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VIEWS & REVIEWS

STARTING OUT

Is clinical examination dead?

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"I tried to listen to some heart sounds last week. Couldn't hear a thing." So an eminent professor of medicine told me recently. "It's all quackery, you know."

This is something I'd thought for a while, but I'd not heard it summed up with such frankness. Although I continue to teach undergraduates the distinction between reverse and fixed splitting of the second heart sound, I have never detected these conditions myself. And I've got a strong suspicion that most cardiologists confidently declare "a clear case of a loud P2" only after furtively inspecting the echocardiogram report.

So why are we promulgating this quackery? Perhaps it's a sense of tradition: this is the way things have always been done. Perhaps also a bit of pride at the perceived superiority of British medicine, and our "we know best" attitude.

The truth is that the sensitivity of such tests is atrocious. As another example, I can't remember the last time I felt an abdominal mass in a new patient who turned out to have cancer, yet I diagnose an abdominal cancer every couple of weeks endoscopically.

We teach our students charades. Kneeling on the floor like a supplicant to examine the abdomen, percussing the lung bases as part of breast examination, and using a piece of paper placed on outstretched hands to check for thyrotoxicosis all hark back to a bygone age.

These clinical tests and others had use in an era when diagnostic tests were unavailable or unreliable, but they are exceptionally operator-dependent and today they are redundant. It is no longer acceptable to use only clinical examination to screen for conditions because the miss rate is just too high.

If we plan on formal testing anyway, what does it matter if we go through the rigmarole of examination? I remember my first clinical firm as a medical student. The consultant used to have the nurse strip each patient naked after taking the history before examining them thoroughly. He would see at most six patients in an afternoon.

Now the consultant is expected to see twice as many and something has to give in the race for efficiency. The inevitable result is that the first nails are already in the coffin of clinical examination. We just need to have the courage to admit it to ourselves and more importantly to our students.

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