Surviving a clinical exam: a guide for candidates

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Most of us find clinical examinations stressful—not because they are necessarily difficult but because candidates fear the unpredictability of the cases they may encounter, how the patients will react and how they will perform on the day. Many unsuccessful candidates feel they knew enough to pass but were so nervous that they made simple errors.

The Royal Colleges' clinical exams require you to reach the standard expected of a senior house officer who is ready to adopt the responsibilities of a registrar. This does not mean that you must always achieve the correct diagnosis; there will be some patients with diseases that you have not seen before. You are, though, expected to show that you can behave professionally with courtesy, examine a patient fully, interpret your findings in a logical manner, and discuss the possible subsequent management.

WELL BEFORE THE EXAM

Although the clinical examination may be one of the final assessments for Membership it should be the first that you start preparing for. This means letting your consultants and possibly administrators know that you intend to take Membership exams and would like to examine patients in an examination setting with your seniors and have feedback and tuition. If you do this early, by the time you come to sit the exam it will be second nature and this will show. Examiners can distinguish a candidate who has been examining patients properly for many months from one who has gone around the ward only the week before.

This does not mean that if you do not prepare early you will not pass the clinical exam—there are many last-minute wonders who get away with it—but it is a lot easier and less stressful on the day if you are well prepared. When candidates seem in danger of failing, examiners favour those who behave well with the patients even when there are some defects in their knowledge.

Get organized early. Look up the Colleges' websites to get all the details of exam timetables and format. Book an exam place, commit yourself, adjust your life around the exam; there is rarely a perfect time to sit the exam. A

common reason for failure is lack of commitment. Some Colleges put late-bookers in the final afternoon of the clinical; if you would rather be seen early in the exam book early. Look at the timetables of different Colleges if more than one is relevant—you may wish to enter two College exams so that if you are unsuccessful in your first you will have a second chance. This can be an expensive strategy.

Book onto a revision course and do this early; the best courses have limited places and fill up well in advance. Medical education is a growing business and there are many courses to choose from. It is wise to find out as much as you can about the course before you commit yourself. Find out who the instructors are for the course, how many there are and how many candidates attend, will there be real patients and so on? Ideally the instructors should be consultants who are or have recently been examiners, and the candidate to instructor ratio should be low.

Some of the Colleges run their own internal courses. Choose one that has been strongly recommended to you. If you think you do not need to go on a course you may be right. However, many trusts permit only a brief period of leave for private study but more if you are on a course. If funds are available and you are entitled to the study leave, make sure you use it.

You should consider setting up a revision group. These can have the benefit of shared knowledge, experience, skills and clinical cases: they can have the disadvantage that misinformation and anxiety can rapidly spread through the group. You might consider learning relaxing skills such as breathing exercises; many performers and athletes use simple breathing exercises to calm the nerves and focus the mind.

NEARER TO THE EXAM

Months before the exam you should make sure you have studied the exam syllabus so that there are no surprises on the day. The syllabus can usually be downloaded from the College website. For example, you might not have appreciated that a particular exam such as the Practical Assessment of Clinical Examination Skills (PACES) requires the candidate to have a sound knowledge of legal and ethical issues in medicine. You will feel much more confident if you know what the requirements of the exam will be. If there are vagaries in the College syllabus you should clarify

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these either with your local postgraduate medical director or, failing this, by contacting the College directly.

Knowing the format of the exam is also important. You will want to know whether there are numbered bays relating to distinct anatomical areas or body systems and how many bays there will be, how long you will have in each bay and how that time is divided into examination, presentation and questions. It is also useful to know the marking system to gauge the relative importance of these three aspects. There are numerous non-College websites for the exam, often associated with courses or books, and these can be helpful. Plan to buy books after the round of exams before yours and you will get a bargain.

Look at your training programme and compare it with the exam syllabus. Are there mismatches? There invariably will be and you should do something about them. This usually involves organizing visits to particular clinics—for example, if you are to sit the MRCS examination and you have not had a specific vascular attachment it is important to go along to the vascular outpatient clinics. With modern working time practices it may not be possible for you to attend other clinics in your 'rest' periods. If you need experience outside your own normal clinics, this will require a supportive consultant.

