Learning Medicine

Interviews and offers

PETER RICHARDS

Opinion differs widely and deeply on the value and fairness of an interview as part of the process for selecting medical students. Two thirds of medical schools interview the strongest applicants and use the interview to decide among them; the remainder interview only a small number of applicants, such as mature students, in an attempt to assess more fully their motivation and circumstances. Applicants who object to interviews, who doubt their ability to speak up for themselves, or who think that in speaking up they may prejudice their chances of admission can confine their applications to schools which normally do not interview (see table).

Interviewing policies of United Kingdom medical schools. Schools interview either normally (shown by a tick) or only occasionally

Interviews		Interviews	
Birmingham	✓	University College	✓
Bristol	✓	United Schools of Guy's	
Cambridge	✓	and St Thomas's	✓
Leeds	Occasionally	Manchester	Occasionally
Leicester		Newcastle	Occasionally
Liverpool	✓	Nottingham	✓
London:		Oxford	✓
Charing Cross and		Sheffield	✓
Westminster	✓	Southampton	Occasionally
King's	✓	Belfast	Occasionally
The London	✓	Aberdeen	Occasionally
Middlesex	✓	Dundee	Occasionally
Royal Free	✓	Edinburgh	Occasionally
St Bartholomew's	✓	Glasgow	Occasionally
St George's	✓	St Andrews	Occasionally
St Mary's	✓	Welsh National	✓

If medicine were merely another university degree course selection would present fewer problems. As it is, learning medicine is a preparation for a professional career, a career which demands more than academic ability. So great are the uncertainties about who is most suitable for the task that some would argue for admission by a lottery governed by chance alone.

The purpose of an interview in my view is to explore whether individuals can reason, not merely regurgitate knowledge; have made their own decisions rather than gravitating into a mould determined by parents or environment; and have some idea of the course and profession to which they aspire. The interview also provides an opportunity to visit a school, to meet staff and students, and to ask questions. Some schools achieve these ends by holding an open day. It is remarkably short sighted of an applicant not to know as much about the school and its course as can be learnt from the prospectus, but surprisingly, some do not take the trouble to find out.

Weighing academic and other factors

The essence of arguments about interviews as a means of selection is whether or not the objective but possibly chancy, small, and, for the future, arbitrary difference of one grade should be given more weight than the subjective impression of personality and commitment. In this matter, as in so many others, there is no absolute truth. Fortunately admission policies differ, and candidates can choose the schools which adopt the approach they prefer.

The time and trouble involved in interviews is in my view justified by several considerations, especially by the opportunity these provide for applicants to speak for themselves. Interviews not only provide a method of choosing between a large number of people who seem equal on paper but also give a chance to those with less on paper because of special circumstances. Some of the latter make such a good impression at interview that they win an offer which would not have been forthcoming on their academic record alone. The challenge for the school is to call as many of these people to interview as possible but they are hard to identify. By the same token a few who are brilliant on paper seem so lacking in either humanity, motivation, or personality that they lose at interview an offer which would otherwise have seemed a foregone conclusion. Most of those rejected after interview are not, however, rejected as unsuitable but as having, in our opinion, a less pressing claim in open competition; some are rejected because they have already received an offer from a school higher in their list of preferences.

The case to be made for giving weight to non-academic factors is strong indeed, and the system probably fails to accommodate satisfactorily to these factors. The slender case for deciding entry only on grades is illustrated by a Schools Council Report which found that

The distinction between the lower boundary of grade B and the upper boundary of grade D, although crucial for many candidates aspiring to enter higher education, can hardly be described as significant in terms of attainments represented by those boundaries.

But this fact must be considered against the background that the great majority of candidates entering medicine handsomely surpass minimum academic requirements and are at the same time people of wide accomplishment and good potential. The problem is not that many unsuitable people are admitted to read medicine but that many who are well suited can not be admitted.

Interviewers are chosen both from teachers of the sciences basic to medicine (who may or may not be medically qualified themselves) and from practising doctors who teach clinical medicine, either as whole time academics or as consultants who are part time teachers. Some schools assemble a large group to interview each candidate; we prefer a small, more informal group.

Members of interviewing panels serve as individuals, not as representatives of particular specialties. They know that medicine offers wide career opportunities; that most doctors will end up looking after patients but that not all do; that more will work outside hospitals than inside; that both the training and

the job itself are demanding physically and emotionally. They also know that whatever the final occupation of a doctor his training involves the need to make decisions (often on incomplete evidence) and to communicate with patients while at the same time attaining and maintaining moderately exacting academic standards. The aim is not to pick men and women for specific tasks but to train wise, bright, humane, multipotential individuals who will find a niche in medicine.

