

# What they are actually marking

Thirty interview stations, what I'm scoring in each one, where candidates lose the marks, and what the ones who score well tend to do.

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Five years on medical school interview panels. Ten years helping applicants. Sat my own in 2008.

I can't give you real interview questions, and I'd be wary of anyone who says they can. Every scenario in here is one I've written for this guide, or one that a medical school has published about itself. Questions change from year to year. What's being marked doesn't.

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## Read this first

I've sat on medical school interview panels for five years and helped applicants prepare for about ten, which started, as it does for most of us, with my own interview in 2008. Over that time the same handful of misunderstandings have come up so reliably that I now assume every applicant has them until shown otherwise. This first section is those misunderstandings, and the stations that follow are where you'll meet them.

### It's an assessment, not a conversation

Applicants prepare as though they're going to meet someone who will decide whether they like them. That's not what happens. You're being assessed against a marking scheme by people who have been trained to use it, and the scheme is, more or less, public. Once you've taken that in, most of the folklore about interviews falls away.

### Stations are scored on their own

In a multiple mini interview you move through six to ten stations of five to eight minutes each. Each has a different interviewer, a different task, and its own score sheet. The interviewer at station four doesn't know how station three went. This is deliberate. One bad station can't sink you, and one charming one can't carry you. What the format rewards isn't being impressive once. It's being consistently adequate ten times in a row, which is a much less glamorous thing to practise.

Some schools still run a panel: one longer conversation with two or three of us. Answers connect, and I remember what you said ten minutes ago. If you tell me teamwork matters and then describe a placement where you did everything yourself, I notice. Find out which format each of your schools uses. It's on their website.

### What the sheet looks like

Applicants ask me this more than anything else, and I can't show you one. I can tell you roughly what's on it. Most schools publish the domains they assess. The names vary, but they come down to something like the following.

| Domain              | What I'm matching you against                                                                            |
|---------------------|----------------------------------------------------------------------------------------------------------|
| Communication       | Clear, at the right level for the person in front of you, checks understanding, listens before speaking. |
| Ethical reasoning   | Sees both sides, names the tension, commits to a position and gives a reason.                            |
| Empathy and respect | Responds to the person rather than the problem. Stays kind under pressure.                               |

|                              |                                                                                     |
|------------------------------|-------------------------------------------------------------------------------------|
| Motivation and insight       | Knows what the job is, has tested themselves against it, can say what will be hard. |
| Teamwork and professionalism | Acts when something is wrong, escalates in proportion, takes responsibility.        |
| Problem solving              | Says what they'd need to know. Builds an answer rather than guessing one.           |

Each domain is a scale, usually one to five or one to seven, with a written descriptor at each point. While you're talking I'm matching what you say to a descriptor. There's usually one global box at the end for an overall impression, and that's the only place "I liked them" lives.

The practical consequence is that the words which map onto descriptors are the words that score. "I'd want to understand why she's refusing before I did anything else" lands on an empathy descriptor and an ethical-reasoning descriptor in a single sentence. A warm face lands on nothing.

### **There's no right answer**

Ethics stations are marked on the reasoning, not the verdict. Two candidates can conclude opposite things and both take full marks. What I'm looking for is that you saw both sides, named the tension, and then committed to a position with a reason. What loses marks is a confident answer with no reasoning, or a balanced answer that never lands anywhere. The candidates who score well tend to say "it depends on", and then say what it depends on. The ones who struggle say "I'd just", and then say the first thing that came to mind.

### **I'm not trying to catch you out**

A lot of applicants come to me believing the interviewer is hunting for a reason to reject them. In my experience it's the opposite. I have a rubric and a room full of people I'd like to score well, and a good candidate makes my afternoon easier. When I push back on your answer, I'm offering you the top band. Hold your position with a reason, or change it and tell me what changed your mind. Either scores. Folding the moment you're challenged tells me something. So does refusing to move when I've made a fair point.

