Organising a Clinical Examination

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Clinical examinations are an important part of undergraduate and postgraduate medicine. Not only do trivial things like the future careers of medical students and junior doctors depend on them, but they also give examiners a chance to meet old friends, make new acquaintances, settle old scores and keep abreast of recent advances. A clinical examination is therefore a double-edged weapon. If it is well organised, it brings immeasurable prestige to the department as a whole and to the host examiner in particular. On the other hand, if it is chaotic, those responsible may become a laughing stock. Crafty host examiners would of course ensure that they take the credit if things go well, and that their minions take the blame if things do not. It was said that if the New York Yacht Club ever lost the Americas Cup, the skipper's head would replace the trophy on its stand. As it turned out, this did not quite happen, and in any case, the medical profession is far more tolerant of failure than the N.Y.Y.C. Nevertheless, it would not be surprising if the culprits who made a mess of organising a clinical examination were required to relinquish less important parts of their anatomy. These would then be preserved in pots in the anatomy museum and exhibited as warnings to their successors. The fate of the remnants of these culprits is often unknown; rumours suggest that they end their remaining days in disgrace somewhere in outer Mongolia or the steppes of Russia.

I had the privilege (misfortune) of being asked (ordered) to organise two clinical examinations—one for the MRCP(UK) and one for the University of London's Final MB. Lady Luck smiled on me on both occasions: I survived and emerged physically, if not psychologically, intact. It is to those future gladiators who will be asked (ordered) to organise clinical examinations, and to the consumers of these commodities that I dedicate the following 'rules' of survival.

Preliminaries

Get a good secretary. A good secretary is the key to success. If necessary, beg, borrow or steal one who has previous experience and is mad enough to want to do it again. She should be efficient, highly organised, hard working, charming and understanding, especially when your wife/husband starts complaining that you are spending all your evenings with *her,* and preferably a good cook (the reasons for this will be apparent later). Under no circumstances must she fall ill before the examination is over.

Get a good nurse. A good sister is almost as important as a good secretary, since she will be the one who organises the examination area and makes sure that all the necessary equipment is assembled.

Negotiate for time off clinical duties before the examination.

Find a suitable area for the examination. The best place is usually a large, well-lit ward, ideally with:

1. Sufficient cubicles where pairs of examiners can grill their victims without disturbance. Examiners function in pairs, not to intimidate, but to observe each other in order to be fairer to the candidates. Also, it is less likely that both of them will fall asleep at the same time.
2. Several 'bays' of 6–8 beds each, with curtains, for patients who need to undress.
3. A large sitting area for patients who do not need to undress. They are usually used as 'short cases'.
4. A room which can be darkened so that a patient's fundi can be examined to best advantage. The alternative of dilating the pupil with topical drugs is not suitable for some patients.
5. An examination room for urine testing.
6. Nearby toilets for all those under stress.
7. A relatively secluded waiting area for candidates.

Finally, a sketch map of the examination area, complete with bed numbers and chair numbers, is invaluable.

About Eight Weeks before the Examination

This is the time when the real work begins, namely, the selection of suitable cases. For medicine, there appear to be three modern trends in clinical examinations:

1. Recently admitted patients, who can be used to test the candidate's ability to evaluate and manage their various medical problems, are preferred.
2. Patients with exotic diseases who have been used for examinations from time immemorial ('museum' cases) are to be avoided.
3. Candidates will be examined on all major systems of the body, without reduplication. For example, if someone had a neurological 'long case', he would be taken to patients with diseases in systems other than the CNS in the 'short cases'.

