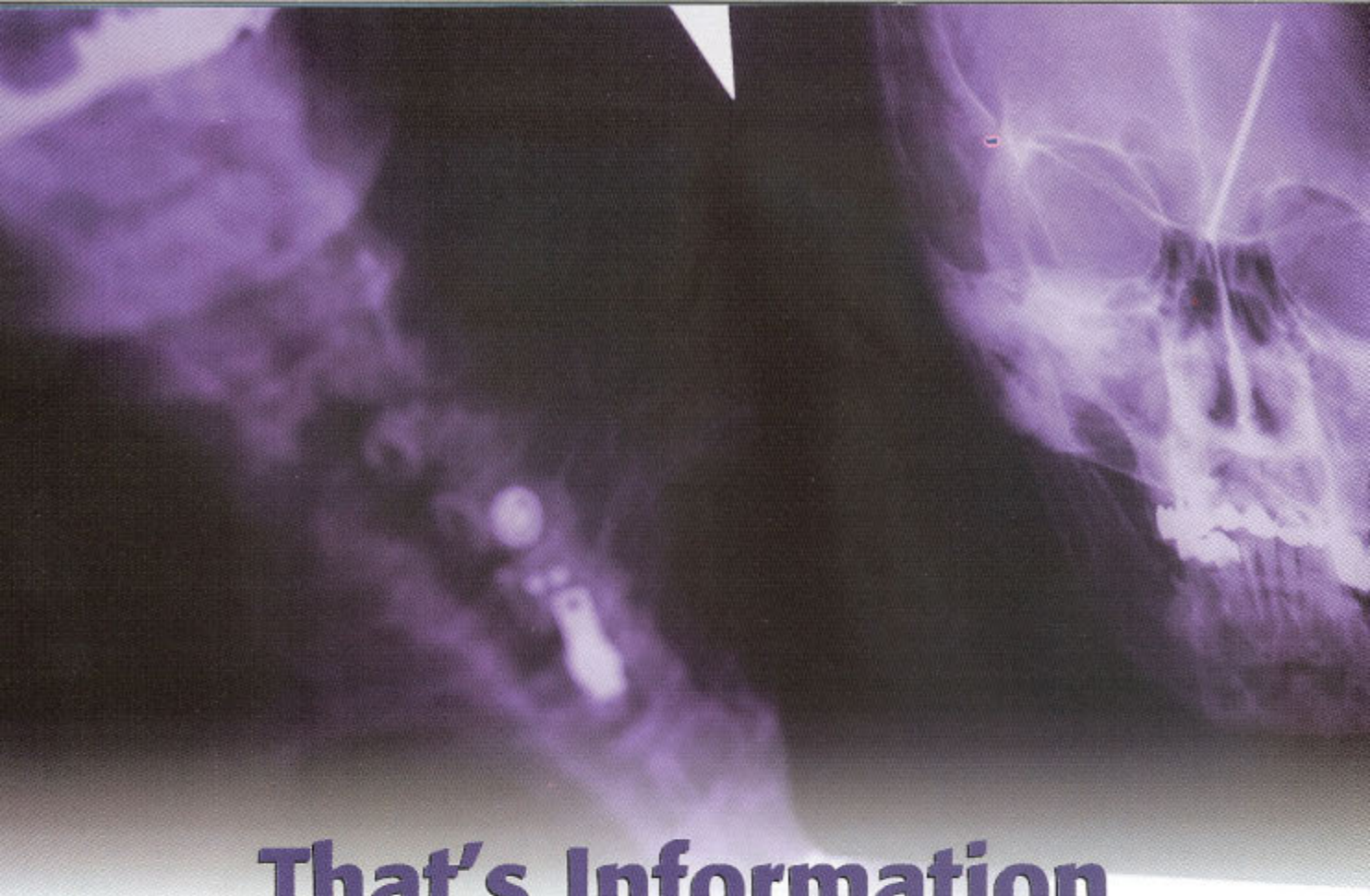


# That's Information We Need to Know

BY K. JEFFREY MILLER, DC, DABCO

I once x-rayed an elderly patient who had been involved in an automobile accident. When the films came out of the processor I placed the lateral cervical view on the view box to check the quality of the pictures. I immediately noticed what I thought was a scratch from the processor over the patient's skull. However, as I continued to look at the film I realized the image was created by a metallic object in the patient's skull. The object was jagged and irregular in shape. Similar objects of smaller dimension were noted around the periphery of the first object. Further study of the film revealed three large holes in the patient's skull. These were holes typically drilled for brain surgery. I quickly flipped back in the patient's chart to the history question regarding previous surgeries. Just as I remembered — the only two surgeries listed were a gall bladder removal and a hysterectomy.

