used is a reflection of the use of euphemisms in medicine. Who but the gastroenterologist could see a foodstuff in a pathological specimen of stool as in redcurrant jelly or chocolate? This last explanation may be considered the most likely, since, in dealing with unpleasantness, a natural defence mechanism is sublimation—to turn the unpleasant into something much more appealing. In other words, we suggest that some doctors are obsessed with the basic human instinct of eating and drinking and would prefer to reflect on the pleasures of life while following less aesthetic pursuits. Gastroenterologists may really be gastrologists at heart.

It is doubtful whether there will ever be SI units of description to replace food terms in medicine. We recommend, however, that all doctors periodically review their own use of these descriptive terms to ensure that others derive a similar understanding as the user—for example, would doctors nowadays recognise the inside of a nutmeg if they saw one, since nutmeg is presented ground-up, packaged in little bottles in many

countries? How many know what an oasthouse is, let alone what is its smell? Who in Britain is familiar with the taste of maple syrup?

As may be expected in English medical publications, the food terms employed show a strong regional and temporal bias. But does *everyone* outside England know what a strawberry is? Yet, if strawberry gall bladder were called equally accurately a lychee gall bladder many people who had never seen a fresh lychee would be totally misled if they imagined that the tinned lychee has the same appearance.

Since the purpose of descriptive terminology is to convey accurately the meaning to other doctors throughout the world, any new attempts to introduce culinary terminology in medicine should be done with caution and the terminology should be kept simple rather than exotic.

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Postmortem medicine—an essential new new subspecialty

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With increasing technical knowledge, medical care has necessarily become more and more subspecialised.¹⁻¹⁰ Both the local community and the government have tried to approach the problem of delivering this care to as broad a segment of the population as possible. Especially notable are the heavily funded programmes in geriatrics research, as all segments of society have come to recognise the increasing proportion of old people in the population. The time has now come for us to focus on the medically most underserved population in the world today—the deceased. The urgency of this is quite apparent. There are more people who have already died than are alive today, and their number is increasing at an alarming rate. Physicians have not focused on the problems of the dead. Aside from anatomy, it is not a subject taught in most medical schools; as a result, early sensitivity of the medical student to the needs of the dead is never formally developed. Postmortem medicine is not a mere extension or subspecialty of geriatric medicine, but a major specific and unique problem in health-care delivery. We have therefore undertaken a pilot project to determine how the medical profession might better serve the dead patient, and this is the subject of the present paper.

The University of East Dakota Medical Center's pilot project on postmortem medicine is a broad-based multidisciplinary undergraduate and postgraduate study programme designed to investigate all aspects of diagnosis and care for the dead patient. Early in their training our medical students are given a one-semester course in psychosocial problems of the deceased human. In addition to didactic sessions, students are taken on field trips to cemeteries and funeral parlours, because we feel that classroom sessions alone depersonalise the dead patient in the student's mind. The members of our psychiatric faculty have responded enthusiastically and like this subject because they get to do most of the talking during patient interviews. Psychoanalysts are especially happy because of the long, meaningful silences they get when treating a dead patient. In the second year of medical school we provide courses in pharmacology and physiology in the dead patient. We have found that the pharmacokinetics of drugs in the formalinised patients are quite different from those in the living. So far we provide only one clinical clerkship in cemetery medicine, but

plan to offer a series of electives for interested students in funeral parlour physiology.

At the postgraduate level we have a pilot postmortem ward (separate from the morgue), which is staffed by two fellows who are supported by a National Institutes of Health (NIH) career development grant. The fellows are supervised by a senior attending physician, who is himself dead and therefore has an in-depth understanding of the specialty. The ward promotes active house-staff and nursing education and is a model for future programmes of similar type in the community. House staff who have just been on a ward with live patients have responded enthusiastically to the leisurely pace of the post-mortem ward.

Research projects are going on, and we are fortunate to have received extensive Federal and local grant support for such studies as postmortem wound healing, the impact of embalming on social acceptability of the dead, management of the person who died before penicillin was available, and so on.

A series of new subspecialties is already appearing—post-mortem endocrinology, postmortem podiatry, and postmortem neurosurgery to name a few. Some of our staff have developed a special interest in the long-dead patient, and we are considering a subspecialty of neanderthology.