Invariably, these trends will have a critical influence on patient selection. My personal 'rules', therefore, are:

Try to get an optimum mixture of 'cold' and 'hot' cases. I think their ideal ratio is about 7:3. 'Cold' cases include those 'old faithfuls' who are frequently used for examinations and teaching (most examination-orientated hospitals have lists of these) and, better still, new unused patients who are in the wards several weeks before the

examination. The latter should be approached before they are discharged, and arrangements made for them to return on the required day(s). 'Hot' cases are those recently admitted patients who are still in hospital during the examination. They have the advantage of being on site so that outside transport arrangements are unnecessary. However, by definition, most cannot be approached until very near the examination, so there is always a risk of not getting enough patients, or too many with diseases of one system and not enough with diseases of another. A further drawback, perhaps the real one if the truth be known, is that it is exceedingly hard work for both the organiser and the secretary to find these patients and prepare case summaries at the busiest time on the eve of the examination.

Aim for a balanced group of patients. (a) There should be enough patients with diseases in each major system. (b) There should be enough patients for the 'long case' and the 'short case' parts of the examination. Some patients are suitable both as a long case and a short case. They are ideal because administration, cost and total patient number can be kept down. (c) Despite the directive on 'museum' cases, it is wise to include one or two. Host examiners can be most upset if their favourite neurosyphilitic is consistently left out, and indeed, the loyal patient can also be displeased if he is no longer invited. You may think that the latter does not matter, but you are wrong because he will surely complain bitterly to your boss the next time he is seen in out-patients.

Enlist the help of colleagues. Sending them written requests for suitable patients may help, but tends to be less effective than cornering them and asking them face to face who they have on the wards at the moment.

Approach suitable patients for consent with care. Most patients are reasonable and will agree if they are asked tactfully. Some may refuse because they live far away or have other commitments. On the whole, it is probably better not to pressurise reluctant patients because they may agree under duress and then simply not turn up on the day.

Prepare brief case summaries, including only the most relevant points. Long discourses waste time and will not be read by the examiners. Needless to say, it is important to check the patient's history and signs before preparing the case summary. A pocket size tape recorder is very useful for on-the-spot dictation, thus saving removing the notes and X-rays from the ward to the secretary's office.

Organise the most reliable means of transport for out-patients. Some patients can come on their own, but others require transport. If hired cars need to be used, choose a reliable firm since punctuality is vital. Patients living near one another can come (and leave) in the same car, but allow plenty of time for delays.

Two Weeks before the Examination

The activities mentioned above intensify during this critical period. In addition, the all-important task of allocating long cases can now begin. Short cases do not need to be assigned. The following rules are helpful.

Always use in-patients as long cases at the beginning of each day because they are not dependent on outside transport.

All out-patients should be asked to arrive well before the start of the examination, but they should be allocated as long cases later in the day. The reason for this is that even if they come late, or do not arrive at all, there will still be time to find replacements.

Take into account patients' personalities as far as possible. Human nature being what it is, allowances should be made for patients' prejudices. For example, it is obviously inappropriate to assign a patient who is a known male chauvinist pig to the secretary of the local women's liberation society. It is surprising how much you do know about the candidates, some of whom will have worked with you.

Ask the host examiners' advice on case allocation. Their opinion is often very helpful. In addition, most of them do not want to do more work than necessary (and getting to know several brand new long cases each day is hard work), so they may prefer to be given some of their favourite patients whom they know inside out.

Always aim to have a few spare patients each day.

Liaise with the hospital porters and all relevant departments. Porters always know what goes on (often before you do), but details like when their services will be particularly required, positioning of signposts and so on, need to be discussed with them. Hospital administrators also need to know, but, unlike porters, some of them do not know what goes on even though you have written to them several weeks ago. Perhaps it is the timing; if you tell them too early, no one will pay any attention; if you tell them too late (like two weeks before the examination), your memo will not be read until the pass list has been published.

A Day or Two before the Examination

1. Finalise patient lists, allocation lists and transport lists.
2. Check on all the arrangements that have been made.
3. Assemble files for the examiners, which should include a map of the examination area with numbered beds and chairs, list of candidates, list of allocated long cases and summaries of all patients.
4. Work out a timetable for the examination. Sometimes, one will be provided by the examining body. Basically, this is a list of times when certain activities need to be performed. These include introducing the candidates to their long cases, bringing them to the examiners, change-over from long to short cases or vivas, serving coffee during breaks and so on. It is very important, because time-keeping is vital to the smooth running of a clinical examination.