I returned to the room where the patient was waiting and said, "Ma'am, the only two surgeries you listed were gall bladder removal and a hysterectomy. However, it appears on the x-ray that you have had some type of brain surgery and there is metal in your head." She thought for a moment and then said, *"Oh honey, I forgot to tell you I got shot in the head in 1972!"* My first thought was, "How do you forget something like that?" Her mind seemed fine for her age; she related that she just did not like to think about that. However, to quote comedian Jeff Foxworthy, "That's information you need to know." He was talking about an entirely different matter, but nevertheless; we all have certain information we need to know.

Several years later a gentleman entered the office with lower back pain. In his history he related that his only surgery was for a hernia repair several years earlier. Also, when asked if he had ever been hospitalized for medical tests or any reason other than surgery, he said, *"No."*

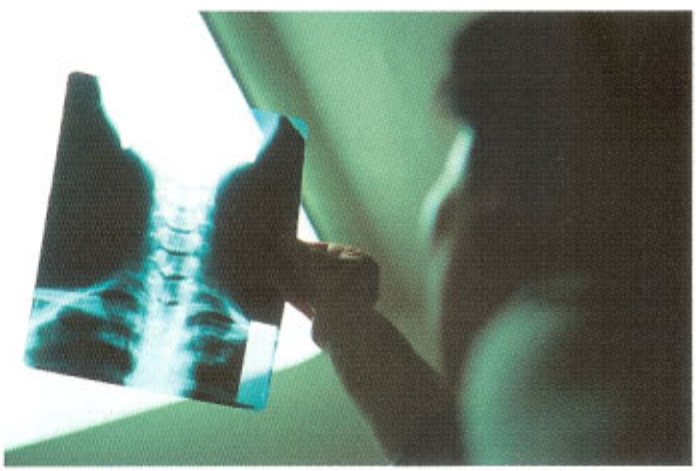
When asked if he had any vascular problems he also stated, *"No."* I had left this patient sitting in the x-ray room while I was in the dark room. When I came out of the dark room he said, *"Did you see that big aneurysm they say I have in my stomach?"* "Well, no!" I said, "Abdominal aneurysms do not always show up on lumbar film, and if you have one it definitely didn't show up on these films. Why didn't you tell me you had an aneurysm?" *"Oh, you're just a back doctor. But, I was curious when I realized you x-rayed near the spot they did. They said that I was not ready for surgery, and I just wanted to know what you thought."*

Most types of manipulation in the lumbar and pelvic regions are not the best things in the world for abdominal aneurysms. Oh, by the way, I have gotten so wrapped up discussing the aneurysm that I forgot to mention the pound of wire I *did* see on the film holding his breast bone together. This was from the open heart surgery he forgot to mention.

Recently, an established patient returned to the office for care. I honestly did not remember the gentleman. So, before entering the exam room I reviewed his file. He had disappeared five months earlier after only two visits for a lower back complaint, giving me the old *"I feel better, don't call me, I'll call you"* speech. Two previous surgeries — tonsils and right knee — were listed. The history update he completed in the reception room said his current trouble was right arm pain.

When I walked into the room he was in obvious distress, writhing in pain. He was holding his right arm in an abducted position and could not extend the arm at the elbow or lower it to his side. When I asked him how long he had been like this he said, *"Two days."* It was Monday, so I then asked, "What were you doing Saturday when this started?" *"Nothing"* was his answer. "Were you in an accident, or did you change your activities in any way?" *"No."* I did a cervical compression test and his arm pain intensified. Cervical distraction relieved the pain mildly. I then told him, "This looks bad. I am going to get a set of x-rays before we go any further." *"Can't you just pop my neck, Doc? I think it is coming from my neck."* "I think it is coming from your neck, too; but, we'll really need those x-rays before we try to do anything about this."

