

## Authors' reply

We thank Dr Fustes and Dr Rodriguez for their valuable comments on our paper.<sup>1</sup> We read with interest the case history they share, providing support for our findings. As they point out, isolated oculomotor nerve palsy is an aetiologically diverse condition, partly related to its neuroanatomical pathway originating in the midbrain and ending in the extraocular muscles. Damage at any point in the nerve's course, divided broadly into the regions of brainstem nucleus, fascicles, subarachnoid space, cavernous sinus and orbital apex,<sup>2</sup> for any number of different reasons can lead to clinical manifestations.

Our intention when writing this paper was to draw attention to a rare complication of a very common and easily treatable condition; an unusual occurrence in neurological practice. Given the patient's presenting features of sinusitis, the focus of our search and the consequent discussion of the paper understandably revolved around the anatomical location of the cavernous sinus, with the additional motivation of ruling out a serious alternative serendipitous diagnosis, such as an intracranial aneurysm. Neuroimaging proved very helpful on both accounts on this occasion, but it cannot be relied upon to elucidate every possible cause. Overdependence on any diagnostic modality can be perilous in medicine, especially given the known inter-rater variation<sup>3</sup> and importance of expertise in neuroimaging reporting,<sup>4</sup> often not available in every centre. Detailed knowledge of the neuroanatomy remains key to consider causes not identified through neuroimaging studies. Our broad, systematic approach was rewarded for example when cerebrospinal fluid studies were unremarkable, making another serious but treatable diagnosis, meningitis, very unlikely.

The guiding principles of two historical Williams, Occam and Osler, can provide an important take-home message from this case. William of Ockham, a thirteenth-century philosopher and theologian introduced the methodological principle of Occam's Razor; that a single, often simple explanation is the most likely. Dr William Osler meanwhile, a pioneer of bedside clinical training, is credited with stating: 'Just listen to your patient, he is telling you the diagnosis.'<sup>5</sup> Much as new technologies will help push the boundaries of what is possible, traditional neurological approaches of accurate history, examination and understanding of anatomical pathways will continue to remain relevant to all clinicians for many years to come.

**Stephanie Jade Larcombe<sup>1</sup>, Duncan Street<sup>2</sup>, Benjamin Wright<sup>2</sup>**

<sup>1</sup>College of Medical and Dental Sciences, University of Birmingham, Birmingham, United Kingdom

<sup>2</sup>Department of Neurology, University Hospitals Birmingham NHS Foundation Trust, Birmingham, United Kingdom

**Email:** stephanielarcombe@gmail.com

**doi:** 10.4997/JRCPE.2021.426

## References

- 1 Larcombe SJ, Street D, Wright B. Isolated oculomotor nerve palsy secondary to acute sinusitis. *J R Coll Physicians Edinb* 2021; 51: 143–145. doi: 10.4997/JRCPE.2021.209.
- 2 Bruce BB, Biousse V, Newman NJ. Third nerve palsies. *Semin Neurol* 2007 Jul; 27: 257–68. doi: 10.1055/s-2007-979681.
- 3 Wardlaw JM, Mielke O. Early signs of brain infarction at CT: observer reliability and outcome after thrombolytic treatment – systematic review. *Radiology* 2005 May; 235: 444–53. doi: 10.1148/radiol.2352040262.
- 4 McCarron M, Wade C, Flynn P et al. The value of neuroimaging team meetings for patients in a district general hospital. *Clin Med (Lond)* 2018; 18: 206–211. doi:10.7861/clinmedicine.18-3-206.
- 5 Osler W, Silverman M, Murray T et al. *The Quotable Osler*. Philadelphia: American College of Physicians; 2008.

## The birth of British geriatric medicine: further information on Scotland

I enjoyed Ritch's paper on the birth of geriatric medicine,<sup>1</sup> which notes that Sir Ferguson Anderson was an early pioneer in Scotland, appointed in 1952 as a consultant physician in diseases of old age in Glasgow. Readers may be interested in further information on the birth of Scottish geriatric medicine.

Ghosh and Ghosh, in their 'History of geriatric medicine in Scotland',<sup>2</sup> note that the genesis of Scottish geriatric medicine was the lecture on old age, entitled 'De Senectute' given to the Royal Medico-Chirurgical Society of Glasgow in 1941 by Professor of Materia Medica Noah Morris, Stobhill Hospital, Glasgow. In 1947, Morris sent his young colleague Dr Oswald Taylor Brown to visit Dr Marjory Warren at the West Middlesex Hospital, and to learn from her pioneering work in geriatric medicine. Brown was appointed in 1948 as assistant physician with a special interest in the care of the elderly at the Southern General Hospital, Glasgow; and became the first consultant in geriatric medicine (and senior lecturer in the University Department of Medicine) in Scotland in September 1951, in Dundee; the year before Anderson (who also trained with Morris) was appointed as consultant geriatrician in Glasgow. In 1961 Brown proposed the formation of the Scottish Branch of the British Geriatric Society; and in 1969 was appointed OBE for his work as architect of Scotland's geriatric services.<sup>2</sup>

Subsequent to these appointments in Dundee and Glasgow, further consultants in geriatric medicine were Ronald Simpson, Perth in 1954; Leslie Wilson, Aberdeen in 1955; Robert Rankine, Kirkcaldy in 1956; and James Williamson, Edinburgh in 1958. In 1961, the President of the Royal College of Physicians (Edinburgh) appointed a committee 'to consider the arrangements and facilities for the care of the elderly in Scotland and make recommendations'. Williamson was the main architect of the report, whose recommendations included academic development: which led to Anderson's appointment to the first Chair of Geriatrics in the developed world at Glasgow; and to Williamson's appointment as the second Professor of Geriatrics in Scotland at Edinburgh.<sup>2</sup>

**Gordon Lowe**

Emeritus Professor, University of Glasgow

**Email:** Gordon.Lowe@glasgow.ac.uk

**doi:** 10.4997/JRCPE.2021.427

## References

- 1 Ritch A. The birth of British geriatric medicine and its struggle for survival as a medical specialty. *J R Coll Physicians Edinb* 2021; 51: 184–91.
- 2 Ghosh UK, Ghosh K. The history of geriatric medicine in Scotland. *Scott Med J* 1997; 42: 158–59.

