

The Mastery of Patient-Centered Practice

The Importance of a Clinically Relevant, Patient-Centered, Presentation of Findings©

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I have stressed in my teaching and mentoring over the years, that the establishment of a strong, trusting, and honest relationship, is critical to the success of your treatment plan, and ultimately, your practice. When you spend the time, energy, and focus demanded to present your findings in a patient-centered way, to the person who *may* choose to become your patient, your presentation of findings (POF) will be a pivotal, and critical, component to the progressive development of your doctor-patient relationship. The POF must be sensitive to the **wants** of your patient, while still addressing the clinical **needs** of your patient. This honest presentation of fact, and options for addressing the problem, or problems, at hand, must also address the actual clinical needs, and realistic potential for improvement, (based upon current scientific knowledge). The POF must never be coercive, argumentative, or confrontational. All of these approaches destroy, rather than enhance, the doctor-patient relationship. It is ethically wrong to present your findings in such a way as to produce fear, or take unfair advantage of the fact that the person you are presenting to is in pain, and therefore, vulnerable, and all too willing to commit to your care protocol under duress.

The transformation of a stranger into a patient in your office starts with the first phone call the new person makes to seek your help, and develops at each stage of your interaction with the new person. Before the POF, you have (hopefully) made a "great first impression", conducted a "patient-centered" interview, developed your interpersonal bond with this person during your examination protocol and radiographic procedure, and finally, further encouraged the new person with a telephone call after you have (legitimately) studied their

examination and radiographic findings. Now, before re-engaging the person with the facts pertinent to his case, you must mentally prepare to meet him again. Preparation is critical to the success of your POF. You must know the new person's case intimately, have already determined the patient's options for care, and most importantly, know what is important to *him*.

Presenting what is important. Every patient has an agenda when seeking your help. It is imperative to your success with patients that you keep this in mind, and specifically customize your presentation of findings to the patient's agenda (stated or not). In other words, the presentation is for them, it is not about your agenda, or what is important to you.

The first point in the Patient-Centered Presentation of Findings© is ***the preamble***. This point includes greeting, and welcoming the patient, and when present, the patient's spouse, significant other or family member, then progresses to an explanation of what the POF is going to cover, then a restatement, or summary, of that which was gleaned from the patient-centered history. At this point, any significant points of concern should also be acknowledged. For example, if the person has expressed concern, or fear about chiropractic care, or financial concerns, or time constraints, these issues must be acknowledged in the preamble. In fact, when the point of concern is an obvious challenge, it must be completely addressed before anything else is presented or discussed. Whether the concern is simply acknowledged, or fully addressed, this step is critical in order to have the full attention of the person to whom you are presenting. The person's complete attention is required in order for you to be able to present the facts. This is necessary for him to comprehend what you are presenting, to make a fully informed decision regarding his relationship with you, and the care you are offering for the problem.

The next step is to compare the person's spinal condition or posture to that of the published norm, the normal spinal model, and or the PosturePrint™ data. You should have decided long before presenting your findings to *any* patient what standard you are going to use as a model. The point is you must be consistent, and honest, in your application of this information. By designating and illustrating the normal spinal model configuration (see CBP® templates for this purpose) on the actual film, and at the same time illustrating the position of the person's spine in comparison, you represent graphically

the disparity extant in each case. The use of colored lines is helpful to illustrate your point. For example, you could follow the common convention of using a "black china marker" to scribe the normal spinal position, and a "red china marker" to scribe the patient's vertebral positions. Another example that has merit, is to use a "solid black line" to illustrate the normal, structurally strong and stable spinal position, and a "red broken line" (a dashed line, for example, along the backs of each vertebrae on "George's Line") to illustrate the position the patient's spine is currently manifesting an abnormal, weakened and unstable position. I recommend that you erase all the other lines of mensuration you have scribed in analyzing the radiographs, or at the very least scribe the lines very faintly. This will prevent unnecessary questions and confusion. I also suggest you avoid mention or discussion of any other observable anatomic or pathologic facts. Despite the fact that a person may very well nod their head in agreement, or verbalize with an acknowledging, "uh huh" or "I see" when you mention or describe "degenerated discs" or "anterior lipping and spurring", or "disc thinning", these individuals may really have no idea to what you are referring. Their affirmation may only be a desire not to appear ignorant in the emotion of the moment. If a person has a pathological condition requiring an outside consultation (radiographic or otherwise), I suggest you discuss this matter after you have presented your findings. If the condition is such that you must obtain an outside opinion before commencement of treatment, then address this point first and defer discussion of the rest of the presentation of findings to a future date when you can present realistic options for care to the person.

Does the person's spinal position and or spinal condition relate anatomically to his symptom picture? If so, present that in all probability the [Insert named symptom here.] pain, or lack of function he is suffering from, is related to the current, abnormal, weakened, or unstable, configuration of his spine. For example, stating, "Your current, spinal position is placing abnormal stress and strain on the bones, ligaments, discs, muscles and, most importantly, the nerves in and around your spine. This abnormal stress and strain produces swelling, and excessive pressure on the delicate nerve tissues. This is what is producing the [insert exact symptom description here] pain you feel. If the person's primary complaint is a loss of function then clearly state the relationship between their current abnormal structure, and the effect that position has on his function.

