

## *The Mastery of Patient-Centered Practice*

### **Effective Initial Examination**

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There are a number of reasons why an initial examination must be conducted. As a clinician, you must investigate the condition of the person seeking your help. You must compare and contrast the person's presenting complaints and history with your observations. You also must document the person's condition, and elucidate the nature of the person's complaints. The truth is, you are *expected* to conduct an examination: expectations are held by the governing board that issued your license to practice, your peers, third party payers, and it is the standard of care of the profession. However, arguably the most important expectation you must meet is of the person who presents to you looking for help, who may choose to become your patient. This important choice is often based solely on their initial impressions and perceptions. If you at least meet a person's expectations of what a doctor represents, and establish a good rapport from the start, you have a reasonable opportunity to succeed.

Seasoned clinicians rely heavily on the patient-centered interview and review of the patient's history in assessing a patient's condition. This protocol is the most important aspect of establishing rapport and trust with a patient, and has a profound effect on patient care outcomes. Most experienced clinicians would concur that it is rare that an initial (or subsequent) examination of a given person significantly alters the treatment approach utilized in addressing the patient's physical complaints.

You must have your observational skills honed to a razor's edge. As a primary portal of entry into the health care system, you must of course be fully cognoscente of the fact that a person suffering from virtually any condition may walk into your office. Aneurysms, occult fractures, malignancies, collagen-vascular diseases, diabetic or

circulatory challenges, organic diseases; all represent conditions that walk into chiropractic offices in my experience. However, I contend that the well-investigated patient history usually leads the discriminating examiner to their diagnostic conclusion. The physical, radiographic and laboratory findings are nearly always only a *confirmation* of what the astute clinician gleans from detailed investigation of the presenting person's history.

I further contend that the most valuable aspect of conducting an initial examination is the furthering of the rapport you began to develop when you first met and began to dialogue with this veritable stranger seeking your help. The better the relationship you develop, the more trust that is granted you. The more the person trusts you, the greater the likelihood the person will become a patient, and allow you the opportunity to provide the care they need. At this stage of your relationship with a new person, the trust granted is conditional, and fragile. You must use the examination to further establish your role as doctor, and compassionate and understanding caregiver.

The transition of the person sitting in front of you, to a person willing to allow you to examine them is very important. If you have done a good job of connecting with the patient on a personal level, **and you ask their permission to examine them**, they will likely grant you that privilege. Honor it. I suggest you have the patient keep their clothes on and their possessions close to them during the history-taking phase of your initial meeting. The person will remain more comfortable, and you can witness the nature of the person before you. Noting the external trappings of a person is often valuable in the overall understanding of the person. Incidentally, the person will always be more comfortable with their back to a wall, and facing the door through which you will enter the room to meet them.

A methodical exam is always best, standing to sitting, sitting to lying for convenience and thoroughness. Methodical protocol also helps create reproducibility and reduces mistakes or omissions. Clinicians should constantly be alert and focused. Constant feedback from the patient is encouraged, as well as your reassurance and clear statement that the patient should not do anything they think will cause them severe pain. Finally, be sure you explain each and every move and test you are performing (without compromising the integrity of the test of course) to reduce the natural stress the patient feels.

When a person grants you permission to examine them, I suggest you first have them stand and face you. Read their posture from the front. (A good practice in general, a more personal way to stay connected with patients on a day-to-day basis as well.) Next, the lateral postural view should be studied. Then, have them face away from you, however, keep your hand on their shoulder, shoulders, or pelvis the entire time they face away from you, to maintain connection and reassure them of your attention.

