Letters to the editor

The medical consultation in historical perspective. Reflections on talking and touching

Two papers in this journal have reminded readers of the patterns of medical consultation which prevailed until the late modern era, very different from that of contemporary times. The paper by Kameledeen and Vivekanantham[1] described how visual inspection of the patient's urine – uroscopy – formed a significant part of the centuries-old rituals used by practitioners of the healing arts. The shape of the consultation, with a virtual absence of clinical examination, illustrated the degree of ignorance of human anatomy and bodily functions. Medical consultation was about talking, and involved no or minimal physical contact. A second paper, by Shuttleton,[2] reported the Cullen Project – the digital edition of The Medical Consultation Letters of Dr William Cullen (1710–1790). In the late 18th century, Cullen was the most respected physician in Scotland, and a much sought-after private practitioner. He conducted a significant proportion of his private practice by correspondence alone. Clearly at this period during the Enlightenment, when medicine had become a profession entered through graduation, it was still considered normal practice and professionally appropriate for a medical consultation to take place even without any direct meeting of patient with doctor, let alone any physical examination, which doctors seemed reluctant to adopt despite the growing new knowledge of anatomy, physiology and pathology. As medicine had become an academic discipline, and the physician a graduate with enhanced societal status, he perhaps preferred to be seen using his brains rather than his hands

The introduction of clinical examination, with visual scrutiny and tactile exploration of many parts of the body, thus represented a fundamental change in the way a doctor went about the search for a diagnosis. This change occurred very gradually during the 18th but mainly the 19th century. Within this changing and increasingly close relationship, both patients and doctors had to feel secure, in a historical era when exposure of the body was regarded as uncivilised, and when social interpersonal physical contacts were generally restricted within a framework of great formality. Perhaps not surprisingly, the change had a significant influence on the whole character of the dialogue between doctor and patient.

Percussion and auscultation appear to have come into use before palpation, which involved a more prolonged period of physical contact. A young Austrian physician, Leopold Auenbrugger, published his researches into the value of percussion in the middle of the 18th century. As a youth he had been accustomed to checking the levels of the wine barrels in his father's hotel by tapping them. In addition to his clinical studies of the information to be gained from percussion, he experimented by injecting fluid into the pleural cavities of cadavers. His new techniques attracted little attention, and their application in practice continued to be ignored for many years. The term palpation was introduced into general usage in medicine as late as the period 1840–1850, though almost a century earlier Morgagni, a pioneer in the study of pathological anatomy, had advocated the value of clinical palpation in routine practice. But his message was again largely ignored, and little change in the pattern of consultations occurred for many decades thereafter.

Laennec (1721–1826) had studied Morgagni's work. Taking advantage of the greater access to the patient's torso which Morgagni had advocated, Laennec devised the first (tubular) stethoscope in 1816. But this modest expansion of clinical examination met with resistance, even in Scotland, the centre of the Enlightenment. Evory Kennedy, a leading obstetrician from Dublin, had learned of Laennec's new device in the late 1820s from John Creery Ferguson, an Irish physician who had met Laennec, and realised he could use Laennec's instrument to listen to the fetal heart. On a visit to Edinburgh, Kennedy demonstrated this new method of auscultation in a pregnant patient. But James Hamilton, the fifth occupant of the Edinburgh Chair of Midwifery was not impressed and asked if it was proposed to apply the instrument to the naked belly of a woman, 'for if so, be assured that in this part of the world at least such a proposal would be indignantly rejected by every young or old practitioner of reputed respectability.'

The adoption of clinical examination as a routine, often required, part of the medical consultation, progressively involved greater exploration of any part of the body and its orifices. Inevitably this proximity influenced the professional interaction between doctor and patient in a wider way. Patients may have felt embarrassed during clinical examination, with the undressing and touching involved. But doctors recognised that, in the setting of extending clinical examination, their professional reputations could be threatened by any inappropriate familiarity. Doctor and patient may be physically close, but emotionally must remain at arm's length. As a result the very word 'clinical' has come to acquire new and wider meaning, e.g. detached, distant, insensitive to natural feeling. Anything from judicial executions to drone airstrikes can now be described as carried out 'clinically'.

