

## *The Mastery of Patient-Centered Practice*

### **Protocol, Procedure, Focus and Instinct**

#### **Dr. Scott J. Heun**

It was late on a Friday evening. The week was coming to a close, I was looking forward to the start of my two-day vacation, a mind-set I had cultivated over a number of years striving for balance between my life work, family, and personal growth. When my front-desk assistant, Jenelyn, informed me of the imminent return of a patient I had not seen for quite some time, I took it in stride, I was raised to put the patient's needs first.

I watched the patient (I will call her Jane Doe, not clever, but HIPPA compliant.) Jane, walk through the office toward the exam room. She seemed distraught and focused almost as though she was in a rush to get there. I saw nothing in her gait to suggest a structural challenge. I postulated she was likely to have an upper extremity or neck problem necessitating her return.

Before I entered the exam room, I reviewed Jane's file; she had a history of headache, neck pain and infrequent lower back pain, nothing out of the ordinary. She was married to another patient of long standing, and her stepdaughter and stepson were also current patients. She had told my receptionist during her scheduling telephone call that she really needed an adjustment; she had had a bad headache for a few days, which just wouldn't go away.

When I entered the room, I was immediately aware that Jane was really suffering. Her forehead was wrinkled, tight, her eyes narrowed and extremely focused. She spoke softly, in gasps. She dispensed with any formality, "Doctor Heun, I really need an adjustment, my neck is killing me, and my head feels like it will explode any minute!" I told Jane that it had been a long time since she had been in for care, and that I needed to investigate further, with an exam and probably some new radiographs. Right away she said, "Do we have to do an exam and x-rays, because I am broke and I can't afford it." "I went to see my doctor and he told me to take Tylenol and when I asked him

for something more powerful, he treated me like a drug addict or something, but he gave me Darvocet." "Does it seem to have helped," I asked. "No, not a bit, I just know it must be my neck like before."

I explained that I absolutely must do an exam, and update her radiographs, as she had a history of abnormal cervical mechanics, and had suffered the insult of two car crashes in years past. Jane reluctantly agreed to my demand. I asked her when the headache started. She explained she had started a new job working for a real estate loan company, answering the phone and scheduling clients for the realtors, and doing a fair amount of filing as well. She noted the onset of neck pain when performing her filing duties for extended periods, and that this "worked its way into a headache after a few hours of work." "Do you spend a lot of time looking down," I asked. "Yes she responded, and that seems to be what makes the pain worse too." "What do you think caused this pain to start?" I asked. "I am not sure, but I think it is just the stress of my new job," Jane replied.

"You indicated on your history form that the pain level is a 9-10 out of ten, ten being the worst pain you have ever felt, is this the worst pain you have ever felt?" I asked. "Yes, it was coming and going, but now is pretty constant at 9-10, it has been all day." Did this pain in your head seem to interfere with your work today? Of course, I could hardly sit still! I responded, "No, I understand the pain was bad, what I meant to ask was, does the pain interfere with your ability to think? To make decisions?" "Do you notice any change in your ability to focus?" "Yes, I seem to feel like I am in a cloud, like it is foggy all around me. I can't think of anything else but this pain and getting rid of it." "Are you dizzy, or do you feel faint?" I asked. "Not dizzy, just like I can't do anything but think of this pain in my head." The point was made, rather than badger her about how her work was negatively impacted by the pain in her head, I summarized for her. So Jane, let me make sure I fully understand your current problem. "You started a new, and somewhat stressful job, and shortly after starting this job, you began to develop neck pain and stiffness, that seemed to develop into a headache that is now constant, and really bad. Is that about right?" "That's right Doc."

She was fidgeting, having trouble sitting still, and yet, wanted to lie down. Her skin was dry, her lips cracked, she had a look of anguish on her face which cried out for help. I felt like she wanted to scream, that only the slimmest remnant of social decorum prevented her from bellowing, and breaking down from her intense pain and the added frustration of it. Something told me this was not just a bad headache.

The history did not seem to match with the onset of the symptoms, nor the severity of the pain.

