

The Physical Assessment

Article by Dr Mike Sheldon. January 2009

Still in note form, not yet completed

Most doctors will probably assume that undertaking the physical part of a whole person assessment is the easiest. We may be a bit hesitant about psychology and spirituality, but the physical is what we do. However it is my belief that we don't do it very well. Because our training is in the scientific reductionist method of practice most doctors find it quite hard to take the physical history in a whole person way.

Purpose of this assessment is to enable the doctor to elicit all of the symptoms and signs from the patient, sort them out to fit one of the disease patterns he or she has been taught and so make a correct diagnosis from which suitable treatment can be chosen.

The doctor has seven main tools at her disposal –

- 1 History from the patient
- 2 Her own observation of the patient's mood and health status
- 3 Results of a physical examination
- 4 Personal knowledge and expertise in medicine
- 5 Skills in questioning and examination to elicit relevant facts
- 6 Past knowledge of the patient
- 7 Awareness of the current context of health in the community

The doctor starts this consultation with many assumptions and beliefs, most of which are subconscious. These assumptions drive and determine much of what goes on in the next 10 minutes during which such important conclusions will be drawn.

- 1 One pathology: most doctors have been taught about Ockham's Razor which may be summarised as always seek the simple answer. Look for one diagnosis that will bring all of the symptoms together and so ignore those which don't fit into a single pattern.
- 2 Cause and effect: there is a linear progression from underlying pathology to effects experienced by the patient and demonstrable on physical examination.
- 3 Physical causes: a sort of dualism where physical pathology is alone assumed to be of importance, and the meta-physical area of feelings, emotions and attitudes can be separated off and so excluded from the diagnostic process. The holy grail for the doctor is not to discover the patient's experience, but the physical causes that underpin the whole illness process.
- 4 Pattern recognition: when faced with an overwhelming amount of information the doctor slips into pattern recognition mode seeking to fit "facts" into known patterns of pathology which can be labelled –

- a. Trivial, everyday symptoms often produced without underlying pathology. These would include the sort of symptoms most people get every day with indigestion, aches and pains, tiredness etc, all of which may be part of the human experience and not evidence of mal-functioning. Such symptoms are experienced but ignored by many people, but examined by the anxious patient and engendering fear.
- b. Minor, self-limiting condition. These would include most of the minor infections which each person will acquire several times a year, and which will usually resolve if left alone.
- c. Major, acute, life-threatening condition needing urgent attention. These are the vital pathologies that the doctor must not miss as the patient's life and future well-being may depend on timely interventions.
- d. Minor chronic condition, often only needing adaptations by the patient. These will include the wear and tear we all experience as we go through life, and the minor long term illnesses such as hay fever and allergies which can be a nuisance but are not life-threatening.
- e. Major chronic condition needing long term care. These will include conditions such as asthma and diabetes which can be life-threatening and need on-going medical interventions.

There are also constraints which put pressure upon the doctor as this process is undertaken:-

- 1 Time (expand this quite a bit as time limitation the major curse of modern medicine)
- 2 Limited medical knowledge (write as GP with undifferentiated illness presenting in early stages, covering all specialities, at any time of the day or night)
- 3 Expertise of the patient (continuum from a position where the patient knows more about one condition than the doctor does, through to patients with odd ideas about the body who don't understand how the normal body works)
- 4 Context of the encounter (each consultation takes place against the current situation in the community where the doctor has knowledge, especially of current infections which are present, and also special pre-dispositions of the patient due to their genetic background – eg Bangladeshi patients and diabetes)

So let us explore the process of completing the physical assessment by the doctor –

History Taking

Looking first at the traditional way of taking a history we are taught to divide up the history into categories such as -

The Traditional method of history taking

Most doctors are taught that the basic model of history taking should follow this pattern, which may be adapted in special circumstances (such as when the patient is unconscious and the history has to be taken from another person).

