The Art of Touching and Listening: Propedeutics as the Foundation of Clinical Thinking

Leticia Viniegra Ramos
CAEM UAEH
leticiaviniegra15@gmail.com

SIt is often said that medicine is a science, but those of us who have crossed the threshold from the classroom into the hospital know that, at its core, it is also an art. After completing the first year of medical training, we learn that propedeutics is, precisely, the art of gathering information.

As students in the basic cycles, we spend years memorizing Latarjet's anatomy or Guyton's physiology. However, integrating that knowledge—anatomical, physiological, nosological, biochemical, and even embryological—to decipher the pathophysiological mechanism behind a real patient's symptom is an entirely different challenge.

This conviction emerged from a "full and vibrant" year of medical experience, guided by a physician whose teaching went far beyond traditional lectures. Despite relying on a core bibliography of more than ten textbooks and Clinical Practice Guidelines, his classes posed challenges that the literature alone could not resolve.

The sessions began with anatomy and physiology that were strictly clinical, never merely descriptive. The true intellectual challenge arose when addressing the aggressive mechanisms affecting the organ or system involved.

This information, essential for understanding the damage, was often not clearly explained in textbooks.

It forced us to investigate, deduce, and connect ideas on our own, becoming the most demanding part of the learning process.

Once the mechanism was understood, we approached semiology with the surgical precision that the professor demanded to identify the affected organ. It was not enough to list symptoms; we analyzed three fundamental pillars.

- The origin, defining the location, radiation, and character of the pain or discomfort.
- The causes, exploring the mode of onset, progression, periodicity, modifying factors, and triggers.
- The impact, assessing the degree of damage through intensity and associated symptoms.

The professor always emphasized that integrating this detailed semiology was the key to differentiating the affected organ even before touching the patient. Finally, we confirmed our hypothesis through physical examination or by grouping findings into syndromes, such as nephrotic or nephritic syndromes. In this way, learning ceased to be memorization and became a cognitive skill.

However, translating theory into practice proved challenging. I vividly remember my first real hospital experience, undertaken alongside my activities at CLEMPS (Latin American Center for Medical Education through Simulation).

The task seemed simple: taking a medical history. Reality, however, delivered a lesson in humility. My team and I spent two hours interviewing the patient. We combined our ideas and mentally reviewed every section, yet when it came time to present the case and identify the involved organ, we realized crucial data were missing. It was difficult, exhausting, and frustrating, but it was then that I understood that diagnosis does not arise from a machine, but from human interaction.

Beyond the intellectual challenge, propedeutics taught me something even more valuable: we do not treat diseases, we treat people. This discipline is the first filter through which we learn that medicine requires tolerance, empathy, and full awareness of the other. The patient is not an open book; they are a vulnerable human being who allows a stranger to inquire into their intimacy in search of help.

This is where technique merges with ethics. I learned that protecting our integrity and that of the patient is non-negotiable. Respecting ethical rules is not optional: from the rigorous use of gloves and protective eyewear when necessary—not only for hygiene, but for mutual respect and biosafety—to the golden rule of physical examination: never being alone. The presence of a third person, preferably a family member or nursing staff, is not a sign of distrust; it is a guarantee of safety, respect, and professionalism for both parties. Propedeutics teaches us to be gentle with our hands, but firm with our values.

Today, there is a silent “decline” in hospitals: propedeutic skills are being lost. As one of my professors once mentioned, it is often forgotten that a thorough physical examination, performed with rigor and patience, can provide between 70% and 90% diagnostic certainty. Nevertheless, the current trend is the opposite. We allow laboratory and imaging studies to dictate our decisions, using them to establish differential diagnoses rather than for what they were intended: confirming what clinical evaluation has already suggested.

Physical examination is a universe of maneuvers and variations. When palpating an abdomen or auscultating a chest, we are not merely searching for signs; we are integrating knowledge. We connect pain in the right upper quadrant with the biliary tract studied in anatomy and the jaundice explained in biochemistry.

Within the context of medical education in Mexico, reclaiming propedeutics is essential. We will not always have access to a CT scan in the emergency department of a rural hospital. For this reason, propedeutics is not just another subject in the curriculum; it is the tool that shapes cognitive skills and forges clinical judgment.

Learning to take a detailed medical history is essential to understanding the patient not merely as a collection of diseases, but as a person. Although there are complex conditions that escape purely clinical reasoning, statistics tell us these are the exception. What is common is clinical medicine. Let us learn to take medical histories not to fill out records, but to understand lives. Because even as technology advances, medicine remains—and will always be—a human science.

C.1.1. Confirmation of clinical judgment: integration of knowledge in the surgical field.