Letters to the Editor

Teaching Proper Cardiovascular Physical Diagnosis

C. R. Conti: *Clin Cardiol* 2005;28:402–403

To the Editor:

I wish to echo Conti's recent editorial on the importance of teaching proper cardiovascular physical diagnosis¹ and on the virtues of the Criley's tutorial on cardiac auscultation.

At a recent ward round, I was presented with a patient with mitral valve prolapse. When I asked the housestaff to show me the evidence, I was handed an echocardiogram of the patient. When I asked the housestaff to describe the physical findings, I was told that the patient should have a midsystolic click and a late systolic murmur. I was surprised to hear the expression "should have" in the answer. Finally, I asked the housestaff if anybody had listened to the patient's heart, and the answer was "No."

This sequence of events reminded me of a story told in the article "The Stethoscopeless Cardiologist" by Nasser,² which reads, in part:

...I decided to have my heart checked vis-à-vis the murmur. I took an appointment with a noted cardiologist and explained what my problem was. At the appointed date and time, I arrived at the cardiologist's office. The receptionist called a nurse technician who ushered me to an examining room and told me to strip to the waist and lie on the table. Before I could say something, she explained that the machine next to the examining table was an echocardiogram. The echocardiogram, she continued, takes a sound picture of your heart and valves. That way, we can analyse your murmur. After that you also need an ECG and a chest X-ray. When all of this is completed, the doctor will analyse the tests and give you his opinion.

I did what was requested.

'Ah, there you are Mr. Doe' said the cardiologist. 'Your heart appears normal and the heart murmur is functional and not from a diseased structure in your heart...Let me know if you need anything else, Bye' and disappeared from the room. Anyway a week later the bill arrived...

It appears that cardiac auscultation has become a lost art and the use of the stethoscope is a skill that is fading in our times of high technology.³ The latter is represented by the six imaging techniques, described by Conti in his editorial,¹ that have re-

placed the stethoscope. But let us remember what Dock said, "You should be the masters of the gadgets and don't let the gadgets master you."⁴

Criley's tutorial on cardiac auscultation as described in Conti's editorial is a superb device to teach how to perform cardiac auscultation; the website given (www.blaufuss.org) is easily accessible and has a lot of goodies that are valuable to both medical students and housestaff as well as seasoned cardiologists.

Although the use of a stethoscope is an art of medicine that is being lost amid growing reliance on echocardiography, nuclear isotope study, magnetic resonance imaging, and contrast computed tomography, it is still a very useful medical instrument in the 21st century. It weighs less than a pound, fits easily into a coat pocket, does not need an electrical outlet or a video recorder, is not radioactive, and has no adverse side effects whatsoever.⁵

Furthermore, just witness all the popular television shows in which the only way to identify the doctors is the stethoscopes wrapped around their necks, because doctors in the hospital do not wear uniforms anymore. I have seen all types, colors, and shapes of stethoscopes carried by medical students and housestaff in my hospital. Some have chest pieces made of gold and others have earpieces of form-fitting plastics. Some have long tubings that can go around the neck twice; others have tubings so short that during auscultation you can look directly into the patient's eyeballs. But it is not these fancy accessories that make the difference. It is what lies between the two earpieces that counts.^{5–7}

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Reference

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