

# Losing touch?

## *Refining the role of physical examination in family medicine*

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The coldness of a stethoscope on exposed skin, the bounce of a patella hammer, saying “ah”—these are familiar experiences for patients and physicians. From simple maneuvers like checking a pulse to sophisticated ones that define the cause of back pain or the presence of excess abdominal fluid, physical examination has always been a part of daily practice. Learning physical examination techniques is central to medical training,<sup>1</sup> and clinicians skilled in performing a physical examination are often held in high regard by their colleagues.

Its use, however, is under threat—some would say even at risk of demise.<sup>2</sup> Evidence-based physical examination, which relies on Bayesian principles and statistical analysis of diagnostic accuracy,<sup>3,4</sup> is in vogue. The annual physical examination and breast and pelvic examination for screening purposes are not fully supported by evidence.<sup>5-7</sup> Diagnostic imaging allows body parts, both accessible and inaccessible, to be visualized with a clarity that was unimaginable 30 years ago. Not only do echocardiography, positron emission tomography, and functional magnetic resonance imaging allow us to see the human body, they also show *how well* (or not) it is functioning. It is not surprising that use of diagnostic imaging is increasing<sup>8</sup> and use of physical examination is decreasing.<sup>9,10</sup> But all is not well with the scientific paradigm. There is tension between evidence of validity, accuracy, and statistical significance and another type of evidence: experiential evidence that physical examination can express humanity and care.<sup>10-13</sup> Is the current trend, as Jauhar<sup>2</sup> asks, an evolutionary inevitability or a crisis that demands our attention? What value does physical examination have in contemporary practice?

### Value of physical examination

One way of alleviating the tension is to consider what types of information physical examination can provide. Evidence-based medicine promotes a type of decision making that is informed by clinical expertise, each patient's unique values, and the clinical context in which decisions are made.<sup>14</sup> The usefulness of

physical examination has been defined statistically by its ability to support diagnosis and estimate prognosis. More recent research methodologies from the social sciences allow us to explore patients' values and the influence of context. Qualitative methodologies have shown how people's everyday attitudes and actions are embedded in their social contexts. Yet theoretical constructs and approaches from the human sciences have barely been applied to research on physical examination. Phenomenology, the study of human experience,<sup>15</sup> could extend our current understanding of the usefulness of physical examination. What might have been dismissed as anecdotal evidence and nostalgia becomes, in a phenomenologist's hands, a window into the richness of everyday moments of practice and patient care.

Verghese<sup>10</sup> evocatively describes placing a stethoscope on the emaciated chest of a young man dying of HIV. He ascribes ritualistic significance to the process of physical examination, which allows both physician and patient to enter into a “sacred space” reminiscent of Jung's idea of *temonos*,<sup>16</sup> the space in which therapeutic relationships take place. The sanctity and intimacy of physical examination legitimizes human connection, mediated through touch. Proponents of physical examination such as Verghese<sup>10</sup> and Ofri<sup>13</sup> argue that it supports the development of trust, empathy, and relationship building. Touch, a primal and potent act, extends beyond skin-to-skin contact to engage an emotional domain of praxis.<sup>17-19</sup> It is an affective dimension of care, the power of which extends beyond words. In addition to focusing on “gnostic knowledge” (information on diagnosis and prognosis), physical examination gives access to “pathic knowledge,”<sup>20</sup> which relates to emotional knowing and is experienced as being present in the moment. Fredriksson<sup>21</sup> supports the idea of touch as a form of connection and expression of presence. This connection is rarely spoken about in clinical practice but contributes to the development of trust between a health care professional and a patient.<sup>22</sup> The work of Cocksedge and colleagues<sup>17,23</sup> suggests that family doctors might be reluctant to use expressive touch (for example, holding a patient's hand) for fear of being misinterpreted; however, interviews<sup>17</sup> and surveys with patients<sup>24</sup> suggest that such misinterpretation is unlikely to happen. Physical examination offers a means of touching patients in a structured manner, which facilitates the pathic expression of shared humanity. This knowledge is integrated into the consultation,

This article has been peer reviewed.  
*Can Fam Physician* 2015;61:1041-3

La traduction en français de cet article se trouve à  
[www.cfp.ca](http://www.cfp.ca) dans la table des matières du numéro  
de décembre 2015 à la page e532.

influencing interview style and decision making. Doctors and patients tacitly integrate physical connection into a whole style of communication and collaborative decision making.

