53 - The Diagnosis Process, How Doctors Think
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Hi. Welcome to the BioBalance Healthcast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. Today we're going to talk about the diagnostic process. We have talked before and we've written a chapter in our book that talks about how to be a good medical consumer. Part of that process is to go through a sequence with your physician that we call the diagnostic interview. There are some terminologies that overlap both of our professions. Actually when Kathy and I started talking about this, and she was telling me what doctors are trained to do, I laughed because that's exactly what we teach therapists to do as well and especially in terms of the way you conceptualize the interview and the notes that you take. There is an acronym called SOAP. I tell my students at the university to take SOAP notes when they take notes about interviewing clients. You use the same protocol or doctors are trained to use the same protocol when they interview patients.

KM: Yes, they figured SOAP, we could remember that one.

BN: So this is actually a class you take, or part of a class you take in school?

KM: It's not really a part of class. It's part of this is how you take a note and everyday it's drummed into your head. This is how you take a note, this is how you interview a patient. So the notes and the interview are supposed to go in this order. However they don't always do that, and part of it is that we don't know how to redirect patients. Patients come in and they say "AHHHHH" and they tell you everything that's happened in the last three or four months.

BN: They kind of just throw up on the table.

KM: Yea, basically. And you can't get in to ask the proper questions like what's the most important symptom you have? What is it that you want me to think about while you're telling me all of these pieces of information. Because the first thing is what is the problem, what is your problem, why are you here?

BN: It's kind of like in an emergency room they do triage and they have a sequence of things that they check first especially if the patient is unresponsive. They check that the airways are clear. So do you.

KM: It's a check list.

BN: It's a check list. And if I come in and I'm so vomitous and I throw out all this extraneous data or I'm so unaware that I don't know what to tell you. What is the checklist that you go through with me? You want to know about the symptoms?

KM: I want to know the primary reason you're there. Because that's going to guide everything else I think about. And so to be a good consumer as a patient then you should think about this list that we're talking about today. Think about it before walking into your doctor's office. This is how they're thinking. If you're thinking is in the same organization, you can get more out of your visit. So even write it down.

BN: I'm laughing because I'm thinking about my own visits to a physician and I kind of go to the doctor generally to see what the doctor wants to talk about. Or what they want to check on.

KM: Because you're not sick.

BN: Because I'm not sick.

KM: Now when you're at a well visit, that's different. When you're well, usually you fill out a form and the doctor asks you all kinds of things, and you fill that out and the doctor kind of goes by that to see if you have all the wellness signs for your age group and then he or she has a plan as to what tests you need to make sure you are well.

BN: And keep you in that zone.

KM: And keep you well for that age group.

BN: But if I go to the doctor because I've got a frozen shoulder that I can't raise and I'm having pain then I need to go in and talk about that and I need to think beforehand did something happen? How long have I been dealing with this? What is my concern?

KM: Have I ever had this before? How did it end up? Because that takes time to think about. And if you think about it ahead of time, when the doctor says "why are you here today? What can I help you with?" Then the patient can say "well I've had this frozen shoulder and I got it two weeks ago and I've tried Motrin and it didn't work. And it hurts more when I go up here. I can't lift my arm above this. Or if I lift something, it hurts less when I'm sleeping. That kind of thing. Pain is easier to diagnose than hormonal issues. Because hormonal issues cover so many different systems in the body.

BN: They are more vague and systemic as opposed to acute or discrete.

KM: But most of our doctor's visits are for a specific reason, if it's a problem visit.

BN: But it matters because so many general practitioners in particular are mass production systems so they've got 7 minutes to get you in and out.

KM: And that's not their fault that the managed care system has given them basically 7 minutes to get you in and out.

BN: And obviously if there is a greater concern, they stretch it, I mean they have that relationship.

KM: Right, we all have done that.

BN: But they try to go in that sequence and so to be a good consumer it helps if you have thought about these issues before you go in. Because you know these are questions that need to have an answer.

KM: I used to take my mother-in-law to the doctor. She is my favorite relative, she was my favorite relative, she's passed on. But she'd go in and start with what she had for breakfast three weeks ago. And she'd use the whole time up and she wouldn't let him intervene, and I'd be going "Ann, Ann, tell him why you're here." And she'd just keep going. And so the whole visit was this bunch of symptoms that nothing really related to why she was there. And so she wasted her time with him.

BN: And it didn't help him to help her.

KM: No I mean he didn't even know which way to go. So that's probably the most important thing is think about all the things that you think might have contributed to this. Even tell your doctor what you think it is. "I think I've dislocated or ripped out or whatever." I don't know I don't do shoulders. But tell them what you think it is.

