

American Osler Society, Inc. John P. McGovern Award Lectureship

**Touching Where it Hurts:
The Role of Bedside Examination**

Abraham Verghese, MD, MACP, DSc (Hon)



John P. McGovern Award Lectureships

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.
2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.
3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.
4. *The 'Open Arms' Reviving: Can we Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.
5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990 in Baltimore, Maryland.
6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.
7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.
8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.
9. *'The Leaven of Science': Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.
10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.
11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.
12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.
13. *Why We Go Back to Hippocrates* presented by Paul Potter, May 6, 1998, in Toronto, Ontario

Cover — Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

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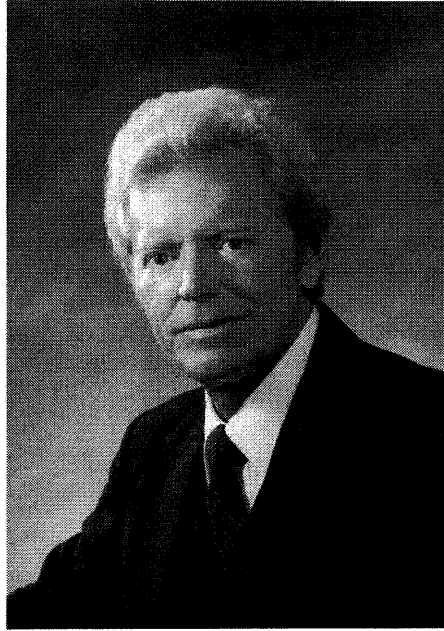
The Twenty-Second John P. McGovern Award Lecture

**Touching Where it Hurts:
The Role of the Bedside Examination**

by

**Abraham Verghese
MD, MACP, DSc (Hon)**

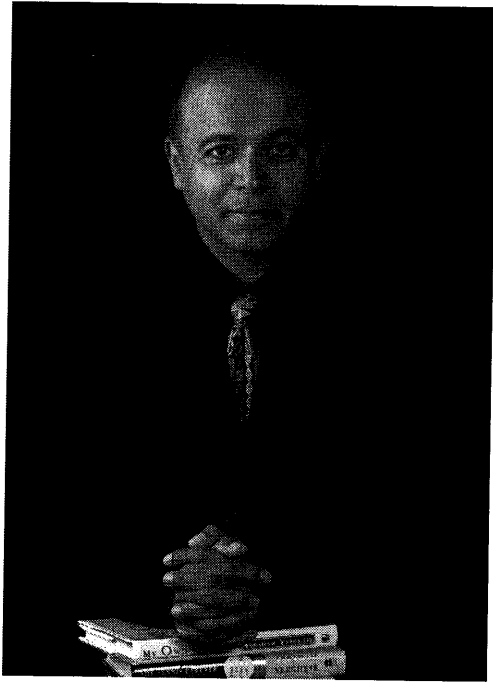
Delivered May 1, 2007
at the Thirty-Seventh Meeting of the American Osler Society
Montreal, Quebec.



John P. McGovern

JOHN P. McGOVERN AWARD LECTURESHIP

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences—in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.



Abraham C. Verghese MD, MACP, DSc

Abraham Verghese, MD, MACP, is Professor and Director of the Center for Medical Humanities & Ethics at the University of Texas Health Science Center at San Antonio. He also holds the Joaquin G. Cigarroa, Jr., MD Chair and the Marvin Forland Distinguished Professorship in Medical Ethics.

The Center, which started in 2002, has as its goal to help students discover within themselves a sense of caring and service that, combined with superb clinical skills, will enable them to reach their full potential as physicians.

The Center's program takes a three-pronged approach:

- A clinically focused curriculum in medical humanities and ethics that is required in all four years of medical school training;
- Service-based education and clinics involving the *colonias* in south Texas and student-run volunteer clinics for the indigent, homeless and women in a drug recovery program
- Restoration of the art of bedside medicine from the point of view of it being critical to the formation of the physician-patient relationship.

A graduate of Madras University, Verghese trained as a resident and chief resident in internal medicine at East Tennessee State University, and as a fellow in infectious diseases at Boston University. From 1991 to 2002, he was a professor of medicine at the Texas Tech University Health Sciences Center, El Paso. He is board certified in internal medicine, pulmonary diseases and infectious diseases.

