

# The Bite That Was Not There

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Emergency departments are built on urgency, objectivity, and efficiency. Every shift demands rapid triage, immediate prioritization, and decisive action. In this environment, chief complaints are often filtered through a clinical lens that emphasizes pathology over perception. However, not all presentations fit neatly into this framework. Some challenge not clinical knowledge, but the philosophy of care itself.

One such encounter involved a patient presenting with a reported “dog bite.” Nursing staff expressed frustration before physician evaluation, noting there was no visible injury and suggesting the visit was motivated by legal intent rather than medical necessity. The physician was encouraged to evaluate the patient quickly and proceed with discharge. The implication was clear that the visit did not warrant clinical attention. However, the physician approached the case differently.

Rather than dismissing the complaint, the physician entered the room and engaged with the patient as if the injury were real and clinically significant. A thorough history was obtained, and a complete physical examination was performed, including careful inspection of the area where the patient reported being bitten. No wound,

abrasion, or erythema was identified. Despite this, the physician acknowledged the patient’s concern, validated the emotional experience, and addressed the perceived injury with seriousness.

The physician expressed understanding that the event must have been frightening and potentially painful. The patient affirmed this. The interaction was calm, deliberate, and respectful. After completing the evaluation, the physician reassured the patient that there was no evidence of a penetrating injury and that no further medical treatment was necessary. The patient appeared satisfied, reassured, and ultimately agreeable to discharge.

From a clinical standpoint, little had occurred. No procedures were performed, no medications were administered, and no diagnostic studies were ordered. However, from a human standpoint, the encounter was profound.

This case illustrates a central principle in emergency medicine; the patient’s experience of illness or injury does not require objective confirmation to warrant compassionate care. The absence of physical findings does not negate the presence of distress.

Pain, fear, and perceived harm exist within a psychological and emotional context.<sup>1</sup> These experiences can be as impactful as physical pathology. The physician’s decision to treat the complaint as legitimate, rather than dismissing it as fabricated or exaggerated, transformed the interaction. The patient left not only medically cleared but emotionally reassured.

This approach reflects a broader understanding of patient-centered care. Validation does not equate to agreement with inaccurate beliefs, nor does it imply

reinforcement of false claims.<sup>2</sup> Instead, it acknowledges the patient's lived experience. In this case, the physician did not confirm the presence of a dog bite but validated the patient's fear and concern surrounding the event. This distinction is subtle yet critical.

The psychological dimension of emergency medicine is often underappreciated. Emergency physicians frequently encounter patients whose presentations are influenced by anxiety, stress, misunderstanding, or external motivations. These factors do not diminish the legitimacy of the encounter. Rather, they expand the scope of what constitutes appropriate care. Encounters involving perceived or "imaginary" injuries present a unique challenge. The physician must balance clinical objectivity with empathy, avoiding both unnecessary medical intervention and dismissive behavior. Failure to acknowledge the patient's concerns can lead to dissatisfaction, mistrust, and repeated healthcare utilization. Conversely, excessive testing or treatment in the absence of clinical indication can contribute to resource overuse and potential harm.<sup>3</sup>

The physician in this case navigated this balance effectively. By performing a complete evaluation and communicating findings clearly, the physician provided reassurance grounded in clinical assessment. By validating the patient's emotional response, the physician addressed the psychological component of the complaint. The result was an efficient encounter that required minimal resources while achieving a positive patient outcome.

This case also raises important questions regarding the intersection of

healthcare and financial or legal motivations. The nursing staff suggested that the patient's visit may have been driven by a desire to pursue legal action against the neighbor who owned the dog. Such motivations are not uncommon in emergency medicine. Patients may seek documentation of injuries, validation of events, or medical records that support insurance claims or legal proceedings.<sup>4</sup> These scenarios can create tension within the clinical environment. Healthcare providers may feel that the emergency department is being used as a tool for financial gain rather than medical necessity. This perception can lead to frustration, bias, and potentially compromised care.

However, it is essential to recognize that the physician's role remains unchanged regardless of patient motivation. The responsibility is to evaluate, document, and treat based on clinical findings. Determining the validity of legal claims or financial intentions falls outside the scope of medical practice. Maintaining this boundary is critical. When providers allow perceived motives to influence their behavior, patient care can become inconsistent and inequitable. Dismissing a patient because of suspected secondary gain undermines the ethical foundation of medicine, which prioritizes impartiality and respect.<sup>5</sup>

From the perspective of a scribe observing this interaction, the encounter provided insight into the art of emergency medicine. Clinical knowledge and procedural skill are essential, but they are not sufficient on their own. The ability to communicate effectively, to validate without reinforcing inaccuracies, and to navigate complex motivations defines excellence in patient care.

In emergency medicine, time is limited, and decisions must be made quickly. However, efficiency does not preclude empathy. Brief interactions can still be meaningful when conducted with intention and respect. The physician's ability to transform a potentially dismissive encounter into a positive experience required no additional time or resources, only a deliberate shift in approach.

Ultimately, the “dog bite” that left no mark became a lesson in the unseen aspects of patient care. Not all wounds are visible, and not all visits are driven by pathology. Some are rooted in fear, misunderstanding, or external pressures. Addressing these elements is not ancillary to emergency medicine, but it is integral to it.

In a system increasingly focused on metrics and resource utilization, it is easy to overlook the impact of these interactions. Yet, it is often these moments that define the patient experience and shape perceptions of the healthcare system. While the bite may not have been real, but the care was. In emergency medicine, **that distinction matters.**

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