On the Days of the Examination

This period is like what is sometimes said of giving anaesthetics—mostly boredom punctuated by spells of blind panic. The major problem occurs when out-patients cannot come or cannot arrive on time for one reason or another. Most responsible patients will ring up the secre-

tary, who would have established a hot line just for this purpose. Sometimes the problem can be solved but on other occasions it may be necessary to switch patients round or use spare cases. Rarely, even the best laid plans can go astray: this happened when a clinical examination organised by one of my colleagues coincided with a public transport strike so that many patients and candidates found it impossible to be punctual. The chaos that existed before God created the universe was nothing compared to what ensued. Somehow, to their great credit, things were sorted out without too much delay. My colleague gained much respect, and it s now rumoured that he is practising walking on water with some success.

Still, there are several rules to be observed.

1. Introduce each pair of examiners to their long cases before the examination starts. They are expected to familiarise themselves with these patients, and a few words about any potential problems the candidates may have with them can be very helpful.
2. Try to put the candidates at ease. Anyone who has gone through the rigours of a clinical examination will undoubtedly have a lot of sympathy for them. However, it is sound to advise them not to discuss patients they have seen with their colleagues. To do so is unhelpful and can be fatally misleading. Examiners detect such exchanges very easily, and many have remarked how successive candidates make identical mistakes on the same patients, or worse still, find the 'correct' signs on the wrong patient while acting on a tip from their predecessors.
3. Keep time strictly. Examiners and candidates must be reminded of their allotted time. Some examiners invariably go on longer than they should, and sometimes this will delay the whole examination. All one can do is to try hard to prevent this.
4. Direct examiners towards little-used short cases. It is almost unavoidable that some short cases are much more popular than others. This tends to tire out some patients, and makes others feel totally unloved.
5. Be ready to respond promptly to examiners' and candidates' requests. Candidates usually want to borrow equipment. Requests from examiners are more unpredictable. Some examples are: help to find missing spectacles/stethoscopes, to leave messages for wives/husbands/secretaries, to confirm signs that you have missed in some patients and to arrange for a call from America to be received during the coffee break. (Those who wish to practise one-upmanship please note.) Sometimes you will need to be in three places at once, but by now this should be no problem.
6. Keep an eye on valuable pocket-size equipment. Many ophthalmoscopes have been unintentionally removed by shell-shocked candidates at the end of their ordeal so that they are unavailable for later use.
7. Thank the patients before they leave, and remind those who have been asked to come on another day when they are required again.

Conclusions

At the end of it all, organising a clinical examination is not as bad as it sounds. It often gives amusing moments. Two incidents stand out in my memory. In one, I mixed up the case summaries of two patients with identical names, and neither I nor the examiners detected this before the examination started. To their credit, they kept a straight face when the candidate presented a totally different history from the one in the case summary. They then examined the patient, agreed with what the candidate found, and took great delight in pointing out my blunder to me. In another, when I went round to thank the patients, I found one of them sweaty, pale and talking nonsense. Intravenous dextrose cured his hypoglycaemia, but it was difficult to tell how long he had been in that state. Neither the candidates nor the long case examiners (one of whom was a diabetician) had noticed anything amiss, so one must presume that the patient became symptomatically hypoglycaemic after they had seen him—or can one?

In both the examinations I helped to organise, I was extremely fortunate to have an excellent secretary. There were many occasions when I was saved from a fate worse than death by her foresight and organisation. In addition, she provided all the examiners and staff with fresh ground coffee and a different snack every single day, culminating in a farewell tea on the final day which was a gastronomic *tour de force.* She is now well-known in the marble corridors of the hallowed halls. Without her, I would not have survived to tell this tale.