Dr. Verghese attended the Iowa Writers Workshop at the University of Iowa where he earned a Master of Fine Arts degree. He is the author of *My Own Country*, about AIDS in rural Tennessee, which was a finalist for the National Book Critics Circle Award for 1994 and was made into a movie. His second book, *The Tennis Partner*, is a compelling story of drug addiction and friendship, and was a *New York Times* notable book and a national bestseller. He continues to write on a regular basis for the *New York Times*, *The Wall Street Journal* and is a writer-at-large for *Texas Monthly*, where he does a column every other month.



It is a great honor to be giving the John McGovern lecture at this, the thirty-seventh meeting of the Osler Society in Montreal.

These last few years I have been involved in two parallel efforts: first, the teaching of a curriculum of medical humanities to medical students, and second, weekly advanced bedside teaching with a focus on physical diagnosis. I think of the first effort as an attempt to keep the right brain alive and engaged during a medical student's four-year journey through medical school; when it is confined to the classroom and lecture hall, I think it is a limited task with minimal effects. I have come to see the latter – the teaching of useful bedside diagnostic skills – as having a critical function in a senior medical student's maturation, particularly in a technological age, and particularly from the perspective of the patient. Indeed, I have come to think that it is only at the bedside that we truly teach medical humanities – where else do we find the patient and the real-life issues with which to instruct? Even the broad shoulders of Chekhov and Tolstoy in the abstract, in the absence of the context of the patient, cannot carry the burden of instruction on their own. Osler, of course, would have loved the notion of taking the student out from the dry lecture hall, out from the conference rooms abutting the wards, and to the bedside, to the examining room.

To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.¹

Perhaps the best way to introduce my subject is to engage the right brain with a story. The writer of this piece is Robert Scot-Skirving. Scot-Skirving was a contemporary of Sir Arthur Conan Doyle, and both trained as medical students with Sir Joseph Bell at the University of Edinburgh. Bell's legendary powers of observation inspired the character of Sherlock Holmes. Scot-Skirving recalled one of Bell's clinics:²

Patient: Good morning.

Bell: What sort of crossing did you have from Burntisland?

Patient: It was good.

Bell: And did you have a good walk up Inverleith Row?

Patient: Yes.

Bell: And what did you do with the other wain?

Patient: I left him with my sister in Leith.

Bell: And would you still be working in the linoleum factory?

Patient: Yes, I am.

Bell (to students): You see, gentlemen, when she said good morning to me I noted her Fife accent; and as you know, the nearest town in Fife is Burntisland. You noticed the red clay on the edges of the soles of her shoes, and the only such clay within twenty miles of Edinburgh is in the Botanical Gardens. Inverleith Row borders the gardens and is her shortest route here from Leith. You observed that the coat she carried over her arm is too big for the child who is with her, and therefore she set out from home with two children. Finally, she has a dermatitis on the fingers of the right hand which is peculiar to workers in the linoleum factory at Burntisland.

This exchange happened before the patient had disrobed or the real history and physical had begun. One can only imagine how much more Bell would understand after he inspected, palpated, percussed and then auscultated.

Bell was exceptional, but probably not unique. There were legendary clinicians on both sides of the Atlantic and in the furthest reaches of the British Empire. The purpose of academic medicine seemed to be to produce this breed of physician or surgeon.

I find when I read this passage to medical students in their first year, they are thrilled, excited. For many this was an important reason to want to come to medical school, even if it was unstated – to be a kind of sleuth at the bedside.

The paradox is that medical students are never more excited by physical diagnosis, never buy more books or instruments related to physical diagnosis, than in their first year of medical school. In four medical schools I have taught students to inspect, percuss, palpate and auscultate well before they have caught the scent of the hospital. Their eyes sparkle as they examine each other under our guidance; they cannot wait to be like Sherlock Holmes or Miss Marple, or Hercule Poirot. This is medicine the way they imagined it to be and the way they imagined themselves being: Semioticians at the bedside, reading the signs to find the rustler and varmint in the patient's body. The drudgery of the first two years of medical school is bearable because of this introductory physical diagnosis

class, which, even when poorly conducted, is at least a promise of what is to come in their clinical years.

