

An advisory committee on cancer registration has now been established

EDITOR,—I was surprised that N E Day and T W Davies cast doubt on whether the new purchasing arrangements would allow cancer registries to achieve the standards laid down in the core contract specification for cancer registries (sent to purchasers under cover of an executive letter ((96) 7) dated 9 February 1996) and by their call for a national body to oversee cancer registries.¹

The executive letter acknowledged the crucial role of cancer registries in monitoring the implementation of national policies on preventing and treating cancer. It also emphasised their importance as a source of data for mapping geographical, social, and occupational trends in disease and mortality for regional, national, and international comparisons and the measurement of treatment outcomes, survival, and service effectiveness. The core contract proposed standards and targets for cancer registration, which aim to maintain and strengthen the cancer registration system, by raising those registries performing at the lower end of the spectrum to the standards of the best. The letter also made clear the need for cancer registries to receive sufficient funding to achieve the recommended standards of service and to perform the functions outlined in the core contract.

Turning to the need for a national body to oversee cancer registration, I am puzzled by the statement of Day and Davies that it is not clear what will replace the steering committee. As both must be aware, a new advisory committee on cancer registration, of which I am to be the chairman, is currently being established to replace the former steering committee. Both Day and Davies were invited in September to serve on the new committee. My letter of invitation set out the functions and draft terms of reference for the new committee.

I am convinced that the action we have taken in drawing up the core contract, and establishing the new advisory committee, should lead to the steady improvement in the quality of cancer registration that we all see as essential.

GRAHAM WINYARD
Medical director

NHS Executive,
Department of Health,
Room 4W53, Quarry House,
Leeds LS2 7UE

1 Day NE, Davies TW. Cancer registration: integrate or disintegrate? *BMJ* 1996;313:896. (12 October.)

Choosing tomorrow's doctors

Students' knowledge of the realities of the profession is important

EDITOR,—Sandra Goldbeck-Wood questions the adequacy of academic achievement alone as a selection criterion for entrants to medical school, focusing on the need to produce doctors who are good for patients.¹ We believe that there is another issue for debate—namely, choosing doctors who can survive the system in order to be good for patients. We therefore offer a complementary approach to use alongside academic criteria.

Our work is based on a postal survey conducted in 1994 to determine morale among preregistration house officers who had been trained in Britain and were working in four health authority regions in England. The response rate was 59% (433/735). Two hundred and forty one of the respondents reported some degree of regret about studying medicine, the main reasons being interference with the rest of their life, long hours, and poor pay. High degrees of regret have implications for a person's wellbeing and morale, which, if that person is a doctor, may lead to detrimental effects on patients'

Questions to ask prospective medical students

- How old were you when you decided to become a doctor?
- Have you ever considered studying for a career other than medicine?
- What is the average number of hours that a preregistration house officer works?
- How long will it take to get to consultant level?
- How strong is your desire to study medicine?
- What would you do if your grades at A level did not match the requirements for entry to medical school?

care. Indeed, those respondents who reported regret were significantly more likely to suffer important psychological disturbances than those who did not report regret.

Several factors, which could be ascertained at selection, were associated with less regret later. These included knowledge of the length of the working hours of preregistration house officers, knowledge of the length of postgraduate training, and always having wanted to study medicine and no other career. Additionally, the strength of the desire to study medicine was significantly associated with regret, with those expressing a strong desire to study medicine experiencing less regret. Those who had decided on a career in medicine by the age of 15 had a significantly stronger desire to study medicine.

The association between knowledge of the realities of the medical profession before entry to medical school and the degree of regret at choosing a medical career suggests that students who can assimilate information and relate long term consequences to current decision making are better prepared for a medical career. The selection of undergraduates might therefore be improved by asking questions such as those in the box, although a prospective study would be required to confirm this. While people who are proactive in seeking information are to be welcomed in the profession, using this as the sole criterion for selection for medical school may result in people with a caring or empathic nature being rejected; this criterion should therefore be used as only part of the selection process.

