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Getting the most out of a medical specialty exam

By Michael N. Brown, DC, MD, DABPMR-PAIN. Reprinted with permission.

Introduction:

Imagine being a physician specialist at a major University Medical Center. The patient has been waiting for 6 months for an appointment. They have had chronic pain for years. The patient's expectation is a comprehensive assessment of their pain and to have something done to help him. They have had countless diagnostic tests, MRIs, x-rays, and procedures. When you enter the room and begin to take a history you find they have had x- rays on numerous occasions but when you ask to review the x-rays they have not brought them for review. They have had two MRIs the most recent just a few months ago.

You ask about the MRI's and the patient tells you they did not bring these MRIs either. They state "I thought my doctor was going to handle all of that" or "my copy is at home in the garage I did not know you would need that". You ask about the MRI report and the patient does not have the report available either. To make maters worse they cannot recall the name of the facility that they had the MRI's taken. They have had several medical specialists see them and render an opinion. These doctors wrote consultation reports to the referring doctor. When you ask for these reports the patient does not have them. They inform you that they do have these records at home but they had no idea that you would need them. Oh… it gets better. The patient has a complex pain problem and a very complex history. A history that the patient has not organized and presents in unorganized, tangential and convoluted manner making it difficult for the physician specialist to organize into a medical record and report. Within 50 minutes of the one hour schedule consultation the patient is not even close to presenting the details of their history.

After one and a half hours of their scheduled 1 hour consultation the physician specialist informs the patient that they are going to have to be re-schedule in order to complete the history and have an opportunity to review the medical records and imaging that should have been present at the time of the initial consultation. The patient becomes upset because their expectation was to have something done "that day" for their problem. The physician becomes frustrated that he has no information to base a decision on about a diagnosis much less a recommendation for care. Both parties leave with a negative feeling about the encounter. I witnessed this phenomena every single day at the University specialty clinics and periodically still have these experiences. These types of encounters were even more problematic in patients who came to the clinic expecting that we would suddenly prescribed high-dose opioid medications because no other physician would continue to prescribe the medications or the patient had abused the previous relationship with their physician. When we were only able to get through a portion of the examination and get to the "bottom of" the real problem they were furious when they were not walking out with opioid pain medications. I will not address the issue of opioid medications and pain management in this article. That subject will be handled in another article.

The purpose of this article is to help those were preparing for a medical subspecialty examination and to share with them both sides of the "fence" so that they may understand the complexity of this interaction and get the most out of time spent with the doctor. The scenario described above is not uncommon with most physicians specializing in spine or chronic pain.

The matter is even more complex for those patients preparing for a specialty examination that are involved in a medical legal claim such as a Worker's Compensation injury or a personal injury

claim. Preparing for these evaluations are also quite important. Often in a medical legal case and insurance company, lawyer, or third-party may have made arrangements for this evaluation. In that case they often arrange for records and diagnostic imaging to be submitted to the physician before the examination date. Do you want the insurance company dictating to you what the doctor will have available for review and what they will not? Many individuals attending medical specialty examinations just simply expect that the referring doctor or medical facility will make all the arrangements and send all the records and imaging to the consultant.
The individual often has extensive medical records that they have collected but never bring them to the consultation expecting everything to be handled for them. That rarely happens.
The first step in getting the most out of the medical consultation is to ensure that arrangements have been made for the doctor to get diagnostic tests, imaging and whatever records they need for the evaluation. The best way to ensure that the doctor has with the need is to bring them yourself. It is the only way to control the outcome. Otherwise you may show up in the doctor may have no records or only part of the records essential to make a decision about your diagnosis

and management. This also causes the consultation to be split up into 2 parts in order to review the records and imaging that should have been there on the first visit.
Folks, please understand that the first thing you need to do to maximize your time with the medical specialist is to have the following records forwarded to the doctor ahead of time or for goodness sake take them with you at the time of your initial consultation. So make sure the doctor has such things as:

- X-rays
- MRI's
- CAT scans
- Procedure reports
- Other diagnostic tests
- Medical reports
- And anything else that you may need to provide the doctor with information about your condition.