Back to the Students

To return to our students, so freshly trained in the art of physical diagnosis (practiced on healthy partners), a rude shock awaits them. It comes on their first day on the wards as third-year students. Their pockets are laden with reflex hammers, tuning forks, ophthalmoscopes, otoscopes, penlights and stethoscopes, and as they look around they realize that real doctors do not carry these tools.

The stethoscope is, of course, the exception, peeking out of the pocket as a hollow symbol of the profession. I prefer seeing it in the pocket than draped over the neck³ like a gym towel; when worn in that vulgar fashion by the young and the inexperienced, it reminds me of the beads and gris-gris that Wodaabe tribesmen string around their neck, a means of signaling in the Sahara (or in a hospital elevator) that the wearer is a sound marriage prospect and has, if not cows and land, then the promise of luxury cars, golf and early retirement.

Students discover too what we have kept well hidden from them until this stage in their training: In the hospital we have so little faith in our diagnostic skills that a patient with a missing finger must get an x-ray before we believe he has only four. Students rarely see physicians on the ward relying on the exam; indeed they often see them skip it altogether.

After learning the rudiments of the physical examination and memorizing the eponymous and delightful signs like the Argyl-Robertson pupil or the Trendelenburg test, students now finds that the ebb and flow on the wards centers around the results of the MRIs, CAT scans, angiograms and the myriad of lab tests that reveal the innards so well.

Before we discuss what happened to the doctors' skills, it is helpful to look at the evolution of physical diagnosis over the years, the 'phylogeny' if you will, because in teaching medical students, we recapitulate this evolution.

The Evolution of the "Art"

An innkeeper's son, Josef Leopold Auenbrugger first described percussion.⁴ I have dreamed this scene between father and son so often that I am convinced it must have happened, and if it did not it should have. Imagine Vienna in the 18th century:⁵

The inn is bustling. It is payday for the itinerant cabinetmakers from Florence who have adopted this inn as theirs for a week. At a signal from his father, young Josef follows him

down the uneven stairs to the cellar. They carry empty wine jugs, and they hold their elbows out to steady themselves against the narrow walls.

Auenbrugger père hums as he descends, enjoying the way his sound enlarges in the cellar, which is cavernous and cool. The facing wall has a low shelf displaying three large casks of wine, like portly giants seated together in fellowship of spirit. Their tops graze the low ceiling, and at the bottom of each cask is a spigot.

Since the casks are not transparent, the question is always how much wine remains. Is it time to replenish stock?

The innkeeper raps with his knuckles on the side of each cask. At the top he generates a hollow sound, a basso profundo like a bass drum. As his knuckles come down the side, there is a point where the sound changes. The earlier sustained echo – the thoom – is stifled and the new sound is dull and flat as if the old sound were decapitated; Josef on tip-toe will tap on the casks just like his father, and confirm the place where the sound changes. Young Josef, just like his father, “sees” through the cask, sees the reflective, liquid surface ripple at his touch. Sound has bypassed the rods and cones of the retina and yet magically it is transformed into a visual image.

We know the little boy must have grown up with a gifted ear because he wrote the libretto for an opera by Salieri.⁶ In Vienna, he would have certainly crossed paths with Mozart and even Mozart’s pupil Beethoven, but physician is what he became.

Perhaps it was his musical inclination, or else he was simply harking back to his experience in his father’s cellar, or perhaps it was mere accident, but Auenbrugger began tapping on patients’ chests. Over a period of seven years, he catalogued the sounds of health and disease, and he published his discovery in 1761 on New Year’s Eve in a book titled *Inventum Novum*. The few reviews were bad and it was ignored. Fortunately, while Auenbrugger was still alive, the eminent French clinician, Corvisart, physician to Napoleon, stumbled onto *Inventum Novum* and further refined percussion.

Corvisart published a translation of Auenbrugger’s *Inventum Novum*⁷ along with his own findings. I love the motto he chose for his book: *Insonuère Cavæe*⁸ (or *The Hollow Cavities Resound*). This is from Virgil’s Aeneid, in which the spear thrown at a wooden horse produces a “thoom” sound.