Proceed as follows:

### Standing Phase

1. Standing lumbar range of motion. Note all cardinal planes of motion, and any discomfort, pain or limitation
2. Lumbar lateral flexion, rotation and extension (Kemp's Test). I suggest for standardization purposes, you have the patient reach and attempt to touch behind their knee with the same side hand) record symptoms, and note fluidity of function, you can then retest regularly as needed with the same actions
3. Heel and Toe Walk
4. Have the patient perform a squat, note both their form and strength and therefore the need for instruction in biomechanics and or conditioning

### Seated Phase

1. Cervical Range of motion
2. Foramina Compression Test with simple pressure and with a gentle tap (Spurling's Test) when further elucidation is required
  - a. Neutral
  - b. Flexion
  - c. Extension
  - d. Right and Left Lateral Flexion
  - e. Right and Left Rotation
3. Shoulder Depression Test
4. (Gentle) Cervical Distraction
5. Seated Straight Leg Raise
  - a. Each leg individually
  - b. Both legs simultaneously
  - c. Both legs combined with cervical flexion
  - d. Both legs combined with cervical flexion and increased intra-theal pressure (Valsalva's Maneuver)

Note: If pain is elicited in the lower spine, or lower extremities during any part of the seated SLR test, the test should be repeated, and the source of the aggravating action noted. *In the case of the lower back pain patient, absent any cervical complaints, when cervical flexion exacerbates the patient's lower back or lower extremity complaints, the connection between cervical flexion and increased lower back pain or lower extremity pain must be conveyed to the patient for reference at a later date.* This one examination finding, so established, can often be the key to explaining the nature of the patient's condition to them, during your presentation of findings.

6. Deep Tendon Reflexes in the upper and lower extremities
7. Muscle Testing in the upper and lower extremities  
(Dynamometer and manual testing)
8. Sensory evaluation as needed
9. Cranial nerve assessment as needed
10. Blood Pressure bilaterally, auscultation of the carotids, pulse and respiration, cervical inspiration with extreme cervical rotation
11. Evaluation of any secondary extremity problem (Shoulder, elbow, wrist, hand, knee, ankle)

Note: Remain observant. Document the movements of the person in altering positions from standing to sitting, sitting to supine.

#### Supine Phase

1. Supine Straight Leg Raise
  - a. Right side, left side Active
  - b. Right side, left side, Passive
  - c. With dorsiflexion
  - d. With dorsiflexion and cervical flexion (Be mindful of the potential for occult cervical complaints)
2. Flexion, Abduction, External Rotation of the hip (Patrick's Test)
3. Sensory evaluation of the lower extremities
4. Abdominal exam, pulses in the lower extremities etc. as needed
5. Inquire as to the person's sleep positions, have the person demonstrate for you

Note: If the patient has no significant findings in the seated position straight leg test, it is unlikely they will experience any significant symptom aggravation in the performance of the supine SLR test. The advantage to this sequential evaluation is that the patient, (especially the lower back pain patient) when in the seated position, is in the

most physically compromised position to elicit pain. In the seated position, the intra-discal pressure is greater than in the standing or supine position. Most people with a lower back condition suffer more discomfort or pain in the seated position. Therefore, if there are no objective findings or increased subjective complaints when the patient performs the seated SLR exam, one can usually safely conclude that no increased symptoms are likely to be elicited when performing the same testing in the supine position. When a person does elicit significant symptoms from the seated SLR test, the supine version can often help to isolate the aggravating position or component of the test and better understand the dynamics of the patient's condition.

A good basic examination should also be supported by a thorough radiographic examination, paying particular attention to the areas or area of pain presented in the chief complaint. In other words, thorough examination should include additional views such as flexion/extension and oblique studies in addition to standard radiographic views to fully assess a patient's condition. The doctor wishing to understand the intricacies of patient postural presentation will also want to conduct a PosturePrint computer aided posture analysis.

The manner in which you conduct the examination of a new person seeking your help is critical to building trust. Use simple words; avoid technical jargon and complex explanation. Speak clearly, reassuringly, and honestly. Do not create doubt or fear in the patient. Engender trust during the examination process. When you present your findings to the patient (usually the next day), your honest and sincere efforts in creating a great first impression, conducting a patient-centered history review, and a thorough and trust enhancing physical, postural, and radiographic exam will be rewarded. The person you present your findings to will likely trust you enough to grant you the privilege of becoming their doctor, and they, your patient.