The Clinical Value of the Pertinent Negative

By Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

Do you like performing patient evaluations? We all have to do it, but sometimes it can be a hassle, albeit a necessary one. After all, exams take time, and worse, it takes even more time after the evaluation to put together a narrative summary of the findings.

Sometimes this process becomes downright tedious. I spend more than a few hours every week just sitting at my desk doing reports. However, this is the standard of care for all health care practitioners. Appropriate, complete and accurate documentation is a necessary part of being in practice today.

During the patient questioning and objective testing parts of the evaluation, we are usually looking for positive responses. A positive SLR with pain down the back of the leg may suggest sciatica. Braggard’s test reproducing this pain then helps to nail down that diagnosis – reproduction of pain down the sciatic helps isolate the problem. But if Braggard’s test does not reproduce traction pain down the sciatic, then you need to look at other possibilities, including hamstring spasm or pelvic dysfunction.

In the above example, Braggard’s test is a pertinent negative – a negative finding that helps you rule out suspected problems. A pertinent negative also indicates that a thorough and complete examination and history were performed. Pertinent negatives vary with each patient interaction and in many cases, are just as significant as positive orthopedic findings.

If a patient presents with back pain, the questions you ask during the interview are important. Does the pain radiate? Is there any loss of bowel or bladder function? Is there numbness or paresthesia into the legs? A positive finding warrants further investigation – in the case of loss of bowel or bladder function, you must suspect cauda equina issues and refer for orthopedic intervention. But when the patient denies these issues, the indication is to look for other contributing factors – joint dysfunction, muscle spasm, etc.

Pertinent negatives are just as clinically important as any other exam finding and should be documented. With care, there should (hopefully) be more negative findings on re-evaluation. If there is a new injury or change in status, you may have new positive findings – but you cannot make the comparison of a new positive finding if you did not previously document the negative.
Such notes are invaluable when documenting your patients’ complaints and the extent of the irritation. These extra notes help document the severity the patients’ complaints and show the progressive response to care. This extra documentation also can help make the difference if you must justify your diagnosis to an insurer or third party.

As my instructor in diagnosis taught, you should have at least three positive orthopedic indicators before confirming a musculoskeletal diagnosis. Basing a diagnosis or treatment plan on the finding of one screening maneuver is below the standard of care for any practitioner.

Again, negative findings are clinically significant and should be properly documented. There is no quick shortcut in a good examination – take the extra few seconds to document your negative findings along with the positive.

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