The clinical style adopted during contemporary consultations attracts criticism from some patients, who feel that doctors appear reluctant to engage with their patients' feelings, relationships and more personal concerns. At the individual level the affective dimensions of ill health may receive at best reduced attention, but in a wider context medical thinking about priorities in the allocation of resources is influenced, with less importance and provision being given to services for mental health.

One can speculate that, in the future, clinical examination may well become a less central part of the consultation, and clinical skills in this area of practice may wane. Use of newer modes of imaging has superseded or replaced many of the traditional routines of assessment by clinical examination. The precision of biochemical analysis of blood and other samples now provides more direct paths to diagnosis, as does endoscopy. The continuing pressures of limited time available for consultation often mean that the whole palaver involved in undressing, then dressing again, can reduce the time available for talking and listening. That then alters the character of the consultation. Will clinicians then feel less inhibition around exploration of patients' feelings and relationships? Will patients feel more at ease in expressing their feelings if they do not have to strip off? Will 'clinical' then lose its acquired and somewhat prejudicial meaning?

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References

1 Kameledeen A, Vivekanantham S. The rise and fall of uroscopy as a parable for the modern physician. *J R Coll Physicians Edinb* 2015; 45: 63–6.
2 Shuttleton DE. The Medical Consultation Letters of Dr William Cullen: the launch of a digital edition. *J R Coll Physicians Edinb* 2015; 45: 188–9.

In memoriam

In memoriam brings to the attention of Fellows and Collegiate Members the deaths of colleagues and friends. Obituaries paying tribute to the life and work of those whose deaths have been reported in *In memoriam* can be found on the College website: www.rcpe.ac.uk/obituaries

Fellows and Collegiate Members are invited to provide the Obituaries Editor (editorial@rcpe.ac.uk) with information that will enable us to write or commission obituaries. Self-written obituaries to be held in readiness by the Obituaries Editor will always be welcome.

Dr B Asgher FRCP Edin
Born: 25.01.1935 Died: 07.12.2016
Specialty: General Internal Medicine
MB Dhaka 1958, DTM&D L'pool 1969

Professor TH Bothwell FRCP Edin
Born: 27.02.1926 Died: 12.11.2016
Specialty: General Internal Medicine
MB Wits 1947, MD Wits 1953, DSc Wits 1965, Hon MD Cape Town 1986, Hon MD Natal 1993, DMedSc Wits 1994

Professor CD Katsetos FRCP Edin
Born: 20.03.1958 Died: 21.03.2017
Specialty: Pathology
MD St George's, PhD Bergen 2002

Dr NJ Macdonald MBE FRCP Edin
Born: 17.01.197 Died: 03.12.2016
Specialty: General Practice/Primary Care
MB Edin 1961, DRCOG 1963

Professor JFK Mason FRCP Edin
Born: 19.12.1919 Died: 26.01.2017
Specialty: Law and Ethics
BA Camb 1939, MB Camb 1942, MA Camb 1944, DipChemPAth Lond 1950, MD Camb 1961, DTM&H 1962, DMJ 1963, LLD Edin 1987

Dr S Nariman FRCP Edin
Born: 30.07.1925 Died: 26.11.2016
Specialty: Respiratory Medicine
MB Mumbai 1950, MRCS, LRCP Lond, MRCP Edin 1959

Professor DG Seymour FRCP Edin
Born: 27.05.1949 Died: 17.12.2016
Specialty: Geriatric Medicine
Bsc Birm 1972, MB Birm 1973, MD Birm 1988

Dr PL Tiwari FRCP Edin
Born: 01.07.1945 Died: 01.07.2016
Specialty: Cardiovascular Medicine
BSc Banaras Hindu, MB Banaras Hindu 1967, MD Banaras Hindu 1971