I x-rayed him and left him sitting in the x-ray room while the films were being processed. When I saw the first film I was shocked. His neck was fused from C4-C7 with a large metal plate and four screws. I looked at the remaining film and then went back to the x-ray room. "Who fused your neck?" *"Dr. Majors"* "Were you planning to tell me about this?" He just shrugged his shoulders. I looked for the scar on his neck and realized I had missed it because of the angle he was holding his head and the collar of his shirt. "You're a 10 ft. pole patient," I said. *"What's that mean?"* "I would not touch your neck with a 10 ft. pole. Either your fusion has failed or the disc above the fusion has herniated, so it is back to the surgeon for you." *"Alright, Doc,"* he said.



I went to the front desk and told Anne to get Dr. Majors' office on the phone and make our patient an appointment. Then, a voice rang out from the reception room, *"Are you sending my husband back to Dr. Majors?"* "Are you Mr. So & So's wife?" I asked. *"Yes, and he already saw Dr. Majors last Friday, and all he did was give him pain pills. Why send him back there?"* "Ma'am, your husband told me he did not start hurting until Saturday, and he didn't tell me about his fusion or seeing Dr. Majors. *"Well, you know how stubborn men are,"* was her justifying answer.

The three cases above are just the tip of the iceberg. I have also experienced similar situations involving shunts draining cerebral spinal fluid from the head into the abdomen, plates and screws from unreported broken jaws, and screws from previously fractured hips and others, all of which were unreported. We generally work under the assumption that a patient who is seeking our

help will be forthcoming with us in order to obtain appropriate healthcare and relief. However, as DeGowin and Brown[1] point out, several factors — including hysteria, malingering, and litigation — affect the degree of cooperation for many patients. We are also restricted by the patient's memory, understanding of medical terms, and ability to report details of complicated conditions.

Because of the situations above and similar cases, I have developed a very detailed history for patients to complete during their initial visit in our office.[2] We also have history updates that require established patients to complete when we have not seen them for a while. Each question on these forms has been thought out and worded in order to obtain information that is vital for diagnosis and treatment. Most patients take these forms seriously and complete them to the best of their ability. However, some patients view the history process as annoying or have one of the attitudes related by the gentlemen described above, *"You're just a back doctor,"* and *"Can't you just pop my neck Doc?"* Some patients check or circle 'no' to everything, just to get the paperwork over with. Even worse are the few patients who deliberately withhold information in order to 'test' the doctor. They want to see if the doctor can find something they have withheld or hidden. Discounting the seriousness of a good patient history can be detrimental to all parties involved.

I have actually included trick questions in our initial patient history, in order to identify patients who deliberately withhold information. Most of the people completing history forms realize that saying 'yes' to a yes-or-no question may require additional explanations and questions. So, they circle or check 'no' to every question to get the paperwork over with. In order to avoid this I have deliberately placed questions in the history that are almost impossible to record 'no' as the answer. Examples: "Have you ever had a cold or the flu?" and "In the past 14 days have you traveled by car or truck?" If every answer is 'no' when the forms are returned to the front desk, we can be reasonably sure the person did not take the history seriously. We then attempt to solicit more accurate responses without embarrassing the patient. The forms are not fool proof, but they do help.

I do not wish to appear mean or sneaky. This is for everyone's own good, and I will not apologize for it. In the past several months I have evaluated patients who turned out to have ankylosing spondylitis, a tethered spinal cord, fractures, carpal tunnel symptoms secondary to fluid retention from an inactive thyroid gland, a unicameral bone cyst and osteonecrosis secondary to alcoholism. All of the above patients had some degree of neck and back pain. In some of these cases the diagnosis was arrived at in our office, while in others the final diagnosis required referral to a doctor in another field. In either situation, the symptoms recorded from the patient's history did not fit those typically reported to "just a back doctor." Fortunately, these patients took the history process seriously.

I hate paperwork as much as anyone, and I realize that when people are in pain they are usually not in the mood to fill out forms or answer lots of questions. Nevertheless, patient entrance and history forms are a vital part of clinical practice. We should all use quality forms and expect our patients to participate in the history process.

**References**

1. DeGowin R, Brown D. *DeGowin's Diagnostic Examination*, 7th ed. United States: McGraw-Hill, 2000.
2. Miller, KJ. *Practical Assessment of the Chiropractic Patient*. California: MPAmedia, 2002.

## ABOUT THE AUTHOR

Dr. K. Jeffrey Miller recently began his fifteenth year of practice in Shelbyville, KY. He has published over 80 articles and is the author of the new chiropractic text, *Practical Assessment of the Chiropractic Patient*, which is published by MPA Media.