WORKING FOR THE CLINICAL

You cannot learn good techniques of clinical examination only from a book. The skills must be learned from tutors and practised over and over. There are, of course, textbooks on clinical examination and they are very useful as *aides memoirs* and to explain the relevance of the clinical findings, but the candidate who has learned clinical examinations mainly from a book will look awkward and be easy to spot.

You cannot predict all the cases you will come across but you can be fairly confident about most of the examinations you could be asked to perform. You must ensure you can perform smoothly and quickly. You should look as if you have done them many times before, as indeed you should have. Eponymous tests, such as the Trendelenburg, Courvoisier and Chvostek tests are classic question topics. You must also be able to use any equipment you may be given. An ophthalmoscope should not give you palpitations, a hand-held doppler machine should be taken up as an old friend. You should also be familiar with terms such as 'purpura' and 'normochromic normocytic anaemia'; you should be able to explain exactly what these mean as well as their causes.

Think about what comes up commonly; revision books and courses are a good source of this information. Consider the heartsink questions: how do you distinguish between a hydrocele and a hernia, a thyroglossal cyst and a branchial

cyst, a lipoma and an epidermal cyst? How do you measure true and apparent leg length? How do you distinguish between a low and a high median nerve injury in a patient with Dupuytren's contracture? Consider how difficult it is for an organizing surgeon to find patients under the age of 30 years. A man under 30 with an above-knee amputation is much more likely to have had severe trauma than an osteosarcoma.

The purpose of clinical examination is to assess form and function. When revising for the clinical exam think in these terms. For example, do not just learn that a tumour of the pituitary gland may produce bitemporal hemianopia. The examiner will expect you to know why.

THE WEEK BEFORE

By now you should have your clinical skills honed to perfection, or as honed as they are going to be.

You should be practising questions and answers and be comfortable, confident and quick with the common and important definitions, classifications and lists. If possible, get a registrar to grill you in the clinic. For example, for an inguinal hernia you must be able to describe how you differentiate direct from indirect and what the treatment options and complications might be. You should consider questions and answers for all of the commonly encountered clinical entities.

ON THE DAY OF THE EXAM

Resist the temptation to stay up late the night before for last-minute cramming or go to a pub for a couple of drinks to relax. You need a good alcohol-free night's sleep and may want to use relaxation techniques at this stage. The day of the exam is not the time to take your first dose of beta blockers. Try to keep the exam in perspective—good candidates will pass. Last-minute revision is rarely helpful and can make anxiety worse.

Never listen to previous candidates' accounts of the diseases that they were asked about—the patient with the radial nerve injury might be in the bed next to a patient with a median nerve injury; the man with the direct inguinal hernia might have been exchanged for a man with a femoral hernia, for the session after coffee. Your informants might be wrong, or mischievous. Do not rely on parking at the hospital at which the exam is being held; if the exam is in the morning consider staying overnight.

APPEARANCE AND ETIQUETTE

You should dress the way a conservative registrar might dress. For men that usually means a dark suit and tie. Women can be more imaginative but should remember they will have to lean over patients or maybe to kneel on the floor and a plunging neckline may be inappropriate. If

the weather is hot be prepared to take your jacket off and wear a short-sleeved white shirt (blue shows sweat stains).

If you have worked for one of your examiners he will excuse himself and someone else will examine you instead. Shake the examiner's hand if it is offered. You may find you forget the examiner's name as soon as you are introduced as you will have other things on your mind. If the examiner is a man do not worry—call him 'sir'. If the examiner is a woman, look for the name badge or avoid using anything at all; few women nowadays like to be called 'ma'am'. Introduce yourself to the patient as Dr Smith rather than Dave. Assume that the patients know their diagnosis and that you can discuss it fully in their hearing—they will have been told that you are a qualified doctor of some years' standing. Assume that the patients are happy for you to examine them; they have after all agreed to take part in the exam, so do not waste time asking if you can examine them.

