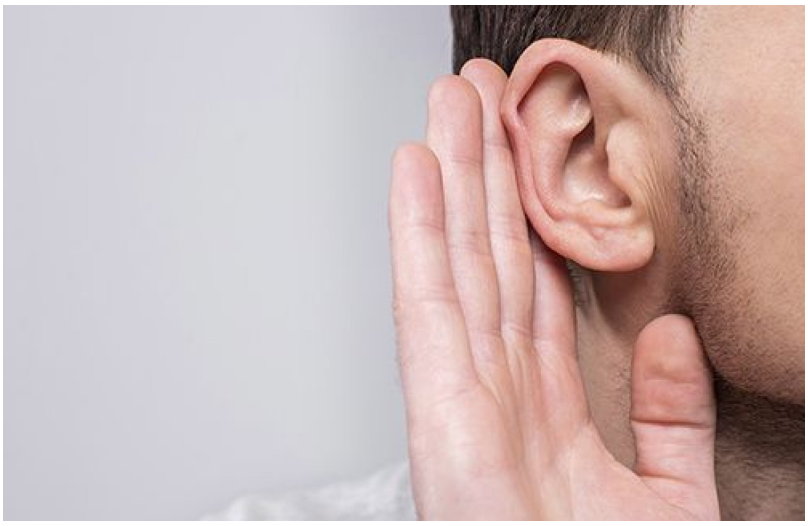
ACUPUNCTURE Today



PATIENT EDUCATION

The Rest of the Patient Story

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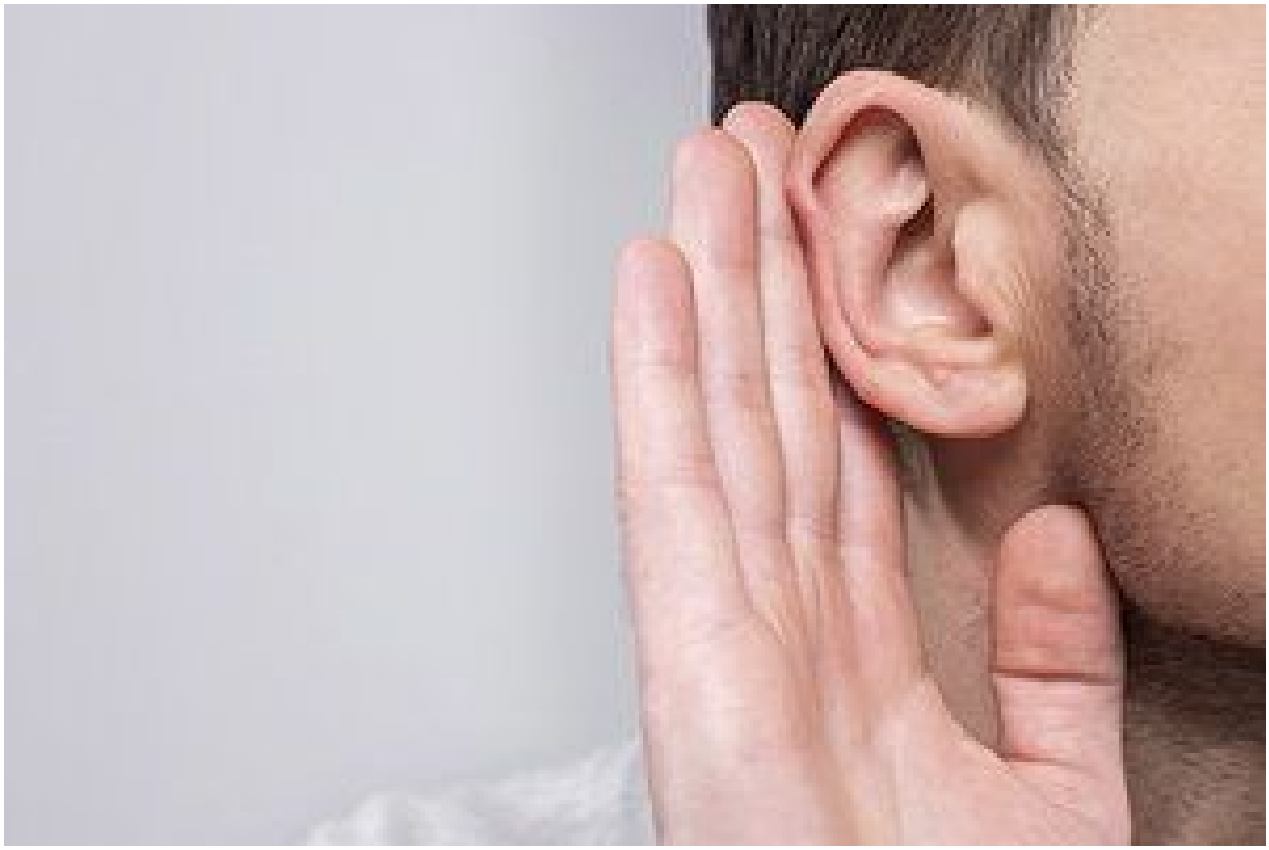
I've written previously about allowing a patient to tell you their story – about taking the time to listen and engage all the aspects of their case history, the injury in question, and the related issues. Most patients come in with legitimate complaints and seeking your help – but you have to have a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

Symptom Magnification

Patients (usually with chronic issues) may "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 called "symptom magnification," it does not mean the patient is intentionally trying to be misleading – they are legitimately trying to convince you that they do, in fact, have a real pain complaint.



Renovated 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, when it is not. This is typically when a patient has had other care, or is under other care for a condition and no longer considers it a health issue. A good example would be blood pressure. I routinely ask about blood pressure as part of my history consult. A patient may have very good blood pressure and deny any issues with blood pressure, but later in the consult will tell you they are taking Avapro or 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 medication 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 here is that patients often think that if their symptoms have been treated with medications then there is no longer an 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.

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Surgeries

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 longstanding 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 was interested in." (Note – that 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 that she had had a complete hysterectomy – with both transverse and lateral incisions. And that surgery was done just months before her current complaints began.

Complete History

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 came in to 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 – the garage door is closed. Now the situation has changed dramatically – this is not just a sudden onset migraine, this 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 patients. It becomes imperative to keep asking questions until you have a very clear understanding of every aspect of what you are dealing with.

If you don't have a good understanding of what is happening with your patient, be very careful. When I was in my preceptorship, we had a patient come in to the clinic. He complained of back pain and headache, and he denied any significant history on consultation. 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 very 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 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 – 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.)

Pay attention. Listen to the story. Observe the patient. And ASK QUESTIONS. 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. The more complete your understanding of the history, the better your care will be.

Think of your notes like a fire extinguisher. You don't want to have to deal with a fire, but when you need it, you are happy to have it there. During a deposition, an attorney can (and will) ask you just about anything about your care of the patient, whether or not you wrote it down. I recently encountered a case where the doctor stated under oath that he had released the patient to return to work light duty 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!

If you are ever called upon to justify the care you provided (or didn't provide) 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 – why did you do what you did. As I've said before and will say again, it's good practice and good patient care.

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