How to do it

Take a clinical examination

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So you are taking a clinical examination and are looking for some help to get over this hurdle—regarded by some as a half-hour disaster session, and commonly painted in garish retrospective colours by those who have already tried to jump it. The first thing to do is to ignore the account of the man who said he failed because he missed the diagnosis of pseudopseudohypoparathyroidism in the short cases; it is more likely that he was unable to locate an obviously displaced trachea or found himself at a loss when invited to palpate for enlarged cervical lymph nodes. Clinical examinations are for testing your command of clinical skills, for finding out whether you can *do* things rather than simply remember, talk, and write about them. Don't expect to get by on bookwork; reciting 57 causes of haemolytic anaemia will not excuse your failure to feel an easily palpable spleen.

A live dimension

You will already have had some experience of showing what you can do with a dogfish, a cockroach, or a dead bacterium, but a clinical examination introduces a new dimension, in that you are dealing with a live animal—one of your own species, and one which is quite capable of bringing some personal bias into your encounter. Fear of the unknown patient probably upsets some students as much as fear of the unknown examiner; this anxiety is accentuated by knowing that you will be spending some time alone with a patient, whereas you might normally talk to a *pair* of examiners, one discussing a problem with you, the other listening, which improves your chances of a fair appraisal.

Clearly the first step you must take is to ensure that you get lots of practice in talking to patients and in examining them physically; the more abnormal physical signs you have met before, and the wider the range of personalities you have had to contend with, the better. The latter is particularly important when it comes to taking a history, including a psychiatric history for which you may need special training.

You must be absolutely confident about your ability to search for the apex beat of the heart, and have a clear plan in your mind as to what you are going to do when you can't find it—percuss the precordium, for instance, remembering that emphysema is commoner than dextrocardia. Be sure that you are comfortable with a knee hammer in your hand and that you appreciate that a niggling hen-pecking approach to the patellar tendon may be as unlikely to provide a reflex as a smart blow on the anterior tubercle of the tibia. And have some idea how an ophthalmoscope works. An earlier candidate, taking the view that the

examination is competitive, may have left it for you with a +20 dioptre lens in position and this will unsight you unless you know how to deal with it; remember that as soon as you lift your head you're going to be asked to describe what you saw, so check the instrument before you start—or carry your own. Though doctors are arrogant in the way they hope to evaluate the retina in ordinary ward daylight, your examiners will have arranged for a pupil to be dilated if there is likely to be any difficulty (you'd better ask the patient whether he has had drops in his eye—he may have Adie's syndrome).

Don't be too hidebound by your training in a rigid framework of inquiry. Use an auriscope if you suspect the possibility of a cerebral abscess; examine the spine of a patient complaining of backache (this is sometimes overlooked), and the head of a patient with headache (rarely undertaken but capable of yielding impressive dividends in the shape of temporal arteritis or osteitis deformans).

It is more difficult to check on adequate history taking than on physical signs, but examiners recognise the overriding importance of taking a history in clinical practice and you will find that the assessment of this special skill will not be overlooked. Some people may advise you to ask the patient three questions: "What's the matter with you?" "What treatment are you having?" And, "What questions are the doctors asking about you?" That such an approach continues to be rewarding is due only to the fact that the examiner is not likely to be with you while you are taking a history (though he will watch you collecting your physical signs). Most examiners are aware of this problem and you will probably do better to take a history in the same way as you would if you were in the outpatient clinic rather than sitting an examination; this will at least protect you from such wrong-footing as has occurred when the patient's answer to the first question was "psittacosis," interpreted as "silicosis."

Giving the right impression

As to dress and comportment, "neat but not gaudy" should be your watchword. It is at the clinical bedside test that examiners will try to decide what kind of a person you are and their judgment will have some influence on your final score. Don't be too upset by this random approach, which is already showing signs of being better organised in some parts of the world; in the mean time there are a number of points to which you can usefully pay some attention.

Wear whatever makes you feel comfortable—some people look excruciatingly uptight in an unaccustomed waistcoat. But don't appear more bedraggled than you can help and be sure that your hands and nails are clean; they will shortly be in contact with another human being who may well be spruced up for the occasion, and it is the least you can do. Give your patient identity; call her "Mrs Robinson" when you are asking her to take off her bra, not "granny," which she may not consider appropriate, nor "my dear," which may well be thought presumptuous on so short an acquaintance. It may be difficult

for you, but try to relax; examiners get put out by signs of tension (sweating, overbreathing, and tremor all distract them from their job), and, although you may not find it easy to believe, they really welcome an opportunity for a quiet and uninhibited discussion with you.

