

REFLECTIONS

Requiem for Babinski

Chris Ellis

With the arrival of the total body scanner and the ubiquitous ultrasound machine, I wonder if I really need to continue examining my patients? Should I discard my patella hammer and tuning fork and just bring my laptop and personal digital assistant to work? What would Charcot, Rhomberg or Babinski think of all those computer printouts revealing the answers in black and white, without having to touch the patient? Babinski would probably have dropped his patella hammer in dismay. His full name was Joseph Jules François Félix Babinski, which suggests that he might have been a Russian aristocrat, and a skilled swordsman to boot – but he was in fact a French neurologist of Polish descent. He is remembered for the eponymously named Babinski reflex. He was also a gourmet. This is rather an inconsequential piece of information, but I like to imagine him, after a vigorous day of testing reflexes, sitting at a pavement café in Paris, savouring a light lemon soufflé and elegantly sipping from a glass of *vin extraordinaire*.

Over the years, I've wondered about some of the more ritualistic physical examinations that I enjoy. This is because I have been a rather nonchalant percussionist. I have at times performed the percussion part of my examination in a perfunctionary manner, tapping away almost in a world of my own. Since I have developed some arthritis in the middle finger of my left hand and become slightly deaf, I have found myself avoiding the procedure unless absolutely necessary. Looking back now as a semi-retired percussionist, I wonder if it was all worthwhile. Was I tapping hard enough? Did I have the correct

wrist movement? Was it dull, stony dull or not dull at all? Or in fact resonant? Does the ear deceive that which the finger does not elicit? This is the sort of stuff to keep one awake in the early hours of the morning, along with the whispering pectoriloquy.

In addition to these misgivings, I have heard that the sensitivity and reliability of many of my favourite pastimes have been called into question. Shifting dullness and tactile fremitus, which were two of my signature performances, seem to have hardly any sensitivity at all and add little value.

I have also had some trouble along the years with testing reflexes. Perhaps it is my swing. Some days I use a full drive down the fairway, and on others I feel I might not have quite got the follow-through absolutely right. Perhaps a fuller back swing would have helped? And then there is the writing up of the results and the agonising over whether to record ++ or +++.

Yet Babinski is always my biggest challenge. Should I use the rounded end of the wooden patella hammer or my car key or perhaps the curtain rail? Most textbooks omit detailed guidance. The strength or force of the movement must also play a part. Should I approach with the wind behind and a steely glint in the eye, or just the lightest of steps?

In my search for confirming evidence, I still seem to suppress those irritating results that don't fit in with my perfect picture. What weight in the clinical reasoning pathway do you give to a contradictory sign or a recording of 'Babinski sign equivocal'?

Many of our physical examinations are now second-tier procedures that tell us what we already know at the end of clinical reasoning. So in the presence of real-time total body scanners, why do I continue to listen and palpate, prod and probe? Well, there is more to physical examination than diagnosis. The medical examination is a complex interaction with personal and social information transferred in both directions, and there is also the therapeutic response to the laying on of hands; it is part of connecting and healing. In addition – and this is something we discover daily – medicine is always full of surprises and no more so than in the ceremony of the physical examination.

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