years ago, I would be pleasantly surprised to learn whether present day chiropractic colleges offer a separate and specific course on how to take a case history, or simply a cursory inclusion in some other course, i.e., office procedure. This speculation is not intended as criticism, but rather as an effort to ascertain whether our current graduates are being adequately trained in this aspect of patient management.

Every case history commences before a word is spoken. Traditionally the doctor and patient nonverbally greet one another, make eye contact, shake hands and sit down. Only then, does the verbal exchange begin. It is during this phase that the doctor and patient are most equal.

The moment a patient starts to recite symptoms, perceived status begins to change; the mere recitation of symptoms diminishes the patient's ethos, and conversely, elevates that of the doctor. The patient's interpersonal status sinks even further as more and more personal questions are asked and answered. In short, the doctor must be keenly aware of the fact that during the taking of any case history, the patient is at a serious communicative disadvantage. It now becomes necessary to address the interview itself: to explore just how the admitting doctor can most tactfully access the desired information and, in the process, preserve the patient's self-respect and dignity.

In the hierarchy of status, doctors rank higher than laypeople. And while this is true in a broad social context, it is relatively less so when the doctor meets a completely new patient. First impressions are quickly processed on both sides of the desk. Such things as age, appearance, dress, language, eye contact, and office decor all influence how each perceives the other.

From the outset, doctors must appreciate the importance of how a question should be asked. Directness is not always the best policy. Stoically asking, "Have you always been bowlegged?" is definitely wrong. Since new patients are perfect strangers, one never knows their psychologically sensitive areas, i.e., their Achilles' heel. Perhaps you have heard the saying, "Never mention rope in a home where someone has recently been hanged." For years, too many doctors have displayed an insensitivity to their patients' feelings. The question of patient embarrassment has led a growing number of women to seek out female chiropractic and medical practitioners. Not only do the women find it easier discussing symptoms indigenous to women, but also to be observed and touched in various areas of the body.

Making excessive notes while taking a case history can also detract from the establishment of a positive doctor-patient rapport. Patients have been made to feel that the doctor is not really listening if he is writing while they are talking. Note taking is an art; it is something that should have been taught and mastered in college. Unfortunately, most doctors are poor note takers. This probably accounts for the use of checklists; the doctor simply asks questions in a particular order and, mechanically, checks off positive or negative responses. A disadvantage of these elaborate lists is that certain irrelevant questions are asked. It is reminiscent of the car mechanic who, instead of going directly to the problem, checks out everything and, hopefully, stumbles onto the real problem. Whereas being thorough is certainly a commendable trait, it too can be overdone.

To offset the inattention that note taking may convey, some doctors have elected to tape record their case histories (with the patient's permission, of course). This would facilitate greater eye contact by the doctor, insure better listening, and create a sense of genuine concern.

During any routine case history, the doctor gives off both verbal and nonverbal messages to the patient; some are positive, others are negative.

Examples of positive verbal messages:

- "That's very interesting. Tell me more."
- "Yes, I see what you mean."
- "Good. Very good."
- "I would appreciate that a great deal. Thank you."
- You are very kind."

Examples of negative verbal messages:

- "That may be true, but I've never heard of it."
- "Is that all you have to say?"
- "What has that got to do with what you have told me?"
- "I'm terribly sorry, I wasn't listening."
- "Is that really important to you?"

Examples of positive nonverbal messages:

- nodding your head affirmatively
- leaning forward toward your patient
- sitting with hands and feet unfolded
- smiling appropriately
- sitting erect

Examples of negative nonverbal messages:

- drumming your fingers on the desk while patient is talking
- frowning or looking bored or distracted
- looking at your watch
- playing with some object: pen, paper clip, etc.
- squirming in your chair

The questions you ask your patients fall into three categories: open, closed, and forced choice. An open-ended question permit patients to expand on whatever they are saying, to go into greater detail. For instance, "Tell me what lead up to your present complaint?" would constitute an open-ended question. A closed question by comparison does not allow for any elaboration: "How old are you?" "Where exactly does it hurt?" These questions are direct and call for a short, precise answer. A forced-choice question does exactly what its name suggests: demands that the patient make a choice. "Do you prefer sleeping on a hard or soft mattress?"

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Editor's note: "Case History as Meta-Message, Part II" will appear in the Jan. 28, 1994 issue.

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