

## Will the doctor see you now?

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The feeling of knives stabbing her abdomen was what brought Robyn Shanks to the doctor in Mississauga, Ont. The 26-year-old suspected she was suffering from food allergies (the pain usually arrived after eating certain foods), and asked her doctor for an allergy test. Instead, he told her she probably had irritable bowel syndrome, and ordered a barium enema test, which Robyn rightly dreaded: it required fasting, taking laxatives, and the insertion of an enema filled with dye. He didn't ask about her medical history, Robyn says, or examine her abdomen, the site of her pain. "He just wasn't listening," she recalls. As Robyn suspected, results came back negative. An allergy test later revealed she had an intolerance to wheat, dairy and eggs. "I wasted a lot of time," she says.

Anecdotally speaking, stories like Robyn's seem to abound: ultrasounds to diagnose constipation, an



appointment with an eye specialist for what turns out to be a bug bite. And there's this frequent complaint: "The doctor didn't examine me." While technology has brought accurate and timely diagnosis, something is being lost, too: the ritual of the old-fashioned physical exam.

*Jim Bourg/Reuters*

Lately, in test-happy and litigious America, the decline of physical exams has been the subject of debate in the popular press. One recent *British Medical Journal* editorial, "In praise of the physical examination," was co-authored by Dr. Abraham Verghese, a Stanford University physician and author who is arguing for a revival of an exam he says is fading in the face of diagnostic technology. (Studies have shown that medical residents in the U.S., as well as the U.K. and Canada, have poor training and technique when it comes to that basic skill of listening to the heart.) In Canada too, where experts on both sides of the border agree the decline in patient examination skills is less dramatic, medical schools have been trying to improve the physical—to reverse what Dr. Brian Goldman, author of *The Night Shift* and an ER doctor at Mount Sinai Hospital in Toronto, calls a sea change. "[It's] a 180-degree flip to the current technological approach, where you almost don't even talk to the patient. You just send them through a scanner, and get 100 blood tests."

Consider one often-cited overused test, the echocardiogram, an ultrasound used to identify abnormalities in heart muscles and valves. "Doctors often hear a heart murmur and they are uncomfortable figuring out whether it's normal or abnormal," says Dr. David Simel, chief of medicine at

the Durham Veterans Affairs Medical Center and professor of medicine at Duke University. With the use of a stethoscope, physicians should be able to determine whether a murmur is benign. But the echocardiogram has something a physical does not: “The allure of proof,” says Simel. “So we have started to become more dependent on these exams to prove normality.”

Or take MRIs. Provincial administrative data suggest that scan rates have increased dramatically in recent years. Researchers from Ontario’s Institute for Clinical Evaluative Sciences found that the number of MRI brain scans shot up from just over 15,000 in 1993-1994, to almost 90,000 in 2004-2005. Similar trends can be seen for MRI scans on other parts of the body. Some of this is explained by demographics, says Ruolz Ariste, program consultant at the Canadian Institute for Health Information (CIHI)—an aging population requires more testing—and an ever increasing number of machines. But even so, it’s a startling climb: “Physicians now rely more on MRIs and CT scans to diagnose, and spend less time with patients.”

A recent report by CIHI showed that medical technology and imaging are two of the greatest drivers of cost increases in Canada’s health care system. “This is a major concern,” says Dr. Michael Rachlis, a consultant in health policy analysis and associate professor at the University of Toronto. “Not only does it cost a lot of money, but you have lines for MRIs that are so long that when people really need them, they can’t get them in time.” There is a much cheaper option, says Rachlis. “A good history and physical would identify people who are more likely to have a neurological abnormality, who might have something to find on the MRI.”

But that takes time. Most Canadian doctors are paid on a fee-per-service basis, and see as many patients as they can. Though doctors have liability concerns to consider when a patient asks for a scan, Rachlis believes these could be mitigated by better communication. “Most of the time, it’s that the doctor didn’t spend enough time with the patient, didn’t explain why there’s no point in doing the MRI, what he or she thinks the real problem is and why.” The obvious corollary is that we aren’t using our health resources as effectively as we could be. As Simel puts it, “The best physician is the one who can make the best diagnosis with the least money.”