We must remember that in Auenbrugger’s time, physicians focused

largely on symptoms, and had no great need to touch the patient (which many patients will argue is where we are now). Knowing what ailed you made little difference, because as far as treatment went, you could be cupped, purged, scarified or bled. Bleeding was to that era what antibiotics are to ours: abundant and overused, and with the same goal of chasing out real or imagined critters.

The barber-surgeon did the bleeding.⁹ The patient held onto a pole in his establishment and the barber sliced and collected the blood in a basin. While there, the patient could also get a tooth pulled, an abscess drained and finish up with a shave and a haircut. The barber-surgeon was nothing if not versatile. At the end of the day, the barbers washed the long strips of bandage and hung them outside to dry.

Medical students are often surprised when I tell them that the familiar red and white barber's pole has its origins in bloodletting, with the stripes representing the bloody bandages and the ball on the top of the pole representing the basin. The upshot of these methods was that if you had a chance to live, the treatment might nevertheless do you in; if you were destined to die, the treatment mercifully hastened the end.

Auenbrugger's discovery had the impact in its day that X-rays would have one hundred and fifty years later. For the first time a doctor could percuss and "see" beneath the intact skin into the innards of the body. With a little practice, percussion allowed (and still allows) a physician to get evidence of a dilated heart, an enlarged liver, fluid around the lung, fluid in the belly, a perforated stomach ulcer and many other conditions. I think of present-day ultrasound as the child of percussion, the ultrasound transducer generating a sound wave that bounces off the tissues and comes back to a sensor.

Like any new technology, percussion had its overenthusiastic practitioners like Pierre Piorry who practiced at the Pitie, France's most famous hospital. Piorry percussed while sitting on a high stool next to the patient's bed and then used colored crayons to outline the organs. The "medical Paganini" claimed each organ had its note, and the body contained a musical scale. An apocryphal story says Piorry went to see the King and on being told the King was out, proceeded to percuss the chamber door and declare that the King was so in.¹⁰

Laennec's *Le Cylindre* came into being in 1816, though he soon renamed it the stethoscope, from the Greek, "I see" and "chest." Laennec's invention of the stethoscope and his publication of *De l' Auscultation Mediate* (1819) inspired Piorry to make a similar offering to the technique of percussion. Piorry's contribution – a backward step, but who knew at the time – was to invent the pleximeter (le plessimetre). As he described it in *De la Percussion Mediate* in 1828, it helped outline the internal organs. In

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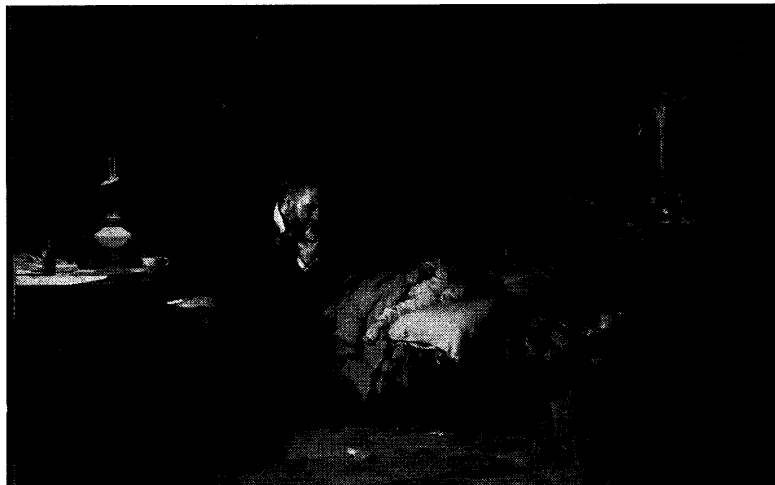
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place of the middle finger over the chest, Piorry favored a flat or oval disc made of ivory or other material with a scale carved into one side.

The percussion hammer, the pleximeter and the stethoscope were carried together and manufacturers had them in a single case. This was a watershed moment in medicine. Carrying a stethoscope in one's pocket indicated one was a physician, a different breed and philosophy than the barber-surgeon. A physician was someone committed to figuring out what organ was affected, exactly how its anatomy had been altered, and by what disease. It was the dawn of true bedside clinical acumen.

