

### Clinical paradigms revisited

Kenneth Wong

**TO THE EDITOR:** Schattner's call to resurrect history-taking and examination as the dominant means of clinical diagnosis<sup>1</sup> is analogous to advocating a return to cave-dwelling and spear-hunting for food in the era of houses and supermarkets. Even the most ardent supporters of history and examination would acknowledge that they can be grossly inaccurate, in possibly up to 30% of cases.<sup>1</sup> Clearly, without using further diagnostic tools, there would be an unacceptably high rate of missed, incorrect or delayed diagnoses with associated morbidity, mortality and financial costs to the patient, hospital and community. Therefore, there is an urgent need to challenge the "politically correct" and entrenched paradigm of history and examination as the initial approach to diagnosis and management.

In my approach to acute abdominal pain, I have long since abandoned using the stethoscope to ruminate over the meaning of mysterious bowel sounds in favour of liberal use of computed tomography (CT) scanning. Gone are the days of inspection, palpation, percussion, auscultation and operation. This often arouses considerable opposition from traditionalist colleagues who are concerned about the cost and radiation dangers of abdominal CT. But their criticism ignores mounting evidence that the modern CT scan is rapid and accurate for nearly all conditions that require emergency surgical treatment.<sup>2</sup> In every study comparing the accuracy of CT scans with history and examination, CT wins hands down.<sup>2,3</sup> The CT scan takes the guesswork out of diagnosing the cause of abdominal pain and, most importantly, reduces the need for laparotomy procedures that frequently produce negative results. Similar conclusions could be drawn regarding the

use of CT scans in head injury or the use of chest x-rays in acute respiratory conditions. Perhaps the new clinical paradigm should be "scan first and talk later".

So, why do some clinicians continue to routinely promulgate the sacred and arcane ritual of taking a history and doing an examination, which, as diagnostic tools, are clearly second-rate. Cost is not a valid excuse, as there is no reason for patients to accept second-best care. The explanation may lie in blind adherence to ancient dogma that has been unchallenged since Hippocrates. Failure to accept that history and examination have severe limitations; to actively embrace newer, more accurate diagnostic tools; and to revise established clinical paradigms may relegate clinicians to the relevance of dinosaurs outside museums of ancient history. At the risk of medical heresy, I would suggest that the obituary notice for history and examination as the dominant diagnostic tools may be long overdue.

**Kenneth Wong**, Registrar in General Surgery  
Gosford Hospital, Gosford, NSW.  
kennethwo@yahoo.com

- 1 Schattner A. Clinical paradigms revisited. *Med J Aust* 2006; 185: 273-275.
- 2 Federle MP. CT of the acute (emergency) abdomen. *Eur Radiol* 2005; 15 Suppl 4: D100-D104.
- 3 Salem TA, Molloy RG, O'Dwyer PJ. Prospective study on the role of the CT scan in patients with an acute abdomen. *Colorectal Dis* 2005; 7: 460-466. □

### Ami Schattner

**IN REPLY:** Wong writes eloquently, and seems utterly convinced of the merit of the “testing first” medicine that he preaches. Yet his arguments are flawed and his system, appalling.

Young physicians not wearing a white coat are a fairly common sight in hospitals these days. Without a coat, they no longer have a convenient means of carrying around essential tools such as a flashlight, reflex hammer or ophthalmoscope. Indeed, if all they have to do is automatically order computed tomography (CT) scans, they will not need such tools. It is exactly to oppose these negative trends in medicine that my article was written. What I was trying to say was not that history and examination should *replace* modern imaging, but rather, that the decision about whether and when to order a test, and what test to order, should more than ever be *based* on skilful verbal and physical contact with the patient. Careful interpretation of basic clinical data such as the proneness of the patient to develop certain conditions (“pre-test probability”), the behaviour of symptoms over time, and the results of very simple laboratory tests are also immensely valuable. Most of this information can only be gleaned from patient-physician communication.<sup>1</sup>

Would Wong's approach to acute abdominal pain (do a CT scan first and then let the diagnosis sort itself out later) hold water in cases of acute gastroenteritis, renal colic, peptic ulcer, acute hepatic congestion, incarcerated hernia or Henoch-Schönlein purpura? All these not uncommon causes of acute abdominal pain can be confidently identified by their typical history and findings and successfully treated with no resort to imaging, which may be not only redundant but also costly and hazardous.<sup>2,3</sup> An additional downside of imaging without forethought is that it is fraught with false negative findings (eg, early diverticulitis or pancreatitis) and false positive findings (eg, “incidentalomas”) that often result in diagnostic confusion, lost time and more unnecessary testing.<sup>4</sup>

When the indirect benefits of patient-physician communication and examination are also

taken into account, the integral value of the clinical paradigm is even more strongly reaffirmed. Medicine is a humanistic profession. Patients experiencing pain, distress or uncertainty look up to the physician who talks to them, touches them, comforts them and is sensitive to their plight.<sup>5</sup> Even the best, latest-generation CT scanner would never be able to do that.