Indeed, research shows that more dollars do not necessarily improve care outcomes. Economists at Dartmouth College in New Hampshire have demonstrated that U.S. states with higher Medicare spending have lower-quality care. Additionally, the Mayo Clinic—among the best health care facilities in the world, where doctors spend more time with patients—also happens to be one of America’s lowest-cost systems.

Costs aside, there are other problems with too much testing. A CT scan of the abdomen, often used for complaints of abdominal pain, has the equivalent radiation dose of 500 chest X-rays and 3.3 years of environmental exposure to radiation. And the refrain by experts is that a proper history and physical examination is the more important test. As Dr. Alan Neville, associate dean of education for the faculty of health sciences at McMaster University, says, “Over 80 per cent of diagnoses can be made on the history alone.”

Others argue that poor clinical skills threaten something at the very core of the doctor-patient relationship: the healing power of touch. Verghese, the Stanford professor, feels machines have created an “illusion that there’s no other way to ‘see’ the body.” Over the telephone from California, he says, “As we’ve gotten better at imaging the body, as we’ve gotten better with technology, the burden of documentation of electronic medical records has taken people away from the bedside.” He notes manual exams have the potential to catch missed diagnoses, and to streamline what tests—if any—to order. But they also strengthen the bond between patient and doctor. “The ritual of telling someone your deepest secrets and allowing touch, that’s a ritual worth doing every time. The transformation is that the patient has faith in what we just did.”

To preserve the ritual, he implemented the “Stanford 25” initiative, which teaches medical trainees 25 essential physical exam skills and their diagnostic benefits. In Canada, med schools such as McGill University, the University of Alberta, and the University of Toronto have launched similar initiatives, creating simulation centres where students can interact with volunteer patients or actors outside of the hospital, and offering courses that emphasize bedside manner.

In late 2010, McGill held a conference focused on improving the teaching of the physical. Among other things, key thinkers looked at how to impart to students the importance of this doctor-patient interaction, and how to properly examine bodies that deviate from the norm. “Nobody prepared me to examine a patient in a wheelchair,” says Dr. Donald Boudreau, a director at McGill’s Centre for Medical Education.

Boudreau is charged with developing courses in “physicianship,” which teach about the physician as healer and professional. Now, he is turning his attention to the physical. He wants to establish something similar to what Verghese is doing at Stanford—the McGill 25, perhaps. “Many people think the physical is the doctor’s way of making a diagnosis, and many medical schools teach it like that,” he says. “But it’s [also] a way to show that you care for a patient, to build trust, to reassure the patient. And it contributes to healing.”

A new Harvard study called “Placebos without deception” lends credence to that last notion. The “honest placebo” study revealed that the placebo effect manifests even in patients who are told they’re getting a sugar pill. A remarkable 59 per cent of participants reported relief of irritable bowel syndrome symptoms, compared to 35 per cent of those in the control group, leading doctors to wonder if patients benefit simply from the act of seeing a doctor.

It will take time for the culture of care to catch up to what people like Boudreau are advocating for in medical schools. For now, some practitioners are working to preserve the patient-physician relationship in their own way. Dr. Jackie Thomas, a gynecologist at Toronto’s Mount Sinai Hospital, occasionally uses manual exam techniques even when they aren’t essential for the results. “Patients want to be examined; it’s comforting,” she says. Thomas has noticed that skills around the physical exam are falling away. She says, “Some doctors won’t even look at the patient until they’ve had an ultrasound, and there are examples where [doctors] are treating a lab result, or treating an ultrasound result, and they are not treating the patient.”

Thomas is more realistic than romantic. Technology can outstrip certain physical exam manoeuvres when it comes to accuracy, she admits. An obstetrical ultrasound at 12 weeks can tell more about the size of the uterus than an manual exam could. “But there are other cases,” she says, “where the laying on of hands tells how we should operate, what tests to order, which incision we might use, whether a patient is sick.” A balanced approach means a physician can better care for his or her patient, and maybe even do that deceptively simple thing that Sir William Osler, Canada’s most famous physician, urged: “Listen to the patient; he is trying to tell you the diagnosis.”