

## Invited Article



# Bed Side Medicine – Forgotten Entity

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French Physicians in the 18<sup>th</sup> Century changed the traditional medical learning from “bookish knowledge and teachers’ personal sagacity to put the human bodies before books, prizing the hands on experience gained through indefatigable bed-side examinations and post-mortems”. Pierre Cabanis (1757-1808) was the father of the golden rule” read little, see much and do much”.<sup>1</sup> The introduction of percussion by Auenbrugger in 1761 and stethoscope by Laennec in 1819 helped the 19<sup>th</sup> century physicians make anatomical and patho-physiologic diagnosis. In the first half of the 20<sup>th</sup> century the bed-side evaluation was the most important means of diagnosis.<sup>2</sup> Even today it is the essence of the practice of medicine and consists of taking history and conducting the physical examination.

## History Taking

Patient should be able to give a history of presenting symptoms, duration, past and family history and that of treatment given. Diagnosis or differential diagnosis is arrived at after taking history. A study from BMJ showed in 66 of the 80 outpatients, the medical history provided enough information for the diagnosis. The medical examination was useful in diagnosing 7 patients and in the remaining 7 the investigations helped in changing the diagnosis.<sup>3</sup>

Eliciting the history from the patient is not a mere listing of the symptoms. His expressions, emotions, gestures and attitude while narrating the history gives an insight into his problems and reflects the personality of the patient. Study of medicine cannot be done without the study of the patient himself.

A good history taking involves primarily listening to the patient and encouraging him to speak rather than our talking. “We have two ears and one mouth and should use them in that proportion” (Elicetus). A patient and sympathetic listening can provide a “therapeutic Catharsis” for the patient. It establishes a good patient-doctor relationship which may reduce the suffering of the patient and instill confidence in the treating doctor.

After listening to the patient’s story, doctor has to ask few questions for clarification and additional information about his symptoms. Certain terminology used by the patient needs explanation. For example many a time patient says that he has a “gastric” problem which means different things for different people. It may mean upper abdominal discomfort, burning, belching, esophageal reflux and abdominal distension due to flatus. There are patients who are likely to underplay and sometimes overplay the symptoms. Further some others, due to sheer anxiety and fear that the disease is incurable or needs surgery may hide some facts. This aspect we see in patients with coronary artery disease for whom the cardiologist is likely to suggest coronary intervention. Immediately, the patient is likely to underplay the symptoms. Hence, questioning the patient which is an art by itself is essential to obtain complete and reliable history. Questions are to be asked diplomatically regarding his

work and sexual life which is not disclosed voluntarily.

There is an increasing tendency in recent years to obtain the history in a printed sheet which are ticked or crossed against a particular box not unlike multiple choice questions. This practice has to be deprecated as one will miss the sequence, evolution and combinations of history.<sup>4</sup>

## Physical Examinations

The objective of physical examination is to identify the physical signs of the diseases. The clinical examination is both an art and a science. Proper elicitation of physical finding is the art and the interpretation is the science of medicine. Physical examination should be performed methodically and more attention to be paid for the system involved as indicated by the history. Don’t we see a huge spleen and liver missed only because the patient’s abdomen is palpated in a sitting position.

Skill in the physical examination is acquired, through keener eyes, ears, smelling, sensitive fingers and more importantly by experience. In the word’s of OSLER “Learn to see, learn to hear, learn to feel, learn to smell and know that by practice alone, you can become perfect”. Further the mind must be tuned to the problem and “what the mind sees, the eye sees”. Thyrotoxicosis, Cushing’s syndrome and Bell’s Palsy may be made out by “Spot Diagnosis” by inspection only. Asymptomatic patients with only hepatomegaly and enlarged kidneys may indicate the hepatic and renal disease. Rigidity of the limbs, diagnostic of Parkinson’s disease is only made out by physical examination.

Sometimes symptoms and signs may change during the course of the disease and re-examination rather than re-investigation may be fruitful.

## Present Scenario – Ancient Profession in Modern Era

The practice of medicine has changed over the last five decades. The newer investigation methods based on Biochemistry, Molecular biology, Genomics and newer imaging techniques like CT scan, MRI and PET Scans contributed to the explosion of scientific information. Our growing reliance on computers and information technology altered the way we practice medicine and exchange information. Many medical centres have electronic medical records. However, its broad based use is limited in view of the concern regarding privacy and cost. The information technology is also used as a tool to make clinical diagnosis.

While the introduction of “high tech investigations has improved the diagnostic and management capabilities of the doctor, it has also generated fresh problems and challenges.

The doctors do not like to spend time on the bed-side examination. Instead he is likely to order a battery of tests before examining the patient and arriving at a provisional diagnosis. Some feel the bed-side examination is redundant, poorly reproducible and waste of time. He would like to spend time in looking at these tests, rather than interacting with the patient.

