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## PHYSICAL EXAMS

To the Editor:

When I entered medical school, my initial impression was that everything that I would learn would have been subject to some sort of scientific study, scrutiny, debate, and eventual publication. I imagine my consternation when I discovered that much of what I was learning to do in medicine was based on medical tradition and could be recommended only on the basis of long-standing practice and clinical impression. The article by Luckmann and Melville in a recent issue of *The Journal* is a welcome iconoclastic view of what constitutes preventive care by family physicians, especially in light of current cultural and political assumptions that adequate wellness by patients and doctors will result in immortality and absence of illness.<sup>1</sup>

I disagree, however, with the authors' eventual suggestions that elimination of the (unproven) comprehensive physical examination from periodic health evaluation would save physicians time, and therefore should be eliminated, as well as their recommendation that the United States Preventive Services Task Force (USPSTF) recommendations be used as the gold standard for preventive care. Published in 1989, the USPSTF recommendations can be considered outdated. As witness are recent studies indicating the benefit in reduction of death when performing sigmoidoscopy as a preventive screen in patients, which was unproven at the time of the USPSTF study.<sup>2</sup>

Rather than calling for cost-benefit analysis, polls of attitudes, and definition of secondary doctor-patient relationship benefits associated with comprehensive physicals, I think it would be of greater benefit to call for research regarding the specific components of the physical exam that are effective in health promotion, illness prevention, or early detection. Until that time, though studies are published and debated, I shall feel justified in offering my patients, especially those over the age of 65 years, a periodic comprehensive physical, recognizing that this is a medical tradition, at least three fourths of a century old and of perhaps unproven benefit, yet not at all unlike many of the hallowed traditions I perform as a physician every

day while waiting for the scientific community to guide my actions.

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*The preceding letter was referred to Drs Luckmann and Melville, who respond as follows:*

Dr Weitz raises several important questions that every primary care physician must consider when deciding which physical examination items to include in the periodic health evaluation of adults. His first concern is that some of the guidelines we cite from the *Guide to Clinical Preventive Services* (USPSTF recommendations) may be out of date. The 1989 edition of this book recommends a very limited physical exam for the average-risk, asymptomatic adult<sup>1</sup>; evaluation of height, weight, blood pressure, visual acuity, and hearing for the patient aged 65 years or older; and a clinical breast exam for women. Even fewer items are recommended for younger patients. To our knowledge, little new information has emerged about the screening physical exam that would lead to substantial changes in the guidelines in the second edition of the *Guide to Clinical Preventive Services*, which is expected to be published later this year. Of course, there are some exceptions. Several new studies have been published on screening for carotid artery disease,<sup>2</sup> colon cancer,<sup>3</sup> and prostate cancer.<sup>4</sup> These studies may lead to some minor revisions of the guidelines.

Dr Weitz's second concern is that the evidence against the routine use of many parts of the physical exam may be weak or incomplete. He suggests that the absence of clear evidence that a physical exam item is ineffective or harmful may be reason to continue to perform the exam based on clinical judgment and medical tradition.

In their comprehensive review of the evidence for and against the use of physical examination items in an asymptomatic patient, Oboler and LaForce cover each examination item point by point.<sup>5</sup> Their recommendations are quite similar to those of the USPSTF with the addition of an abdominal exam for aortic aneurysm in older adults and one-time or occasional skin and cardiac exams. When clinical trials or well-designed observational studies comparing outcomes in screened and un-screened populations were available, they relied on evidence from these studies. However, for most aspects of the physical exam, such studies have not been done. Therefore, they often relied on other types of evidence to support a recommendation *not* to perform a given exam:

- *Low prevalence of a condition:* Screening for very rare conditions likely to benefit few people, especially if there is no proof that early detection saves lives (eg, the testicular and thyroid exams).
- *Poor reliability of the exam when performed by typical physicians:* If the average physician does not perform a test accurately much of the time, it is very unlikely it will be effective for screening in the primary care setting (eg, fundoscopic examination for early diabetic retinopathy and glaucoma).
- *Limited sensitivity and specificity of an exam:* If the sensitivity and/or specificity of an exam are poor, it is unlikely that it will be useful as a screening test, and more likely that false-positive results will lead to potentially harmful follow-up testing (eg, auscultation of the lungs, rectal exam for colon cancer).
- *Limited clinical significance of a finding:* If an abnormal physical finding in the asymptomatic patient is rarely related to a serious, treatable disease, performing an examination to identify that finding is not likely to benefit many people (eg, examination of the lymph nodes and spleen).

Oboler and LaForce also use basic clinical, biologic, and epidemiologic information to support some of their recommendations to perform some exams (eg,

examination of the abdomen for aortic aneurysm).<sup>5</sup>

Thus the evidence supporting an abbreviated physical exam is eclectic and of varying strength. Clearly, there is much room for debate and the exercise of clinical judgment in the selection of items to be included in the physical exam. We will all have different thresholds for considering a condition "rare" or "serious," and varying degrees of willingness to accept large numbers of false-positive findings in the interest of identifying one true positive. The screening physical exam must also be tailored to individual patient needs and risks. The patient who cannot give an accurate and complete history warrants a more detailed physical examination than does the patient we can trust is truly "asymptomatic," and the patient at high risk for a specific disease may deserve a screening exam aimed at detection of that disease.

We agree with Dr Weitz that we need more high-quality clinical studies of selected physical exam items to determine their effectiveness with more certainty and we called for such studies in the conclusion to our article,<sup>6</sup> but until the ultimate studies are available, we must do the best we can with existing evidence. We feel that, based on the work of the USPSTF, Oboler and LaForce, and others, there is clearly room for trimming the comprehensive physical exam, especially when the objective is to make more time available for other preventive measures that have been shown to be successful (eg, smoking-cessation counseling).

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COMPENSATING PATIENTS FOR ADVERSE EVENTS

To the Editor:

The article by Ely et al presents anecdotal information on perceived causes of family physicians' errors, which may serve as a springboard to mitigating the incidence of errors.<sup>1</sup> Realistically, though, given the inescapable fallibility of human nature, patients will continue to suffer adverse consequences associated with provider error, and there will also continue to be cases in which patients will suffer untoward results *not* associated with provider error.

A logical progression to the valuable data culled by Ely et al is to design studies intended to garner information regarding the attitudes and feelings of family and other physicians regarding how patients should properly be compensated in instances of adverse events associated with provider error, as well as adverse events not associated with provider error.

The present malpractice system is woefully inadequate as a mechanism for compensating patients for adverse events. Ely's data, for example, reveal that merely 4 of 53 errors led to malpractice claims, even though, following the error, most patients sustained a severe adverse out-

come. These data are consistent with other data in the literature, showing that, although there is a substantial amount of patient injury associated with medical management including that resulting from substandard care,<sup>2,3</sup> medical malpractice litigation rarely compensates patients for injuries associated with medical negligence.<sup>4</sup> No compensation is provided by this mechanism for patient injuries not associated with substandard care.

Although the Ely data are informative, and may indeed assist in the development of preventive strategies, more is needed. No-fault mechanisms have occasionally been touted as a way to compensate patients who suffer undesirable results. If, however, patients are to be compensated for injuries related to medical treatment, regardless of negligence, it must be shown that the effects of medical treatment resulting in injury can be reliably distinguished from effects of the underlying medical condition.<sup>5</sup>

In the end, the Ely data provide a piece of a puzzle that is far from solved.

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