

A Critical Evaluation of

Pages with reference to book, From 221 To 224

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The final professional MBBS examination is a certifying examination i.e. an evaluation whether we have been able to reach our objectives in training students to acquire a certain standard of theoretical knowledge and psycho-motor skills necessary before being licensed to practice medicine and surgery. The importance of the examination therefore is self evident.

This is all the more so, since at the moment no internal assessment record is officially required to guide the examiners, half of whom are "External" to begin with, and even the "Internals" may be seeing the candidates for the first time as they may have been trained in the other units during their clinical years. Therefore the duration of this clinical examination is the ONLY time available to the examiners to evaluate the last 3 years of clinical expertise acquired by candidates. This is an undertaking of tremendous responsibility as it determines the standards of our degree; as well as our instructional strategy.

Current Examination Procedure

The way the examination is conducted at present is that a batch of candidates varying from 20 - 35 per unit attends for a clinical examination each day. The number of units examining are two to four and each unit has one internal and one external examiner. At the beginning of the examination at about 8 A.M. one long case (90 marks) is allotted to each candidate which the candidate begins immediately. As a result of this allotment only 4/5 cases sometimes borrowed from other wards are available to be used as short cases (75 marks each). The examiners begin with either 2 short cases per candidate (75 marks each) or a Table Viva (20 marks each examiner). During Viva X-Ray (15 marks) and instruments (15 marks) are also shown. Sometimes while Vivas are being conducted the short cases are being seen by some candidates while the others are examining their long cases happily unobserved. During this process two slides (10 marks) which have been mounted by the House staff are reported on by the students in turn.

When the Vivas, short cases and the slides are complete the examiners from one unit go to the other unit and examine the students in the other unit on the long cases (90 marks), Urine Examination (10 marks) and prescription writing (10 marks) and examiners from the other side come over to this unit for their long cases.. However, it is not often that this interchange is simultaneous and one set of examiners may finish their examination even a couple of hours or more earlier than the other set!

Of the 3 major sub-divisions of clinical examination namely: the Vivas (whose marks go with the theory), two short cases and one long case, I intend to confine the present discussion to the long case alone. The discussion which follows is equally applicable to medicine and surgery although there is a slight difference in marks of long and short cases.

"The Long Case"

The long case carries 90 marks. This is the maximum for any single item in whole of the examination as each theory paper carries 80 marks and each short case carries 75 marks. Since 120 marks are required in the 3 cases to get through in 'clinical' part of medicine; it follows that if a candidate scores (by whatever means) high marks e.g. 80 in this ONE item alone he CAN get through in the clinical even if he fails in BOTH the short cases by getting e.g. 20 marks in each (The same applies to Surgery). The rest of the practical examination e.g. slides, prescription writing, and urine examination is a total farce and nobody ever fails in this section.

If therefore it is considered that the long case is so important that on its strength alone, a candidate may virtually sail through the clinical examination, then it is imperative that considerable stress is laid on the conduction of examination of the long case.

The real objective of the long case is to see whether the candidate can:

Take a good history of a New patient.

Conduct a thorough physical examination.

Arrive at a reasonable clinical diagnosis.

Order the appropriate investigation.

Synthesize this data into a meaningful whole.

Determine how to treat the patient.

Evaluate Progress.

Unfortunately precisely the reverse takes place:

And all this must be done in a “true-to-life” situation.

The long case is allotted at the beginning of the examination at 8 or 9 a.m. and is the last item to be examined on, and the last long case may be seen at 5 p.m. (or later!). Throughout this period of upto 8 hours (or more) which the candidate spends with his long case (except for brief breaks for viva and short cases), he is totally unobserved and left entirely to his own device which are many and ingenious. The long case is seldom ‘NEW’. He has either been examined by the candidate the night before (and promised its allocation ext morning by the house staff who may be class fellows) or has been communicated all that is necessary in the 8 available hours without any problem since the examiners are busy with vivas or short cases or have already left for examining long cases in the other wards! By the time the last few cases are left later in the afternoon (or evening) neither the tense famished candidate, nor the tired irritable examiner is in any frame of mind for any worthwhile intellectual exercise.

