# How To Do It

## Organise a clinical examination

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Chance favours only the mind that is prepared.—PASTEUR

**From *How To Do It: 2*, a new collection of useful advice on topics that doctors need to know about but won't find in the medical textbooks. To be published in October 1987, this is a companion volume to the popular *How To Do It: 1*, also published by the *BMJ*.**

The clinical examination is a trial not only for the candidates but also for the organiser, who has to ensure that candidates receive a fair assessment by providing a careful selection of patients and a calm environment for the examination. He must also ensure that all runs smoothly to allow the examiners to make unbiased judgments on the candidates. The combination of fractious examiners and flustered candidates, as a result of poor organisation, is bound to be detrimental to a candidate's performance.

### Three to four months before the examination

Read carefully the examination regulations and any advice given to organisers from the examining body. Efficient organisation requires the cooperation and coordination of several individuals, so once the examination date is known check your own availability and that of your colleagues, nurses, and secretary. You may need to reorganise clinics and holiday and study leave. Try to arrange for the examination to be held in a single ward, used solely for the purpose. Contact the nursing management to arrange for the provision of staff: smooth running on the day greatly depends on an efficient nursing team.

### Two to three months before the examination

Prudent organisers will already have a bank of patients to refer to, but, if not, you must start selecting patients at this time. The examining body must tell you the number of candidates and sets of examiners who will be attending; once this is known you must arrange schedules for the patients, who should not have to attend for more than four to five hours, that is, for either a morning or afternoon session. To ask a patient to attend for eight continuous hours is, I believe, reprehensible, and it is unfair to candidates, especially late in the afternoon in "long cases."

Long cases need not have any physical signs, but good histories (and historians) are required. The number of "short cases" per session can be approximately calculated from the following formula:

$$1{\cdot}5\times(\text{number of candidates in session}+\text{number of sets of examiners}).$$

One long case will generally be needed for each candidate. Any long cases with good physical signs should preferably be used early so that they can be used as short cases later in the session.

Short cases must have clear cut physical signs as it is then easier to test a candidate. Poor candidates show their deficiencies more readily in their inability to recognise clear cut physical signs than in their inability to elicit equivocal abnormalities. At the very minimum, most medical clinical examinations require each candidate to examine cardiovascular, abdominal, neurological, and chest systems.

Once you have decided the days and times that individual patients are required you can send out a letter explaining the examination and suggesting time and date of attendance. Give the patient the opportunity to offer an alternative date in the reply slip and always send a stamped addressed envelope. Make it clear if lunch or transport is to be provided and ask whether these will be required. State the time the patient will be able to leave the examination and never underestimate this.

Keep an up to date list of patients' schedules so that you can reorganise if necessary to ensure a satisfactory number and spread of disease and physical signs. Make sure that the short cases are complete at an early stage. It is an advantage to have some long cases as inpatients at the time of the examination so that a prompt start can be achieved. I always send a second letter to the patients confirming the date and time that they have agreed to come.

### Three weeks before the examination

Now comes the arduous task of writing summaries about the patients. These should be concise and consist of relevant information only. Do not use more than one side of A4 paper—and usually considerably less. In short cases one or two lines will suffice, for example, "splenomegaly due to chronic lymphatic leukaemia." There is no need to elaborate; the examiners will assess the patients before the examination starts and make their own notes. The case notes of all long cases and any suitable radiographs or other investigations for long and short cases should be available.

Scripts of case summaries should be stapled together (long cases first), with a contents page at the front listing all patients, their diagnoses, and a number code that corresponds to bed numbers in the ward. There should also be a page showing the ward plan with beds clearly marked with their numbers. Always have a blank top sheet to prevent candidates seeing the contents page.

Check that nurses and porters know about the transfer of patients from ward to ward and the number of patients who will need lunch. If the regulations require it, obtain name badges and white coats for the examiners. Arrange to have well printed, clearly written numbers to put on to beds corresponding to the bed numbers on the ward plan. Earmark side rooms for each pair of examiners and a

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waiting room for candidates. Arrange with the catering staff for coffee, biscuits, and soft drinks to be available on each day of the examination both for examiners and candidates. If possible, build into the time schedule a short break in mid-morning and mid-afternoon. Try to arrange a quiet, restful place in the hospital for lunch for the examiners and don't forget to buy some sherry. Finally, arrange for signposts to be put up around the hospital directing candidates to the appropriate ward, and alert porters, receptionists, and telephonists.

## Examination day

Arrive at the hospital well before the examination starts. There will always be unexpected problems: the main road to the hospital may be blocked with snow; the coffee urn may have broken; the examination ward may have been taken over by decorators; your secretary may be off sick (the worst possible catastrophe); you may have forgotten to rearrange an outpatient clinic; or the key to the office containing the patients' scripts may be lost. There will be the inevitable last minute cancellations by patients and a few "disappearing physical sign syndromes." Always have a few spare patients in the wards (especially with cardiovascular and abdominal signs) who can be substituted. A round of the main wards the day before the examination can be rewarding and will put your mind at rest.

Try to start the examination on time as it is very difficult to pick up time if you begin late. When the examiners arrive, coffee and biscuits will promote a friendly start. Check the patients' physical signs yourself and then introduce them to the examiners; allow about half an hour for 12 short cases.

