From the Editor's Desk

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Physical Examination, Diagnostic Imaging, and Medical Errors

My recent 2-week stint on the inpatient hematology teaching service led me to reflect on the importance of the physical examination. Most of us spent a lot of time in our own training learning to detect subtle heart murmurs and elusive spleens, to characterize breath sounds, and to ferret out disappearing axillary lymph nodes and subtle breast masses. In practice, I have found serial palpation of lymph node size and percussion of liver size and pleural effusions invariably useful; I always emphasize these techniques when I demonstrate physical examination to medical students and house officers.

Like most oncologists, my practice is in the outpatient clinic, but I now spend four weeks on the inpatient hematology service. In my recent 2-week stretch, I had two medical residents, four interns, and three third-year medical students. I was responsible for daily rounding on an average of 22 inpatients, and for the teaching and training opportunities these patients represented. Most had acute leukemia or lymphoma. They were all sick, but we had only one patient die. After I finished, I did a retrospective count, finding that we ordered 67 computed tomography (CT) scans and 18 magnetic resonance imaging (MRI) scans on the 57 patients passing through the service. This seemed like a lot of expensive imaging studies to me. We did make three unexpected diagnoses that could not have been made by physical examination alone: presumed hepatosplenic candidiasis in a woman who continued to be febrile after her neutrophil counts normalized, unexpected pulmonary emboli in a man with mantle cell lymphoma, and a subsequent retroperitoneal hematoma after therapeutic anticoagulation. The 85 imaging studies were useful, but the physical examination was an important part of the patient care and teaching experience.

I continue to believe that an accurate and reliable physical examination is useful not only when the CT scanner is broken, unaffordable, inconvenient, or unavailable. I also believe that patients derive therapeutic benefit from the physician's touch. Imaging examinations should not substitute for the physical connection, the laying-on of hands, that the traditional physical examination provides. Katharine Treadway, in describing one of her own teaching experiences, noted that touching her patients reminds her to "try to remember to treat the patients as well [as their medical problems and physical findings]—to touch them in small ways as well as large" (Treadway K. *N Engl J Med* 354:1112-1113, 2006). My colleague Howard Markel reminds us that listening to the patient and use of the stethoscope "embod[y] the essence of doctoring: using science and technology in concert with the human skill of listening to determine what ails a patient" (Markel H. *N Engl J Med* 354:551-553, 2006). It is too early to relegate the stethoscope, and the rest of the physical examination, to the museum shelf. Like so much of what we do, it is difficult to demonstrate the value of an accurate physical examination, and to be paid for the time taken to perform it.

In our original research section, we continue to focus on ways to make patient care safer. In this issue of the *JOP*, Clyde Ford et al describe a 2-year study of medication administration errors on a hospital inpatient oncology ward. A system of nurse and pharmacy double-checks, examination of identified medical errors and "near misses," and an attitude of system improvement rather than blame, can keep medication error rates low. Studies of medication errors are easier to perform in the hospital inpatient setting than in offices and outpatient clinics. However, many of the techniques described by Ford et al in our current article, and those in past original research articles, can be ported to the outpatient clinic and physician's office setting. We at the *Journal* will be interested in publishing contributions about efforts in other venues.

Three approaches to medical malpractice are described in this issue. Patricia Legant provides a primer for oncologists on current features of the medical malpractice system. She introduces the field and provides some practical tips for avoiding the nasty process of malpractice litigation from her vantage point as a board member of a large malpractice insurance carrier. My colleagues Sybil Biermann and Rick Boothman comment on the proactive, systemic approach to "supervised apologies" and aggressive defense of nonmeritorious malpractice claims that is employed at the University of Michigan. Gay Cox introduces the collaborative practice model to dispute resolution, which may be most applicable to business disputes. All three pieces make for excellent reading, and will be useful to readers who may find themselves caught up in a malpractice claim or business dispute.

As this issue appears, I'll again be on the inpatient ward, no doubt ordering more CT scans, positron-emission tomography scans, and MRI scans. I'll start over with a newly minted batch of interns, residents, and medical students. We'll care for a group of scared, sick, and vulnerable patients. Touching our patients in ways small and large is a healing modality for the patient as well as the oncologist.

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