BN: But I was laughing because many years ago in the early days of television, Marcus Welby was a major national television show. And they actually had journal articles come out to warn physicians about what they called Marcus Welby syndrome. Where people would watch the show and then the next day they'd call their doctors and they'd have all the symptoms that Marcus had dealt with the night before and they wanted to know if you were a good enough doctor and could figure it out.

KM: Just like Marcus. So you should always watch that show. So that's the initial thing. Most diagnoses are made from history and that's in the first part of your visit which is the S: symptoms. And the second part is usually your vital signs, your weight, which are objective kinds of pieces of data or your exam. And my exam basically in anti-aging is looking at the patient watching them walk in, how they sit, looking at their face, their skin color, their thyroid, now everybody's going to be paranoid when they come into my office. But look at how their hair's growing, is it thick, is it thin, is it receding, do they have hair on their hands, do they have hair on their.

BN: Check their finger nails. To see if they have ridges if they have spots.

KM: Or are they all torn, or if they've been chewing them, you know the anxiety kind of thing. You can see a lot if you just look as a physician at the patient. Now here's the

problem now everybody's typing on a computer. Which is a problem because you should be spending your time staring at your patient trying to figure out what's wrong with them and all of those things that you were trained should be running like a computer in the back of your mind. And I should not, not the patient, the docto,r and I'm thinking about all the different things it could be and my mind is picking out.

BN: Absolutely. That's fascinating because that's exactly what I train students to do that want to become therapists. You don't take notes in the session. Pay attention to the client. Look at them. You have to be a trained observer. You have to have experiential database that says if I look at this and if I see that that's a signal, it's a warning sign. Let's go talk about that. And when doctors don't do that they really miss an opportunity to get information that may be critical.

KM: They may miss your diagnosis by not looking at you. I've not gone to dentists who didn't look at me while they were turned away and writing like this, how can you tell how I speak the way I'm using my teeth, that's what they do, and see if they're misaligned. You can tell that by watching someone talk.

BN: But you're talking about objective observations and you're talking about more subliminal observations. Do I wince? Do I move stiffly do I hold my head? Can I turn my neck? You may ask me that question and I may or not know the answer. But you will have an observation. But you also take weight, blood pressure, and temperature.

KM: If you do a normal physical exam in my world, it's more about looking at the patient, talking to them looking at laboratory data and doing an extensive history because I get more of my diagnosis through that and a lab. And the lab is part of the O in the SOAP. It's observational, it's objective, and it's something that is not going to change, it's right there on paper.

BN: And you don't do prostate exams?

KM: No I don't. I have all of my male patients, because I'm a gynecologist, go to someone who's done prostate exams for the last 20 years.

BN: Who knows what they're looking for.

KM: Who knows, yes.

BN: Again, it's an objective observational experience.

KM: And so for me my exams and evaluations are different. My objective data is that lab in front of me. And I see that before I even see the patient. But I have to put them both together to get an idea of what's wrong. So I think about what they told me, I think about what I'm observing. I think about all the objective data, If I were examining them and sometimes if I'm feeling their thyroid and things like that. All of that is objective.

BN: You have that lab and all that history if you've had previous encounters with that patient. But if it's a brand new patient when do you make the assessment part to say well I need to get a lab, a blood test some other kind of x-ray, whatever it might be.

KM: I actually have people get labs before I ever see them to see if their lab's in the range. That sorts out all the people who really don't need to see me who need to see someone else. I save them a visit that way.

BN: Okay.

KM: And so then I know they have hormonal imbalance.

BN: So even a first time visit you would have that information.

KM: Right, I do. And then A is the assessment. That's the part where you go okay, history, physical, observational, lab, everything I've got, what does that make me think the patient has? Then I have a list. Doctors call it a differential diagnosis. That means there's a whole list of diagnoses that that patient could possibly have. And then it's my job to either order a test or order a trial of a medication. And then bring them back and see what the test showed, how did they feel with the medication. See if I've changed anything or if I've made them better. This is assuming a non-emergent situation. This goes a lot faster in the ER. But in the office, this is office practice we're talking about, this is how we do it. And then we want you to come back for that lab generally because then we've got to discuss what we want to do for treatment. So our plan, the "P" in SOAP has to do with all the things we want to do to figure out which one of those diagnosis are true. And we've got lots of choices, thousands of blood tests, x-rays, ultra sounds, management with medication to see how they feel, or check blood pressure afterwards. So there's all kind of Plan you can have. My most important take home message on this is don't leave your doctor's office without a plan unless he says you are well on a well person visit. You're well. You're healthy, but if you have symptoms, you should say "what is the plan?" It is acceptable to say that.

BN: Okay so the doctor says your weight and your blood pressure is creeping up. You're not in a range that's critical or of immediate or emergent concern. But you're in an age group where those become issues. We're looking at a diabetic history in your family, so we want to get your blood pressure down, we want to get your weight down. So you have a plan for doing those things.