Next, make a complete list of all the medications that you are currently taking. Make a list of your medication allergies. It is also very helpful to know what medications you have taken in the past that did not work. This way all you have to do when you fill out the doctor's form is to reference the list saving you time and the physician's time.

Organize your history! Type a summary of your past medical history, surgeries, hospitalizations and medical illnesses in your past. If possible it is helpful to date them or estimate the year this problem occurred. Summarize any specific treatments that you have had that helped as well as did not help your condition. Organize this and don't ramble! If this brief history is well organized it will save incredible time for the medical specialist which provides more time for you to talk to him or her specifically about your problem. I have given you a sample of a format that you can use to write up your medical summary at the end of this document.

For those of you who are involved in medical legal cases either a Worker's Compensation case or personal injury claim there is additional advice that I would like to share with you described below.
HIDDING REPORTS AND OPINIONS IN THE MEDICAL LEGAL SETTING:

I have encountered on countless occasions during a medical legal examination where patients have shown up for evaluation and purposefully suppressed information or tried to hide reports from me. Sometimes the patient simply removes the report from the records submitted because they not like the opinion of a particular doctor. The patient may feel they do not want to "bias" the doctor's opinion by reading the opinion of another provider. It is my humble opinion that the honest approach is the best approach. Present all the records. You can discuss what transpired any specific consultation with a provider that you may disagree with. But hiding medical reports

may weaken your physician' s ability to defend his opinions and you when he is trying to represent you in a deposition, arbitration hearing, or expert witness testimony in court. A patient who appears to be hiding something is looked upon by the entire system with suspicion. At the moment that I am writing this article I am scheduled in a few weeks for a deposition on a patient I saw for a rear end motor vehicle accident claim.
The patient became upset when I wrote in my initial consultation that she had previous problems with her neck. These previous problems were well documented in previous medical records which were accessible by all parties. The patient wrote letters, made many phone calls all of which were documented. She wrote multiple emails also stating that she did not want this information disclosed in my medical report. I was ultimately able to convince her that only by providing this information and the truth can I truly defend her injuries that she may have sustained in a subsequent accident. When records were copied these letters were also copied.

Who do you think is now requesting a deposition with me? The defense firm representing the insurance company is now requesting my deposition. This patient is now perceived as someone who was trying to hide something and that will be a main focus of the deposition.
THE PAST INJURY COVERUP:

When I am requested to represent one of my patients in a hearing, trial, or before a Worker's Compensation Appeals Board and I always request a brief pretrial conference with the patient's attorney. Why, you might ask? To ask the question "is there anything in this patient's past medical history that are going to be a surprise to me? Is there any previous injuries, accidents, medical care, etc. that I do not know about?

On occasion a nervous attorney then hands me medical reports or other independent medical examination reports that I have been unaware of that contains details of pre- existing injuries and conditions that I was not aware of despite my thorough questioning of my patient during the course of care. One can only imagine what a physician thinks when that happens. How can I support someone who has made efforts to cover previous injury or past problems.

There are many reasons why a patient tries to hide previous accidents, injuries, and medical care. Sometimes these actions are well intended. Sometimes they are not. When I evaluate a patient for work-related injury or from a personal injury I have encountered countless cases where the patient has denied any previous difficulties or injuries in the past. It always catches up with them. It does not take much forensic work from your doctor to find the "cover up". This behavior interests me. I have had the opportunity to ask patients what was the reason they felt it necessary to hide the truth about their past medical history? There are times when a patient is simply trying to defraud the system for personal gain. But there are those with other reasons. Some people have made the decision that their previous injuries were not as severe or possibly did not contribute to the recurrent problem and therefore they wanted to simply control the information that gets put into the medical record. They are afraid that a physician will make a "big deal" over a past injury and the value that her current situation. So they make a conscious decision to not disclose an accurate past medical history. They want to avoid "messing up their case" as if hiding the facts would not catch up with them.