The next point is to present to the patient ***legitimate options for care***. If the patient is an otherwise healthy individual with a

reasonable probability of tolerating all your procedures and protocols, you may offer them the option of pain relief as well as spinal rehabilitation. If, however, the person presents a general physical condition that is not amenable to traction and or exercise, you may not legitimately offer a rehabilitation protocol as an option. There is a limitation of matter. If a person has severe degeneration in his spine, and he is also symptomatic, the option for care must be to work for a few weeks to see how the person's body responds. If the response is favorable, additional steps to attempt to rehabilitate the person's spine may be employed. All too often, doctor's are presenting a generic two option choice of either "patching up" or "fixing or getting to as near normal as possible" the person's spinal problem. In the real world of practice, life is rarely this "black and white" or should I say, "Black and Red"? If the person you are presenting to has emphysema, diabetes, or a collagen vascular disease, or some other disease or condition, and therefore, is not a good candidate for traction or even exercise, can you legitimately offer a rehabilitation approach to care to this person? I contend you should not, in most instances. Perhaps all you can offer (yet still a very important care option) is to reduce or eliminate the person's pain temporarily, due to the natural progression of his disorder or condition. Present the facts. Be empathetic, but be real, and offer legitimate options.

Every patient has the right to choose. You are the presenter of fact. The patient is the customer. It is his right to make a choice as to what he wants in the way of care for his problem. You must not use any scare tactics. You must not attempt to coerce or convince, cajole or influence. It is not your decision. Whatever the person decides must be honored and respected. To do anything less is not in keeping with our primary goal of patient interaction, namely, building a trusting, life-long relationship. If you have presented simple, honest and factual information, in all probability, the person will choose a form of care. If you have not established a solid relationship with him from the beginning, or, if you have presented his case in a convoluted, confusing or overly complex manner, the person will say something like, "I need to think about this." Or "I don't know...maybe I should speak to my medical doctor about this" or even, "This sounds serious I better get some advice from a real doctor". All these responses to your query regarding what kind of care the patient would like, are indicative of a confused customer. Simple must rule the day, complex or coercive ultimately fails. If the person asks for what care you recommend, you are compelled to answer that it is not your decision to make, it is his. If the person simply states that he does not know what to do, I suggest you clarify first, and then softly suggest second.

If the person presented with painful complaints, you should clarify that at least one of their reasons for seeking your exam and care was to reduce or eliminate the [state exact symptom(s) here] pain they are experiencing. If the person acknowledges that this is the case, then, and only then, you may offer that the person at least commit to working with you short term to reduce or eliminate his pain. In most instances the person will choose to begin care on a limited basis with the goal of addressing the immediate concerns. You can then present other legitimate facts related to chiropractic care in your office in your in-office educational program. The person may elect to modify his original choice after learning more about what you offer. He may not. Again, it is not your choice--you are merely the presenter of fact. The goal is to create a life-long doctor-patient relationship, and therefore, provide the care the patient can commit to at that point in time. In all probability, he will return at some point in the future, when you have fostered an honest relationship with him, and delivered on your promises and agreements.

In-office education is an acknowledged component of most successful care programs. You should offer a "new patient orientation", "spinal care class", "spinal health class", or "doctor's report". The more a patient understands about your care protocol, and his condition, the more likely the probability the patient will continue with care and be successful. Furthermore, offering a simple, fact based education program, taught by you, the doctor, often strengthens the doctor-patient relationship, and therefore, builds upon the goal of developing "life-long" patients. I strongly suggest that if you are not currently teaching a weekly patient education program, you immediately implement one. The only bad program is the one that is never offered.

Potential patient ***financial consultations*** are best conducted by the doctor. Simple is always best. Present the facts, and make whatever arrangements are required to streamline the process of being paid for the service you provide. Do this and address any objections or challenges the patient may have. Start off with a sound business agreement; the best doctor-patient relationships are rooted in honest agreement.

Starting the patient's care. The patient should be comfortably, and reassuringly, led to the adjusting room, or if you are in an open setting, the adjusting suite, and shown how to prepare to receive their adjustment. The first adjustment should be mostly about connecting even more intimately with your new patient. Do not destroy the

budding relationship with an overly aggressive approach, or doing anything that would endanger the doctor-patient relationship.

In conclusion;

1. The presentation of findings must be focused to address the needs of the person you are presenting to.
2. Only the pertinent facts should be presented. Simple, is best.
3. The preamble, the first point in your presentation, should address any, and all, expressed or anticipated concerns, of the person to whom you are presenting.
4. The clinical standard you use to compare your patients to must be established ahead of time, it should be part of your *practice platform*.
5. The person's complaints should be attributable to the structural challenge they exhibit, if not, so state.
6. The options for care must be legitimate. Only offer that which is actually probable and realistic.
7. Honor the patient's choice. Build the doctor-patient relationship.
8. Present the fact that you will teach the patient about his condition and what you will do about it in your named class or orientation.
9. Talk frankly about the cost of care in your office. No one else has the "weight" to discuss your financial policy or prices.
10. Start care. Exude concern and compassion. Take the process slowly, but affirmatively forward.

Your "Presentation of Findings" must be clinically relevant to be defensible to criticism from our peers, and the scientific community. It also must honor the person on whose condition you have been hired to evaluate, opine and perhaps treat. It can be the start of a life-long relationship when managed appropriately. Be honest, and respectful, connect with the person to whom you are presenting, and in all probability, you will succeed. In so doing, your patient will have the opportunity for a successful resolution of his problems, as well as the opportunity for a paradigm shift in his view of the role of chiropractic in his structural, and perhaps, overall health.