Portrait of the Ideal Physician in the 19th Century

Sir Luke Fildes, who painted *The Doctor*, one of the most famous paintings in medicine, lost his eldest son, Phillip, in 1887 on Christmas morning. The doctor who attended him was totally committed in his attention to and care of the child during his illness until ultimately, the boy died. His doctor's dedication made a lasting impact on the painter and years later, when Sir Henry Tate commissioned him to do a painting – and allowed him freedom of choice about the subject – Fildes drew upon the memories that were seared into his very being. He painted the intensely moving scene of a family physician at a bedside vigil for a desperately ill child.



Art critics and commentators ask us to observe many choices the artist has made:¹¹ The stage is lit by two central figures: the physician and the patient. The scene is a room in a small cottage with simple furnishings. The low ceilings add to the deep atmosphere of emotion and grief. The colors overall are muted and dark with light coming primarily from the

lantern on the medicine table, but with a glimmer from a small window.

The physician, seated in the darkened room, is formally dressed and facing away from the medicine on the table and toward his patient, focusing intently on the child who, even though limp and inert under his pale pillow and yellow-gold blankets, immediately draws the eye. His bed is cobbled together on two dining-room chairs. The boy is clearly ill and weak, his body limp, hair tousled and arm restlessly extended beyond the pillow before he fell to sleep. In the painting, the boy is resting and his parents are on the perimeter of the scene, hardly visible in the dark. Both mother and father project despair and watchfulness – he stands anxiously waiting with his hand on her shoulder for comfort. She sits with her face in her hands.

This painting was immediately acclaimed and even today resonates with audiences, especially in the medical community. The physician's empathy and dedication are clear and he is a beloved model for the medical profession. *Could the physician's attentiveness have been conveyed but by being there at the bedside?*

This image has endured and retained its popularity over the years. It has been featured on postage stamps in the United States and Britain. It still lingers, particularly among older patients, as the public perception of the ideal physician. It is one of the fifty-seven original pictures in Tate's new museum.

The question always arises as to whether this child will die. Fildes answered this way: "At the cottage window the dawn begins to steal in – the dawn that is the critical time of all deadly illness – and with it the parents again take hope into their hearts, the mother hiding her face to escape giving vent to her emotion, the father laying his hand on the shoulder of his wife in encouragement of the first glimmerings of the joy which is to follow."¹²

Furthermore, Fildes notes that his motive for choice of subject is "to put on record the status of the doctor in our own time."

I bring up this painting because I have the distinct feeling that the patient in America has become invisible. On rounds at any institution, she is in danger of being unseen and unheard. She is "presented" to us in a conference room away from where she lays. Her illness has been translated into binary signals to be stored in the computer and handheld. I will ask a question about her, and the intern's head instinctively turns to the computer screen, like a pitcher checking first base. I realize what has happened: the patient in the bed is merely an icon for the real patient who exists only in the computer.

I gently insist we go to the bedside. But the bedside is a place where I feel the team is no longer at ease. How strange, because at the bedside

the patient's body, like some illuminated manuscript, helps us clarify the situation. In an elderly patient with a "problem list" that is in the double digits and scrolls off the screen, it is only at the bedside that one can sort out which problem is the most important. As my brother-in-law who buys and sells cars says, "You have to kick the tires."

In kicking the tires in such fashion, I have come to observe aspects of bedside diagnosis and the use of technology that we can call 'disjunctions.' Here are seven I would list:

1. Certain diagnoses can only be made during a physical examination. If you miss it, you miss it. Hemiparesis and aphasia do not show up on CT or MRI, and if the patient is aphasic and cannot tell the examiner he is weak on one side, the hemiparesis may go unrecognized. There are many such examples: Erythema nodosum is another example. One either recognizes it or does not.

2. Certain physical diagnosis tests are not useful (splenic percussion) but are still taught. Many others that are useful are not well taught, and students therefore hardly believe that one can map out a pleural effusion in the lung. They are doubtful that they can have a good suspicion for the nature of a valve lesion based on pulse, blood pressure, neck veins, and precordial impulses and thereby have a good suspicion, prior to pulling out the stethoscope, of what one is about to hear.

3. The "trees for the forest" problem: students and housestaff who stumble on a single finding do not have the practice or the experience to look for the constellation of other physical findings that might occur in such conditions.