A good forensic investigator will find the records. And if your physician does not have accurate information on which to base a medical opinion you are risking your entire case being dismissed even though you may have legitimate injury. The system has zero tolerance. It has become that way because of tremendous fraud and abuse that is rapid within the system. Do not put yourself into a position that you appear to be trying to defraud the system. I want to know the truth. It is the only way I can appropriately address whether or not past injuries, accidents or other medical conditions may or may not contribute to the current clinical picture. It is the only way a medical provider can walk into a medical legal setting and remain bulletproof. If you are not looking for an honest physician who seeks the truth then you are probably preparing to see the wrong doctor if you have set up a consultation with me.

After years of caring for individuals involved in medical legal cases I can tell you that being less than honest or trying to hide information from a specialist evaluator is the worst thing that you can do. All parties involved have the right to the truth. If you have had previous problems in your past you need to explain what those problems were. A good physician is capable of sorting out past difficulties from current problems. I have seen many cases who had legitimate injuries have their claims denied or their cases diminished or put under suspicion by independent medical examiners because they were able to demonstrate that they were less than honest about their past. Or also tried to fake or feign the extent of their pain on an examination. It is an assumption to all that if an individual is being less than honest about such a thing then they are in fact less than honest about everything. It is important for the physicians who are you are consulting and treating you to be aware of your previous difficulties. Talk to them and describe why you think your previous problems were different. Describe those differences and similarities if any. When your doctor has the information he or she can address the previous problems in their reports and records and help you defend your position.

One of the most embarrassing thing to have happen is for your treating doctor to first hear about all of your previous problems you had on the whiteness stand in court or in a deposition when the defense attorney has collected a host of information about you that you had no idea he could obtain. Your doctor cannot be supportive in that case. He or she may in fact reverse his or her opinions on the spot about you and take a very different view of you and your alleged injuries. If on the other hand the doctor came in prepared to explain your previous difficulties he could defend both his and your position. Your previous history and frailties may be the reason the condition is worse than expected after an accident. So, the take-home message is by all means tell the medical specialist the facts.

THE DOCTORS FORMS

There is one “fact of life” you will have to accept when you go to see most medical specialist… FORMS! Every doctor has chosen his or her own intake history forms. These are legal documents that become an important part of your medical record. Each facility or doctor needs to have such a record. The legal system has made this a necessary process. It is quite common place to have patients become very upset about filling out forms when they come in. I have heard far too many comments such as, “all my information is in my doctors records you can get my information from them.” I have also heard, “didn’t my doctor give you all my information?”

Most of the time when I have been told that the doctor or the doctor staff is little to no information about this patient. And most of the time if I do have medical records submitted they may not have the information in the detail that I want.

I have seen far too many patients “lose their cool” over this issue and set up the wrong kind of relationship on the initial evaluation. It reflects on you to the doctor and to their staff before you even get started. Remember the doctor’s front desk staff is only doing what they are told to do by either an administrator or the doctor himself. In the case of chronic pain patients there is one thing that you need and that is service! The doctor’s staff member is someone who you want on your side. After all they have the doctor’s ear. Don’t you think that when you throw a fit at the front desk about forms, registration, etc. that they are going straight to the doctor and tell them what you have done before he sees you? I can guarantee it! Some physicians and office staff are more tolerant and others so it is best that you behave reasonably. They are not required to take care of you and the relationship that you set up with your physicians are very important.
So take my advice, take a deep breath, relax and FILL OUT THE FORMS!

It is helpful if you have trouble sitting and filling out forms or want to eliminate this unnecessary hassle at the last minute to contact the doctor and get them to email or mail the intake forms to you. Many do this on a routine basis anyway. Our clinic always does. Many times the intake forms are on the doctor’s website. Our personal website has these forms available. I am sure you

will find this helpful and reduce the stress associated with sitting in a waiting room filling out intake history paperwork.

