

Managing the Acute Patient With Compassion and Common Sense

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Patients presenting to chiropractic offices in moderate, to greater than moderate pain, (very few patients present in severe pain, defined as the inability to function/get out of bed) present unique clinical and communication challenges. The proper handling of the acute patient in particular often results in the establishment of a life-long relationship. When handled improperly, the result is usually a disappointed or disgruntled patient, forever lost to chiropractic. The acute patient presents in a state of fear: desperation, anguish and occasionally anger dominate the patient's consciousness. Often, any shred of hope is grasped at hungrily. The common thread that unites doctor and patient is *hope*.

It is highly advised that you determine each patients understanding of chiropractic analysis, diagnosis, and treatment. For example: "What is your understanding about what chiropractic treatment might do for you?" "Why do you feel chiropractic treatment is a good choice for you?" or "What do you expect to gain from chiropractic treatment" If the patient responded to a brochure or an ad, it is essential you determine what it was that triggered the instinct to call or walk-in to investigate what you might do for them. Ads and websites often create an implied promise of successful treatment. Patient perception must be thoroughly investigated and elaborated upon to avoid failed expectation. Each doctor must know the mind of the patient in order to create a solid doctor-patient relationship.

Every acute patient is in a heightened state of consciousness. When pulse rate is elevated; all the senses are *hypersensitive*. Every new patient has this elevated sense of focus, however, due to pain and fear, the acute patient has an even higher level of focus on the office environment, doctor and team, and therefore the potential for a significant positive or negative emotional experience exists. Each patient's every need must be acknowledged and met, and handled sincerely, and tenderly, always with a solid expression of confidence

by doctor and team. This is very important as it replaces the patient's sense of fear with hope, and promotes confidence that the new patient has chosen wisely.

Review of Patient History

A comprehensive review of each patient's history is essential to understand who, and what you are dealing with. *The more you understand each person who would be your patient, the better able you will be to assist them with obtaining what they want, in order to create the opportunity to provide them with what they need.*

Pay particular attention to the nature and extent of the patient's past history and review of systems. What injuries have they sustained in the past? What conditions or injuries have they experienced that may impact their current condition? How did they feel about these injuries? Once you determine the answer to these questions, you will be far better prepared to address the demands of their condition as well as be in a better position to explain to them their reasonable options for care. *Remember, the most important thing each doctor can do when reviewing the patient history is to determine **how** patients feel about **what** they feel.*

Examination

Ask permission often: permission to ask sensitive questions, and permission to proceed with increasingly more probing physical investigations. This practice will endear you to the patient and insure you build trust. The acute patient who is antalgic may not be able to sit; they may need to lie down, be sensitive to their needs. Touching the point of maximum pain is essential to connect you to them, *after* you ask permission. The patient must know that you know where they hurt, and that you are fully appraised of the nature and extent of their pain and current disability. ***Ask often during the exam how they feel about what they feel...***

Each patient must know from your body language, tone of voice and methodology that you are confident, and in complete control. For a patient to allow you to treat them, you must maximize their trust in you, and create a bond with them that will transcend their fear, and any doubt they may have. Often, despite your deep exploration of their patient history, other suspicions or concerns will remain. The greater the degree of trust you have developed with them, the greater the probability that you will be in a position to help them.

Timing

If possible, schedule the acute patient at the point in the day when the patient is in the most pain. Note this as a reference for subsequent treatment time, whenever possible, you want to evaluate and then treat at the point of maximum pain, to allow yourself the added advantage of the natural pain cycle...the alternative is to risk being blamed for an increase in pain that is not related to your exam or care at all.

Treatment

I suggest ice, gentle stretching and perhaps trigger point therapy or myofascial release on a limited basis on the first visit. A brief *presentation of the relevant findings* (POF) is mandatory prior to delivery of any treatment. However, due to the patient's inability to find a comfortable position, and often their inability to focus on anything other than their pain, a follow up POF is deferred until the patient's focus is improved to insure maximum clarity and compliance. Emotion must be part of the decision making process, but a doctor must never take advantage of a patient's fear during the POF.

The orientation of the POF content to the acute patient should reflect and address exactly what the given patient's expectations are, and focus on only the most urgent and immediate wants of the patient. Providing the patient clinically relevant information when they leave the practice for the day is important. However, planning to telephone the patient on a regular basis is critical. Patients should be informed of the rules of engagement regarding doctor-patient contact during the POF. Explain that you will stay in very close contact in order to monitor their progress. Make sure each patient has your mobile phone number to call or text you as needed. This also helps to reassure the patient during their most challenging periods.

When a patient is in enough pain that they are unable to move about, or they have difficulty ambulating, sitting etc., they should remain in the office for as long as possible. They should be nurtured; their immediate wants and needs must be met including food and drink and help with the bathroom. Treatment throughout the day can be most beneficial.

It is better to err on the side less treatment than more. When, patients symptoms increase, or they are just sore as a natural consequence of care, they often quit...never to return. This mistake is a serious one, one that is made all too frequently. In an effort to do good, and due primarily to patient expectation being misunderstood, or just not accurately determined the patient's opportunity for health with

chiropractic care is destroyed. Always determine expectation and act accordingly.

Psychological Factors

The level of desperation in the acute patient's mind often has a carryover to those around them. For example a hurting husband can engender that same sense of desperation in a wife's mind that he is feeling...producing in her a desire to act. Feeling his fear she may direct a course of action away from chiropractic towards more traditional forms of care: the infamous trip to the ER. When the patient leaves the doctor's immediate control, the reservoir of trust built up by the compassion and care exhibited by the doctor and team members must extend to those in the patient's immediate circle. In maintaining regular contact with the patient and patient's support system complications are reduced. I recommend at a minimum, daily calls and optimally, twice to three times daily. Timing the calls to correspond to when the patient is known to be at their worst, can provide some comfort to the fearful patient, and can put the doctor on the same "playing field" as the other people in the patient's immediate care circle. Thus obviating any potential distractions or suggestions for alternate action to the patient.

In conclusion, remember that close personal contact, physically and verbally, related to that which is most important and relevant to each individual patient, will produce trust, and create the basis for a long-term relationship. The greater the reservoir of trust you create, the greater will be your ability to help your patients through their acute and fearful challenge. In so doing, you set the stage to offer them a rewarding long-term doctor-patient relationship and optimum care throughout their life.