## Comments on ‘Seven reasons why the physical examination remains important’

We read with interest the article by Garibaldi and Elder describing the importance of physical examinations (PE) when treating patients.<sup>1</sup> As final-year medical students at King’s College London, this article was of particular interest as we were able to reflect on many of the points raised from personal experiences, having gone from being taught PE skills since our second year to completing our fourth year objective structured clinical examinations (OSCEs) without being tested on any PE. Under the current COVID-19 restrictions, it was understandable why real patients who may be at risk were not invited as subjects, but healthy actors used instead. However, the lack of any actual PE for a cohort of final year students is an important point to be discussed.

As articulated by Garibaldi and Elder, the COVID-19 pandemic has challenged the logistics of bedside teaching. The use of personal protective equipment protects people from transmission of the virus; however, it hinders trainees from receiving adequate bedside teaching. Being restricted from percussing, auscultating and palpating has resulted in students not only deskilling, but also compensating by relying more on history and investigation results, thus forgetting the fundamental basic structures taught throughout their medical degree.

Although our reflections agreed with this article, we felt that the authors could have explored the limitations of PE such as subjectiveness of PE and why it may be deemed that ‘the stethoscope is worthless’. Although the importance of standardisation of PE<sup>2</sup> has been reiterated throughout medical training, it is near impossible to standardise PE presentations to that of investigations, thus leading to what the authors label as ‘over-investigation’.

As with many other industries, technological advances can be utilised to improve PE skills in clinical settings. As students there have been numerous times when we have been turned away by patients, for example in an intimate examination or for cultural reasons.<sup>3</sup> For these situations, mannequin simulations or augmented and virtual reality (AR/VR) devices can provide alternatives to practice and hone trainees’ PE skills. A study by Barteit et al. provides evidence for the effectiveness of using AR/VR devices in medical education; it also ‘demonstrated greater enthusiasm and enjoyment in learning’ by healthcare professionals.<sup>4</sup> The use of mannequin simulations to mimic critical care scenarios is another example in which trainees would benefit more from studying their assessment and PE skills in a safer environment, thus becoming more competent.<sup>5,6</sup>

To conclude, the use of PE as part of a physician’s assessment of a patient is a fundamental aspect, alongside history and investigations, and the points raised by Garibaldi and Elder in this article provide strong evidence for this. However, as final-year medical students who have experienced times when we have been limited in having the ability to perform them and reduced teaching, we believe it is important to look forward to technological and more standardised solutions. The increased use of mannequin simulations or AR/VR can overcome a lot of issues faced by bedside teaching and improve trainee satisfaction.

### Karusan Srithar, Simeon Harrow, Aauran Nadarajasundaram, Albert Mensah

Final-year medical students, King’s College London, UK

**Email:** karusan.srithar@kcl.ac.uk

**doi:** 10.4997/JRCPE.2021.428

## References

- 1 Garibaldi B, Elder A. Seven reasons why the physical examination remains important. *J R Coll Physicians Edinb* 2021; 51: 211–214.
- 2 Lee P, Koo S, Panter S. The value of physical examination in the era of telemedicine. *J R Coll Physicians Edinb* 2021; 51: 85–90.
- 3 Attum B, Hafiz S, Malik A et al. Cultural competence in the care of Muslim patients and their families. *StatPearls* [online] 2021. Treasure Island (FL). <https://pubmed.ncbi.nlm.nih.gov/29763108/> (accessed 15/08/2021).
- 4 Barteit S, Lanfermann L, Bärnighausen T et al. Augmented, mixed, and virtual reality-based head-mounted devices for medical education: systematic review. *JMIR Serious Games* 2021; 9: e29080.
- 5 Oman S, Magdi Y, Simon L. Past present and future of simulation in internal medicine. *StatPearls* [online] 2021. Treasure Island (FL). <https://pubmed.ncbi.nlm.nih.gov/31751073/> (accessed 15/07/2021).
- 6 Pacheco Granda F, Salik I. Simulation training and skill assessment in critical care. *StatPearls* [online] 2021. Treasure Island (FL). <https://pubmed.ncbi.nlm.nih.gov/31751085/> (accessed 15/08/2021).

## Enhancements to Simulation via Instant Messaging – Birmingham Advance (SIMBA): addressing clinical communication

We read with great interest the recent article by Morgan et al.<sup>1</sup> which aimed to explore SIMBA as a mode of delivering medical education during the COVID-19 pandemic. We commend the authors for devising a heuristic teaching method that was engaging, relevant to clinical care and utilised familiar and widely available platforms. Moreover, developing skills through interventions such as SIMBA will enable medical students to become proficient in the virtual consultations that have become the new norm given ongoing restrictions due to the pandemic. While SIMBA is an innovative approach, we noticed that it presents limited scope to hone communication skills. This was particularly evident in the study’s notably lower improvement in communication skills compared with other domains. As medical students, we propose minor modifications to SIMBA that could address the gap in improving communication skills.

Although instant messaging is practical and efficient, we believe that it leaves little room for the development of the