| | | |
|-----|------------------------------|-----------------------------------------------------------------------------------------------------|
| CO | Complains Of: | these are the symptoms the patient now complains about |
| HPC | History of present complaint | the history of these symptoms, when they started, the severity and nature, associated symptoms etc. |

| | | |
|----|--------------------|----------------------------------------------------------------------------------------------------------------------|
| PH | Past History | a complete past history of relevant diseases, operations and medical events |
| DQ | Direct Questioning | a series of direct questions from the doctor checking to see if other symptoms are present and not already mentioned |
| SH | Social History | details of work, family and social background |

- Patient complains of – an attempt to allow the patient to express in his own words what are the symptoms he is experiencing. This hopefully open-ended start to the consultation should allow the patient to describe the symptoms which are important to them.
- History of present complaint – now the doctor goes into a more doctor centred enquiry to gather details of these symptoms, how long they have been there, what is associated with the symptoms etc.
- A past history – usually fairly brief and majoring on previous medical encounters and the conclusions reached by other doctors. The compliant patient has remembered the diagnoses given in the past and is able to recite these back.
- Some direct questioning by the doctor seeks to elicit and “hidden” symptoms which may be relevant but which the patient hasn’t mentioned. Most doctors have a personal check list and they fire questions at the patient, most of them having no relevance to the patient’s complaint.
- Finally a brief social history is taken to elicit the patient’s context and level of social support.

Most of this model is doctor centred and involves the patient answering the doctor’s questions. This model is therefore to a large extent doctor centred and doctor-led, with the patient supplying information in answer to the doctor’s agenda and thought patterns. Most patients get used to this model and fall in appropriately, but it is not ideal and can often cover up important information which is necessary for diagnosis and management. I still remember the old physician who taught us clinical method who had the memorable phrase “Let the patient talk for long enough and they will always tell you what is wrong”. Of course we laughed at him (behind his back naturally) because we knew that the real diagnosis could only be made after performing the correct investigations, and we didn’t want to waste our time talking to the patient. However there was much truth in his wisdom, and letting the patient talk is at the heart of a whole-person approach.

The following method of obtaining a whole person history provides a skeleton from which the doctor can base his or her own method of “hearing the patient’s health story”. It is important to remember that this history is patient centred and patient led, but the doctor takes an active part and inter-acts with the patient to draw out important details.

Whilst in a new patient this is likely to take slightly longer than the traditional method of obtaining a history it is much richer in information which is of use when diagnosing and managing this particular patient.

I find that one hour is more than enough for a complicated history where the patient has consulted with many doctors previously, and it may be spread over more than one occasion if required. On many occasions I have undertaken a complete history and relevant examination in a whole person way in 15 to 20 minutes. I don’t think it can be done satisfactorily in less than this unless the problem is very simple.

The whole person “herstory” taking can be divided up as follows –

- Introduction - a brief scene setting interaction to ascertain what the main problems are, how many the patient wants to deal with, and why they have presented now, that is what was the deciding factor to “medicalise” their problems at this time. The doctor may need to negotiate at this stage as to what will be tackled and in what order.
- Problem description – a patient-directed and open-ended period where the doctor enables and facilitates the patient to adequately describe the issues, problems and complaints they have. Encouragement can also be given to explore the meaning of these problems to the patient, and what the patient’s beliefs are about them. Especially try to find out what other people have said about the problem as this may have influenced the patient’s beliefs and behaviour.
- Feedback to complete understanding – the doctor has been attentive during the patient’s dialogue and now explores the problem by sympathetic questioning. The doctor can be quite direct in the questions asked and the following dialogue may be considered typical –
 - Dr: So Mr G you have had odd stomach pains for about 6 months and unexplained bouts of diarrhoea for 4 months. Why did you wait until now to come and see me?
 - Mr G: I was afraid it might be cancer, you see my father had the same symptoms.
- Elaboration of complaints and health issues – this takes the place of direct questioning and consists of invitations for the patient to describe any other complaints or odd events out of the ordinary.
- Clarification – this lead to a process of clarification where the doctor explores any aspect of the complaints which are not clear.
- Summary – finally the doctor summarises the history in medical shorthand with any additional patient centred aspects which have been discovered.