Have a plan showing when each candidate has to be with each set of examiners, and give the plan to all invigilators and to each examiner, so that there will be no confusion as to which examiners should be with which candidate and where. For example:

| | Candidate Nos 215-217 | | |
|---|---|---|---|
| Examiners | 1000-1100* Long cases | 1120-1140 Short cases | 1140-1200 Oral |
| A and B | 215 | 216 | 217 |
| C and D | 216 | 217 | 215 |
| E and F | 217 | 215 | 216 |

*Allow for 15-20 minutes' questioning on the long case.

## Conduct of the examination

Ensure that the relevant instruments are available on a trolley in a central area and that the ophthalmoscopes are working. Candidates will also require paper and clipboards; have a few pencils available. Patients used as long cases should produce a urine sample but must never be forced to do so. Try to keep the long cases separate from the short cases. Patients who require fundoscopy examination should be put in a darker area if possible. I generally dilate the pupils; if this is done don't forget to constrict them at the end of the examination.

You will need one or more colleagues to help invigilate and to ensure accurate, synchronous timing and guiding of candidates and examiners. Registrars are a valuable asset for this and can help put candidates at their ease. They also find it a useful experience, especially if they can be paid a small honorarium. It is best to keep time from a wall clock in the ward that is clear for everyone to see. I usually give a half time warning and a warning two minutes from the end to examiners, as well as a final warning by bell or alarm—even if they say that they will time themselves—so that I feel completely in control. Sometimes a little gentle bullying is necessary to ensure that examiners keep to their schedules. (I have never heard of an examiner complaining that lunch came too early.)

It is important that all patients are seen during the examination. Keep a mental tally during the session, and if a patient is not being used inform the senior examiner and tactfully ask if the patient could be used when it is convenient.

When a candidate has finished never succumb to the temptation to discuss the correct diagnoses even if the day has ended. This is unfair to previous candidates and will often result in concern rather than succour.

## End of the examination

Collect all relevant paperwork that has to be forwarded to the examination body, and thank all the patients and staff who have helped. If the examiners have left any sherry this may be a good time to offer some liquid resuscitation to the many staff who have helped in the invigilation.

Do not expect organisation of an examination to be a particularly gratifying experience, other than to give much personal satisfaction. You may be motivated by the proverb that "humility goes before honour" but you are more likely to feel, in Sir Walter Scott's words, "unwept, unhonoured and unsung."

I thank Mrs Mary Craw for typing the manuscript.

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*A poorly controlled insulin dependent diabetic woman in her 30s wishes to be sterilised. She has completed her family and is taking an oestrogen-progestogen contraceptive (Trimordial). Should she be sterilised?*

This question clearly relates to the relative safety of sterilisation as opposed to continuing the combined pill. Even if the patient wished to continue with the pill all authorities agree that diabetes is a strong relative contraindication to the combined pill, becoming absolute above age 35 or if there are other risk factors—for example, cigarette smoking or hypertension—or any evidence of diabetic tissue damage (retinopathy, neuropathy, arteriopathy, or nephropathy). There were no fewer than four cases of serious arterial disease (cerebral thrombosis (three), myocardial infarct (one)) under the age of 30 in a series of 120 diabetics taking oestrogen containing pills.[1] Laparoscopic sterilisation, on the other hand, is safe, with a mortality of less than 10 per hundred thousand.[2] The progestogen only pill would be a reasonable alternative, should this couple be unhappy with the finality of sterilisation after counselling.[3]—J GUILLEBAUD, senior lecturer in gynaecology, London.

1 Steel J, Duncan LJ. Serious complications of oral contraceptives in insulin dependent diabetics. *Contraception* 1978;17:291-5.
2 Chamberlain G, Brown JC, eds. Gynaecological laparoscopy. In: *Report of the working party of the confidential enquiry into gynaecological laparoscopy 1978*. London: Royal College of Obstetricians and Gynaecologists, 1978.
3 Steel J, Duncan LJ. The progestogen only contraceptive pill in insulin dependent diabetics. *British Journal of Family Planning* 1981;6:108-10.

*What advice about work should be given to a singlehanded general practitioner with Menière's disease?*

Menière's syndrome is often misdiagnosed, so it is important to establish that the diagnosis is correct. The many other possible causes of episodic vertigo should be excluded. The onset of the syndrome is rare after the age of 50 and vertigo in individuals over this age is usually secondary to other causes. The symptomatic triad of episodic unilateral hearing loss, tinnitus, and true vertigo should be present and the diagnosis may often be confirmed by pure tone audiometry and labyrinthine function tests. As to prognosis it is unusual that the condition cannot be controlled by a labyrinthine sedative—for example, prochlorperazine or cinnarizine—or betahistine given either singly or in combination. Exacerbation of the condition tends to occur at intervals when baseline treatment may be increased, but as the condition progresses these exacerbations tend to become less frequent. There is no reason why a general practitioner in a singlehanded practice should not continue in his work provided that symptoms are controlled and there is no potential danger in driving a motor car. In summary, therefore, assuming that the diagnosis is correct the vast majority of patients with Menière's syndrome can live and work normally. The more severe cases should be under the supervision of an ear, nose, and throat surgeon, so that surgical intervention may be considered in the rare cases in which it is justified.—A R WELCH, consultant ENT surgeon, Newcastle upon Tyne.

J D K Dawes, personal communication.