LOOSING YOUR COOL:

During an evaluation you are trying to “tell your story”. The physician is trying to understand your story. Some doctors have a better bed side manner than others. Some patients who are seeing a doctor have an agenda and certain expectations. To maximize what you can get out of an evaluation DO NOT LOOSE YOUR COOL! The physician is providing a service. He probably is not going to be harmed in anyway if he loses your business. If you upset him or her, even if the doctor is being a “jerk” you are not going to help matters by escalating emotions during an evaluation. There may be at least good information you can obtain from them even if you decide early you are not going to see them again !

If you have a negative experience with a doctor, there are few things that you can do. More than likely you have been referred to that doctor by another doctor. It is important for the referring doctor to know what your experience was with the specialist. Let your doctor know you had a negative experience. If the referring doctor gets enough complaints they will stop referring to that individual. When you have a negative experience just leave with some dignity and report your experience to the one who referred you.

LETTING YOUR SPOUSE DO ALL THE TALKING: It is wonderful when you have a spouse or loved one that is concerned and supportive enough to go with you to an evaluation. It is also not a problem for the spouse to ask questions, get clarification on issues or provide information that they feels may be helpful. But trust me, the doctor wants to hear from you. He needs to hear how you describe your problems and pain. He needs to hear how YOU feel. He needs to have you provide the medical history. Please do not let your spouse ramble on and dominate the conversation and consultation. Make an agreement on this before you go to such a consultation.

ORGANIZE YOURSELF AND DO NOT RAMBLE.

A significant amount of time is spent by a physician consultant obtaining rather routine information. This information may seem to be of little importance to you but the information is very important to the physician. Most people who ramble on do not know that they do this. Those who understand what I am talking about probably do not need to be told this.
Those who do have recognized they do therefore this section of the article may be a moot point. It is very helpful to organize your personal information before you get to the consultation. Please review the next section on past medial history summaries to prevent unnecessary time spent covering routine information that will reduce valuable time that could be spent dealing the more important issues.

MEDICAL HISTORY SUMMARIES:

Most medical specialists that you will be seeing want a chronological and detailed review of the history of your problem as well as details from your past. The doctor will want to know when you first began to have such difficulties and any and all treatment, evaluations and special tests that have been performed. He will want to know the results of these tests and the effect of any treatment that you have sought has had on your condition. The doctor will want to know about your past medical history even if you think that the past medical illness and surgeries have little to do with the current problem you are seeking their care for. They may also want to know about your family history.

A great deal of time can be saved if you would consider organizing some of this information ahead of time. I would suggest that you consider writing up this history and providing it at the time of your consultation. It may be helpful to give it to the office staff when you turn in your

paper work to the doctor. That's right you will still have to fill out the paperwork and forms! However you can refer to the summaries that you write to save you time. I would suggest that you write up such a summary on a computer if you access to one and update it when necessary. The following is a guideline for a summary of your medical history that you can follow. History:

- Brief summary of how the symptoms developed i.e. accident, injury or insidious onset.
- Date of injury or initial onset of symptoms
- A chronological history of the providers or care you have received and if you had any benefit from the treatment.
- A description of your current complaints which will include the location of your pain, any radiation of pain, the intensity and character of the pain. Be brief and don't ramble.
- In addition any previous complaints of pain or difficulties that you had that may have been the same or similar to what you are currently experiencing.

Past Medical History:

- List any past illness, medical illness that you have had such as hormonal problems such as hypothyroidism, hypertension, diabetes, etc.
- List any surgeries that you have had.
- Past injuries that you have had such fractures, sprains, etc.
- Previous difficulties you have had that were in a similar location or may be related.
- Provide a list of all accidents that you have had. Even if you did not have any injuries in the accident they should be listed and can be referenced as non-injury accident. List all work related and personal injuries such as motor vehicle accidents, slip and fall or other injuries.

Medications:

- Current medications that you are taking.
- Allergies to medications

Family History:
Provide a list of your immediate family members (brothers, sisters, mother and father). List their whether or not they are currently living and their age. If deceased what age they died and cause of death. List any known medical illness that they have experienced specialty of interest is.
1 Cancer
2 Diabetes
3. High blood pressure
4. Arthritis
5. Back or neck problems and any spine related surgeries or chronisities.

