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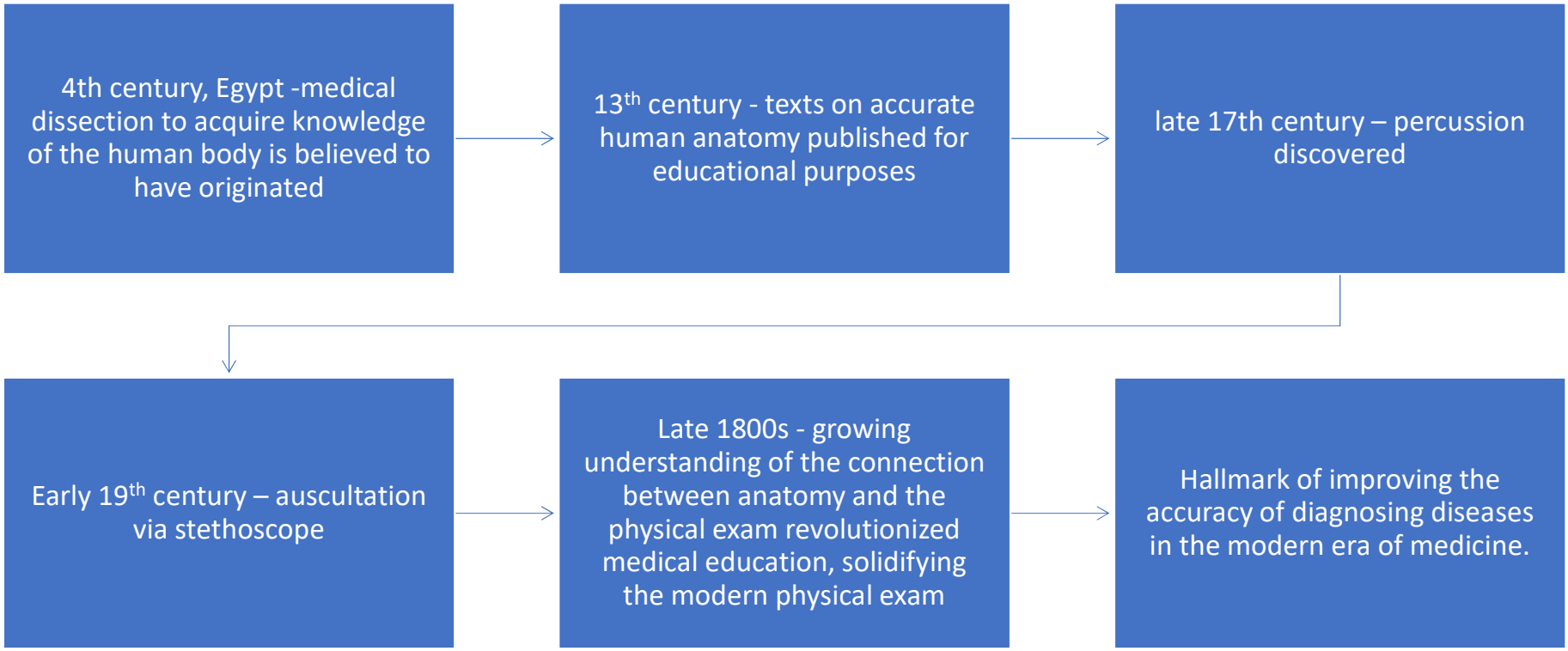
Clinical And Radiation Oncologist

Is the Physical Exam a Thing of the Past?

Talk Structure

- Background of Clinical Skills
- The Good Clinician
- The doctor-patient relationship & its evolution
- Benefits of the doctor-patient relationship
- The doctor as person and clinician
- Ethical principles of medical practice
- The healing relationship: Patient-centred care
- Conclusion

Background- Clinical Exam



The good clinician

Core skills - taking a complete history and performing a thorough physical exam→ +80% yield in accurate diagnosis

- Faustinella F, Jacobs RJ. The decline of clinical skills: a challenge for medical schools. Int J Med Educ. 2018 Jul 13;9:195-197
- Multifactorial:

- clinicians are afforded less and less time at the bedside with families
- increasing reliance on advanced medical technology
- two years of social distancing brought on by the COVID-19 pandemic

"Observation, Reason, Human Understanding, Courage; these make the physician."

— Martin H. Fischer (1879 - 1962)

The Good Clinician - Does it matter?

