Admitting physical examinations: should they be generic or problem-based?

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In this issue of the *The Canadian Journal of Gastroenterology*, Freeman (pages 337-339) reports the results of his retrospective chart review of 100 patients admitted to the medical teaching unit at a teaching hospital. The article focuses on potential deficiencies in the admitting physical examinations and their documentation, and thus lends itself to an exploration of potential educational interventions that could remedy these deficiencies.

At least four areas of concern are raised by this article, and there is little reason to believe that the results reported would differ in any other hospital setting. The first deficiency was the apparent quality of the rectal examinations that were actually performed. This study confirms an impression that, for medical students and residents, the main focus of the rectal examination appears to be the evaluation of the stool for overt (or occult) blood. The written assessment often fails to include important aspects of the examination, including inspection of the perianal area, rectal tone, prostate, masses and anatomical abnormalities such as rectoceles. This problem can be corrected by teaching a systematic approach to the rectal examination, as is done for other parts of the physical examination such as the cardiac examination. This can proceed as follows: inspection, followed by palpation of anterior, posterior and luminal structures, ending with a neuromuscular assessment of the area. A systematic approach is the best way to make this examination complete on a routine basis.

The second area of concern, which warrants interven-

tion, is to enhance the quality of the documentation, which was also clearly problematic in this study. The educator's perspective is that we need to focus on the principle of repetition, starting at the clerkship level and continuing throughout training, which should come from the attending physician's involvement and attention to proper documentation. This is the best way to ensure that quality documentation becomes engrained in the cognitive framework that surrounds the history and physical examination.

A similar process needs to take place in order to correct the third and perhaps most potentially damaging problem of obtaining and documenting nurses' involvement in these delicate examinations. Again, it is only through attentive repetition that this important matter may be engrained in the trainees' practice.

Were the endpoints of the study relevant? Great emphasis was placed in the study on the percentage of actual rectal, pelvic and breast examinations performed. This is a matter of debate, but it is possible to disagree with the blanket statement that these examinations are mandatory for all admissions to hospital. Physical examination is a test like any other, and should be done only if it is relevant to the presenting problem at hand. The counter-argument can be made that these examinations are part of the current screening guidelines for various cancers. In that context, examinations are used as screening tools, and although they are central to primary care, they may not be viewed as quite so important to a busy internal medicine team doing several admissions

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during the day. Taken a step further, if this is the role of the admitting team, where does the responsibility end? Should the team take responsibility for ordering screening mammograms, Pap tests and fasting lipid profiles on all the appropriate patients?

From my perspective, an appropriate number of rectal examinations were done. Most of the gastrointestinal patients had an examination, but even in the field of gastroenterology, exceptions are possible. Does a young person with hepatitis need a rectal examination at admission? Finally, it is debatable as to how critical to be about the failure to test stool for occult blood. An argument can be made to avoid indiscriminate fecal blood testing of patients on presentation because most have not been on a proper diet or perhaps are taking medications such as acetylsalicylic acid. The false

positive rate of occult blood testing without appropriate preparation is probably too high to recommend its routine use on presentation.

CONCLUSIONS

Freeman provides some eye-opening statistics on the deficiencies in the performance of internal medicine admission physicals, and there is certainly room for improvement. I do not agree with the conclusion that simply failing to perform these procedures in all patients admitted to the hospital should be the primary outcome measure. Surely the appropriate application of screening examinations in the population deemed at risk should be considered when evaluating student and resident performance on the wards.