Expecting help from outside, baby's at fault not herself or her marital situation: baby difficult at night, can't cope, something to settle him.
Protecting environment which is shaky with signs of outward normality: attempting to get pregnant though unstable domestic situation; question large four-bedroomed detached house.
Trying to keep husband in shaky domestic situation: getting pregnant.
'We're all right—we're a normal couple with nothing wrong': Jenny's denial of husband's sexual problems, which he admits.
Blocking out previous psychological/physical trauma and associated upsets: 'don't tell anyone about my previous terminations'.
Ignoring situation: virtually all consultations were with Jenny although both partners were obviously having problems.
Easy option: husband going off with other woman instead of trying to resolve marital problems.

Figure 1. *continued*

V: Oral examination

THE main advantages of oral examinations is their flexibility and the fact that examiners can explore the range and depth of the candidate's thinking and, in the medical context, his decision-making in clinical and practice management situations. The main disadvantages of oral examinations are their logistics. Orals should therefore be restricted to assessment in those areas which cannot effectively be examined by other more economical means.

In the MRCGP examination, candidates who achieve a minimum level in the written papers are called for two 30-minute oral examinations, each of which is conducted jointly by two examiners. The basis of the first oral is the candidate's log diary in which he provides details of his practice, his workload and 50 patients. During this oral some of the time is spent in exploring the candidate's knowledge and attitudes in the areas of colleague and staff relationships, practice management, reading and research; and the remainder in his decision-making in the management of his own patients. A list of topics covered in the first oral is passed by the candidate to the examiners conducting the second. During this examination any subject relevant to general practice may be explored and, as in the first of the orals, a considerable proportion of the time will be spent in assessing the candidate's reaction to clinical problems in the setting of general practice.

Throughout each oral examination the examiners independently record marks for each topic covered and at the end of the examination make independent overall assessments of the candidate. They discuss any differences and produce a consensus mark. When the marks for each oral are available, the candidate's final mark in the entire examination is calculated. Candidates whose marks are near the borderline are discussed by the four examiners, who will have then been provided with the candidate's marks in the written papers. At this point they may modify the oral marks if necessary, justifying their decision in the examiners' meeting which takes place at the end of the day.

Validity and reliability

Set in the context of the experience of the examiners, all of whom are in active clinical general practice, the oral is seen as a particularly valid technique. Because of the large number of examiners, a number of methods have had to be developed and adopted in an attempt to ensure reliability. For every three, three-hour examining sessions, each examiner must spend one session observing orals conducted by his colleagues, during which he must award marks as though he were an examiner. At approximately every third examination each examiner is videotaped and later in the day he views the tape, appraises his examination technique, re-marks the candidate and explores any discrepancy with his colleagues.

All examiners are expected to attend the annual examiners' workshops at which calibration exercises of this type are carried out. At the beginning of their first day at each examination, all examiners are required to view and mark a standard 15-minute videotape of an oral examination thus calibrating their own marking standards before they begin. All these exercises aim to encourage self-criticism rather than peer-criticism. They provide the opportunity for examiners to increase the reliability of their technique and to monitor the validity of the topics they choose to cover.

Satisfactory construct validity of the oral examination is dependent upon its assessing those candidate attributes which are not assessed by other techniques and avoiding those which are. One particular problem is that of assessing factual knowledge. While this is most reliably assessed by the MCQ paper, it is not possible to examine clinical decision-making without reference to the candidate's knowledge base. For example, the candidate who describes with excellent sensitivity his method of handling the parents of a baby with Down's syndrome should have been able to recognize the condition in the first place. The examiners would find it difficult to award high marks to a candidate who could not make the initial diagnosis. While the assessment of

knowledge is therefore inevitable, a good oral of a good candidate should not involve more than 25–40 per cent of questions which require a factual answer.