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

Inadequacies of Physical Examination as a Cause of Medical Errors and Adverse Events: A Collection of Vignettes

CrossMark

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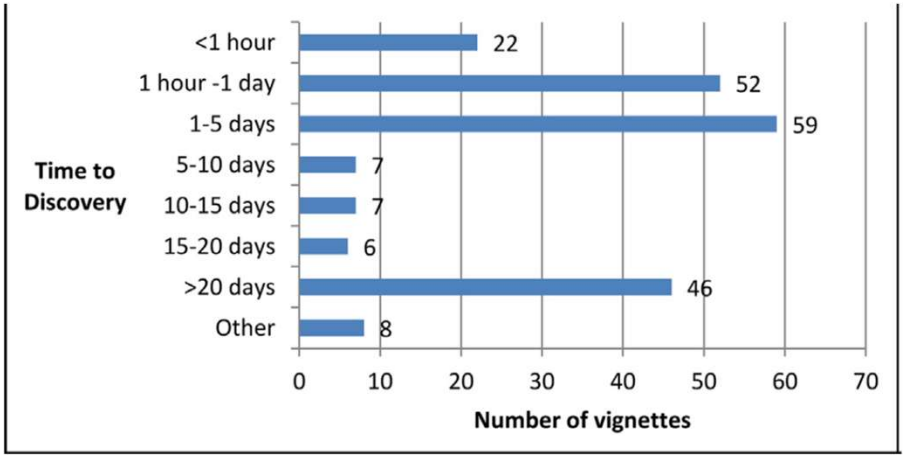
- A well-known connection exists between incomplete medical exams, diagnostic errors, and adverse events.
- Skipping to the answer via diagnostic tests results in higher medical costs and may lead to delayed, incomplete, or inaccurate diagnoses.
- Omitting the physical exam can have potentially life-threatening consequences, including the application of potentially harmful and unnecessary treatments.

A cross-sectional study using an 11-question qualitative survey for physicians.



- Most errors in the physical examination that lead to consequences are related to not performing an examination.
- Failure to undress the patient and examine the skin is a frequent cause of error.
- In a patient with abdominal pain, failure to examine the groin, rectal area, and hernia orifices can have dire consequences.

The decline of clinical skills: a challenge for medical schools

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Perspectives

The decline of clinical skills: a challenge for medical schools

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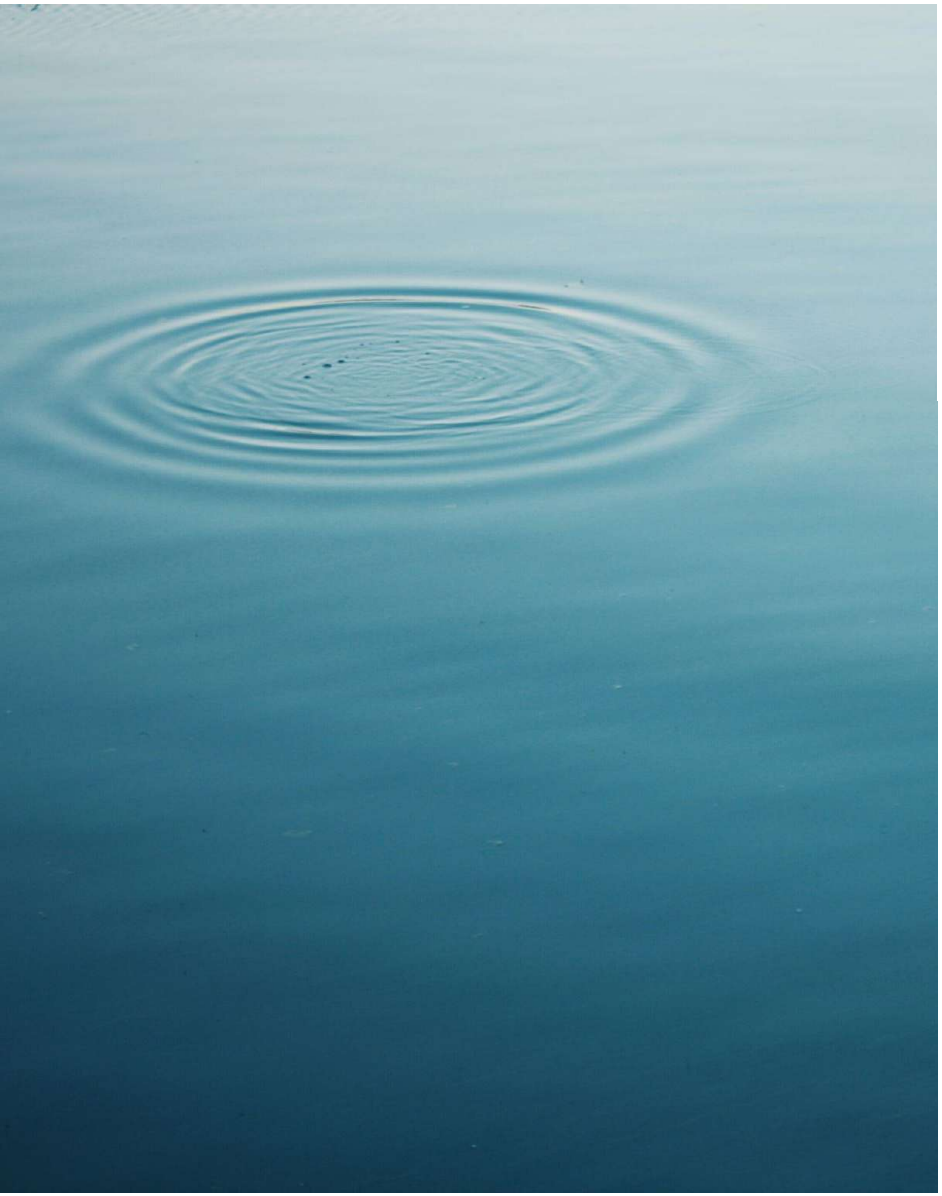
Common Errors in Clinical Skills