**Ami Schattner**, Associate Professor of Medicine  
Hebrew University Hadassah Medical School,  
Jerusalem, and Department of Medicine, Kaplan  
Medical Centre, Rehovot, Israel.  
amiMD@clalit.org.il

- 1 Silen W. Cope's early diagnosis of the acute abdomen. 21st ed. Oxford: Oxford University Press, 2005.
- 2 Weisbord SD, Palevsky PM. Radiocontrast-induced acute renal failure. *J Intensive Care Med* 2005; 20: 63-75.
- 3 Markowitz GS, Nasr SH, Klein P, et al. Renal failure due to acute nephrocalcinosis following oral sodium phosphate bowel cleansing. *Hum Pathol* 2004; 35: 675-684.
- 4 Kirch W, Schafii C. Misdiagnosis at a university hospital in 4 medical eras. *Medicine (Baltimore)* 1996; 75: 29-40.
- 5 Tumulty PA. What is a clinician and what does he do? *N Engl J Med* 1970; 283: 20-24. □

## The essence of the art of medicine

**C Ross Philpot**

**TO THE EDITOR:** Your thoughtful editorial comment<sup>1</sup> in the 21 August issue laments that the essence of the art of our profession was potentially diminished recently by the report of a working party of the Royal college of Physicians of London.<sup>2</sup>

My medical dictionaries and textbooks are curiously silent on the notion of an “art of medicine”, so I went to “the source” and discovered that “Life is short, and the Art long” comes from quotes of popular Latin authors as “Ars longa, vita brevis” — in turn from Hippocrates' original Greek,<sup>3</sup> ὁ βίος βραχύς, ἡ δὲ τέχνη μακρή.

A native Greek-speaking medical colleague of mine points out that the Greek word used in the quote implies “long through to the end” — presumably the end of one's career or the end of one's life. So we (and Hippocrates) are evidently referring to a rather grand concept of the art of medicine, not just a narrow view implied by the term “judgement”, as proposed by the working party.

I see judgement as being but one of many essentials of the art of our profession, and agree with Van Der Weyden's assertion that the proposed use of the term “judgement” in place of “art” is indeed reductionist and should be rejected.

**C Ross Philpot**, Physician  
South Australian Infectious Diseases Services,  
Adelaide, SA.  
ross.philpot@nwahs.sa.gov.au

- 1 Van Der Weyden MB. From the Editor's Desk: The essence of the art of medicine. *Med J Aust* 2006; 185: 185.
- 2 Royal College of Physicians of London. Doctors in society: medical professionalism in a changing world. Report of a working party. London: RCP, 2005. <http://www.rcplondon.ac.uk/pubs/books/docinso/c/docinso.pdf> (accessed Nov 2006).
- 3 Partington A, editor. The Oxford dictionary of quotations. Revised 4th ed. Oxford: Oxford University Press, 1996. □

### Norman Shum

**TO THE EDITOR:** I agree with Van Der Weyden's quotation from Osler: “The practice of medicine is an art, based on science.”<sup>1</sup> In my medical training in the 1960s, I was taught that medicine was both an art and a science — perhaps more the former than the latter, given that the technological age was not yet fully upon us. It saddens me that there is now an almost inexorable trend towards the use of advanced technology in medicine and away from human interaction between doctors and patients. I do not believe in reducing humans to mere numbers on a pathology results form or images on a computer-driven x-ray monitor. This is what helping patients “judge” which path to take “through the indeterminacies” back to health<sup>1</sup> suggests.

Gordon expressed similar sentiments in an earlier article:<sup>2</sup>

The arts, humanities and social sciences act as a counterbalance to the relentless reductionism of the biomedical sciences ... [M]edicine will attract students who are interested in the biomedical sciences, many of whom are particularly good at processing and memorising information. Unless they have adequate time for reflection, such students may ultimately adopt a dogmatic or overly technical approach to clinical practice ...

As a “doctor” — in the sense of a modern version of an ancient healer — I accept that my role is “to cure sometimes, to relieve often, to comfort always”.<sup>3</sup> There is cold comfort if we lose the “art” of medicine.

**Norman Shum**, Psychologist and Physician  
43 Hauteville Terrace, Eastwood, SA.  
mencius@senet.com.au

- 1 Van Der Weyden MB. From the Editor's Desk: The essence of the art of medicine. *Med J Aust* 2006; 185: 185.
- 2 Gordon J. Medical humanities: to cure sometimes, to relieve often, to comfort always. *Med J Aust* 2005; 182: 5-8.
- 3 Strauss MB, editor. Familiar medical quotations. Boston: Little, Brown and Company, 1968. □