If you're a man, you will have to give some thought to what tie you are going to wear; it should depend on how you feel when you get up on The Day—a bow, a recognisable club, or something anonymous—whatever is comfortable—but tuck it in if it is long, as it may exhaust the abdominal reflexes while you are auscultating the left chest. You also have to decide what to do with your hands, which are better out of your pockets.

If you're a woman, you have different problems; heavy rings may be uncomfortable for your patient when you palpate for axillary lymph nodes, long hair may flop over the anterior chest wall, swinging earrings get in the way. Your examiner may be an experienced man who is able to pick up a prophetic whiff of "Je Reviens," so watch your scent. It is better not to be obviously

pregnant. Though everyone accepts its increasing prevalence in medical students, the effect of pregnancy on examiners is unpredictable, ranging from avuncular concern to uncertainty whether you have got your priorities right.

It is no longer so urgent as it used to be to discover the identity of your examiner. Pairs protect, and prophylactic action is taken by examining boards to avoid lethal combinations of examining genes. You will, of course, meet hawks and doves and the occasional peacock, woodpecker, cuckoo, or owl, but don't let this worry you: it will enlarge your experience and you may rest assured that, whatever their avian characteristics, the vast majority of them are trying to find out what you *do* know, not what you don't, recognising that an examination is no more than a milestone in a continuum of medical education.

Let me wish you good luck—you will still need a little bit of this.

Eventually this series will be collected into a book and hence no reprints will be available from the authors.

Aspects of Australian Medicine

Restrictions on NHS prescribing in Australia

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British doctors feeling themselves suffocated by NHS bureaucracy sometimes look to Australia as a country where medicine may be practised in freedom. In most regards this is true, and Australian doctors are certainly better rewarded financially than their British counterparts in all branches of the profession.

Yet in one way Australian doctors accept restrictions on their clinical freedom that would be regarded as quite unacceptable if proposed by the British Departments of Health: under the pharmaceutical benefits scheme, which subsidises almost all drugs prescribed outside hospital, not only is the range of drugs available restricted but there are also controls over the dose, the duration of treatment, and in many cases the clinical indications for which they may be prescribed.

Medical care in Australia

Most general practitioners and hospital consultants in Australia work on a fee-for-service basis, and their patients are required by law to take out medical insurance either through the government-operated Medibank scheme or through one of the non-profit insurance companies. The major hospitals, teaching and non-teaching, are operated by the state governments, and again the charges they make to patients are reimbursed by the insurance schemes. The cost of drugs supplied in hospitals is shared between the state governments (which run the hospitals) and the Federal Government, which controls the import and licensing of drugs.

As in Britain, when a general practitioner prescribes for his patients, the prescription is dispensed by a retail pharmacist. If the drug is on the list of "pharmaceutical benefits" approved by the Federal Government then the patient has to pay only a fixed charge of \$2.50 (about £1.40). Pensioners are exempt. If, however, the drug is not a listed pharmaceutical benefit then the patient has to pay whatever the pharmacist charges, and in practice in addition to the cost of the drug most pharmacists charge a dispensing fee close to double the rate paid under the pharmaceutical benefit (also known as the NHS) scheme.

When the scheme was first introduced in the early 1950s the intention was for there to be a list of life-saving and essential drugs provided by the State and for patients to pay for all their other drugs. In practice, however, the first very restricted list of 90 drugs proved unsatisfactory; for when they wanted to save patients money doctors were soon tempted to use the "essential" drugs for unsuitable indications. The list was, therefore, expanded to provide a fuller range of drugs, and about half of the preparations on the ethical market in Australia are now listed. With the expansion of the list, there are now very few non-listed drugs that are prescribed in large quantities; and the selected drugs that appear on the pharmaceutical benefits list account for 90% of all prescription medicines dispensed.

Restrictions on prescribing

The primary aim of the pharmaceutical benefits scheme was to keep down costs, and as the list of drugs available has been expanded the restraints on their use have been maintained and strengthened. Some products may be prescribed freely, but others are restricted to specified conditions. A few drugs are available only with the written authority of the Director General of Health. Finally, a few preparations such as influenza vaccine are available as pharmaceutical benefits only to pensioners.

Doctors in Australia are supplied free with a blue booklet