Offers

After each interview our panel members individually grade the candidate as A (make an offer), B1 (make an offer if the competition and number of places left allow, otherwise put on waiting list), B2 (waiting list, to be reconsidered after the A level results) and C (reject). The panel then agrees its overall decision and the chairman explains and if necessary amplifies each decision to the dean within 24 hours of the interview. On the rare occasions that the panel is unable to agree the decision is left to the dean.

An offer made to an applicant who has already achieved the minimum academic requirement is unconditional. All candidates who have already attained the minimum grades required

at first attempt cannot automatically receive a place because far more applicants reach this standard than the school can take. We make offers on all round merit and potential as best we can assess them on all the evidence. If the A level examinations have yet to be taken an offer is conditional on the applicant obtaining these grades at the first attempt. We occasionally set a higher target to an applicant who seems in need of an incentive to work, but he or she would be accepted with the minimum. Sometimes a lower than normal minimum target is set either to take the pressure off candidates working under unfavourable circumstances or to attract an outstanding applicant.

Some medical schools take the highest grades as the final arbiter of admission. Others use grades primarily to ensure sufficient academic ability, although most entrants to these schools achieve substantially higher grades than the minimum requirements. In 1980 less than 1% of students were accepted to read medicine in the United Kingdom with A level grades below an average of CCC. The mean A level score was ABB. Most schools require higher grades if candidates retake A levels—for example, they may require an A in chemistry and two B grades instead of a B in chemistry and two C grades if a further year of study is undertaken. When examinations are repeated within only a few months the target is likely to be intermediate between the original requirement and that for a year later.

Medicine and the Media

A FEW YEARS ago I noticed that in some of my patients cancer seemed to have been precipitated by personal tragedy such as divorce, death of a spouse, or even unemployment. Linking this to the increase in deaths from cancer seen after the Bristol floods and some prewar Pavlovian studies which suggested that the nervous system might influence the immune response, I postulated that a patient's attitude of mind could influence the progression of his cancer.

Since this was the theme of two television programmes with the general title *Mind over Cancer* I was prejudiced to give them a fair hearing. The first, "Search for a Link" (BBC1, 2 August), dealt with the scientific evidence in favour of such a link: firstly, psychiatric opinion that there is a "cancer personality." The components were: a poor relationship with strict parents, early bereavement, morbid responses in ink blot tests, suppression of strong feelings, self denial, religiosity, and recent psychological trauma. The message seemed to be that nice people get cancer. The second type of scientific evidence was immunological. It was based on the concept of immune surveillance—the idea that we are constantly generating small cancers which normal immune systems detect and wipe out. A lot of experiments were described whereby doing unpleasant things to rats affected their lymphocytes. Similarly, studies on the immune systems of people who had undergone psychological trauma were described. I choose my words carefully because although we had good descriptions of methods and much discussion, there were few results.

A television programme is not a scientific paper, and you cannot expect to be able to analyse the data critically. In this case, however, I believe that the trappings of science were used to give a spurious respectability to highly contentious theories. The psychiatric data are soft (akin to the finding that blood donors score low on the Machiavellian IV scale), and the immunological data are lacking. In any case, immunological surveillance is a theory that has probably had its day and is barely respectable among immuno-oncologists.

The second programme, "The Patient's Dilemma" (BBC1, 9 August) looked at the possibilities from the patient's point of view. Is there some way that through thought the patient can influence his (or more often her) cancer? We had suggestions that getting angry with the disease, or getting at peace with your body through meditation, or even visualising your cancer being eaten by great white sharks in your blood might do the trick. Unfortunately, as we learnt after the show, each method has its failures. Interestingly, the types of cancer that the programme dealt with—breast cancer, melanoma, Hodgkin's Disease, and myeloma—were types that are known occasionally to remit spontaneously. I was also struck by the fact that the patients were mostly women. One group told of a young man who had joined them but "couldn't take it."

I still don't know whether the mind has an effect on cancer. I still suspect so, but these programmes did nothing to convince me. What the programmes did do for me was to reinforce the conviction that the patient with cancer wants to be involved in his treatment, needs to understand what is going on, and deserves a sympathetic and supportive doctor. If he doesn't get one he is liable to cross the line to quackery—a line that these programmes tried to stay the right side of and didn't entirely succeed.—TERRY HAMBLIN, consultant haematologist, Bournemouth.

Is there any inconsistency in using calcium antagonists for angina and—in the same patient—using calcium supplements to correct a negative calcium balance and to treat osteoporosis?

The term "calcium channel blockers" may be more appropriate than "calcium antagonists" for those compounds that are used principally for the treatment of angina and hypertension. They interfere with at least one of the mechanisms for transporting calcium ions across the membranes of excitable muscle cells within the cardiovascular system. It is unlikely that any of them will influence overall calcium balance or bone metabolism.—D A CHAMBERLAIN, consultant cardiologist, Brighton.