Social History: Marital history, number of kids, do you smoke, do you drink, and he had any history of drug abuse or alcohol abuse. What kind of education do you have? Where do you work?

When you have this information ahead of time you will save significant time. By doing so you will minimize the time spent obtaining this information and maximize your time with the physician focusing on your diagnosis and care.
Remember once again, to bring any records, reports, x-ray, scans etc.

SEETING YOUR EXPECTATIONS :

There may be a number of reasons why you are seeking the consultation of a specific medical specialists. What do you want to get out of this consultation? Sometimes your expectations can get in the way of a positive experience with your consult. Occasionally, I will see a patient who has had a 20 year history of chronic back pain and they are seen expecting something to be done

immediately for the problem they have had for 20 years. They expect to have something given to them or done to them on the day of the consultation as if they are at a McDonald's restaurant where you can drive through and pick up a new back.

If you have an idea of what you're expectations are you will have much better chance of directing the consultation to meet these expectations. If you have been told you need a surgical procedure and you are seeking consultation with another provider for "nonsurgical options" and to find out if the surgery that another physician has really recommended is your best option then you should state that early on in the course of the interview with the doctor. You may be only seeking answers to questions. You may be asking for his or her opinion as to what is the proposed diagnosis and recommended treatment. Whatever the reason for the consultation you should prepare a few basic questions that you would like to have answered on the date of the consultation. If you have prepared properly for the consultation and have saved the doctors time in collecting records and information that will allow you to get over the more preliminary stuff like you medical history, then there should be ample time to get some of your questions answered. If you come with a four pages of questions you may need to revise your questions.

Think them out clearly. More than likely, there are probably about 5 basic questions that you are really seeking answers to. You will have a much more successful encounter than presenting 25 questions that are not well thought out and prepared. Remember the doctor will more than likely be giving you information at the time of this visit and you will need to ponder this new information and may need to return for a subsequent visit with the doctor for further clarification. You should be able to fit these questions on one page. If you have five to ten pages of questions you are going to probably look a bit neurotic even though they may seem legitimate.

DEALING WITH THE DIFFICULT DOCTOR

What can I say? Every profession has them. Look folks… the fact is that doctors are a peculiar group of people. Physicians many time represent the top 3% of the college graduates. Let's face it, those who are the brightest academically are not always the most well rounded socially. Some doctors survive the academic world, medical school, residency and the tremendous pressures involved in that industry and

have still manage to maintain a wonderful personal touch. Others are not as well rounded socially and may not be as emotionally secure. They succumb to the tremendous pressures of the industry and become bitter with time. Dealing with the public and the demands of patient care can be a very difficult aspect of running a medical practice with stress placed on them with insurance companies, staff, etc. It is no wonder that they can become impatient and difficult to deal with.

If you run into a difficult doctor some people have the natural ability to bring out the best in these types of people with their own humor and personal touch. Sometimes you just cannot establish a rapport with the doctor regardless of what you do. If you cannot establish the relationship that you want with the provider you then you need to make a number of decisions. The first decision is whether or not you are going to have to remain under this persons care despite the relationship or not. If you are in a managed care healthcare plan with a limited number of medical providers and specialists that you can see you may be in the office of the best provider available to you. If this is the case then make the best of it. In a managed healthcare plan you can sometimes be at a dead end. It is one of the frustrations of the managed care systems. And be prepared because it is about to get worse not better!

If you do have other choices or a healthcare plan that will allow you to locate and select your own provider then count your blessings. If you run into a difficult doctor you are in a "no win situation." You should try and not make a rash or quick decision. Come prepared for the consultation by having the records and information that I have suggested to maximize your time spend with the doctor. Keep your cool. You may be the one with the superior social skills and the doctor may have the social skills of a toad! If you are smart you may be able to gain valuable information for

yourself in the encounter. You will have partial control of the situation by keeping yourself organized and your questions well thought out. Finding the great doctors is part of the journey through the system. When you find one, they are worth their weight in gold. Most are not lucky enough on the first try. Do your homework. Be an informed consumer. Be prepared.