COMMENTS

Is clinical examination for prostate cancer becoming redundant?

THIBAUD HAASER

Abstract

Prostate cancer is a paradigmatic example of the impact of technological change on current medical practice, because biological and radiological assessments appear more reliable compared to clinical examination. Thus, the prostate specific antigen blood-test is the key factor for patients' follow-up and for medical decisions. In this context, the possibility arises of medicine without clinical examination; and if, indeed, it would be ethical to perform clinical examinations such as digital rectal examination if it has no direct consequences for care. However, clinical examination could have a residual value for clinical practice, no more as a central factor for medical decision making, but as a key element in shaping the patient-physician relationship. Attention must be focused on identifying the changing role of clinical examination and on discussing its ethical acceptability.

Keywords: *Prostate cancer, screening, urooncology, clinical examination, digital rectal examination, care relationship*

Introduction

Prostate cancer is the most prevalent cancer among males (1). Population-based prostate cancer screening is still controversial, but in France this procedure is recommended for men aged from 50 to 75 years (2). Screening is based on digital rectal examination (DRE) and a prostate-specific antigen (PSA) blood test; elevation in the latter, while not specific to cancer, is considered a tumour biomarker. Urological studies demonstrate that the PSA blood test is clearly more sensitive than DRE for cancer detection (3).

After cancer diagnosis and radiological assessment of possible tumour extension, a uro-oncology multidisciplinary committee (tumour board) considers therapeutic options (surgery, external radiation therapy with or without hormone therapy, high-intensity ultrasounds, interstitial brachytherapy, active surveillance or watchful waiting). Treatment efficacy is assessed mainly by PSA level follow-up after oncological treatment. PSA is a strong and reliable marker of cancer remission or recurrence, and radiological examinations or second treatments are usually decided based on its results. Monitoring of PSA allows therapeutic intervention long before a cancer becomes symptomatic. Thus, the role of clinical examination is very limited for prostate cancer follow-up after treatment. DRE is not a reliable modality of post-therapy follow-up (4, 5, 6); however annual DRE is still recommended after treatment. Similarly, other clinical examinations (like bone palpation) have no major impact on patient care.

Prostate cancer may be seen as a paradigmatic example of the impact of technological change on current medical practice. This is especially relevant in connection with the role of clinical examination when compared with the more reliable biological and/or radiological assessments. This may seem a minimal issue at first, but raising the possibility of medicine without the clinical encounter signals a major shift from classical notions of care for both patients and physicians.

Redundancy of clinical examination

At each stage of care, clinical examination seems less important, to the extent of being pointless for patients treated for prostate cancer. As previously mentioned, PSA is the key marker of remission or recurrence. Moreover, prostate cancer is asymptomatic most of the time. The main clinical signs are treatment-related side effects, so that therapeutic sequelae are the only subjective symptoms for most patients, and clinical examination is rarely required. Medical treatment may be carried out without any clinical examination; PSA and careful patient questioning should be the only requirements for patient follow-up.

There is a psychological and conceptual context to performing DRE in prostate cancer patients. The prostate gland is associated with virility, power and reproductive capacity. The side effects of prostate cancer treatment, from surgery or radiotherapy, are considerably influenced by these associations (because of erectile and ejaculatory dysfunction, and possible urinary incontinence). The perception of body image and sexual life are strongly disrupted. All this can lead to a feeling of shame that may be reinforced by performing DRE. Within the elderly male population, DRE can lead to feelings of subordination and, sometimes, humiliation. Consenting to DRE means submitting to a medical authority. DRE is an obvious marker of the gap between patients and physicians.

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PSA is the main driver for assessment and change to the plan of care. A systematic clinical examination could be considered unethical when the balance between utility and futility leans clearly towards the latter. DRE, and more generally clinical examination, seems useless considering its therapeutic insignificance, lack of impact on patient care, and negative associations.

Residual role for clinical examination

Nonetheless, daily medical practice tends to preserve a place for clinical examination. It remains essential in shaping the patient-physician relationship and resolving problems between them. The ethical challenge now is to determine whether any role remains for clinical examination in prostate cancer care.

First, clinical examination can be an opportunity to share information. Integrating the reality of cancer is frequently hard for patients because of the absence of symptoms and the impact of PSA. For example, PSA levels may rise after radical surgery. At 0.2ng/mL (known as biochemical recurrence), there may be an indication for salvage radiation therapy. In this situation, patients do not have any clinical manifestations (except surgical sequelae). Patients often report how difficult it is to consider themselves as a "person with a severe disease" or feel that "there are no changes and now I have no choice but to receive radiation and be harmed". Patients see their medical situation and daily quality of life challenged without any objective symptoms. These reactions echo Georges Canguilhem's thoughts about people's normativity. Illness (as with healing) has medical definitions that patients do not entirely agree with. Canguilhem argues that every individual has personal definitions of normal or pathological status. "Ill" and "healed" are categories with a multitude of definitions, according to individual normativity (7).

DRE is sometimes considered a means of concrete and direct evaluation of cancer. It can even be requested by patients during follow-up consultations. DRE represents a human way of evaluating cancer. Clinical examination provides an opportunity to reach out to patients. It gives patients a chance to voice their concerns and physicians a chance to strengthen their role of caregivers. On the other hand, PSA evaluation remains disembodied and patients may not have confidence in a solely biological evaluation. Although subjective and restrictive, clinical evaluation remains essential for certain patients, precisely because it is embodied in a trustworthy professional.

