cardiac output and systemic blood pressure following the use of epidural anaesthesia and maintain that it should be avoided in high-risk patients, particularly those with conditions associated with fixed or limited cardiac output, such as aortic stenosis.

It is implicit in the statement 'the mode of delivery and particularly the type of anaesthetic should be discussed well in advance', that this should involve the obstetric anaesthetist. Such interdisciplinary communication and consultation in the investigation and management of patients with valvular heart disease is one of the central tenets of the guidelines' publication.

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Diagnostic logic and validity for the 'short' case

Editor—Dr Hoffbrand's views on the short case were clear and most welcome (July/August, pages 374–5).

My criticism of the short case is three-fold. First, I find the distinction between history-taking and physical examination artificial. True, the initial few minutes should be to listen before touching the patient, but with a focussed short history the clinician is ready to examine. In certain instances the short case could even be limited to the history only, eg an adult with multiple somatic symptoms suggestive of a somatoform disorder.

Second, the short case should attempt to mimic the real life situation in a busy outpatient clinic. The candidates should be allowed to question, examine for relevant features, question again if necessary etc. This process could be guided by the examiner with comments like 'now that you have elicited those signs do you have any particular questions to ask which will help in the differential diagnosis?' This would enable the examiners to assess the diagnostic process and encourage critical reasoning and active learning [1] in which case educators could begin to elucidate the validity, reliability and objectivity of the short case as an assessment of the diagnostic process. A modified version is already being used in assessing clinical skills of residents by the American Board of Internal Medicine [2]. These mini-clinical evaluation exercises (mini-CEX) concentrate on the resident's ability to solve patient problems regardless of the type of encounter.

Third, in many medical schools (certainly in Sri Lanka and in other Asian countries) the short case is an artificial exercise, with an inductive approach (with instruction like 'examine the cardiovascular system' being given to the candidate). Furthermore, it is confined to the physical examination. This defies logic. How many patients will ever state 'Doctor, my problem is shortness of breath and the problem is in the cardiovascular system'?

A step forward in the assessment of clinical skills would be the following: an OSCE to assess specific skills in physical examination and communication [3], short cases to assess the diagnostic process, and 'long cases' to round up the assessment in a holistic manner, which is especially relevant to inpatient care [4].

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