- Language barrier
- Jumping to investigations without taking a proper history
- No communication with the patient – copying of the EMR
- Excessive reliance on tests
- Disproportionate time spent at the computer
- Limited time for ward bedside rounds and teaching
- Prevailing perception that certain clinical skills are not valued (why spend time in diagnosing a murmur with a stethoscope at the bedside, when an echocardiogram can give us the answer right away?)



“To be listened to is healing,”

— **Abraham Verghese, The Covenant of Water**

The doctor-patient relationship

“The relationship between the doctor and patient has a very pronounced association with the model of illness that dominates at any given time”

N.K. Jewson

- Disappearance of the sickman from medical cosmologies 1770-1870

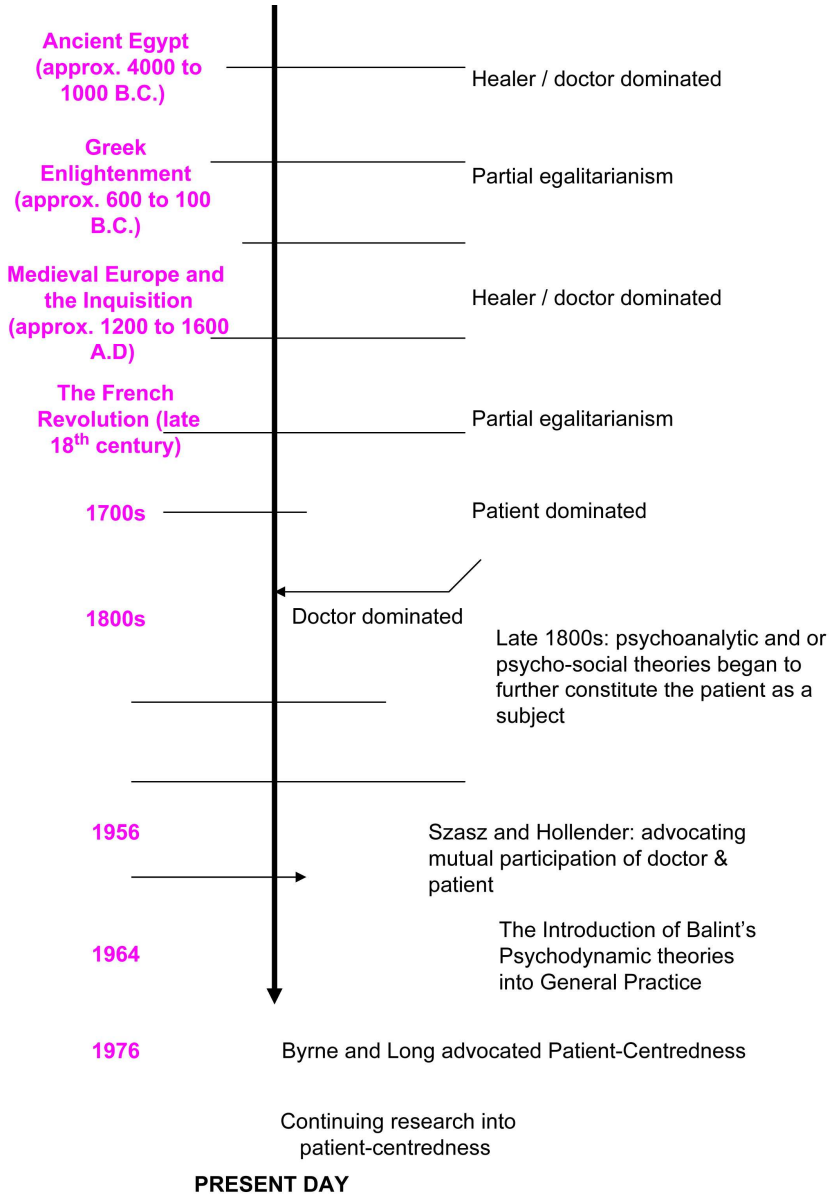
Evolution of the doctor-patient relationship