4. Skills are declining, hairlines receding, teachers retiring and demonstrable knowledge and valued skill sets are not being passed on. Or, to use a religious metaphor, the catechism is being taught to potential new converts by agnostics. We need to celebrate these skills and ensure they are valued in the next generations.

5. Lack of ease in performing the exam. Exams are clunky and uncomfortable rather than skilled and smooth, and patients pick up on this, and their doctors, in turn, sense their discomfort.

6. The "no-one-felt-my-breast-though-everyone-

listened-to-it" problem – the patient feels the care is generic, that there is not sufficient attentiveness to her as a person.

7. "Best practice" and "critical pathways" are great as long as you are on the path and not lost in the woods.

The Physician's Touch

Lewis Thomas, in his book, *The Youngest Science; Notes of a Medicine Watcher* describes medicine in the 1930s and the 1940s as a period of "the laying on of hands," by which he meant the number of conditions cured was very limited and there was little to be done.¹³ Pneumonia was a self-limiting disease with high mortality until the use of specific antisera and sulfa drugs in the 1930s and antibiotics in the 1940s. Penicillin only became available to civilians after World War II.

Diabetic coma was treated with fluids and with insulin after its discovery in the 1920s. Acute heart failure was treated with bleeding, digitalis, and oxygen; duodenal ulcers with Sippy powders and atropine; tuberculosis with rest, sunshine, and pneumothorax and syphilis with heavy metals. What a blessing that we now practice in an age where we have so much more to offer than the laying on of hands. Indeed, in the technological era, the idea of laying on of hands is viewed as bordering on quackery, and there may be grounds for such a view when considering the entity of "Therapeutic Touch" (TT) which under a pseudoscientific guise gained popularity in the 1970s. The "human energy field" has parallels with Mesmer's 18th century "magnetic force" and indeed the concept underlies many current "New Age" ideas.

"Therapeutic Touch" was conceived in the early 1970s by Dora Kunz, a fifth-generation "sensitive" and a "gifted healer"¹⁴ and Dolores Krieger, Ph.D., R.N., a faculty member at New York University's Division of Nursing.¹⁵ The "human energy field" TT theorists postulate resembles the "magnetic fluid" or "magnetic force" hypothesized during the 18th century by Anton Mesmer and his followers.¹⁶ Today there are said to be more than 100,000 people worldwide trained in TT technique, including at least 43,000 health care professionals.¹⁷ TT generally involves four steps: (1) "centering," a meditative process said to align the healer with the patient's energy level, (2) "assessment," said to be performed by using one's hands to detect forces emanating from the patient, (3) "unruffling the field," said to involve sweeping "stagnant energy" downward to prepare for energy transfer, and (4) transfer of "energy" from practitioner to patient.

Although it may satisfy patients, a fourth-grade science project pub-

lished in JAMA cast doubt on 'therapeutic touch.'¹⁸

If I have taken pains to try to debunk at least the scientific validity of 'therapeutic touch' it is only so that it is not to be confused with what I mention next.

Anecdotal Experience on Touch in an Evidence-Based Age

At one point in my career I had the unfortunate reputation of being willing to see patients with chronic fatigue syndrome. I say "unfortunate" because these are often patients who have been rejected by the medical system, disbelieved by their families and therefore arrive with the sense that you are another person likely to disappoint them. I hit on a method with these patients which involved scheduling one hour for them to tell me their history. I tried not to interrupt and looked through the volumes of tests and other information they brought with them.

I scheduled the physical exam for another session on a later date. On that date, I had the nurse prepare them and I then came in and did the most thorough exam known to man, invoking every neurological and orthopedic maneuver, necessary or not. An interesting thing happened with many of these exams, in that the patient quieted down and I began to have a sense of the two of us participating in a sacred ritual, almost like a mass. When I was done, it was common for the patient to say, "no one has ever examined me like this before."

After they dressed and came to my office I would tell them what they had heard in many other places: namely, that this was not in their head and that it was real; unfortunately, it did not have a discrete cause and it was my belief that many different conditions could lead to this state of fatigue. The good news was that there was no sign of cancer, histoplasmosis, or lupus or other potentially fatal illness. The bad news was that there was no magic bullet for their symptoms. The important thing was to move on. I would then prescribe what had been recommended at other medical centers, namely graded exercise and physical therapy, and other measures, and try and reassure them that with time their symptoms would get better. If the patient accepted these recommendations and gave up the quest for the magic test or the magic drug or the magic doctor who could cure them, I always felt it was because the physical exam created a trust that allowed them to accept my recommendations.

