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Inadequacies of 'Inadequacies of Physical Examination'

To the Editor:

I read with keen interest "Inadequacies of Physical Examination As a Cause of Medical Errors" by Verghese et al.[1]

Represented as a clinical research study, it contains tabulations of anecdotes reminiscent of what Voltaire famously observed, that the art of medicine is amusing patients while nature takes care of the disease process. At best instructive, and at worst notoriously devoid of quantifiable substance, the collection of anecdotes in this paper is neither unbiased nor controlled. Were the survey respondents first, second or third persons connected to the anecdote in point; the less frequently the reporter is the first person, it becomes hearsay and rules of evidence recede from the scene. Presumably, the survey subjects were adequately credentialed given the voluntary and random participation unlimited by the type of specialty or clinical setting. That about 2800 of the respondents had teaching affiliations may or may not be an endorsement of their clinical skills. The first introductory examples given for the survey were right on the money, while the second one was not, because proximal joint pain, as opposed to distal, is not a common feature of hypertrophic pulmonary osteoarthropathy. Question #5 was purely arbitrary. No survey subject is in a competent position to assess the objective statistical detail being sought here because there are no validated tools.

From simple inconsequential omissions like missing skin findings of subcutaneous emphysema to grave and negligent errors like hysterectomy in twin pregnancy, the supplementary list contains a wide spectrum of circumstances, at times repetitious and vague. Included in the list are difficult physical signs like liver laceration (there are much better and more accurate ways to diagnose it), or rare entities like constrictive pericarditis, which today is a diagnosis for the catheterization laboratory. Mention is made of the physical findings of pulmonary tuberculosis. What are they? A pleural rub, apical rales, or presence of an apical pulmonary cavity will be caused by respiratory diseases more common than tuberculosis today. As to a missed bruit in a patient with renal failure and hypertension: but what sort of bruit? Bruit of an aortofemoral bypass or an arteriovenous fistula can sometimes be conducted to the precordium and therefore, be audible on auscultation. In that instance, physical examination was done, albeit misinterpreted. A giant ovarian cyst is an age-old masquerader of ascites, unless one elicits the central dullness and peripheral resonance on percussion, just the opposite of ascites. Minimal are the consequences of mistaking the murmur of mitral stenosis (a rare disease now) for a much more prevalent entity like aortic stenosis or sclerosis; the error is on the safer side; granted, physical findings are different. Finally, I will add that missing free air on plain abdominal film has nothing to do with physical examination.

The authors concluded the paper by alluding to the culture of nondisclosure of errors or near-misses in medical practice, unlike examples of errors learned from the aviation industry. Anonymity and immunity for disclosure is permitted in the aviation industry, and categorically not in medical practice.

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Reference

1. Verghese A, Charlton B, Kassirer JP, et al. Inadequacies of physical examination as a cause of medical errors and adverse events: a collection of vignettes. *Am J Med*. 2015;128:1322-1324.