Physical Examination Pet Peeves

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A great deal of consideration has been given to how our trainees present patient cases.[1,2] Prior to each of these presentations, the medical student or resident conducts a history and a physical examination. Like all medical educators, I spend a lot of time observing these interactions and, in doing so, I have developed a few pet peeves about how we interview and examine our patients.

I hesitate to go on as I am far from Oslerian in my own skills. I interrupt patients too soon and too often. I listen to hearts and lungs through T-shirts (though, I swear, never through a puffy jacket). My neurological examination would make a neurologist vertiginous. As a general internist, most of the examination maneuvers I perform in my outpatient practice are not meant to diagnose an illness but are intended to establish a therapeutic alliance or are a form of continuing medical education—relistening to textbook Velcro rales or feeling the goiter that has been present for 20 years. For these examinations that are not really diagnostic in their intent, a thin layer of cotton between my stethoscope and the chest wall affects nothing.

I also admit that I (and at least 1 patient) have been burned by my less than perfect examinations. Many years ago, I saw a patient in the emergency department with a fever and leukocytosis. I found nothing on the physical examination and discharged the patient with instructions to follow up if necessary. He was back the next night with a raging lower extremity cellulitis. The resident who admitted him asked if I thought that maybe he had a preclinical cellulitis when I saw him. It was only preclinical in the sense that I did not see it through his socks.

So, while avoiding the tired "don't examine patients through their clothes" screed, here are my physical examination pet peeves, presented in the order of an examination, more or less.

Standing while taking a history. Despite their dubious health benefits, standing desks have probably not done any harm. Hovering over a patient while taking a history does nobody any good. Sit down. Get at the same level (or below) your patient. Slow down, relax, listen.

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The quick listen. I am certainly not the first to call attention to this.[3] Do not introduce your examination with, "I will now quickly listen to your heart." I know we are trying to say, "I will not trouble you," but to many patients the comment translates to, "now I will do a crummy, cursory examination."

The random maneuver examination. The physical examination is a diagnostic test. Each maneuver should test a hypothesis. However, because many trainees have been taught a head-to-toe examination, physicians often perform utterly nonsensical maneuvers. A shoulder examination has no place in the examination of a patient with a lower extremity cellulitis. There is no reason to check for whispered pectoriloquy in a patient with a normal lung examination or rebound in a patient without abdominal tenderness.

The levitating legs. Examination tables have extendable supports for a patient's legs. Use them. Most patients see us for a physician visit, not a Pilates class.

Examining the abdomen from the left side of the bed. We are a right-handed species (apologies to the 700 million or so humans who are not). Examining a patient's abdomen from the right (and correct) side of the bed avoids a backhanded examination and keeps you from looking like an amateur.

The trinity of random jabs. For both the patient's comfort and the physician's power of detection, an abdominal examination should be slow, thoughtful, and deliberate. Use one hand to feel and, when necessary, the other to apply pressure. Too often, 3 pokes, with 3 fingers, in 3 random locations passes for an examination.

Pants. I promised to avoid admonishments against examining through clothing, but a couple of points are necessary. An abdominal examination cannot be done while a patient is wearing pants. Depending on a person's fashion sense, more than half of the abdomen may be concealed by pants or figure-slimming garments. One cannot examine McBurney's point

(and risks digital injury) by trying to slide a hand under a girdle.

Bras. Even more egregious than examining the lower abdomen through pants is examining the breasts with a bra in place. I have seen people hike bras up, push bras down, or just ignore them completely during the course of an examination. If breasts need to be examined, bras need to be removed.

Be hygienic but be reasonable. Wash your hands before and after the examination, do not touch anything after examining the feet or perineum, but do not routinely wear gloves (unless you or the patient has a syphilitic or otherwise contagious rash).

Be empathic but diligent. The longer I practice the more I realize that human beings are amazing creatures. We can learn to endure almost any disability. Often, part of how we do this is by concealing the problem. As physicians, though, we must expose the abnormalities. Be sensitive, but realize that you are examining patients in the service of helping them. Psoriatic nails cannot be seen through polish, acne cannot be assessed through foundation, and scarring alopecia cannot be seen through a wig.

And lastly, do an examination. Sometimes the problem is not poor examination skills (or perfectly reasonable skills that offend my delicate sensibilities) but not taking the time to examine the patient at all. Developing good examination skills takes practice. You will occasionally do something that a supervising physician will find amusing or even appalling. More often, however, you will learn something for yourself, help your patient, and give your teacher the pleasure of seeing you comfort a patient, make a diagnostic discovery, or connect with a person seeking help.

References

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