When I touched her neck and felt her suboccipital muscles, they were tight, her jaw musculature was clenched, it was all she could do to simply sit still and honor my demand to investigate her problem. Her previous cervical radiographs confirmed a pre-existing cervical kyphosis, with associated degenerative disc disease and marked facet arthrosis. Her head posture was over 25 mm forward of normal position. There was ample biomechanical insult to her spine and nervous system, certainly sufficient to produce a severe headache, especially if her structural condition had worsened.

I presented the previous radiographic findings to Jane, and then proceeded to expose new radiographs of her cervical spine. While these new films were processed, I continued to examine her.

Her pulse rate was near 100 beats per minute, her blood pressure 155/90, she was breathing at a rate of 18 shallow breaths per minute. Her skin was clammy. I noticed her hands shake while I removed the cuff from her upper arm. I auscultated her neck and supraclavicular spaces and noted no abnormalities. Her pupils were dilated and her eyes bloodshot. During the intraocular exam, I noted the vessels were very pronounced, yet nothing conclusive. Cervical range of motion was reduced in extension and lateral flexion 20% and 10% in rotation, consistent with her cervical kyphosis and DJD. When I attempted to perform foramina compression test, even in the neutral posture, Jane could not tolerate pressure on her cranium at all, her neck muscles splinted, and the suboccipital muscles went into a true spasm. She let out a gasp.

I had her lie down, and put an ice pack under her neck while I reviewed the new cervical radiographs. A mild increase in cervical degeneration and disc thinning was evident. Jane's head had progressed further forward, to 32 millimeters of translation. In the few years since I had worked with her. Her neck remained in a kyphotic state. She had not made the choice to address her structural problems previously, electing only to address her immediate symptoms at the time perhaps she would consider a structural approach to her problem a priority now.

I was concerned. I had seen many people in extreme pain. Yet, something told me this was not simply a severe tension headache. It was not just the pain, but also the onset; the blood pressure and pulse

being elevated, and the look on her face of complete despair. I decided to refer her to the emergency room. There must be a problem in her cranium I deduced, she had plenty of structural problems to address, however, those would have to wait until this immediate concern was deemed not to be a threat to her life.

Jane did not take my decision well. She began to cry, then to sob. As the tears came down her face, she grasped my hand, and begged me to just adjust her, she just knew that would make the pain go away, and besides, she had no money to spend at the emergency room, it would likely cost hundreds if not thousands all for nothing. As hard as it was for me to defer her requests, I endured.

I called her husband; we'll call him Larry. He was an amiable sort, with a bit of a financial chip on his shoulder, a passion for golf, and old hot rods. A former minor league baseball player he had just missed the pros, and seemingly never got over the loss. He was a fine big-hearted fellow, down on his luck. Jane was the best thing that he had going. "Hey doc, ya got her fixed up yet?" he asked. "Larry, you need to come and drive Jane to the ER, if you cannot be here in five minutes, I will call an ambulance," I insisted. He knew from my tone I was serious, and that my mind was made up. I did not leave any room for discussion. He arrived shortly after I hung up the phone.

After helping Larry put Jane in the car, I gave them my cell phone and home number, and also a card with the same information for them to give the ER doctor upon their arrival at the hospital. I insisted on a call as soon as she was admitted. I told Larry privately on the driver's side to tell the ER doctor I suspected a problem in her head, not her neck or spinal muscles. I said to tell them to rule out a problem inside her head, that I did not think the cause of her pain was from her neck. He asked me if the problem was serious. I said, "it may be very serious", and added, "do not stop anywhere, go straight to the ER". I then said, "Call me immediately if the staff tell you that you will have to wait, I will speak to the nurse on duty if need be." They drove off into the night.

