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Editorial

HYPOSKILLIA: The Quiet Atrophy of Clinical Judgement A Call to Restore Bedside Medicine

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Introduction

"There is, I believe, a real danger lest the increased use of laboratory tests, X-ray examination, and other shortcuts to diagnosis should lead to a neglect of the information to be obtained by the skilful use of the unaided senses, and to a comparative atrophy of these from disuse. Most clinical teachers must be aware of this." — Sir Robert Hutchison (1928)

Time inevitably brings change. Some changes benefit mankind; others, though subtle, erode foundational values. The last century has witnessed extraordinary advances in medical science. Knowledge about disease has expanded exponentially, and technology has entered medicine in an unprecedented way. However, alongside these advances, commercial interests have quietly but steadily infiltrated the profession.[1]

One unintended consequence has been the widening gulf between the physician and bedside clinical medicine. There has been a gradual attrition in clinical skills, and even more so in their practical application. Ultimately, it is the patient who suffers.[2] Today, a young doctor often takes a history primarily to determine which "panel" to order: a cardiac panel for chest pain, a liver panel for jaundice, a respiratory panel for cough. Reliance on one's clinical reasoning has diminished, while dependence on machines has increased.

Is this wrong? One may argue that it is merely progress. Yet there is a problem. Treating laboratory reports rather than the patient can lead the clinician into a maze of confusion — more tests, greater ambiguity, delayed diagnosis, escalating costs, and erosion of patient trust. The "non-touch" approach distances the doctor from the patient. The reassuring hand, the attentive listening, and the empathetic presence — often more therapeutic than medication — are gradually disappearing. Patients seek not only treatment but also reassurance, dignity, and understanding.[3]

Why is this happening?

There are multiple reasons. Chief among them is the loss of conviction that detailed history-taking and thorough physical examination can lead to a diagnosis in nearly 60–70% of cases. The temptation of shortcuts is universal. Ironically, while the doctor's time may appear saved, the patient's wait for diagnosis often becomes longer.

The commercialization of healthcare further compounds the problem. In some institutions, physicians are evaluated not by the compassion they show or the precision of their clinical judgment, but by the number of investigations they order. Expensive equipment must generate returns; loans must be repaid. Thus, clinical reasoning risks being replaced by protocol-driven investigation.

What, then, is the solution? "Listen to your patient; he is telling you the diagnosis." — William Osler.[4]

The answer lies in restoring primacy to history-taking and physical examination in both undergraduate and postgraduate training. Morning reports should begin not with laboratory values, but with the patient's overnight complaints and new clinical findings.[5]

The art of history-taking requires patience and discipline: allowing the patient to speak, gently organizing the narrative, clarifying ambiguities, and understanding the temporal relationship of symptoms. Each organ system may harbor hundreds of diseases, yet presents through a limited set of symptoms. It is the pattern, timing, and intensity of these symptoms that guide diagnostic reasoning.

A thorough physical examination rests upon five pillars:

1. Understanding the scientific basis of the sign.
2. Mastery of examination technique.
3. Recognition of normal findings.
4. Identification of abnormalities.
5. Interpretation of those abnormalities.

Clinical excellence demands not only observation but reflection. The habit of pondering — analyzing signs and symptoms, synthesizing possibilities — is essential. Much like Sherlock Holmes, assembling scattered clues into a coherent whole, the physician must cultivate disciplined analytical thinking.

Only after this structured reasoning should investigations be ordered — not as shots in the dark, but as arrows aimed at the bull's-eye. Every test must be understood in principle, performed correctly, and interpreted thoughtfully. For example, serum calcium measurement requires attention to fasting status, posture, avoidance of prolonged tourniquet use, and correction for serum albumin levels.

The classical pathway of clinical medicine is demanding. It requires time, intellectual clarity, patience, and integrity. Yet once embraced, it becomes deeply fulfilling. Relying on one's knowledge, skills, and ethical judgment — supported by judicious use of investigations — transforms patient care into an academic romance. The satisfaction of arriving at a diagnosis through reasoned clinical judgment is incomparable.

Once experienced in its true spirit, it captivates the physician for life.

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