Clinical skills still provoke debate

Clinical skills are complemented by technology

EDITOR,—J Goodwin's editorial on the importance of clinical skills fails to offer any worthwhile evidence for the hypotheses proposed.¹ The author opines that only the "clinically inexperienced" depend on the Swan-Ganz catheter for measuring intracardiac pressures in critically ill patients, yet the author offers no evidence to support this "good example" of undue reliance on technology and ignores objective studies that show that clinical assessment of the haemodynamic status of critically ill patients is extremely unreliable.²

Having insulted those of us who use pulmonary artery catheterisation, Goodwin then accuses those of us who teach of allowing our clinical skills to wane by citing a "recent" (1988) story in a Sunday newspaper (fictitious) and two articles from a single issue of *Annals of Internal Medicine* in 1992 (both wrongly referenced),^{3,4} which are of no relevance to medical training in Britain and do not show that doctors are less skilful now than they were in Goodwin's imaginary good old days. When Goodwin refers disparagingly to the use of computers in diagnosis I presume that this is an allusion to the development of artificial intelligence and expert systems. Those who develop such systems have done much research into the logical processes of expert clinicians and attempt to emulate them. This work serves to preserve and enhance rather than destroy the best clinical skills.⁵ Goodwin's final unsubstantiated insult is to imply that those of us who use technology fail to talk to our patients.

I agree that basic clinical skills must be preserved and taught, but if colleges are to draw up guidelines on clinical skills these must be based on balanced evidence of their practical utility and not on technophobic prejudices. Uncritical reliance on values obtained by machines can be dangerous, but uncritical reliance on clinical skills is no safer.

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1 Goodwin J. The importance of clinical skills. *BMJ* 1995;310:1281-2. (20 May.)

2 Eisenberg PR, Joffe AS, Schuster DP. Clinical evaluation compared to pulmonary artery catheterisation in the hemodynamic assessment of critically ill patients. *Crit Care Med* 1984;12:549-53.

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

3 St Clair EW, Oddone EZ, Waugh RA, Corey GR, Feussner JR. Assessing housestaff diagnostic skills using a cardiology patient simulator. *Ann Intern Med* 1992;117:751-6.

4 Noel GL, Herbers JE Jr, Caplow MP, Cooper GS, Pangaro LN, Harvey J. How well do internal medicine faculty members evaluate the clinical skills of residents? *Ann Intern Med* 1992;117:757-65.

5 Kowalewski DC, Carlson RW. Artificial intelligence and expert systems in critical care medicine. In: Carlson RW, Geheb MA. *Principles and practice of medical intensive care*. Philadelphia: W B Saunders, 1993:95-108.

Swan-Ganz catheter can help patients—but which ones?

EDITOR,—J Goodwin is right to emphasise the importance of clinical skills in medical practice, but I dispute the suggestion that use of the Swan-Ganz catheter to measure intracardiac pressures is "a good example of the clinically inexperienced being dependent on high technology."¹ Several studies have shown the inaccuracy of the results of clinical assessment compared with the information derived from a pulmonary artery catheter.^{2,3} In a mixed population of patients receiving intensive care Steingrub *et al* compared physicians' estimates of pulmonary artery wedge pressure with the measured values.⁴ In 53% of cases the physician was unable to predict correctly whether the pressure was low (<10 mmHg), medium (10-18 mmHg), or high (>18 mmHg). There seems to be little doubt that in critically ill patients the Swan-Ganz catheter provides information that is not available from simple clinical observation. The only remaining uncertainty concerns the selection of patients for whom the benefit of this information exceeds the not insignificant complications of insertion of the catheter.⁴

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2 Eisenberg PR, Joffe AS, Schuster DP. Clinical evaluation compared to pulmonary artery catheterisation in the hemodynamic assessment of critically ill patients. *Crit Care Med* 1984;12:549-53.

3 Tuschmidt J, Sharma OP. Impact of hemodynamic monitoring in a medical intensive care unit. *Crit Care Med* 1987;15:840-3.

4 Steingrub JS, Celoria G, Vickers-Lahti M, Teres D, Bria W. Therapeutic impact of pulmonary artery catheterisation in a medical/surgical ICU. *Chest* 1991;99:1451-5.

Confidence in clinical skills is vital for GPs

EDITOR,—I support J Goodwin's defence of clinical skills from the perspective of general practice: it is in the patient's home in the middle of the night in a darkened room, where minimal bedside tests and no special investigations are available, and in the presence of anxious relatives, that some of the most difficult clinical decisions are made. Unless primary care physicians are able to elicit physical signs confidently and use them effectively to inform diagnoses they will end up simply as triage artists. Their only decision will be about whether unloading responsibility on to the hospital sector is defensible. Thousands of children with uncomplicated upper respiratory tract infection are admitted every night with a diagnosis of "? meningitis" because of such thinking. Part of the atrophy of clinical skills, however, is a perception of the need to practise

defensive medicine and the problems that management at home can create for busy general practitioners.

I recently saw a child with a cough that had persisted despite treatment with amoxycillin. Having spent three years in British general practice, in which primary care physicians are seldom responsible for hospital management, I did not initially construct a differential diagnosis; my first thought was that this child was sick enough to warrant admission. But when I went back to basics it became fairly clear that she had an atypical pneumonia, and I was in a better position to consider management at home. I was then, however, confronted by the mother's rejection of this approach and by thoughts of what would happen if the child did badly (despite appropriate treatment) and if a complaint was made (even if the child did well). Also, management at home would mean that I would have to visit again. So why bother making a thorough clinical assessment if the result is extra work, vulnerability, and sometimes aggression?

If we use clinical skills to prevent inappropriate use of expensive and sometimes dangerous resources then we need to feel secure that we will not become scapegoats when things turn out badly or patients disagree with us. The defence of clinical skills must incorporate a determined assault on the belief that admission to hospital and assessment by machines are by definition superior, and research evaluating the effectiveness of management based primarily on clinical skills is urgently needed. The organisation of primary care, especially after hours, needs to be structured so that the effective use of clinical skills does not become a thankless burden.

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Author's reply

EDITOR,—Tom Woodcock and Adrian P H Steele both concentrate on the issue of pulmonary artery catheterisation in critically ill patients, but my main message was the importance of using high technology investigations to complement rather than replace clinical skills in patients who are not acutely ill. I am aware that clinical signs can be unhelpful in desperately ill patients with severe circulatory problems, but that does not mean that clinical signs can be ignored. I agree with both Woodcock and Steele that assessment by Swan-Ganz catheterisation is crucially important in acute intensive care. This makes it all the more vital that all who use the technique fully understand its value and limitations and do not ignore clinical features entirely.

I thank Woodcock for pointing out that the page numbers of two of my references were wrong, and I apologise for this. I do not know what he means by his comment about a story in a "Sunday newspaper." Perhaps he is referring to the passage that I quoted from the *Observer*, which is the house journal of the American College of Physicians.

The tone of Woodcock's letter suggests a deep sense of personal outrage, which I much regret. I had no intention of insulting anyone: my purpose