- 18th Century - the symptom was the illness
- Doctors were few in number and their patients mainly upper class and aristocratic
- This status disparity ensured the supremacy or dominance of the patient and doctors had to compete with each other in order to please the patient.
- The doctor found that it was less necessary to examine the patient but rather more important to be attentive to their needs and experiences manifest in the form of their symptoms

Birth of the Biomedical Model

- During the late 18th Century hospitals emerged as places to treat patients who were underprivileged.
- Doctors now found themselves providing medical treatment for those who were traditionally regarded as more passive.
- a new Medicine developed that focused not on the symptom, but rather on the accurate diagnosis of a pathological lesion inside the body – the biomedical model of illness.
- This new theory suggested that the symptom was no longer the illness, but instead acted as a unique indicator for the presence of absence of a particular pathology.

- This new model required the examination of the patient's body and the expert clinical and anatomical knowledge possessed by the doctor to formulate a diagnosis, and thus the patient became dependent as a result.
- The relationship was between a dominant doctor and a passive patient, i.e. an activity-passivity (paternalistic) model.


Ancient Egypt (approx. 4000 to 1000 B.C.)
Healer / doctor dominated
Greek Enlightenment (approx. 600 to 100 B.C.)
Partial egalitarianism
Medieval Europe and the Inquisition (approx. 1200 to 1600 A.D)
Healer / doctor dominated
The French Revolution (late 18th century)
Partial egalitarianism
1700s
Patient dominated
Doctor dominated
1800s
Late 1800s: psychoanalytic and or psycho-social theories began to further constitute the patient as a subject
1956
Szasz and Hollender: advocating mutual participation of doctor & patient
1964
The Introduction of Balint's Psychodynamic theories into General Practice
1976
Byrne and Long advocated Patient-Centredness
Continuing research into patient-centredness
PRESENT DAY

Benefits of the doctor-patient relationship

- improving the doctor-patient relationship can produce health effects as beneficial as some common treatments, such as taking a daily aspirin to prevent heart attack
- training health care professionals in relationship strategies led to better health outcomes for their patients
- Strategies included making more eye contact with patients, paying close attention to their emotions, and helping them set goals
- A good relationship fosters better communication, which improves diagnosis
- encourages people to tell their doctors about symptoms they might not otherwise disclose
- a good relationship with your doctor makes it more likely that you'll follow a recommended treatment and believe it will work, which can increase the treatment's success

Beyond the clinical

- touch promotes mental and physical well-being
- Physical touch increases feelings of trust, reduces stress, and lessens feelings of loneliness.
- Researchers found no difference in health benefits in adults when comparing touch applied by a familiar person or a health care professional.

"Wherever the art of Medicine is loved, there is also a love of Humanity. ”

— Hippocrates

The ‘doctor-as-person’

- patient-centred medicine is *“two-person medicine”*, whereby the doctor is an integral aspect of any such description
- Sensitivity and insight into the reactions of both parties can be used for therapeutic purposes.
- Balint et al. (1993)[26] describes how emotions provoked in the doctor by particular patient presentations may be used as an aid to further management (*“counter-transference”*)
- Winefield et al. (1996)[27] described the dimensions of patient-centeredness as attention by the doctor to cues of the affective relationship as it develops between the parties, including self-awareness of emotional responses.

