Don't just look at it, doctor

As medical students take their finals, **Dr Simon Wessely** discusses the possible demise of a venerable examination

This is the most anxious time in any medical student's career — the week of their final examinations. For most this period will commence with written papers, which are difficult enough, but by common consent the worst ordeal is kept until last — the clinical examination. Here, watched by at least one senior doctor, the student will be asked to examine a variety of patients, and to identify their various conditions.

The details of the ordeal vary. At King's College School of Medicine, we work in pairs. I examine in psychiatry, while my colleague does the medicine. Each student has half an hour to impress us. The first 15 minutes is given to psychiatry, and then I can relax while my physician colleague puts the students through their medical paces.

One unexpected side-effect of being an examiner is the opportunity it gives me to have an annual revision course in basic medicine. It is also an opportunity for nostalgia, since the process has not changed in any noticeable manner from the time when I was a terrified student. Indeed, the accounts of student examinations in the classic books of Richard Gordon, set in the immediate postwar period, still ring true, and even the stories of medical student life by Arthur Conan Doyle and A.J. Cronin are familiar.

The unchanging nature of medical student finals is surprising, because medicine has changed beyond recognition. Take the issue of physical signs. Most of the clinical examination consists of testing the student's ability to detect the physical signs of disease. For this purpose we recruit patients who have obvious signs of physical illness (obvious to the examiners, that is).

Paradoxically, the patients must also be in good health, able to stand several days of being poked and prodded by nervous students. Hence the examination hall is populated by long-suffering patients with stable signs of previous disease. Favourites include people with heart murmurs after rheumatic fever or neurological signs of old polio. My personal favourite is a charming gentleman who has been left with unusually large hands and feet, the consequence of a pituitary tumour many years ago.

Last year I was paired with a particularly distinguished physician with an interest in the history of medicine. Once the student had demonstrated the required physical sign, my fellow examiner would ask the student about the history of that particular sign, and who had first described it. I remember his pleasure when a student not only identified Corrigan's pulse, a sign of aortic valve disease, but was able to tell us that Corrigan had described the sign when a medical student himself.

Like Corrigan's pulse, most of these physical signs were named in the last century, when physical examination was virtually the only tool available to the doctor. Many of the great physicians managed to get their name attached to at least one clinical observation or disease. One of the greatest of them all, Jean Marie Charcot, has given his name to at least four signs and one disease. Thus the modern student might be asked about Charcot's joints, Hutchinson's teeth, Moon's molar, Clutton's joints or Argyll-Roberton pupils. Other, more modest, physicians invented memorable terms for certain physical signs — hence we have sabre tibias and seagull murmurs.

But a modern doctor will rarely, if ever, encounter these classics of the literature. All the physical signs just mentioned are characteristic of advanced syphilis. Syphilis is now easily treated and, even when not recognised, the liberal use of antibiotics for other conditions has virtually eradicated advanced disease.

The same is true of rheumatic heart disease, which gave rise to all those complicated heart murmurs that are the staple diet of examinations, but is now rare. Immunisation has virtually eradicated poliomyelitis in the developed world. The classic diseases, and thus the classic signs, are in retreat.

The physical examination itself is also no longer the only skill a doctor needs. Instead, most diagnoses are made on the basis of investigation.

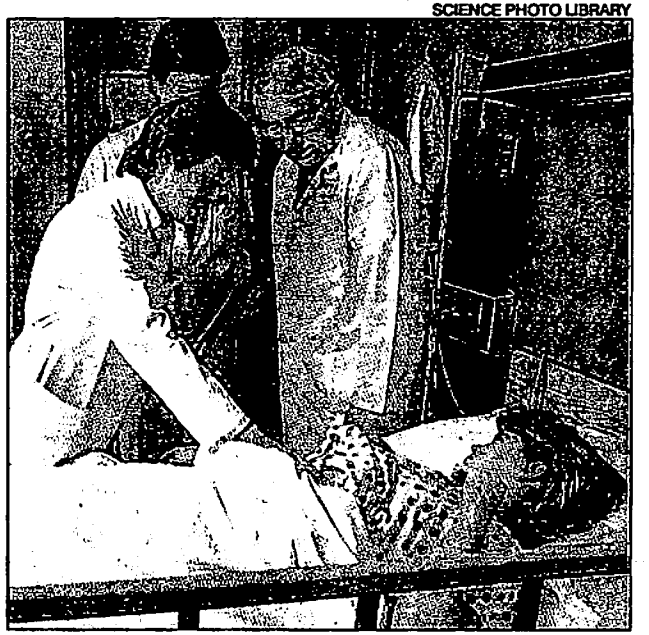
Modern cardiologists would not dream of diagnosing a heart-valve problem without the aid of the ECG, echocardiogram and cardiac catheter. An endocrinologist uses a range of hormone-stimulating tests for pronouncing on any possible endocrine abnormality. New imaging techniques mean that a neurologist can see the intricate structure of the brain, and not rely on his tendon hammer alone. As these and many other tests continue to improve, the relative importance of the physical examination must decline.

With the blessing of the General Medical Council medical schools are now responding to these changes. The examination of the future will include interpreting tests once undreamt of. Testing the student's ability to communicate with, inform and reassure patients will be given greater prominence. Few can doubt that many students leave medical school able to detect a subtle cardiac murmur but lacking the simplest skills in telling a patient what it means.

The consequence will inevitably be the end of the traditional ordeal of the final examinations. I know this is right and proper, but I will regret the day when my old friend with his huge hands fails to make his annual trip.

● *Simon Wessely is Senior Lecturer in Psychological Medicine at King's College School of Medicine*

SCIENCE PHOTO LIBRARY



Diagnosis no longer depends on physical examination