

The Hands of a Healer

The article in this month's SWJPCC - "Physical Examination in the Intensive Care Unit. Opinions of Physicians at Three Teaching Hospitals" (1), is a fascinating insight to medical practice and how it has changed with the advent of new technology. The study at three large teaching facilities addressed the questions of how often a physical exam was performed in the ICU, what the perceived utility of the physical exam was, who examines patients most, and an interesting question pertaining to what exactly constitutes a physical exam. Participants were given theoretical scenarios and answered questions pertaining to the role of a physical exam. Even though the format was a questionnaire and not direct observation, the results support what I see in clinical practice. The results show that the physical exam, at least in the ICU, is not deemed a critical tool in our armamentarium and that reliance on technology has supplanted the traditional exam. One point that has yet to be formally addressed by this or other studies, is actually how often the physical exam changes the clinical course.

Those of us in my generation remember the days when physical exam was paramount. Indeed, when I was in medical school in England, it was essential and when we presented cases, we had to make a differential diagnosis solely based on the history and physical exam, and then, and only then, would we order specific tests. That was about 25 years ago in London. I suspect that many of my colleagues from that era or earlier, had similar experiences. Modern US practice is to use the physical exam, order a battery of tests and imaging, then come up with the diagnosis. It has not been shown unequivocally that our reliance on modern imaging and labs is necessarily better.

There are still some scenarios that no laboratory test can pick up. Even in pulmonary medicine, we still teach to treat the patient, not the ABG; and the diagnosis of respiratory failure does not require anything other than a look at the patient. Wheezing shows up on no commonly use lab or imaging in the ICU (excluding less commonly used techniques such as measurement of respiratory system resistance using the ventilator's sensors and algorithms). There is no question that modern testing is more accurate and provides much more information to us than any, even Oslerian levels of clinical examination could. It also leads to work ups for incidentalomas that may have no real relevance. Conversely all of us probably have anecdotal stories of an exam changing the course. For example, I recall the physical exam that picked the cause of the patient's agitation, an ulcer on the back of a ventilated, heavily sedated patient. This led to less use of benzodiazepines and a focus on pain control perhaps preventing or mitigating the clinical detriments of excess sedative use in the ICU.

Ordering tests and imaging is usually quicker for the MD than doing a physical exam – one can order three CT scans on three patients in less time than it takes to physically go and exam three patients. This is clearly an improved efficiency for the MD's work

load. The question is then whether the improved efficiency for the MD and added information about the patient from the ancillary testing is worth the extra cost. The physical exam is free except insofar as the time it takes and the effect this has on billing, i.e. that it is still a necessary part of the billing matrix.

The nature of what is a physical exam is also changing. Incorporating bedside imaging with ultrasound is no more a stretch than was incorporating the auscultatory findings when the stethoscope was first introduced. Palpation and percussion in this study, were not deemed necessary parts of the physical exam, which is in sharp contrast the traditional teaching. The perception amongst US physicians that physical exam is more utilized outside the US (England being a typical example) may or may not be true. From the results of this particular study, it seems not to be the case, as there was no difference in responses amongst those who had medical school training outside the US. However even currently, it is impossible to progress in England to higher postgraduate training MRCP or FRCP (member or fellow of the Royal College of Physicians) without being grilled on a physical exam (2).

So where then is the correct balance? As the authors point out, the classic physical findings we were taught are usually present in extreme or end stage disease whereas our purportedly better technology now finds these processes earlier in the clinical course. Pure reliance on either the physical exam or the ancillary testing is not likely to be the correct approach. The answer has yet to be ascertained. A study addressing how often the clinical exam changes the course of a patient's care significantly (however one may define this) has yet to be done. My prediction is that within 20-30 years, the physical exam will be almost never done in clinical practice.

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References

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