Whole Person method of History Taking

| | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Introduction | Open the relationship and invite the patient (with open-ended questions) to recount what has made them come at this time. |
| Problems | Patient is invited to tell the story of each of their health problems in their own words. They are then invited to prioritise them. |
| Feedback | The doctor feeds back to the patient what he or she has heard so that the patient can check and add anything else they have forgotten. |
| Elaboration | Invite the patient, in an interactive way, to complete the story of each of their problems. |
| Clarification | Final chance for the doctor to ask any clarification questions, and add any questions which may be relevant (in line with the old Direct Questioning). |
| Summary | Final summing up by the doctor at which the patient can add any corrections |

Whilst listening to the patient’s story the doctor has made sure that –

- They have facilitated the patient to tell the whole story
- Demonstrated empathy to build up a trusting relationship

- They haven't over-medicalised the patient's issues
- Picked up both verbal and non-verbal clues
- They don't focus down too soon, but keep an open mind
- List problems at this stage rather than trying to make diagnoses

Past knowledge of the patient

This is of great importance when the patient's problems are a combination of physical (especially chronic conditions), psychological, social and spiritual. However be aware that "familiarity breeds contempt" which means that the doctor can be fooled into thinking that he knows the patient and so stops listening. Often the patient will develop new conditions which are masked by the old familiar ones.

Observation

One of the greatest gifts of a doctor is the ability to observe through actions, words and the whole range of non-verbal communication.

The physical examination

This is an important time for gathering more information from the patient. It can enhance the level of trust as the doctor asks permission to examine and explains findings to the patient as they go along.

The method of conducting the examination would be the same as in the traditional medical model.

Context of the encounter

The doctor conducts all of the above assessment taking into account the following –

- 1 Age and sex of the patient which makes some conditions more or less likely
- 2 Genetic background of the patient which may pre-dispose to some conditions
- 3 Life-style, wealth, habits such as smoking in the family which may affect health
- 4 Community conditions and infections to which the patient may be exposed.

So that completes the physical assessment of the patient, although in reality the other aspects of assessment (psychological and spiritual) have been going alongside this process. For example when conducting the physical examination, a doctor may discover much about the feelings, fears and experience of the patient.

This is the everyday experience of all doctors and health care professionals – the detailed psychological and spiritual assessments which follow will be outside the experience of most doctors, however we will finish the next two chapters with a brief assessment process which can be added to the above physical assessment to complete a "whole person health assessment".

ADDITIONAL NOTES

“Making a diagnosis in primary care: symptoms and context” by Nick Summerton (BJGP 2004).
Article 11.10. His points –

- 1 diagnosis is difficult, especially in GP where the major and important conditions present rarely in the middle of hundreds of minor conditions, which often have similar symptomatology
- 2 undifferentiated presentations with few investigations available.
- 3 Symptoms which seem to defy a clear cut organic explanation – the whole-person presents – so many symptoms do not indicate physical pathology on which medical science is based.
- 4 Need to avoid unnecessary investigations.

“Eliciting patients’ concerns” by McClean and Armstrong (BJGP 2004), article 11.04.

- 1 they see less value in a patient centred approach.
- 2 Used a prompt (ie one question, to explore the patient’s experience) and were then surprised that this didn’t have a statistical effect on patient satisfaction with the consultation, so they concluded that the extra minute spent (11 minute consultations instead of 10) was wasted.
- 3 They saw no benefit in trying to elicit “patient’s concerns”

“Normalisation of unexplained symptoms by GPs” by Dowrick et al (BJGP 2004) article 11.03.

- 1 Patients present with physical symptoms that doctors cannot readily explain.
- 2 The process of reassuring these patients is difficult.
- 3 Doctors try to “normalise” the patients symptoms.
- 4 This process is often ineffective and may exacerbate the patients’ presentation
- 5 Importance of developing educational interventions for GPs

“Voiced but unheard agendas: psychosocial cues that patients with unexplained symptoms present to GPs” by Salmon, Dowrick et al (BJGP 2004) article 11.05

- 1 unexplained symptoms is often attributed to patient’s beliefs and demands for physical treatments
- 2 these patients do present opportunities for doctors to address psychological needs.