The patients' request for clinical examination is also a request for a "one to one" relationship. In oncology consultations, relatives are often present while very intimate matters are addressed. Approaching those topics with relatives present can be unsettling and can lead to incorrect assessment. Clinical examination in a private room with a closed door creates a sense of intimacy. The absence of others makes it easier to approach delicate topics. This is an opportunity for physicians to better understand what is at stake. Concerns regarding erectile dysfunction or anxiety are often expressed during clinical examination. It can be a way to focus care on patients as individuals.

Information and communication are key to acceptance of the reality of a disease and adhering to medical recommendations. Clinical examination can have a role by focusing on communication, rather than just on investigating cancer recurrence. Oncological consultations are times of crisis with possible bad news, treatment proposals, and difficult discussions. Misunderstandings or angry reactions often occur and negatively impact the quality of care. Conflicts about therapeutic proposals are frequent. Clinical examination allows time to de-escalate tensions when necessary. The conflict between a presupposed medical authority and the patient's autonomy can be resolved through clinical examination. Physicians endorse the position of caregiver rather than instructor through clinical examination. This recasting is essential not only for the patient's care but also for the physician and the relatives. Clinical examination ensures that the physician's attention remains focused on the patient, and this may have a calming effect. Latent conflicts do not fade away, but both entities can understand the position of the other. Emotional reactions and impulsive decisions are avoided. Discussions remain challenging; but by staying close to the real lives of patients and their ethical and psychological issues, discussion can be frank and calm, and include clear and rational opinions of both patient and physician.

Conclusion

Technical advances in imaging and biology call into question the relevance of clinical examination in prostate cancer. This stimulates a need for significant change in our professional identity as physicians. Yet, clinical examination remains essential in medical practice, no longer as a performative efficient medical tool, but as a means of communication. Clinical examination provides space to answer intimate queries, convey difficult information, approach intimacy, and redefine roles in the care relationship.

One could question the ethics of this use of clinical examination. Patients may consent to clinical examination because they are convinced it will bring them significant information. Using clinical examination other than for a purely medical purpose could betray a patient's confidence. Clinical examination could be performed for seeking essential medical information (for example, signs suggesting a specific syndrome) but also for more relational reasons. If physicians are perfectly aware of this difference, patients may not be. Performing a clinical examination without informing patients of its true goal could be considered unethical. This could be interpreted as undermining the vital respect for the patient's autonomy.

But pragmatism is necessary and the stakes in oncology plainly justify the recourse to clinical examination, even if the main goal is not to provide direct and technical information regarding care. Clinical examination is necessary to provide

care with the emphasis on personal attention and individuality of the patient, which is ethically acceptable. Thus, clinical examination remains essential for cancer patients as long as physicians value its true function. From this perspective, clinical examination is no longer an isolated part of a medical investigation, but a crucial means for physicians to adapt care to the expectations and needs of each patient.

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The Student's Pledge – an oath of initiation for modern times

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Abstract

The taking of oaths by medical students at graduation or other times during training have become common practice globally, particularly in the last century. While some use the modern versions of the Hippocratic Oath, other colleges encourage students to frame their own. Inspired by the Oath of Initiation of Caraka, a student oath at the start of medical education, when idealism is high, can be formative as it introduces the values of the profession. The proposed student pledge could find a place in the foundation course and white coat ceremony of the new MBBS curriculum.

Keywords*: student's pledge, initiation ceremony, orientation, medical curriculum, fraternity.*

Introduction

At the start of undergraduate medical training, it is not unusual for colleges to introduce students to this new phase through an extended orientation programme, designed to introduce all dimensions of campus and academic life. In the new MBBS curriculum implemented in August 2019, this has taken the form of a structured "Foundation Course". Sometimes, this includes a session at which the students as a group formally read aloud the Hippocratic Oath, its modern versions, the World Medical Association's Declaration of Geneva, 1948, or the Physician's Pledge, 2017, or other student pledges, in the presence of their peers, faculty and parents (1,2). This form of activity is designed to sensitise them to new responsibilities as they enter medical training; a welcome into a wider fraternity and a rite of passage. Towards the end of the foundation course a white coat ceremony may be organised, when white coats are symbolically handed over to the new students. The student pledge could be taken at this time as part of this ceremony.

There are several forms that a medical student pledge can take at the time of initiation into medical studies. One form is a version of the Hippocratic Oath. This early in student formation, however, it is uncertain if the significance of each weighty sentence of this time-honoured oath really sinks in to make an impression. For this reason, the oath is usually administered at the *end* of medical training on Graduation Day, before the student transitions into professional life. Proponents of use of the Hippocratic Oath as the initiating student pledge argue that the use of the oath is not premature since students pledge to be honourable as medical students rather than physicians, and that the oath at this stage is really a statement of intent (3). Others suggest that the students cannot know or understand at this stage what they are pledging to, and this then becomes "ritualistic recitation." (4) Another issue with the Hippocratic Oath is that it does not specifically address the ethical issues of medical studentship. The Oath of Initiation by Caraka (5) was taken by his students before a sacred fire, once they were chosen to begin their medical training. It conveyed commitment to the chosen profession, honourable conduct, dedication to their practice, adherence to a meaningful student-teacher relationship and supplementary study. (6, 7)

Following this tradition, with the intent to form values and character, student pledges can serve an important purpose at the start of college years, when candidates are idealistic and filled with positive resolve. A pledge is a solemn oath or

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