In co-operation with the NIH and Rand Corporation, we have developed an extensive computerised programme of health-care services, delivery evaluation, assessment of the dead patient with peer review panels, and HMO (Heaven's Medical Offices). Our social-professional interface is progressing nicely. We already have a board certifying examination, and memberships are now open for our National College of Postmortem Medicine. The women's auxiliary of the American Dead Society has actively supported our many community efforts.

We have made substantial inroads in a neglected area and it is our hope that other universities will benefit from the billions that our government now wants to spend in this exciting new subspecialty.

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Random assessment by projected examination scripts (RAPES): a new look at examination marking

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Introduction

An apocryphal story from Oxbridge concerns the technique of a don who was wont to throw examination papers down the stairs outside his room and allocate degree placings by the distance the papers travelled; scripts that fell the furthest away were awarded the higher placings. Despite the intense interest that has been shown in examination methodology in the undergraduate medical curriculum, this technique has not been properly evaluated. The purpose of our investigation was to rectify this omission by comparing the technique (RAPES) with a well-established but labour-intensive conventional method.

Materials and methods

- (1) Standard university exam scripts of eight pages were used. These measured 29.5 cm by 21 cm and a random sample of 10 scripts gave an average weight of 28.25 g (weighed on a Salter No 511 balance, weighing up to 900 g in 5 g stages).
- (2) One flight of steps were selected in a large lecture theatre at the Medical Sciences Institute, University of Dundee. These consisted of 20 steps each of 198 cm width with a vertical height varying between 19 and 20 cm, and an angle of elevation from horizontal of 44.73°. Steps were carpeted with a rough pile carpet and had metal edges.
- (3) Fifty exam scripts used were from a previous anatomy written paper. Each paper had consisted of four essay questions. Each question had been marked by a different individual and the allocated marks summated.
- (4) The lecture theatre used was at a constant temperature; the doors were closed; and wind speed was estimated at zero miles per hour.
- (5) Throwing technique: in each method listed below the papers were held in both hands and were projected forwards with an easy throwing motion, the eyes being kept shut to obviate any inclination to throw them towards any particular part of the experimental stairs.
- (i) Block of 50 papers, face up, and with staples pointing laterally.
- (ii) Block of 50 papers, face up, and with staples pointing away from the thrower.
- (iii) Block of 50 papers, face up, with staples pointing towards the thrower.

- (iv) as in (iii).
- (v) Block of 50 papers, face laterally, edge forward, with staples pointing towards the thrower.
- (vi) Block of 50 papers, face laterally, edge upward, with staples pointing downwards.
- (6) The stairs were divided into five segments of 20 marks each from 0 to 100 marks, and the papers which fell into each of these divisions were counted.

Observations and results

EXAMINATION OF THROWING TECHNIQUE

Pilot observations had indicated that the method of throwing the scripts was of importance in determining the final distribution of the scripts on the stairs. An initial experiment was undertaken to establish which of the throwing methods resulted in a distribution of scripts that did not differ appreciably from the distribution achieved by the conventional technique. The results are shown in Table I. Statistical analysis was carried out using the χ^2 test. Method VI was the only throwing technique in which the distribution of scripts (RAPES) was similar to that of the conventional method (CONVENT).

TABLE I—Tabulated results of expected marks by the conventional technique compared with observed marks by RAPES using techniques (i)–(vi)

	0-20	21-40	41-60	61-80	81-100
Conventional technique—expected mark	1	14	29	5	1
Throwing technique:					
(i) Observed mark	0	5	34	11	0
(ii) "	1	14	13	14	8
(iii) "	0	6	44	0	0
(iv) "	0	10	39	1	0
(v) "	3	19	28	0	0
(vi) "	3	10	34	3	0*

* $\chi^2 = 5.06$ $P < 0.01$

DIRECT COMPARISON OF RAPES AND CONVENT MARKS

Method VI was then used to compare directly the mark achieved under the RAPES system with the actual mark achieved by each candidate under the CONVENT method.

Two RAPES were made with the scripts arranged at random (as they are likely to be collected under examination conditions), and then with the scripts arranged alphabetically. In both instances after throwing the scripts the observed (RAPES) mark and the actual (CONVENT) mark obtained by each candidate were recorded. The results are given in Table II.