ETHICS AND THE DOCTOR–PATIENT RELATIONSHIP

- Fiduciary relationship - Oath of Hippocrates

-The physician has a duty to act in the patient's best interest and to refrain from exploiting the patient. Respecting the fiduciary relationship and the trust of the patient is a cornerstone of the ethical physician's practice.

- Boundary violation - any behavior on the part of a physician that transgresses the limits of the professional relationship

- have the potential to exploit or harm patients (not boundary crossing)
- include personal or social boundary violations, business relationships, and sexual activity

The Oviedo Convention and human rights principles regarding health- Values

- Human dignity
- Primacy of patient interests over societal and scientific interests
- Right to life
- Physical integrity
- Privacy and identity
- Informed consent
- Right to know and right not to know
- Prohibition of discrimination and inequality in access to healthcare
- Quality of care standards

Models of the (ideal) doctor-patient relationship

- Paternalistic Model - vests the vast majority of decision-making power in the doctor.
- Informative Model - vests the vast majority of decision-making power in the patient
- Interpretive Model - The ultimate choice of intervention still rests with the patient
- Deliberative Model - The aim of the deliberation is moral persuasion, but not coercion, with the patient ultimately deciding on the appropriate validity and priority of these values in their life.
- ‘instrumental model’ - the patient’s values are given no importance; rather, the doctor takes a decision or convinces the patient to choose a particular course of treatment on the basis of external values such as social or scientific good.

Professional ethics in medicine

- virtue ethics – Influential approach

medicine can be considered a “moral practice” with virtues describing character traits required of doctors in addition to the “medical scientific knowledge, practical skills and experience that ensures that the doctor does the right things with the right attitude in order to reach the goals of medicine.”

Why? - because as a profession it self-governs, defines, and upholds internal standards of good medical care and accreditation processes to uphold these standards.

Telos of Medical Practice

- “the ends of medicine are...the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort or disability.”
- The doctor-patient relationship, understood as a type of “healing relationship,” is the primary mechanism through which these ends are realised.
- the healing relationship involves both clinical interventions and information or services provided to patients for the sake of knowledge, empowerment or self-care.

"God will judge us by what we did to relieve the suffering of our fellow human beings. I don't think God cares what doctrine we embrace."

— **Abraham Verghese, Cutting for Stone**

the healing relationship

- A virtue-based approach emphasises the importance of treating the patient as a whole and promoting the patient's well-being through good practice.
- Standards are defined against goods – Core Aims

-compassion that "safeguards that the patient is not only seen as a number,"

-contextual understanding of the patient's values, history and concerns, an "interest in the inner processes of the patient…

-an adequate skill in responding non-verbally and by skillful and sensitive dialogue," alongside

-technical skill in 'fixing' the patient's disorder or managing a persistent condition.

Traits of the healing relationship

- Vulnerability and Inequality - an imbalanced relationship
- Fiduciary Nature- trust, moral obligation
- Nature of Medical Decisions - technical and moral features
- Characteristics of Medical Knowledge - non-proprietary

Doctors have a moral obligation to act as stewards to this knowledge, ensuring it is readily available to others, used ethically in the treatment of patients, and not purely for self-interest.

- Moral Complicity - The doctor is the channel through which medical interventions flow to the patient

Ideal patient-centred care

- The patient not the illness should be the primary focus of medicine
- The primary objective of the doctor is to listen to the patient in order to identify what the ‘real’ problem actually is, instead of simply eliciting symptoms and signs.
- Shared decision making between the doctor and patient will determine the most appropriate and best course of action for an individual patient.
- The doctor in this patient-centred model is ideally placed to bridge the gap between the world of medicine and the personal experiences and needs of his patients.

Conclusion

- Some diagnoses cannot be made without examining a patient in person
- More than a tool that informs diagnosis and treatment - it is a means through which to pause and physically connect with patients
- a tool you can use to persuade patients and reevaluate their narratives
- provides a measure of objectivity that can help rethink a patient’s narrative
- the physical examination as ritual and its importance to patients - brings physicians satisfaction through human connection

“The world is influenced by each of our actions and inactions, regardless of our awareness.”

— **Abraham Verghese, Cutting for Stone**

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