### Embodied knowledge


Physical examination is not just a set of techniques but an embodied praxis. Embodiment refers to how our bodies negotiate our everyday lives by mediating, interpreting, and interacting with our physical and social environments.<sup>25</sup> In the 1960s, French philosopher Merleau-Ponty<sup>26</sup> challenged Cartesian dualism—that mind and body are separate. Rather, he emphasized that mind and body exist together. We cannot leave our bodies. Flesh is the materiality through which we know the world. He introduced the idea of “body-subject,” asserting the preeminence of the physical body as the constant through which we know the world. Physical examination maneuvers are, literally, the hands at work: sensing, responding to the body, body to body. Touch is reciprocal; whom or what a person touches also touches the person (Newton’s third law). Ask any clinician about his or her “sixth sense” when it comes to physical examination—when words fail to articulate a “gut feeling” or intuition that “something is wrong.” Such tacit knowledge<sup>27</sup> is embodied. It develops over long periods of time through the process of touching many normal bodies.

There is a facet of touch that is unique to family physicians, whose personalized knowledge of what is normal for any individual becomes embodied over the duration of long-term relationships. Whereas clinical notes identify abnormalities, physicians’ bodies retain a physical imprint of what is normal for their patients. For example, a patient reported that his tongue was getting bigger. Findings of the physical examination of the oral cavity, head, and neck were normal, yet something “felt wrong.” The patient was referred to an ear, nose, and throat specialist, who ordered a computed tomography scan, results of which suggested there was nothing amiss. Yet still the patient was adamant, and his physician’s personal knowledge of him influenced her to pursue his complaint. She reexamined his tongue. Years of experiencing the flexible, fleshy softness of normal tongues alerted her to the fuller, meatier texture of his. Eventually, he was diagnosed with amyloidosis secondary to myeloma.<sup>28</sup>

The concept of embodied knowledge—that the body is sentient and determining<sup>26,29</sup>—challenges the lauded objectivity of medicine. Yet embodiment theory is influential in, for example, nursing and social work. Should doctors reflect on its potential contribution to medicine before we capitulate to the technical and celebrate the digital body over reality? Consider, for example, how medical training might look if we could articulate such intuition

and bring it from a prereflective “feeling” into consciousness.<sup>20</sup> We understand little about how we learn and use touch in medicine. Estabrooks and Morse,<sup>18</sup> in contrast, studied how nurses learn to touch and described a “touch gestalt,” whereby verbal and nonverbal cues determine how practitioners respond to and evaluate their patients.

### Healing touch

Embodied knowing, communicating empathy by means of touch, and “laying on hands” have been part of the history of medicine since Asclepius, a legendary god of ancient Greece, healed people by touch. A pathic, tacit, and embodied form of acumen has progressively developed over time. Application of this knowledge moves beyond “thin thinking,” in which we focus merely on the technical, to the “thickness of living,”<sup>30</sup> embracing the fluidity, complexity, and dynamic nature of patient care. These ideas are encapsulated in “judgment-based care,”<sup>31</sup> which “draws on all our human sensitivities including our emotions” and “integrates background understandings, felt meanings of a situation, imaginative scenarios, prior experiences and perceptive awareness.”<sup>31</sup> By extending our consideration and study of physical examination, grounded in rich philosophical thinking and supported by empirical investigation, we suggest a move beyond nostalgia to a clinical practice that is evidence based in all its diversity. 

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#### Competing interests

None declared

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**The opinions expressed** in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

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