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For example when he makes a ward round in ICU he spends more time in looking at the monitor and ventilator readings than at the patient.

Today, there seems to be a lack of emphasis on the importance of bed-side examination even in the teaching institutions. The teacher and students spend more time in studying scientific advances-especially high tech investigations leaving very little time for bed-side clinical examination. He may be able to interpret ABG and MRI scan but may not know how to palpate spleen and differentiate vesicular from bronchial breathing.

The neglect of bed-side examination results in disturbed doctor-patient relationship. No doubt high technology of medicine expanding rapidly at the expense of art of medicine. Art of medicine is a multi-faceted approach to the patient care, that takes into consideration the patients' emotional and physical state. In earlier days, patients accepted whatever the doctor advised and he had a "doctor knows best" attitude - a "paternalistic" approach. Today, we have patients who are well informed and would like to discuss regarding the diagnosis, prognosis and management of the disease. The doctor has to develop good communication skill to interact.

The arrival of high tech medicine, in medical practice distorts the professional approach to clinical problem. This leads to irrational and unnecessary high tech investigation of the patient. For example, the CT scan heralded as the greatest discovery after that of X-ray by Roentgen 1895 and it is the only way to look at the brain substance. It helps in the diagnosis of infarctions tumors and other masses in the brain and abdomen. However, many a time the CT/MRI scans are used inappropriately i.e. ordering CT scan in all cases of dementia, headache and metabolic encephalopathies. The inappropriate investigations ordered may be due to practice of defensive medicine, patients demand, specialists' ego and sometimes due to lack of knowledge. As the profession is being commercialized, "kick back" culture may also be responsible.

In recent years, there is a growth of "consumerism" in the health care field. The patient is a consumer and that the doctor is mere health care provider. The patient is increasingly demanding, critical and litigious. With the result the doctors are also increasingly practicing "defensive medicine" resulting in more number of investigations and cross references.

The adverse effect of modern medicine like disturbed doctor-patient relationship, inappropriate use of high technology, growth of consumerism, practice of defensive medicine and commercialisation may be minimized by the practice of good bed-side medicine with well learnt art of communication skill with the patients and relatives.

## Limits to Investigations and Advantage of Bed-side Medicine

There are many clinical signs which indicate the diagnosis and cannot be discerned by any other investigations e.g. Clubbing, Lid lag, Rebound tenderness, Cushingoid features, Thyroid disorders, Herpes zoster and many other skin lesions. When a patient c/o chest pain and the history and physical examination suggesting pain, hyperesthesia and vesicles along the dermatome, it is diagnostic of herpes zoster. The initial bed-side examination spares the patient of investigations like ECG, Cardiac enzymes, Chest radiography and probably Echocardiography, which is likely to be ordered in this patient.

Most of the common disorders like epilepsy, migraine, tension headache, Parkinson's disease, other movement disorders and

dementia are diagnosed by the bed side. CT or MRI scan does not play a major role. Further, incidental findings like lacunar infarcts, atrophic brain, small granulomas, kidney and liver cysts, cholelithiasis are seen on imaging, may cause anxiety in the patient. For all that we know, unless there are clinical correlates, the above findings are insignificant.

Ordering the investigations without bed-side examination is impersonal and investigation alone do not determine the management. Patient-doctor relationship which is developed by the bed-side medicine is essential for the proper management of the cases. An asymptomatic Coronary artery disease and Cholelithiasis needs inter action with the patient for the further management.

The other limiting factor is the cost of high tech. investigations which may be unnecessary, unkind, unsafe and unwise. The cost is all the more important in resource poor countries where the value of bed-side skill is obvious.

## Future of Bed-side Medicine - Can we afford to forget?

The bed-side skill is fast being replaced by high tech. investigations. However the limitation of such investigations and information technology is discussed above. It is not possible to replace the bed-side medicine especially in the diagnosis of certain diseases and in the management where there is need for an inter-action with the patient and relatives. Further, even when the investigations are essential the history and clinical examination ration and rationalises the investigations.

The study of the man and his disease is best done at the patient's bed-side. Was it not Osler who said "It is more important to know what patient has the disease than what disease the patient has?" Unless the doctor learns the bed-side skills he will never be a competent doctor. Knowledge gained by the books and internet is insufficient to face the real life situation. It is again Osler who said "that studying patient without studying books was liking sailing a ship without charts, but studying books without studying the patient's was like never sailing at all"

## Conclusion

The accurate clinical diagnosis is obtained by a good history, thorough clinical examination and rational investigation. The findings are interpreted in the light of knowledge and experience. Hence bed-side medicine one cannot afford to forget and it is still valid and accurate. It can only be supplemented by investigations. It is a combination of both science and art. Knowledge is the science and wisdom is the art. It is when both knowledge and wisdom join hands the patient gets the maximum benefit.

"Knowledge comes, wisdom lingers"

Lord Alfred Tennyson

## References

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