Assessment of decision-making abilities

The candidate's decision-making abilities can be reliably assessed during oral examination by skilled examiners. Because of the flexibility of the method the candidate can be offered a wide range of clinical and management dilemmas in rapid succession and his reaction to the salient points of each explored. The reliability of the method, however, is dependent upon the examiners' definition of the purpose of each question. In clinical, behavioural and social areas the examiners are able to mark reliably if they explore the candidate's range of options rather than seek for a single 'correct' solution to the problem. While there are situations in which a single answer may be correct, problem solving in general practice is so complex that the examiners have been encouraged to explore and mark the candidate's range rather than his single choice. Questions may explore three main areas:

1. Have all the appropriate options been considered? For example, 'What various diagnoses or actions are you considering at this point?' not 'What is your diagnosis or what would you do?'.
2. Are the advantages and disadvantages of each option fully understood? For example, 'You mention termination as one solution. What are its advantages and disadvantages for this patient?'
3. Can the candidate justify a reasonable final choice in the light of his answers to questions 1 and 2?

Clinical skills

Many clinical skills are capable of being assessed during oral examination. Interpersonal communication with the examiners; information gathering and interpretation; selection of examination methods and investigations; communications with patients, relations and colleagues are some examples. The use of photographs, slides, laboratory reports, and ECG tracings can introduce highly relevant and valid aspects of clinical work. Only frank physical examination and direct communication with the patient are missing. The extent to which the absence of a patient detracts from the validity of the examination or the total assessment of the candidate has been repeatedly debated without conclusion. Experience of some other examinations suggests that the reality introduced by the presence of a patient is counterbalanced by the difficulty of ensuring reliable patient performance and by the logistic difficulties which are inevitable when a large number of patients, candidates and examiners are involved. For the time being, clinical skills in the MRCGP examination are assesed by proxy.

Attitudes

The reliable assessment of attitudes presents many problems. Even if they were capable of reliable assessment, there is no guarantee that the attitudes demonstrated during an oral examination will be subesquently translated into practice. During the oral examinations therefore, the examiners limit their assessments and inferences about attitudes to areas where they feel they are capable of marking reliably. In practice this means exploring the candidate's awareness and understanding of the implications of many of the decision-making options that apply in clinical or management situations. The candidate may be asked, for example, 'What are the reasons why patients change their doctors?' and subsequently 'Why may we, as doctors, find this threatening?' or 'A patient asks for a sick note because his wife is in hospital. What are the various problems this situation presents and what are the advantages and disadvantages of the possible solutions?'

Present position of the oral examination

Analysis suggests that the validity of the orals is appropriate and that reliability is being maintained at a level which is both constant and fair. Methods of monitoring the orals, however, will continue to be used and developed and the relationship between the orals and the other methods of assessment kept under constant review.

Marking, administration and results

Each component of the examination contributes equally to the assessment process and candidates who have low marks in one particular paper may compensate by higher marks in another. While initially all candidates were called for oral examination experience showed that those whose marks in the written papers were one standard deviation below the mean were unlikely to be able to compensate by a superior performance in the oral examination and that the expense and inconvenience of attending were not justified. Not all candidates who attend the oral examination may therefore be regarded as having 'passed' the written papers, but all are in a position where they are capable of achieving a successful outcome in the examination.

Following the oral examination, each candidate's total mark is calculated. Those whose mark places them within 3 per cent of the pass mark are discussed by their oral examiners and their recommendations made to the examiners' meeting which concludes each day and at which the performance of all candidates seen that day is reviewed. The examiners' meeting on the final day of each series has the pleasant responsibility of determining the level and number of distinctions. After this meeting, the final pass list is prepared and letters informing candidates of their result posted, whenever possible by the following Monday evening. The pass list

is published in the College 24 hours later and is posted to examiners, faculties, regional advisers, postgraduate deans and the press. It also now appears on Meditel.

Unsuccessful candidates are invited to write to the Chairman of the Membership Division if they wish for details of their performance. The majority do so, and whenever possible are given more specific advice if they intend to resit the examination. Finally, candidate and examination data are analysed to provide regional statistics which allow the College, the faculties and regional advisers an overview of the role of the examination in the assessment of vocational and continuing education in general practice.

The future

Each of the components of the present examination is the responsibility of a working group of the Panel of Examiners who continually analyse and develop their methods. The reduction in the number of multiple choice questions from 90 to 60 is the result of an appraisal of the efficiency of this particular method in the assessment of factual recall. The use of videotape techniques in peer appraisal and self appraisal of oral examination methods is increasing the effectiveness of these particular procedures, and TEQ and MEQ papers are being similarly reviewed.

