Letters to the Editor

Clinical audit: time for a reappraisal?

Editor—Anthony Hopkins rightly points out that clinical audit too often fails to address aspects of care which are of importance to patients (September/October 1996, pages 415–25). This is largely, of course, because no-one ever asks the patients what these are.

Perhaps one of the main problems is identified in the question 'who is being audited?' Surely it is the care patients receive which should be audited rather than any individual or group of health professionals meting out an aspect of care?

If this were more readily accepted, perhaps we could get away from the defensiveness and divisions which characterise much current audit and make way for more patient-centred audits.

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Diagnostic logic and validity of the 'short' case

Editor—How refreshing to read Barry Hoffbrand's excellent criticism of today's clinical teaching. During our last MRCP course here I asked one of our candidates to show me how to elicit tactile resonance. The patient concerned had a left pleural effusion. Using the ulnar surface of the hypothenar eminence of both hands the candidate proceeded to plot a course over the surface of the back from the shoulders to the lumbar region. At the end of this long process there was a pause. 'Resonance is increased on the right', was the assessment.

Now I know that the textbooks give a list of conditions in which tactile resonance is supposed to be increased, but I defy anybody to be able to distinguish between normal and increased resonance.

Furthermore, when did you last palpate an object using the edge of your hand rather than with your finger tips? I later discovered that the majority of our candidates examined the chest with the edge of the hand. Where has this virus come from?

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Editor—Despite the best efforts of the Royal College, examiners remain a heterogeneous group with a variety of ideas as to what constitutes a satisfactory short case examination. Some wish to see a complete systematic ritual, others an appropriate sequence related to the presenting problem (and unfortunately many examiners still do not introduce the patient with an appropriate scenario). As a result candidates do not know what individual examiners require. By and large, candidates are expecting an assessment of bedside techniques as well as diagnostic skill and it should surely be reasonable to allocate a percentage of marks for technique.

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Editor—Rituals of the type exemplified by Professor Hoffbrand (July/August 1996, pages 374–5) abound, not only in the MRCP 'short' case scenario, but also in the context of clinical investigative practice, instanced by the preference for 'routine' ultrasonography as an antecedent to endoscopic retrograde cholangiopancreatography (ERCP) even when both biochemical and clinical stigmata unequivocally favour the diagnosis of the 'surgical' type of biliary obstruction. A preoccupation with the exercise ECG test, to the exclusion of any consideration of evaluation of left ventricular systolic function (using left ventricular systolic volume or left ventricular ejection fraction) flies in the face of the information that the latter investigation possesses not only superior prognostic accuracy [1,2], but also the ability to identify those subjects most likely to benefit from disease-modifying strategies such as angiotensin converting enzyme blockade.

References

1 Lee KS, Marwick TH, Cook SA, *et al.* Prognosis of patients with left ventricular dysfunction, with and without viable myocardium after myocardial infarction: relative efficacy of medical therapy and revascularisation. *Circulation* 1994;**90**:2687–94.

2 Gill JB, Cairns JA, Roberts RS, *et al.* Prognostic importance of myocardial ischemia detected by ambulatory monitoring early after acute myocardial infarction. *N Engl J Med* 1996; **334**:65–70.

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Editor—The fact that the short case section seems to work in ranking candidates is not, in itself, a justification for it. If it is to continue to enjoy its pre-eminent position in the Part 2 MRCP examination (carrying more marks than any of the other sections) it must have validity. The examiners have the means, and are encouraged to ensure that each short case is a problem to be solved by the candidate. The examiner should give a brief introduction in terms of history or even physical findings or investigations which requires further investigation by the candidate: 'this patient was recently admitted with haematemesis—please examine the abdomen to see if there are any relevant findings', or 'this asymptomatic young

man was thought to have a murmur at a routine medical examination—can you confirm and comment on this'.

ERIC BECK
Chairman MRCP(UK) Part 2 Board

Editor—I was disappointed that Dr Hoffbrand's article on the validity of the short case was not more critical of the membership examination, which distorts medical training and enjoys virtually no support outside the committee rooms of the Royal College.

The skills required to be a good doctor are only tangentially related to those necessary to pass examinations. It is a pity therefore that the Royal College did not take the opportunity presented by Calmanisation to redesign the membership examinations so that learning could be more closely directed to the goal of producing good physicians. At a time when doctors are being urged to base their activities on evidence, the Royal College should not persist with the ritual of short cases in examination despite their lack of validity.

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Calman cometh

Editor—David Shaw, writing as Medical Coordinator of the Joint Committee on Higher Medical Training, encourages us to remain calm over Calman and give the scheme time to bed down. Neurology is for 'Calmanisation' in January 1997 but until very recently neither heads of departments nor postgraduate deans had any answers to the range of questions our trainees are asking. As a former president of the Association of British Neurologists, Professor Shaw might reflect on the threats which the *implementation* of Calman poses to academic neurology.

It is said that neurology in Cambridge represents the best example of what has gone wrong with the unified training grade. We have five training posts in East Anglia and 18 clinicians who aspire to a clinically active career in British neurology: three are already in training posts; of the remainder, nine have MRC or Wellcome Trust fellowships, three are supported by other research grants and three are funded through the pharmaceutical industry. The 15 trainees currently holding research posts run into the following problems on 1 January 1997:

1. Seven previously held posts in neurology, and therefore have national training numbers (Research) [NTN(R)s] but are not in a training post. Under Calman they are East Anglians and can no longer, as of right, transfer regions unless fixed up by the postgraduate deans; although highly qualified, their perception is that further progress is currently blocked.
2. Two others already have a PhD and wish to continue in academic neurology in Cambridge where their special interests are well represented. These two would-be academics now learn that their MRC/AMRC fellowships have lost the accreditation status they previously enjoyed under JPAC.
3. Eight clinically trained research staff came directly into neurological research from general medicine and only qualify for NTNs at the discretion of their postgraduate dean—a welcome revision. At least during transition, they may be ineligible for appointment to any training post until the baron-deans have brokered all the surplus NTN(R)s. The same embargo applies to bright young SHOs who had been considering a neurological career.
4. On 1 January 1997, 12 research staff will have completed the one year in research allowed under the unified training grade arrangements for neurology, and the remaining three will be in the same position by October 1997.

Six of these 15 research staff are now a problem for our postgraduate dean. Four are already a nuisance to other deaneries who have enough problems of their own to sort out; the rest will soon follow. So, as the present arrangements stand, the training clock will slow or stop ticking altogether for 15 disenfranchised doctors sometime during 1997.

There are solutions which, even now, might save the situation. The allocation of training posts in neurology is at least 25% lower than the most recent census of people known to be in the system: neurology has expanded hugely with the NHS reforms; there is an overall shortage of trainees and many consultant posts are unfilled.

1. Upward adjustment of national training posts to match the number of individuals known to be in the system and committed to specialist training (irrespective of the sequence which their career has followed) would give a positive signal to academic neurology and end squabbles between academic and NHS neurologists on who should choose the trainees.
2. Restoring the training status of MRC/AMRC clinician scientist fellowships, would encourage applicants and advantage departments able to host these prestigious awards; it is a simple matter to ensure that the clinical training of fellows remains appropriate for a specialty where academic staff continue to provide general neurological services at regional centres and in the district.
3. Research requires a disproportionate concentration of individuals in certain regions at particular stages in their training and, for these purposes, the geographical boundaries of deaneries should be abandoned. There is nothing special about academic neurology in this respect and, although the geographical details differ, identical arguments relate (*inter alia*) to neurophysiology and rehabilitation.
4. The arrangement whereby