Commentaries

Chief Complaint

I have been wondering for many years how the term "chief complaint" became so deeply embedded into our medical history and presentations. In medical school I was required to begin every written consultation with the "chief complaint," abbreviated "CC" as it was universally known, and every oral presentation with the age, gender and chief complaint. In every rotation but one, we were also required to give the race of the patient. In neurology, the chair actively discouraged this, unless the race was relevant, as with sickle cell anemia. He thought it irrelevant or even worse, a distraction.

I am not usually one for political correctness, although that certainly may have its value and may be something we disparage too often. Witness the overdue consignment to "the dustbin of history" of terms such as "reptilian stare" for the expression in Parkinson's disease, the "simian stoop" of the same disorder, or "amaurotic idiocy" for Tay Sachs disease, "idiot" as a general classification for epileptics or "senile" as a generic term for demented.

"Complaint," in my mind suggests a "complainer" rather than a complainant. It conjures up the image of a person who complains, rather than a person who is presenting a problem. We think of a medical complaint as a perception of the human machine gone wrong, whereas a complaint about a product suggests some aspect of shoddiness, either poor design, poor execution or lack of durability. A person who has multiple complaints seems like a "whiner," an adjective that has no virtuous interpretations.

Another word I have come to find irksome is "refuses," as in the patient refused to have another CT scan. I think of refusing as taking an active stance against something, rather than simply not embracing a suggestion. I have come to prefer the word "decline." I view myself as a patient advisor. I suggest treatments to the patient, which the patient is free to reject. I am not a "my way or the highway" sort of doctor. I think that my role is analogous to a financial planner. He suggests buying junk bonds and I decline, which would likely be the way most people would view such an interchange, rather than my refusing to buy junk bonds, suggesting a fight between advisor and advisee. So if I suggest taking L-Dopa, and the patient states that he'd rather wait to reassess at the next visit, I will write, "Patient declined to start L-Dopa" rather than, "patient refused to take L-Dopa."

However, there are other situations in which the term "refused" is appropriate. The patient refused to lower the drug dose despite my telling him that it is causing him severe side effects. My use of the term reflects my belief that we did, in fact, get into a significant difference of opinion in which I thought that there was a correct path (mine) and an incorrect path (his). For example, my patient refused to take L-Dopa despite falling down every day, so I reduced the number he can get on his next prescription. I remained his doctor, but told him he was making a mistake.

We use more passive sounding terms for patients not doing things as instructed. Mr X did not begin an exercise regimen; didn't start the newly prescribed medication; didn't make an appointment to see a psychiatrist, etc. This conveys less sense of the patient directly opposing you. He simply didn't follow through. In fact, some doctors describe this in exactly that way in their notes. "Mr X didn't follow through with his intended diet." He failed to find a consultant who took his insurance; failed to exercise as directed, etc.

Does our choice of words matter? When our records remain within our own office, no. In fact, I might prefer to write that the patient whined about this or that, or that he was immature, or self-centered, or that I tried to give him botulinum to the vocal cords to shut him up. However, our patients sometimes obtain copies of their records, and when I put myself in their shoes, reading these notes that have grave importance for their lives, determining their insurability, their family relationships and how they view their life path, I think that I would like to see measured and thoughtful descriptions. The notes also tell the patients how we view them, and sometimes our terminology, which is value-free to the doctor, may not be so value-free to the reader. "Obese" or "overweight?" "Loquacious" or "talkative?" We generally write or dictate our notes under severe time constraints. Our grammar may not be perfect. Our phraseology is not what we would choose had we time to produce the ideal note.

I occasionally have patients take copies of my notes. That way they can share it with whomever they like and bring the notes to new doctors, thus guaranteeing that the notes get to where they're supposed to. We need to keep in mind that our words may convey meanings we did not intend and nuances can be very important in determining how the message is interpreted.

Remember when you write a note that it's permanent and unchangeable and available to your patient. Think of how you'd like to be described by your own doctors.

– Joseph H. Friedman, MD

Disclosure of Financial Interests

Joseph Friedman, MD, and spouse/significant other. Consultant: Acadia Pharmacy, Ovation, Transoral; Grant Research Support: Cephalon, Teva, Novartis, Boehringer-Ingelheim, Sepracor, Glaxo; Speakers' Bureau: Astra Zeneca, Teva, Novartis, Boehringer-Ingelheim, GlaxoAcadia, Sepracor, Glaxo Smith Kline, Neurogen, and EMD Serono.

Conflicts: In addition to the potential conflicts posed by my ties to industry that are listed, during the years 2001-2009 I was a paid consultant for: Eli Lilly, Bristol Myers Squibb, Janssen, Ovation, Pfizer, makers of each of the atypicals in use or being tested.