may undertake any medically related study at home or abroad. Most students take the opportunity to see medicine in a different setting in another country and often obtain practical experience at the same time. Some take the opportunity to repeat parts of the curriculum or to obtain further experience of particular specialties which interest them but play only a minor part in the undergraduate course, such as radiology or mental handicap.

Assessments

Schools adopt different systems of assessing students' clinical progress. Most still put the major emphasis on a final MB examination divided into two sections: pathology, taken 6-12 months before the end of the clinical course, and medicine, surgery, obstetrics and gynaecology, and clinical pharmacology and therapeutics, taken together at the end. The important conditions covered in the "minor" specialty attachments are included in the major subjects.

The final MB examination in pathology comprises multiple choice questions, essay questions, and practical examinations. The examinations in medicine, surgery, and obstetrics and gynaecology also include multiple choice and essay papers but put great emphasis on clinical examinations at the bedside, which test practical skill in talking to patients, examining them, and making a diagnosis. Oral examinations are also held. However brilliant their theoretical knowledge, students generally cannot pass the final MB if they fail a clinical examination.

Students are also assessed generally on their performance in each part of the course, sometimes by a practical or written examination. These assessments are used to certify satisfactory completion of the course and do not contribute to the mark in the final MB at most schools. Nevertheless, all parts of the course must be satisfactorily completed before students are allowed to enter the final MB examination. Some schools, such as Birmingham, spread assessment formally over the whole course so that a major final examination has become a relic of the past, at least for all except the weakest students.

Personal Paper

Subarachnoid haemorrhage

MAY DUDDLE

I never do things by halves: 20 years ago it was a malignant melanoma; seven years ago it was pancreatitis after mumps (most undignified at my age, and painful); and five years ago it was a subarachnoid haemorrhage.

It began in a classic way: I was bending down cutting the grass edges in my father's garden in Cornwall one Saturday morning, when suddenly something happened in my head. I straightened up thinking I was dizzy with bending down, but it did not clear and, most frightening of all, my right arm and leg jerked slowly without volition. That still makes no sense—it should have been the left side—but it made a worse nightmare of the following hours because of my conviction that the left side of the brain must have been affected and I would have speech problems—particularly difficult for a psychiatrist. I began to be aware of a dull ache in the region of my right temple and, worse, an ache at the back of my neck, and I could no longer touch my chin on my chest—neck rigidity—an odd sensation.

I went into the house and the telephone rang. It was a friend crying off from the sail we had arranged for the afternoon because there was no wind. I did not try to stop him, realising I would be unable to sail—ever again?

My husband came in from the garden and I said, "I'm sorry, I'm afraid something has happened." (Why do women always have to apologise?) By this time I think I knew what it was, and he, a neuropathologist with a special interest in cerebral vascular disease, soon guessed too. I went to lie down and we debated what to do. It was Saturday and near Easter; we were 350 miles from home. Our first impulse was to get in the car and

flee back to those whom we knew could help. That seemed ill advised, so my husband rang all the colleagues he could get hold of (not too many because of the holiday) for advice and support. Finally, we decided to make for Plymouth, the nearest neuro-surgical centre. I went first, however, to a nearby hospital for a lumbar puncture to clinch the diagnosis. I think I first really accepted the diagnosis when the registrar held up the pink lumbar puncture fluid for me to see. Until then I did not believe it could really be happening to me.

Worst of all was the journey by bumpy ambulance 50 odd miles through a gale and a snow storm, with an ambulance attendant who had a streaming cold. I kept thinking that the bleeding was going to start again and that I would get pneumonia after my operation by catching the cold. After the lumbar puncture the pain in temple and neck was worse, and it was only because I asked for some Distalgescic tablets before the journey that it was at all bearable.

Diagnosis

Then I had carotid angiography, mercifully under general anaesthetic, and the diagnosis was aneurysm at the junction of the right posterior communicating and internal carotid arteries. I remember the surgeon telling me this. I was lucky to have a young American neurosurgeon who respected my need to know what was happening. He explained the pros and cons of an early operation, and they decided to operate next day (day 5), much to my relief. Waiting for rebleeding while they delayed operation to minimise the risk of vascular spasm would have been purgatory.

The next few days are hazy. I remember going for a brain scan to check whether things were satisfactory but thought this happened before the operation, not after. I remember calling a nurse when I had a severe chest pain but have no recollection

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that this happened three times; and I had an electrocardiogram. It is just as well that I did not realise at the time that sympathetic overaction can cause a fatal coronary at this stage.

I remember my three children with wives and husbands all appearing to see me from a few hundred miles away, and I know I became very emotional with them—I am not normally an emotional type, but I found it hard to control tears at all sorts of improbable times for several weeks after the operation.

On one occasion when the family were there my neurosurgeon came round with a copy of the operation notes, which we all read together with interest. As with all medics, things had gone wrong: the clip would not control the bleeding and then it slipped and the aneurysm tore and I lost 1000 ml blood and my blood pressure went down. Then, finally, a new type of clip (Sundt-Keys) worked by fitting over the internal carotid without constricting it, but the posterior communicating artery had to be clipped as well. It all read like an episode from a television series. One thing that was apparent was the need for a good anaesthetist: the knowledge that there was one at Plymouth had been one of the factors finally reconciling us to the unit there.

