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Editorial

Physical examination: The dying art

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“He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.” – Sir William Osler

When was the last time we as clinicians have performed a thorough physical examination on a patient who has walked into our clinic? The answer would surprise the best of clinicians amongst us. The problem is, we are not alone, as physical examination is indeed a dying art in today's medical practice.

We remember elicitation of clinical signs would be the essence of learning clinical medicine when we were in Medical school. Hearing out the symptoms, elicitation of a detailed history and a meticulous clinical examination was the *raison d'être* of the clinician. How often we would especially go to acute medical wards to listen to the early diastolic murmurs in the aortic area and a pan systolic murmur in the mitral area! Missing out a split second heart sound was a real embarrassment. Correlation of a stony dull percussion note of the chest and bronchial breath sounds on chest auscultation with a chest radiograph had a different sense of accomplishment. Is it a UMN or a LMN lesion, the level, the extent and possible cause of the neurological disease was a diagnostic conundrum? In short, the patient was your classroom and the time spent in good history taking and a thorough clinical examination were mandatory steps one had to take in the long arduous climb up the mountain of clinical medicine.

This was the art of clinical medicine where the patient took center stage and everything revolved around him or her. Modern medicine and technology have turned the concept of clinical medicine on its head. Lab investigation modalities including molecular biology techniques are more precise and specific than ever before, imaging modalities have evolved manifold making diagnosis of complex defects feasible nearly immediately but the modern clinician has gone far away from the real patient and real close to computer console. A deluge of

modern day gadgetry has made the clinical medicine of yore antediluvian and perhaps irrelevant. The moot question is as to who decides as to what was better? Can we be the judge, jury and the adjudicator all at the same time?

Clinical observations dates far back to the ancient Egyptians, Babylonians and Indians who relied on the skills of hear, touch and feel in addition to the ubiquitous common sense to clinch the diagnosis. But clinical examinations as we all know it today is indeed a recent development. It all began with the discovery of percussion by Leopold Auenbrugger in 1761. Leopold Auenbrugger was the son of an innkeeper who was inspired by his father's practice of tapping wine casks to ascertain the amount of wine left in the casks. Auenbrugger published his findings in “*Inventum Novum*” in 1761 but it was poorly received at first. Percussion as a tool for diagnosis gained popularity only when Jean Corvisart, the famous French physician who was personal physician to Napoleon Bonaparte recognized its worth and popularized it in his ward rounds and later published his findings in 1808.¹

The stethoscope owes its origin to Laennec who in 1816 had this serendipitous moment when he chanced upon children in the streets playing with long hollow sticks with their ears glued to each end transmitting sounds with blow pins.¹ Public acceptance of the stethoscope was such that within a decade physicians felt that they must use the stethoscope or jeopardize their reputation.

Thus began the journey of physical examination of patients by physicians at close quarters. Physicians of those times were quite close to books and far removed from real patients. The real patients of those times were at the mercy of the barber surgeons who performed a wide range of activities aimed at cure like blood-letting, cupping, lancing abscess and gall stone removal.

The past few decades have witnessed a decline in the fine art of physical examination due to the explosion of diagnostic

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and laboratory tests which have supplanted the doctor's kind hand with the impersonal touch of new fangled technology. Technology however is not the enemy; the misuse of technology is the problem. Salvatore Mangione in his article wrote that he has seen "many cases in which technology, unguided by bedside skills, took physicians down a path where tests begot tests and where, at the end, there was usually a surgeon, and often a lawyer, sometimes even an undertaker".² The clinicians of today have to devote many hours mastering the technological metrics that they have scarcely any time left to master the vital and essential clinical bedside skills. Though technology is invaluable in showing us things in the patient's body that we cannot and will not be able to visualize, it cannot detect a tender spot in the abdomen or a raised jugular venous pulse or how a patient feels that morning.

One essential component of bedside clinical activities of yester-years was the grand rounds wherein each patient was discussed threadbare with the entire faculty and residents in attendance. The rounds of today happen in front of the computer peering into some image or lab tests with all except the patient in question in attendance. Clinical examination as Verghese et al mentions is a ritual and a transformational experience³ wherein the patient willingly subjects himself to being examined by his doctor revealing things that he has never revealed in front of anybody. This sacred ritual is being overlooked in the present day medical practice much to the peril of the physicians. Numerous examples abound wherein patients in the A&E or in the wards have had a missed diagnosis due to an improper or omitted physical examination. Studies have consistently shown that the patient's history and physical examination are the most important factors in arriving at a correct diagnosis, whereas lab tests and imaging studies play complementary roles, and that excessive reliance on technology has not necessarily improved the quality of patient care.³

As we stand at the cross roads we need to understand that technology is here to stay as also that our patients are not

inanimate objects made only of flesh and bones. The logical way forward is the path which incorporates the judicious use of technology along with the humane touch which is so essential to this sacred relationship between a doctor and her patient. Programs like bed side medicine are underway at Stanford and John Hopkins wherein students are taught bed side skills to be used in conjunction with technology to bolster the diagnostic accuracy, curbing unnecessary investigations and also to help the doctors bond better with their patients. The wise sayings of Sir Robert Hutchinson seem to ring more true than ever before:

From inability to leave well alone;

From too much zeal for what is new and contempt for what is old;

From putting knowledge before wisdom, science before art, cleverness before common sense;

From treating patients as cases; and

From making the cure of a disease more grievous than its endurance,

Good Lord, deliver us.

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