**Toward a uselessness of clinical examination?**

**INTRODUCTION**

Prostate cancer is the most prevalent cancer in males (1). Population-based prostate cancer screening is still controversial, but in France this procedure is recommended for men aged 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 tumor biomarker. Urological studies demonstrate that PSA blood test is clearly more sensitive than DRE for cancer detection (3).

After cancer diagnosis and radiological assessment of possible tumor extension, an uro-oncology multidisciplinary committee (tumor board) consider 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 exams or second treatments are usually decided on it. Monitoring of PSA allows therapeutic intervention long before cancer becomes symptomatic. Thus, the place 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. Likewise, other clinical examinations (like bone palpation) have no major impact on patient care.

Prostate cancer seems to be a paradigmatic example of current changes in medical practices, especially concerning the role of clinical examination when compared to more reliable biological and/or radiological assessments. The roots of this fact may seem minimal at first, but questioning the possibility of medicine without clinical encounter is a major shift from classical notions of care for both patients and physicians.

**USELESSNESS OF CLINICAL EXAMINATION**

For each step of care, clinical examination seems less important, to the extent of being useless for patients treated for prostate cancer. As previously mentioned, PSA is the key marker of remission or recurrence. Moreover, prostate cancer is most of the time asymptomatic; the main clinical signs are treatment-related side effects. Therapeutic sequelae are subjective symptoms and clinical examination is rarely required. Medical practice may be performed without any clinical examination; PSA and careful patient questioning should be only needed for patient follow-up.

There is a psychological and conceptual context to performing DRE in prostate cancer patient. The prostate gland reflect to virility, power and reproductive capacity. Prostate cancer treatment’s side effects, 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 male elder population, DRE can lead to feelings of domination and sometimes humiliation. Consenting to DRE means submitting to a medical authority. DRE is an obvious marker of the gap between patients and physicians.

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

**REMAINING PLACE FOR CLINICAL EXAMINATION**

Nonetheless, daily medical practice tends to preserve a place for clinical examination. It remains essential in uning the patient-physician relationship and solving problems between them. The ethical issue is to determine and to discuss the remaining roles of 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 occurrence, patients do not have any clinical manifestations (except surgical sequelae). Patients often report how difficult it must be to conceive themselves as a “person with a severe disease” or 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 share. He argues everyone has personal definitions of normal or pathological status. “Ill” and “healed” categories have 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 a time to reach the patients and their body. It can legitimate patients’ concerns and strengthen impressions of care. At the opposite, PSA evaluation remains disembodied and patients may lose confidence in a sole biological evaluation. Although subjective and restrictive, clinical evaluation remains essential for certain patients, precisely because it is embodied by a trustful professional.

Patients’ request for clinical examination is also a request for a dual relationship. In oncology, relatives are often present while very intimate themes are addressed. Approaching those topics with relatives can be unsettling and can lead to incorrect assessment. Clinical examination in a private room with a closed door creates the conditions 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 for erectile dysfunction or anxiety are often expressed during clinical examination. It can be a clear way to focus care on patients.

Information and communication are key to accept a disease’s reality and adhering to medical recommendations. Clinical examination can have a role by focusing on communication rather than investigating cancer recurrence. Oncological consultations are real 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 when necessary. The conflict between a presupposed medical authority, represented by clinical examination, and patient’s autonomy can be solved through clinical examination. Physicians endorse a position of caregiver rather than instructor by clinical examination. This recasting is essential not only for the patient’s care but also for professionals and relatives. Examination can direct attention to the patient by a figure of benevolence. Latent conflicts do not fade away, but everyone can understand the position of the other. Passionate reactions and impulsive decisions are avoided. Discussions remain challenging. But by staying close to the real life 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 question the imperative of clinical examination in prostate cancer. This urges a need for significant change in our professional identity as physicians. Yet, clinical examination remains essential in medical practice, no longer as a performative medical tool, but as a mean of communication. Clinical examination provides space to answer intimate request, convey difficult information, approach intimacy, and redefine roles in a 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 significant information. Using clinical examination other than a purely medical purpose could betray patient’s confidence. Performing clinical examination without informing its true goal could be considered unethical. This could be interpreted as questioning the imperative respect for patient’s autonomy.

But pragmatism is necessary and the stakes within oncology plainly justify these unusual uses of clinical examination. An approach based on underlying intentionality helps to understand that the greater finality that consists in providing care with attention and adaptation to singularity, could enlighten the need for those practices. Thus, clinical examination remains essential for cancer patients as long as physicians evaluate its true necessity. In this context, clinical examination is no longer an isolated part of a medical investigation, but one possible way for physicians to adapt care to the expectations and needs of each patient.

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