Look for clues. If there is a glass of water near the patient, think thyroid; if there is a sheet of paper, think nerve injury and test for muscle power. Do not, however, rely too much on these clues since they may have been left there by a patient from the morning session. If the examiner asks you to examine the abdomen, establish whether he wants you to do the alimentary system (starting with the hands) or to go straight for the belly. If you are uncertain about what the examiner is asking, ask for the question to be repeated or clarified. You may get around the impossible in the spurious conditions of the exam by using words: 'I would transilluminate the scrotum, but at the moment the room is too bright'; 'I would listen for a carotid bruit, which I can do here but would be better done somewhere quiet'. Sometimes you will have difficulties in making a diagnosis, for example in the lumps-and-bumps aspect or short case aspect of the exam, so consider using words. The examiners may be content, and possibly impressed, with a different diagnosis and management plan rather than the correct diagnosis—'I think that this mobile, circumscribed subcutaneous mass is benign and either a neurofibroma or a lipoma; I would excise it under local anaesthesia and the pathology report will tell me precisely what it is' can sound quite good.

If the diagnosis is visibly obvious say what it is early. This gives the examiner a chance to move on, and you score the points quickly: for example, divarication of the recti can be seen from the end of the bed and no further examination is then needed. On the other hand, if you have been told by your chums that there is a patient with Albers-Schönberg disease, it is unwise to leap straight to that diagnosis without taking a history.

Expose the patient adequately, but conversely establish whether a woman is wearing knickers before going for the groin with a doppler. If you forget your stethoscope or

torch or wristwatch do not worry: they will all be available in the bay. At the end of a bay thank the patient but do not overdo it. Take a couple of deep breaths, using your previously learned breathing and relaxation techniques to clear your mind, and go into the next bay with a clean sheet.

Many candidates worry about whether to explain what they are doing as they go along or just do the examination and then present the findings at the end. There is no rule. Unless you are told otherwise on good authority, it is best to do whichever you feel most comfortable with. It is worth remembering, though, how boring it is for the examiner to watch candidates silently examining patients. If you talk as you go along it may help you to assimilate the findings in your mind for later and it lets the examiner know exactly what you are doing. It may also keep the examiner awake.

Between patients it is usual to offer candidates a squirt of an alcohol-based disinfectant but often towels are not provided to dry your hands on. Time is pressing and you need to keep up the pace, so take an old handkerchief with you and throw it away later.

Although there is certainly a theatrical element to a clinical exam, it is an impromptu affair and you should not memorize lines from revision texts. Some texts are presented rather like stage plays with the lines you should memorize for each clinical encounter. This has the advantage that it ensures the candidate always does certain correct things such as introducing himself, but there are thousands of other candidates all reading these books. If you all use the same words, you sound like automata. This does you an injustice—you are a doctor who has examined hundreds of patients; you are more than capable of saying the right thing without learning lines catechismally; you should behave as you would in a real clinical encounter. Examiners are more impressed by a candidate who looks as if he is doing just what he has done many times before than by one who delivers his libretto as if he were at an amateur dramatics audition. Do not learn lines.

Similarly you might need to adapt your usual technique to suit the artificiality of the exam. With a patient with a hernia, if you are used to asking him to 'Look over your left shoulder and give a big cough please' (so that you are not showered with the oral remains of his tea-and-biscuit) it would be best to look up to check that the examiner has not drifted into the line of fire.

AT THE END OF THE CLINICAL

When the bell goes, stop talking and wait to be told to leave. Say 'thank you' and leave quietly and promptly. Do not grimace, weep or look desperate. Do not torture yourself by dwelling on instances of 'Oh dear' or 'Never

mind' that the examiners have said to you. Clear your mind and move on: easy to write, very hard to do.

CONCLUSIONS

Whichever College you wish to join you must prepare early and fully commit yourself. If you fail you can use the experience to raise your chances of success at the next attempt. Find out why you were unsuccessful; most

Colleges will give you details of your marks, help you to find your weak areas and offer helpful advice. The examinations are not easy but anyone who has passed medical finals and makes the effort will pass Membership exams.

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