The Membership Division and the Panel of Examiners have been conscious for some time of the disadvantages of an assessment procedure which takes place at the end of vocational training and which is, therefore, of limited educational value to the individual candidate. A working party is therefore exploring methods of assessment of relevance to the midpoint of vocational training which will primarily be of educational value to the candidate and his trainer and which might be seen as an appropriate preliminary assessment, guiding the candidate in his preparation for a later membership examination.

Equally the assumption that success in the membership examination predicts subsequent satisfactory performance in general practice requires exploration. Studies of the predictive validity of the examination are therefore being organized and it is the intention of the Membership Division and the Panel of Examiners that their activities will continue to be central to the major purpose of the College, which is to raise the standard of patient care in general practice.

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GENERAL PRACTICE LITERATURE

BOOK REVIEWS

CLINICAL REACTIONS TO FOOD

M. H. Lessof (editor)

Wiley, Chichester (1983)

222 pages. Price £14.50

A fascinating attempt to distill the cool facts from the present hot soup of fashions, fancies and fads about food allergies. The title itself avoids the use of the word allergy and several of the contributors to this book (edited by the Professor of Medicine at Guy's Hospital Medical School) are at pains to decide the nature of food intolerance and point out that true allergy is likely to be rare. The chapter by Barnetson and Lessof and another by Ferguson and Strobel are particularly helpful in clarifying the current state of knowledge about reactions to food and the immunological and physiological complexities of digestion.

All who are interested in food intolerance and food allergy will welcome this well-balanced appraisal of the current state of knowledge in this controversial field.

E.G.B.

BOOKS RECEIVED

PRACTICE OF PSYCHOSEXUAL MEDICINE, *Katherine Draper (editor), John Libbey, London, 1983. 257 pages. Price £14.95.*

ABC of HEALTHY TRAVEL, *Eric Walker and Glyn Williams, British Medical Association, London, 1983. 39 Pages. Price £3.50 (paperback).*

TREATMENT AND MANAGEMENT IN ADULT PSYCHIATRY, *G. E. Berrios and J. H. Dowson, (editors), Bailliere Tindall, London, 1983. 502 pages. Price £18.50*

ENDOCRINOLOGY, *Harold E. Carlson, (editor), John Wiley and Sons Ltd, Chichester, 1983. 308 pages. Price £31.15*

LECTURE NOTES ON EPIDEMIOLOGY AND COMMUNITY MEDICINE (2nd edition), *R. D. T. Farmer and D. L. Miller, Blackwell Scientific Publications, Oxford, 1983. 214 pages. Price £6.80.*

FAMILY MEDICINE for students and teachers. *R. T. Mossop and G S Fehrsen, Academica, Cape Town, 1983. 123 pages.*

1983 USP DI DRUG INFORMATION FOR THE HEALTH CARE PROVIDER, *C. V. Mosby, London, 1983. 982 pages. Price £22.50 (hardback).*

PROBLEMS IN PERIPHERAL VASCULAR DISEASE, *P. E. A. Savage, MTP Press, Lancaster, 1983. 118 pages. Price £7.95.*

THE FAMILY PHYSICIAN, *Kupat-Holim Health Insurance Institution of the General Federation of Labour in Israel, 258 pages.*

THE NEW GOOD BIRTH GUIDE, *Sheila Kitzinger, Penguin Handbooks, Middlesex, 1983. 443 pages. Price £3.95 (paperback).*

COMMUNITY MEDICINE, *A Textbook for Nurses and Health Visitors, W. E. Waters and K. S. Cliff, Croom Helm Ltd, Kent, 1983. 146 pages. Price £6.95.*

LARYNGECTOMY, Diagnosis to Rehabilitation, *Yvonne Edels (editor), Croom Helm, Kent, 1983. 309 pages. Price £18.95.*

COMMUNITY HEALTH, *June Clark and Jill Henderson (editors), Churchill Livingstone, Edinburgh, 1983. 317 pages. Price £6.95 (paperback).*