The worst moment, though, was when I realised that something had gone wrong with my left side. I could not make my left hand obey me, and when I sneaked out of bed to see whether my leg would hold me it gave way and I collapsed in a heap on the floor and was told off by the sister. The physiotherapist was a great help—she started me off with a tripod, and soon I could, with some support, get to the loo. I tried then walking with a stick, and one day she said, "Walk to me on your own," and I did. From my experience of physiotherapy I would comment that the personality of the physiotherapist is the most important thing of all. I was able to try much harder for the one I had more rapport with.

Two major worries

Two things preoccupied me during this period: one was bowels and the other hair. The only mismanagement in the hospital concerned bowels. They let me get quite "glued up." I was terrified to push in case the clip slipped off, and I was given no medication to help until I asked, by which time it was too late. I then had to undergo manual removal, which is a most undignified and excruciatingly painful procedure.

Hair became an obsessive concern. My surgeon shaved the whole head; other surgeons usually leave part of the hair, but the nurses agreed that this was worse than useless as it had to be shaved off later to match the rest. After the large bandages were removed we all wore stockinette "Noddy" caps, and a lady came round to try on wigs. Unfortunately she had her own ideas about what we should have. She thought that I needed a nice pinky grey one in a wavy style to suit my age, and I was too intimidated to point out that I had always worn my hair straight and brown, leaving only the front streak its natural white. The family came next day and were horrified, and my husband rushed out and bought me a wig in a local store, which served until I got home. We managed to persuade the lady to take the other one back and order me a short, grey one, which I later wore successfully. I believe that some neurosurgeons do not consider it necessary to dispense National Health Service wigs after operations as the hair grows again in a few months, but it takes at least five months to reach a respectable length, and before this what do you do? The trauma of neurosurgery is surely sufficient without the added psychological problem of baldness, and patients could be asked to return wigs later, as I have done.

After effects and recovery

Home at last after a month. I practised walking down the garden and playing ball, and gradually it all came back. For a while there was some confusion about telling the time, and for some months I had little interest in food, made worse by pain

in the right temperomandibular joint on opening my mouth. This began immediately after the operation and gradually improved over the next year. I did manage to sail again: the August after the operation in April we got over to the Scillies and southern Ireland from Falmouth, where we had been keeping our boat. We took on an experienced couple as extra crew instead of sailing together as before—just as well, as they had to heave me across the cockpit each time we went about in any wind. I was back to full time work in five months, but people still tended to treat me as a bit fragile, and, indeed, after five years some still do.

My main long term problems have been orthopaedic. I had two frozen shoulders in the first few months despite early physiotherapy, and six months after operation I developed severe pain in the right tendo Achillis, probably due to overwork to compensate for the weaker left side. A partial tear put me in plaster for a month, but it recurred and operation was suggested. At this stage my husband, perhaps not surprisingly, had a coronary and went on to bypass surgery. So I declined the operation, which would have immobilised me for some time, and gradually the ankle settled down. Now I have no trouble with it.

After this I began to have severe pain in the right hip and knee, which made walking more than a few yards excruciatingly painful. This went on for a year or two, and I was dosing myself with flurbiprofen and resigning myself to permanent disability when our local professor of rheumatology, to whom I shall be eternally grateful, put one finger on my right thigh, which made me almost leap off the couch with pain. He diagnosed trochanteric bursitis, injected cortisone, and after the usual few hours of agony I was able to walk almost normally again. This setback, I am sure, was also due to the altered mechanics of the joint.

Now, to casual observers all is back to normal, but I am aware that my left hand is still a bit clumsy. If I attempt to carry a full cup with this hand I have a disconcerting habit of tipping it up and spilling it unless I look at it all the time—some loss of position sense, I suppose. When I am tired my leg drags a bit, and I still have increased reflexes in my left arm and leg, but I can walk a reasonable distance.

The exact aetiology of the hemiplegia has puzzled us: there was no sensory loss. "Ideational apraxia" was often mentioned and, certainly, my intentions seemed to have difficulty getting through to my muscles, but there was loss of power, too. Was it all caused by diminished blood flow after operation due to a combination of loss of blood, low blood pressure, and temporary contraction of some vessels and permanent occlusion of the posterior communicating artery? Or was it the most dreaded of complications—vasospasm—which is said to occur more commonly in those operated on early? It was certainly apparent as soon as I came round from the anaesthetic.

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During several years in general practice I have repeatedly encountered a physical sign that I have called the "ballooned rectum." This is present in patients with gastroenteritis on digital rectal examination. The sensation is of entering a rectum that is distended and quite distinctly ballooned. This finding is almost invariably present in patients with abdominal pain and diarrhoea who subsequently get completely better and in whom, therefore, I diagnose viral gastroenteritis. Is this a recognised physical sign and is it useful in making differential diagnosis between appendicitis and gastroenteritis?

This is an interesting question. I can find no references to this physical sign but I have also noticed a similar sensation in patients with watery diarrhoea of various aetiologies. Distension of the rectum is usually associated with constipation (rectal dyschezia) and a narrowed, fibrosed rectum is associated with the diarrhoea of inflammatory bowel disease. Physical signs and symptoms in gastroenterology are currently being re-evaluated in large groups of patients with the aid of computers and perhaps in the future this observation should also be included.—B GAZZARD, consultant gastroenterologist, London.