CARON GRAINGER
Consultant in public health medicine
ELEANOR HARRIES
Research fellow

Institute of Public and Environmental Health,
University of Birmingham,
Birmingham B15 2TT

1 Goldbeck-Wood S. Choosing tomorrow's doctors. *BMJ* 1996;313:313. (10 August.)

Interviews should be structured or semistructured

EDITOR,—Sandra Goldbeck-Wood refers to the fact that using A level results allows medical schools to attenuate "numbers sufficiently to make individual interviews practicable."¹ This suggests that the interview is an appropriate technique to augment other selection procedures. There are, however, numerous problems associated with using the interview as a selection tool. Most of these problems pertain to interviewer bias, which results in low validity and interrater reliability coefficients. The sources of this bias have been studied extensively by occupational psychologists and include the following: the effects of information available before the interview (particularly unfavourable information) on both the questioning style and evaluation of the candidate's performance; errors associated with judgment (principally those

relating to leniency and severity of rating); bias due to contrast effects (that is, an average candidate may seem better or worse if interviewed immediately after a succession of either very good or very poor applicants); the interviewer's own prototype of the "ideal" candidate; and prejudice on the grounds of race and sex.²

Research by psychologists has shown that much of this bias can be eliminated by use of either a structured or a semistructured interview. A meta-analysis of the literature on selection interviews reported average validity coefficients of 0.35 (uncorrected) increasing to 0.63 (corrected) for structured interviews.³ This dropped to 0.20 (corrected) for unstructured interviews.

Medical schools use either semistructured or unstructured interviews when selecting medical students.² In recent years a small number of medical schools have attempted to improve the validity and reliability of the selection interview by using structured interviews; most, however, still use an unstructured format.⁴ This implies that neither the attributes to be assessed nor the required levels of attainment have been defined appropriately before the interview. Furthermore, evaluation of the effectiveness of the interview as a selection technique tends to be carried out on an ad hoc basis. None of this is surprising in the absence of agreement about the most appropriate criteria on which to select medical students.⁵ Until there is concordance on this issue it is naive to suggest that one selection technique is better than another.

MAIREAD BOOHAN
Lecturer in medical education
ROBERT W STOUT
Dean

Faculty of Medicine,
Queen's University of Belfast,
Belfast BT7 1NF

- 1 Goldbeck-Wood S. Choosing tomorrow's doctors. *BMJ* 1996;313:313. (10 August.)
- 2 Edwards JC, Johnson EK, Molitor JB. The interview in the admission process. *Acad Med* 1990;65:167-77.
- 3 Weisner WH, Cronshaw SF. A meta-analytic investigation of the impact of interview format and degree of structure on the validity of the employment interview. *J Occup Psychol* 1988;61:275-90.
- 4 Powis DA. *Selecting medical students*. Dundee: Association for Medical Education, 1994.
- 5 Rolfe IE, Pearson S, Powis DA, Smith AJ. Time for a review of admission to medical school? *Lancet* 1995;346:1329-33.

Correction

Contraceptive implants

Owing to an editorial error, the key to figure 1 in the third letter in this cluster, by John J Ferguson and Martin G V Jenkins, was incorrect (5 October, p 881). The correct figure is reproduced here.

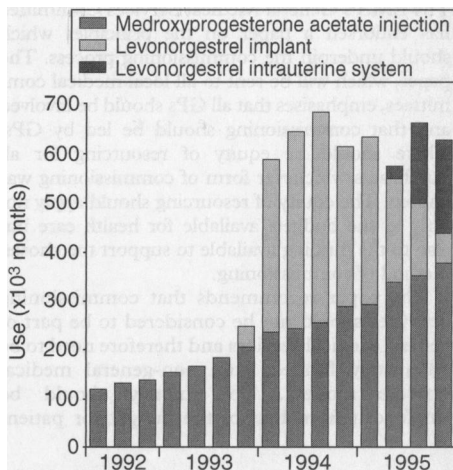


Fig 1—National trends in use of depot contraceptives, England, 1992-5