Unsticking the pendulum

by Deanna Telner MD MEd CCFP

She had taken off her sweater for me to examine her painful shoulder when I noticed the irregular black mole on her upper back.

He was here to discuss his back pain, but the smell of cigarettes on his breath filled the room. I think of how I am going to bring up his mood in our discussion- always the trigger for his smoking.

'I think it's probably another flare of my gout' he states, as he bends down to take off his shoes. His left hand has a tremor that I am sure I would have seen before, had it been there.

She came in to discuss birth control, but as she is holding her baby I notice faint bruises on her arms.

Observation is a powerful tool that we, as family physicians, learn to master. We are constantly looking, assessing and examining our patients, both for the things they are concerned about, and for things that we notice based on our extensive training. It is a skill that is developed over time and experience. Clinical observation has been a central part of medicine dating back to the time of the ancient Greeks and Hippocrates when the value of examining the body became apparent. Looking after our patient's physical, mental, social health by directly observing them during our encounters and analyzing their interactions with us as we examine them, we pick up on signs and non-verbal cues that lead us to best diagnose and treat them. As William Osler once said "the whole art of medicine is in observation" [1],"learn to see, learn to hear, learn to feel, learn to smell and know that by practice alone can you become experts". [2]

The role of the physical examination in family medicine has, in many ways, declined over time. We now know that there is little value in the 'annual health examination', and this has been replaced by a periodic health examination involving counselling and screening based on risk factors. We have advanced imaging and other diagnostic tools that help us in diagnosis. Yet studies have shown, time and time again, that the physical examination is of significant value. It may confirm a diagnostic hypothesis based on history or pick up early signs of disease not evident to the patient. Even if the examination is normal, it may be a therapeutic intervention in and of itself.[3] To patients, close proximity during examination strengthens doctor-patient relationships, reduces patient anxiety and can have a healing effect[4]. Physical touch can be used to communicate comfort, trust and reassurance.[5] It can convey recognition and empathy. Studies have shown that patients are more satisfied with medical visits in which they were physically examined.[6] This is not only true for patients; a recent qualitative study of family physicians found that the physical examination is part of the identity of family physicians as they see, hear and feel patient's illness experiences. [7]

With COVID-19, we have been thrown into virtual care for our patients. Phone calls, video visits, emails have replaced most, and in some cases all, in person appointments. This has served as an important change to keep our patients safe, and we should be proud of how quickly we have adapted. There are many advantages of this for us, and for our patients. Logistically, virtual care removes constraints of time and place; it eliminates hassles of driving, parking, time off work. For those in remote areas, virtual care is particularly helpful, and may facilitate access that would otherwise not be possible.

Copyright © 2020 The College of Family Physicians of Canada

Personally, phone medicine has always been an important part of my practice. I frequently call parents to follow up on children I've treated for infections to insure they are improving. My patients know that if their UTI recurs, they can call me and after a quick few questions, I will often prescribe without seeing them. I will call patients with their test results, or to do a quick check in about side effects of new medication. This has been a regular part of my practice for decades. There are many situations where phone or virtual medicine is appropriate; where the likelihood of missing a diagnosis is very small, especially with good follow up. I've always encouraged the trainees I supervise to learn good phone medicine skills and incorporate them into their future practices. However, these situations are triaged- they are by no means the way to run a family medical practice. They are based on the fact that I know my patients, have examined them over the years, and know the situation. The risk is low. I would never consider using this when I meet a new patient, for a new clinical concern or for a patient who I have not seen in some time.

I have heard and read much about virtual medicine being the 'new normal' of medical care, in a post-COVID-19 era. Many state that the shift to virtual medicine should continue. Hearing these statements upsets me at my core and makes me feel very uncomfortable. This is not because of a lack of willingness to change, but because of a fear that we will be losing the skills that have been the pillar of our profession. Do hundreds of years of medicine focused on observation and examination of the patient in person get discarded? Does disregarding these skills and replacing this with a 'virtual visit' really accomplish the same thing? Is providing the best care in the setting of a COVID-19 pandemic being confused with providing the best care?

Now that we are 'opening up' our clinics more, there are many guidelines on who to see in person and who to see virtually. We should only be seeing patient 'when a physical examination is necessary'. This implies for diagnosis only. But we know there is no much more to the care we provide than diagnosis of patient's presenting concern.

It is an unfortunate time for our family medicine trainees- they desperately need to see and examine patients in person. Visualizing a child's small, normal tympanic membrane thousands of times will help them recognize an infected one, or an effusion. Examining fundi over and over again will help them identify discs that are blurry or the presence of early signs of systemic disease. Direct interaction with an anxious or angry patient in the office teaches them how to interact, build rapport, or de-escalate. Trainees need to learn the nuances of the physical examination and they need to learn to pick up on all the observations that lead us to feel qualified to practice the highest level of care, combining the science and art of medicine. It has been shown that skills not emphasized or learned during training years are unlikely to improve significantly thereafter.[8] We must ensure that these trainees, our future physicians, will get this exposure during their training. We may need to discuss implementing formal mentorship and learning programs after they begin their practice.

My neighbour tells me "you must love your new professional life---doing it all from home, so much easier!" I think of all the times I've casually complained about my long commute to work, the challenges of balancing carpools for my kids on the days I work evenings, and unexpected add-ins that make my day longer than anticipated. But this isn't the alternative I was looking for. If I wanted an easy professional life, I wouldn't have chosen one in medicine.

The pendulum has swung to virtual care. This is a necessity now, at least partly, to keep our patients who need to be home safe. But it should not be the future. We need to unstick this pendulum.

Continuing and expanding virtual care as a main role in our practice threatens our profession. It starts a path where we can be replaced by computer algorithms or by others with far less training than we have. We are not technicians. The gold standard of care should still continue to involve keen observation and in-person examination. We must realize the limitations of virtual care as we plan for our future. We owe it to our profession to keep this high standard that we have worked so hard to attain.

Copyright © 2020 The College of Family Physicians of Canada

Deanna Telner is a family physician at the South East Toronto Family Health Team and an Assistant Professor in the Department of Family and Community Medicine, University of Toronto.

References

1. William Osler "The hospital as a cottage', Aequanimitas 1914:332

2. "Osler the Teacher" Johns Hopkins Bulletin 1919, XXX: 198

3. Novack DH, Epstein RM, Paulsen RH. Towards creating physician-healers: fostering medical students' self-awareness, personal growth, and well being. Acad Med. 1991:74(5):516-520

4. Lida J, Nishigor H. Physical examination and the physician-patient relationship: A literature review. Med Ed Publish 2016;5(3) 14

5. Bruhn JG. The doctor's touch: tactile communication in the doctor-patient relationship. South Med J. 1978;71(12):1469-73

6. Robbins, JA & Bertakis, K & Helms, L Jay & Azari, R & Callahan, Edward & Creten, DA. The influence of physician practice behaviors on patient satisfaction. Family Medicine 1993;25. 17-20.

7. Kelly MA, Fremman LK, Dorna T. Family Physicians' Experiences of Physical Examination. Annals of Family medicine 2019;17(4)304-310

8. Olson D, Roth K. Diagnostic tools and the hands-on physical examination. American medical Association Journal of Ethics 2007;9(2)113-118

Copyright © 2020 The College of Family Physicians of Canada