Rebuttal: Routine Daily Physical Exam

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While we agree that a well-honed physical exam is one of the most important diagnostic tools than an internist can use, we have several responses to Drs Kanjee and McNamara's point that a routine physical exam is essential for hospitalized patients.[1] They argue that this exam might be helpful as a deliberate practice to improve skills for effective diagnostic exams. To this, we have two responses: the first is that the typical "routine" exam—a brief auscultation of the chest and abdomen—is performed frequently enough that additional practice should not be necessary for any practicing hospitalist. Performing a true full exam that would hone infrequently used skills, such as a full neurological exam, an orthopedic knee exam, or fundoscopy, comes at the expense of time spent talking to patients, as well as the potential harm of downstream testing cascades leading to adverse events. Second, we would argue that the real skill being developed is not "recognizing normal" but instead learning how to appropriately use physical diagnostic skills. Knowing precisely what exam maneuvers might be beneficial in a given hospitalized patient is incredibly complex, far more so than charts in evidence-based exam textbooks would suggest. It is this skill, not "recognizing normal," that requires deliberate practice.

We agree that even during routine hospitalizations, daily exams may help detect complications of therapy, such as a patient with cellulitis on intravenous fluids developing volume overload. We are not against performing physical exams for diagnostic or monitoring purposes. In fact, it may be that most hospitalized patients would benefit from some sort of daily exam. However, rarely performed maneuvers, such as walking with patients or performing a validated delirium screen, are likely to have a higher yield than routine lung auscultation. It may also be true that hospitalized patients would benefit from certain screening exam maneuvers, but again, evidence is lacking, and decades of experience in the outpatient world would suggest the contrary.

Finally, and most ardently, we disagree that performing a routine daily physical exam can somehow inoculate against burnout. That is a view wholly unsupported by any evidence. The physical exam was originally developed as a diagnostic tool, not as a method to connect with patients. However, this traditional "routine" exam has been taught in medical schools as normal ever since, with very little serious interrogation of its utility or downstream effects. Increased cynicism about the exam's usefulness, in our opinion, reflects physician cognizance of actual disutility of routine exams, rather than pining for a halcyon era that never existed. In fact, we believe a more hypothesis-driven diagnostic use of exams enriches physical diagnosis. For instance, listening to the chest of a patient with cellulitis on intravenous fluids is no longer "just listening," it is an exercise specifically looking for a finding that affects management. Patient-centered care means tailoring all of our care—including the physical exam—to the needs of the patient. Doing a cursory, routine exam day after day for every patient with the goal of "recognizing normal" is not patient-centered, but rather physician-centered.

We do not doubt the importance of ritual, especially in such a stressful situation as a modern hospitalization. But rather than use a diagnostic procedure with downstream effects, we urge hospitalists to consider instead a ritual dating back to the time of Hippocrates—the compassionate physician sitting at the bedside, laying a hand on the shoulder, and listening to the patient's concerns. That is authentic human connection rather than performance.

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Reference

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