

Response Letter to “The Enduring Importance of The Clinical Examination”

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Dear Editor,

Murphy’s editorial, “*The Enduring Importance of the Clinical Examination*”, prompted reflection rather than disagreement¹. The concern about erosion of bedside skills is familiar to many clinicians, but it sits within a healthcare system that has changed fundamentally. Advances in diagnostics, the emergence of artificial intelligence, and sustained system pressures now frame how many parts of clinical medicine are practised².

Within this environment, fear of error and medico-legal consequence has become an ever-present influence. Modern imaging and laboratory testing have undoubtedly improved patient care. In many settings, they outperform physical examination alone, and individual clinical signs often lack the sensitivity or specificity we would wish for. Relying on examination in isolation can risk missing pathology, particularly in time-critical or high-risk presentations. The increasing use of investigations, therefore, does not necessarily reflect a loss of skill, but rather an adaptation to evidence, patient expectations, and accountability.

What is more uncomfortable is how this environment shapes training and behaviour. Students are taught the mechanics of examination yet are immersed in systems where investigations are frequently obtained early, sometimes before a meaningful bedside assessment has taken place. Presentations are commonly approached through structured “rule-out” pathways that prioritise safety and standardisation. These pathways are defensible and often effective, but they can displace individual clinical judgement. Where a normal examination might once have reassured, it is now rarely sufficient on its own, particularly in the eye of the legal system. The question then remains, is the current method of teaching bedside examination technique reflective of the job that students are training for?

A further disequilibrium lies in how we teach the clinical examination itself. Many examination techniques taught to students predate the widespread availability of modern diagnostics and have remained largely unchanged for decades. This raises an uncomfortable but necessary question regarding our educational emphasis. Rather than teaching examination as a universal, static tool, we must modernize the curriculum to reflect a

landscape where rapid diagnostics are the standard. In the emergency setting, this involves integrating traditional bedside skills with technologies like Point-of-Care Ultrasound (POCUS), which serves as a contemporary extension of the physical exam rather than a replacement for it³.

Fear of error reinforces this shift. High-profile cases and retrospective review mean that normal examination findings often feel inadequate for the protection of the clinician. Objective investigations provide something tangible: results that can be documented and defended. In this context, over-investigation is protective. The unintended consequence, however, is leading to a growing over-reliance on investigations, and potential over-use of under-resourced healthcare services.

Recognising the limitations of the clinical examination is not a rejection of its value. Rather, it reflects the need for an educational approach that teaches clinicians to understand what examination can and cannot offer. We must integrate history taking, bedside assessment, and diagnostics into coherent clinical judgement. The history and examination must be tied together as a diagnostic tool that allows us to appropriately and judiciously use investigations, while keeping patient safety and risk to a minimum. As Osler suggested, “medicine is learned at the bedside”, but it must now be practised with an honest understanding of how the bedside fits within modern care⁴.

Declarations of Conflicts of Interest:

None declared.

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