The history which the candidate has taken hours to write (or copy) is seldom read- at best it is casually skimmed over. It is almost never confirmed by the examiner by questioning the patient, although even the “internal” examiner does not know the history as he examines the long case in someone else’s unit to say nothing of the external who may have flown in late on the morning of the examination or has to take an early afternoon flight on the last day.

The physical signs mentioned by the candidate are not confirmed by all examiners. Some never do it, others occasionally confirm these themselves but hardly ever is the candidates method of eliciting the physical signs checked.

The patient has often been hurriedly admitted for “examination purposes” and not been properly investigated so that relevant data e.g. biochemistry, E.C.G., X-Ray etc. are frequently not available for discussion with the candidate. The last and the most important point is that the average time taken to examine a candidate on a long case which as mentioned earlier, could ALONE determine the candidates success in the clinical examination is about 5 mins. The minimum time has been observed to be as short as 2 minutes and this includes questions on urine examination and prescription writing. These figures have been obtained after critical observation of examination of 150 candidates in a university examination.

These precious moments are usually spent in 3 or 4 routine questions like;

What’s your case? or,

What’s your diagnosis?,

Why do you say that?,

Could it be something else?

How would you investigate this case?

A question on urine examination (usually sugar or albumn)

A request to write a prescription, while the examiner has already moved to the next long case.

More often than not this goes on without so much as glance at the patient (as the examiner casually skims over the history note book). As a matter of fact the patient may be in the bathroom or may indeed have been specifically got rid of by the candidate intentionally.

In other words it is virtually a bedside viva, (where the patient’s role is minimal) which carries 110 (90

for the long case and 20 for verbal urine examination and prescription) conducted in as little as 5 minutes (or even 2 minutes) in which in-depth assessment is neither conducted nor possible. All this goes on at the cost of total disruption of the ward work; neglect of patients food and drug-routine, and utter disregard of the discomfort of the unfortunate patient who happens to fall sick near or during the examination season.

It is only logical, therefore, that some other method should be devised by which these serious flaws in the conduction of the long case are rectified.

The student starts writing histories from the beginning of 3rd year and is expected to continue to improve his expertise till he takes the final professional examination. History taking and writing, therefore, should be a part of internal evaluation and the considerable wastage of time and flaws which are inherent in the examination as pointed out above can all be avoided by abolishing the long case. Its place can easily be taken by the introduction of a 3rd short case which may be used essentially to judge the history-taking ability of the candidate (as it is the “taking” and not merely the “writing” of it that is important) whereas the other two short cases as at present are meant to test the psycho-motor skifi in clinical examination. The history taking and clinical examination should both be made objective with check llsts and rating scale. A short relevant discussion of each of the short cases would be appropriate. With the third short case a candidate could finish his final professional medicine examination in, at the present rate of working and methodology, in just half an hour and save every one a lot bother, without any adverse effect on the standard whatsoever.

The biggest advantage of abolishing the long case would be the immediate availability of 20-30 patients giving a wide variety of clinical material, as short cases who would normally be “tied up” as long cases for the whole day. Since there will be the regular ward cases they would be better investigated, and appropriate for a better discussion instead of using the same uninvestigated cases hurriedly admitted for the examination.

The other alternative is to replace the clinical part of the examination with Objective Structured Clinical Examination (OSCE)^{1,2} but this would take sometime to implement as it can only be employed when all teachers of Clinical Subjects and all students are familiar with this method.

References

1. Elahi, F. Objective structural clinical examination (OSCE). NTTC monography No. 1, 1984, CPSP, Karachi.
2. Jafarey, N.A. The final MBBS (Certifying) examination. JPMA., 1984 ; 34: 251.