



View point

Medicine is ever changing, so also medical practitioners

Medicine is arguably the noblest profession in the world. In this country, people equate doctors with divinity: doctors save lives and ease suffering. Doctors are trusted more than anybody else and are believed to do their best. But do we really?

Open any book of Medicine, it gives a disclaimer at the beginning - "*Medicine is ever changing, we are not responsible for.....*". But I say "it's not Medicine that is changing as much as its practitioners". In the pre-industrialization era, doctors would diagnose conditions on clinical examination alone. What change did the advent of technology and development bring to the medical field? Today, the computer may be slowly taking the place of a doctor. Some software can do just that: type your symptoms into the computer and it will guide you with differential diagnosis, points of exclusion, investigations followed by the treatment. The advent of technology is devaluing the art of clinical examination. Is this movement in the right direction? My answer is 'No'. Many teaching set-ups have meager clinical material, and stretch regulations. Rampant corruption by supervising and governing bodies, are producing doctors who rely more on technology than on clinical clues. Technology should never take the place of clinical examination but rather should help in confirming the clinical diagnosis and in providing additional information for therapeutic and prognostic purposes.

I present some examples from my practice of Orthopedic Surgery.

A young lady reported with back pain radiating to the leg- the latter being more acute than the back

pain. The attending surgeon, ordered an MRI scan, after which he labeled her as having a 'disc problem'. He offered her surgery, but she was reluctant to go under the knife and subsequently arrived for work up at a different medical facility. There, the distal pulses in the painful leg were found to be very feeble. This lady was reluctant to submit for a more detailed physical examination, but when she finally agreed after persuasion, the doctor found a 'tumor in the popliteal region with nerve compression which was the probable cause of her leg pain. Treatment by excision provided complete relief of pain. 'Palpation of distal pulses', an established part of 'routine clinical examination had not been carried out earlier. Here the cause of pain was established to be in the leg itself.

A boy complained of 'sciatica'-like pain in the leg since a few months, and had been given different NSAIDs and nerve-protective drugs. The pain had persisted. What had been missed was an *abdominal mass* pressing upon the nerve, which was subsequently found on just palpation. Therefore the importance of examining the patient *in total*.

A middle-aged employee met with a road traffic accident and presented to Emergency Medical Department with an injury of the forearm associated with severe pain. His X-rays were normal and distal pulses were palpable. He was discharged with an arm-sling and prescribed NSAIDs. Subsequently he worsened, and then had to later undergo 'fasciotomy' to save his limb. It was an impending compartment syndrome. The inordinate should have alerted the doctor to do a simple clinical test of passive extension of the fingers which sharply increases the pain in this syndrome.

A retired Civil Servant had been under treatment for 'disc pathology' for a long time, without experi-

encing any relief. A CT revealed a small lesion in the vertebral lamina. He was taken to the operation theatre, but had hemorrhagic complications and subsequently died. The biopsy revealed it to be a highly vascular secondary metastasis from thyroid carcinoma. The enlarged thyroid had been obvious, beside the patient being cachexic, anemic and showing other signs of neoplasia. A radionuclide bone scan should have been requested, and this might have saved the patient.

A middle-aged lady presented with aches all over the body with only partial relief obtained from NSAIDs. The doctor diagnosed it as 'Fibromyalgia Rheumatica', a rare condition and a diagnosis of exclusion. Later when she developed renal calculi, hyperparathyroidism was confirmed. A few skiagrams or routine tests could have helped at the beginning.

These are only a few, from the many cases known to us. The growing trend of asking for hi-tech and costly investigations without a thorough clinical examination, even to the extent of contemplating surgery without proper assessment, can be very dangerous. *Nothing* can replace the art of clinical examination. Though *medicine is changing ever*, our basic approach *should change never*.

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The practice of medicine is still something of a skill, and much of this skill resides in the clinical examination of the patient. True, that with rapid advancements in technology, medicine is much less of an art than before: this is not necessarily a bad thing. The advent of evidence based guidelines have accomplished a greater uniformity in standards, and the widespread application of clinical practice algorithms and medical checklists have substantially contributed towards decreasing human error. The real art of medical therapeutics therefore, lies not in the skill of the doctor, but in methodical evaluation and constant monitoring of the patient—Editors