An hour after helping to put my babies to bed, and sitting down to await the call I suspected would come, I described to my wife what had transpired earlier that evening. As always, she understood my philosophy of patient care, and was extremely supportive. Just then, the phone rang. As I suspected, it was the triage nurse from the county hospital. "What made you think Jane had a serious issue with her head?" she asked. I explained Jane's uneventful history to her,

her examination findings, and my intuition that due to her present state, and the unrelenting pain, that her presentation demanded an investigation to rule out a subdural bleed, aneurysm or other reason for increased intracranial pressure and the severe pain. I also mentioned that she had been consuming Darvocet and 2-3 times the recommended dose of Tylenol with no effect on the pain for a few days. I continued with the explanation of my findings: cervical muscular rigidity, intolerance to cranial pressure, and her abnormal vital signs. Then I explained her radiographic findings, and that they were consistent with neck and upper back symptoms, as well as both tension headache and migraine, yet, that the symptoms and signs Jane exhibited were more severe than I expected. I suggested Jane's symptoms and findings demanded an immediate Magnetic Resonance Scan (MRI) of her head. To my relief, she agreed to pursue this line of investigation. They would perform the scan immediately.

I was able to relax in the thought that I had done all I could at this point in time to help my patient. She was in the best hands I could manage to place her with all the variables extant. I waited to here the results of Jane's tests. Fortunately, I did not have to wait long. Before midnight, the phone rang, and the head physician of the ER at the County Hospital in Martinez, CA was on the phone. The first thing out of his mouth was thanks. Thanks he said for saving Jane's life. My suspicions were correct. She had a subdural bleed of modest proportions. She had been admitted, and was being monitored in intensive care, she had been given intravenous medication, and was much more comfortable. Surgery would only be done if the bleed did not respond favorably to the medications they had administered. The doctor was optimistic because we had intervened when we did. Time was on our side, now we would all just have to wait. I asked that he call me to keep me informed regardless of the time, and he promised he would. Fortunately, she stabilized, and no calls were necessary until Monday morning. After being in the hospital for 10 days, Jane was finally in the clear.

When Jane and Larry walked into my office nearly two weeks after that fateful Friday night past, the tears were of joy, not of pain. Jane hugged me, and began to sob, she thanked me for being such a good doctor and for caring enough to do what was right, not just what was easy. Larry couldn't speak; he just pumped my hand and seemed not to want to let it go. I acknowledged their kindnesses, and told Jane that in a month, when her neurosurgeon gave her the ok, she needed to begin to do what we could to improve or correct her abnormal neck and head posture. She willingly agreed.

When you hear hoof beats, don't look for zebras. That's right, just as in a case of fever, nausea, fatigue and the like is not likely to be a case of cholera, every headache case is not an intracranial lesion. Was there a key point in the history of the present complaint that made me suspicious of a more grave condition? Was there any finding in the exam that was more conclusive than any other? Was there any sign or finding pathognomonic of intracranial challenge? The answer is no. However, the weight of the history, the exam findings, and the effect of the patient's problem on her life heavily weighed in the decision to send her for more rigorous testing. The *history* of the present illness is the most critical component in the investigation of a clinical problem. Also, being fully present and focused on the patient in the gathering of the historical information, and during the examination process provides for a much more accurate first impression to deduce from. I am sure that what made this interaction successful, rather than tragic, was being fully engaged, without interruption, and allowing myself enough time to fully study Jane's problem. To rush through any examination, especially one involving potentially serious or fatal consequences is not only ill advised, it is likely to be a case of malpractice. Do not set arbitrary limits for your history and examination periods. Focus yes, listen more than you speak for sure, but give each patient their just due, and be as thorough as possible, every time.

When you approach each patient, you must do so as a detective. You must weigh each component of the present illness and the past history against the effect the symptom has upon the patient's function and life. Organize your investigation logically. And, know your weight. If the situation you are presented with is a chiropractic problem the patient is in the best place they could be. If however, the patient needs other intervention, do all you can to insure they get it. Remember, you are a doctor, not a technician. Your method of therapeusis happens to be chiropractic care. However, you must never forget your first responsibility, to determine the nature and extent of the patient's problem before providing treatment.

**Authors note: This case story is a summary of an actual case from my practice. By sharing the details of this unusual case, I hope to teach a few lessons and perhaps challenge others to be as thorough as possible in their patient assessment protocols. I have intentionally changed some of the details to obscure the identities of the people involved. Thanks to Richard Heun, DC, Ross Ziegler, MD and Richard Stonebrink, DC, DABCO for the great education they provided me in preparation to practice chiropractic as a doctor, rather than as a technician.**