Opportunities if We Strike the Right Balance between Technology and Skilled Bedside Exam

I see the bedside exam as key in the establishment of the physician-patient relationship. The value of the 'laying on of hands' in this context

is that it demonstrates our attentiveness to the patient. But much more than that, a skilled exam allows better and judicious use of lab tests, allows us to ask better questions of the tests and allows for a cost-effective practice. I have radiology colleagues tell me that they will sometimes call up housestaff to get clinical background on a CAT scan or MRI that they are being asked to interpret. The housestaff will often say that they have not as yet seen the patient. Surely this is not an effective practice?

Perhaps the most important reason for advocating a return to bedside diagnosis is that students and clinicians will develop the self esteem and satisfaction that comes from having confidence in these skills. In performing a skilled exam, we are also reliving the ontogeny of medicine and reminding ourselves of the rich history and the colorful men and women practitioners who helped this art to reach its peak before we had the kind of technology we have now.

I think of William Osler, superb bedside clinician that he was, and how he had to perform several hundred autopsies a year to get the kind of correlation between the signs the body showed and the disease within. We now get this feedback instantly with echocardiograms, MRIs, angiograms, endoscopes. I think Osler would have been a hundred times more skilled at the bedside with this kind of instant information. It is ironic that technology has had the opposite effect on the rest of us. I hope that the need for cost-effective medicine and the painful rationing of medical resources that is sure to come about will push us to revalue and celebrate the bedside exam and take it to the level that Osler would have were he alive today.

Let me end with a quote from this wisest of all physicians about the teaching and shaping of physicians. To me it encompasses the philosophy that should be in our minds as we use our individual positions of authority and influence to help guide the medical students and doctors of the next generation:

"The hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a college course, not a medical course, but a *life course*, for which the work of a few years under teachers is but a preparation. Whether you will falter and fail in the race or whether you will be faithful to the end depends on the training before the start, and on your staying powers, points upon which there is no need to enlarge." *Sir William Osler (1849-1919), from: The Student of Medicine.*



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¹²Wilson
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Endnotes

¹Osler W. Of Books and Men. In: *Aequanimitas with Other Addresses to Medical Students, Nurses, and Practitioners of Medicine*. Philadelphia, Pa: P Blakiston's Son & Co; 1904.

²Obituary. *The Lancet*. 18 August 1956; 268(6938): 360-62.

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Endnotes

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John P. McGovern Award Lectureships

14. *Health Care in the Next Millennium* presented by John D. Stobo, M.D., May 5, 1999, in Montreal, Canada.
15. *"Writ Large": Medical History, Medical Anthropology, and Medicine and Literature* presented by Gert H. Brieger, M.D., PH.D., May 17, 2000, in Bethesda, Maryland.
16. *Reflections on American Medical Education* presented by Kenneth M. Ludmerer, M.D., April 18, 2001 in Charleston, South Carolina.
17. *John Shaw Billings as a Historian* presented by James H. Cassedy, Ph.D., April 24, 2002 in Kansas City, Kansas.
18. *The Evolution of The Controlled Trial* presented by Sir Richard Doll, May 23, 2003 in Edinburgh, Scotland.
19. *Practising on Principles: Medical Textbooks in 19th Century Britain* presented by W.F. Bynum, MD, PhD, FRCP, April 20, 2004 in Houston, Texas.
20. *Just Call Us Children: The impact of tsunamis, AIDS and conflict on children* presented by Karen Hein, MD, April 11, 2005 in Pasadena, California.
21. *A Leg to Stand On: Sir William Osler & Wilder Penfield's Neuroethics* presented by Joseph J. Fins M.D., F.A.C.P., May 2, 2006 in Halifax, Nova Scotia.
22. *Touching Where it Hurts: The role of the Bedside Examination* presented by Abraham Verghese, M.D., DSc(Hon), May 1, 2007 in Montreal, Quebec.