KM: You should ask what the plan is because normal non-doctors don't know how to get their weight down, they don't know how to get their blood pressure down, they don't know the importance of salt, they don't understand any of the importance of diet in generally, the general population doesn't. So you have to tell them what you want them to do as well to try to accomplish the goal.

BN: When you say you have to tell them what you want them to do.

KM: I'm doing some things which is testing my patients.

BN: So you have to tell me what you want me to do, or do I have to ask you?

KM: No generally the doctor will tell you what you have to do. This would be more like the end of the second visit. We already know what you have, we know what the problem is, we've done the testing, you're in the second visit, we ask the same kind of questions you know, how do you feel? Is there any difference if you'd tried a drug? Then we go down to the bottom and say here's the deal, I now know what you have, I now know what we want to do, I now know that we're going to have to do diet and exercise and this medication and I want a repeat testing in 6 months and I want you to come back in 6.5 months. That would be a reasonable plan for a follow up visit to that one problem. So I know you have different plans for your patients when it's counseling.

BN: Yes but again, I'm assuming it's similar. The patient is involved in devising the plan. I mean we talk about the issues that they're presenting, the symptoms, the problems, the observations all of that, and we talk about what do we think needs to happen, and are they able to focus on that and try to do that. And part of that dance is to figure out what they're really going to do, because a lot of people are non-compliant. They say oh yes, I'm going to do that, and then they don't do that. So in terms of a physician if you were to say, alright I want to see you in three weeks or three months and I want you to cut back your caffeine consumption by two thirds, I want you to cut out your salt by 80%, and I want you to lose 10 pounds. And I go "okay". And then I leave and I don't do any of that. Or I don't do that well. I don't do enough.

KM: That's why we have a follow up visit so we know if you've done it and we can say why didn't you do it, or why did you do this? Sadly it's kind of like being a parent. You have to check on the person that you've told to do the chore or whatever that they have to change their lifestyle. Lifestyle changes are the hardest things to get somebody to do. So giving them help like a medication or a particular diet that they can look at on a piece of paper is helpful. Giving them some guidelines that they can look at, now not everyone's going to do it, but it's their health, not our health. They have to understand that it's not going to get better if they don't change things. Because I can only change so much.

BN: Exactly, because a heart surgeon can come in and clean out the valves and say alright we've done this and that's going to buy you 10 years. But if you don't change your lifestyle it's only going to buy you 10 years or it's going to buy you less and we're going to be back at the same place, and you may die. And in that setting when people are afraid, they're much more likely to be responsive. But when they've gone for a period of time and they're somewhat symptom free, then they start to drift away from disciplined behavior. Lifestyle changes require discipline. You're more likely to get that discipline if you have an informed and involved consumer. So if I talk to you and you can explain to me from your knowledge base why this matters and invite me to

participate. And if I buy in to that then I'm much more likely to follow through. And so part of your dance is certainly to know the things that you know, but part of it is the skill of convincing me that I need to do these things for my own survival or for my own good health.

KM: With doing BioBalance pellets, with doing hormone replacement it's so much easier because I replace the hormones and it gives them enough energy and enough positive reinforcement where they go "oh yea, that worked, so now whatever she gives me is going to work." Instead of just saying "yea, yea, they always told me that diet stuff is going to work." But so that it's my goal.

BN: So do you think there's a predictive value if you can say "alright you're going to take these pellets and then in about three weeks you should see this."

KM: Yea. If I'm a race horse that's won a couple times or won once, you're going to bet on me again. So I have a 95% rate with the hormones so somebody's going to look at me and go "well I guess I'll follow her diet." So I better be darn sure I'm right on the diet, I better be darn sure I'm right on my lasers and my skin care. Because I am now risking the fact that I might not be so successful with those so I make sure that they work. I don't want to lose credibility with that patient. It's very important.

BN: I think a 95% success rate is phenomenal.

KM: It is.

BN: And that's both through self reporting, people who say I'm experientially satisfied, but it's also through follow-up labs where you can say that the test results were this and now are this.

KM: The cholesterol's better, the hormone levels come up but the cholesterol's better and the blood sugar is better and people are pulled away from the edge of getting diabetes.

BN: So it's not just a subjective experience.

KM: Nope, no.

BN: So it all begins, this whole process, this whole journey to better health, to being able to resist the inroads of aging begins with a good diagnostic interview and that involves the SOAP approach and a critical part of that SOAP approach is observation. The doctor has to sit down and look at you and talk to you and pay attention to you, and hopefully this podcast will help you to be aware of those things and to seek out providers who provide those kinds of interventions and treatments for you. If you have questions about this or about any of the information that you were exposed to on these podcasts you can reach us.

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