Commentary: Oral exams—get them right or don't bother

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We all recognise the importance of good communication, and in medical education we invest much effort in teaching students how to maximise their communication skills. The objective is always to talk and listen in ways that minimise the potential for misunderstanding. Roberts and colleagues provide a fascinating study of doctors talking to each other in an examination setting. Although this is a relatively small study, the methodologically exacting paper offers an example of the everyday practice of medical examinations writ large.

The importance of the study is twofold. Firstly, it shows the value of discourse analysis in understanding how human interactions go wrong, leading to the entirely unintended potential for discrimination. In the context of oral examinations, the interpretation of answers through the culture and language of institutional discourse can lead to misunderstandings by examiners and candidates. This misinterpretation adversely affects some groups of candidates and can lead to indirect discrimination. Although ethnicity was used as an example in this study, the findings could equally apply to candidates from working class backgrounds and, in some instances, to female candidates.

Secondly, and equally importantly, the paper raises some fundamental questions about the use of the oral examination as an assessment tool. Examiners need to be aware of the ways in which the complex interactions involved in oral exams can affect the performance of candidates. Such awareness can only be achieved through improving the training of examiners.

The board of examiners of the Royal College of General Practitioners should be congratulated on

sponsoring the study. But what of the other royal colleges that use oral examinations in their assessment procedures and whose examination candidates include many who have been trained overseas? Are these candidates getting rough justice? Only the Royal College of General Practitioners has carried out and published a systematic analysis of the failure rate of ethnic minority candidates and then sought to understand why some groups are disadvantaged.¹ If the royal colleges are hoping to use their qualifications as a minimum requirement for embarking on consultant training, they need to satisfy candidates that the process is fair and the criteria used for assessment are as explicit as possible.² Medical schools using oral examinations as an important part of the assessment process need to ensure that the examiners are adequately trained. It is only a matter of time before these issues are tested in the courts. Forthcoming legislation will make it possible for candidates and students to force such changes on professional bodies and higher education institutions. Students have an expectation that when they are assessed, cultural differences between examined and examiner will not determine a pass or fail. In the litigious culture of the United States, the final medical examinations do not include oral exams precisely because of the potential for these problems. The lessons for the United Kingdom must be—get it right or don't do it at all.

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1 Wakeford R, Farooqi A, Rashid A, Southgate L. Does the MRCPG discriminate against Asian doctors? *BMJ* 1992;305:92-4.

2 Wakeford R, Southgate L, Wass V. Improving oral examinations: selecting, training, and monitoring examiners for the MRCPG. *BMJ* 1995;311:931-5.

A memorable event

New doctors

It was set to be a wasted day. The postgraduate dean's office had decided that all house officer appointments in the region should be made using a regional matching plan. We had been given a list of possible candidates to interview and the date. I had to cancel my planned sessions for the whole day.

Our interviewees had all just started their final year of training. Some had been interviewed already for house officer posts elsewhere, but others had probably not had an interview since applying for medical school. They were refreshingly honest in answering questions. They were telling us what they thought of what they were learning at the moment and what they were gaining from their training. They told us what they felt, rather than a politically correct version more applicable to a job interview. They were all bright and enthusiastic about the prospect of being a doctor this time next year. They all wanted to come to a busy district general hospital, which is why they were applying to us, and they all wanted to work hard and gain a lot of experience. There was no cynicism about the NHS, and no real worries about the future—apart from a few examinations. Few had any real idea what they wanted after house jobs; that was the only target in sight at present.

These students had recently returned from electives. They all had fascinating stories to tell about their experiences. Between

them they had helped orphans in South America, backpacked around Sri Lanka, visited Indian hospitals, explored the borders of Pakistan, gone through jungles, and visited centres in north America and Australia. We learnt about the priorities between getting in the harvest or losing the sight of an eye in the Third World. It was a good day. I was buoyed up by the enthusiasm of these young people who wanted to come and work with us. There was not a single candidate that we would have even considered rejecting. I had been fascinated by their amazing experiences. What goes wrong later? Why are we losing this enthusiasm once they achieve their first goals? Not only did I enjoy the day, but I realised that it is partially up to us to try and keep the fires of enthusiasm burning. I am already looking forward to next year's interviews.

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We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to.