### **Silence is allowed**

One thing I notice in the candidates who score well is that they're comfortable with a pause. "Can I take a moment?" Then take it. Five seconds feels like an hour to you and like nothing to me. It reads as judgement, because it's what a good doctor does when a relative asks a hard question. If you lose your thread mid-answer, stop, say so, and start the sentence again. Composure is on the sheet.

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## The five stories

Applicants ask me how many answers they need prepared. The number is five, and they aren't answers. They're stories. Five true things that happened to you, each about thirty seconds long, each with a detail in it that only someone who was there would know. Most of the personal questions you'll be asked are one of these five wearing different words, and the skill is hearing which one is being asked.

| Story                                                    | What it answers                        | The detail that makes it true                        |
|----------------------------------------------------------|----------------------------------------|------------------------------------------------------|
| A time you led                                           | Leadership, initiative, responsibility | What you decided, and what it cost you               |
| A time you followed                                      | Teamwork, humility, taking instruction | Something you disagreed with and did anyway, and why |
| A time you failed                                        | Resilience, honesty, insight           | The real failure, then what changed afterwards       |
| A time you were kind when it cost you                    | Empathy, values                        | What you gave up                                     |
| A moment from placement that changed how you see the job | Motivation, realistic insight          | One person, one thing they did, what it told you     |

Write them below as paragraphs, not scripts, and then say them out loud until they're yours. Rehearsed words are easier to spot than applicants think. I usually know within a few seconds: the rhythm goes smooth and slightly fast, and the answer lands on the question you prepared for rather than the one I asked. Rehearsed material is a different thing. It doesn't get caught, because it's simply true.

### 1. A time you led

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**2. A time you followed**

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**3. A time you failed**

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**4. A time you were kind when it cost you**

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**5. The moment from placement**

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# Ethics

Eight stations. In each of them I'm marking the tension you name and the reason you give, not the side you take. Every candidate I've interviewed can list the four pillars. Very few can use them. They're a tool for finding the tension, not a list to recite, and one tension named and argued scores more than all four pillars in order.

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## 1. The operation she doesn't want

*An 80-year-old woman with a bowel obstruction refuses the operation that would probably save her life. She understands what will happen without it. What do you do?*

### What I'm marking

Whether you know that a person with capacity can refuse anything, including the thing that would save her, and whether you can hold that without abandoning her.

### Where it goes wrong

Looking for a way round her. "I'd get her family to persuade her" is pressure, and I mark it down.

### What the good ones do

They check capacity: does she understand, retain, weigh, and communicate? If she does, the decision is hers. Then they get curious. Why? Fear of the operation, of dependence, of dying on the table. Most refusals are about something specific, and some of it can be addressed. Then they're honest, once, about what they expect to happen. And they leave the door open. She can change her mind, and her care continues either way.

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## 2. The diet instead of the chemotherapy

*A 40-year-old with a treatable cancer refuses chemotherapy and wants to try a diet she's read about. What do you say?*

### What I'm marking

The same principle as the first station with a younger patient, and I'm watching whether that changes your behaviour. It shouldn't.

### Where it goes wrong

Applicants find this one hard because they assume the job is to change her mind. So they lecture her, or they give up and agree with her. Both are the same failure: they've stopped listening.

### What the good ones do

Capacity first. Then they ask what she's read and what she's afraid of. Then they say plainly that they disagree and why, once, without repeating it. Then they offer what they can: she can come back, the option stays open, and nobody will think less of her. Respecting a decision you believe is wrong is most of the skill.

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### 3. One bed, two patients

*There's one intensive care bed. A 30-year-old who has taken an overdose and an 80-year-old with pneumonia both need it. Who gets it?*

#### **What I'm marking**

Whether you can resist answering, and ask instead what you'd need to know.

#### **Where it goes wrong**

I've watched this station go wrong in the first sentence more often than any other. The sentence usually contains an age, or the words "self-inflicted". Either one ends the station.

#### **What the good ones do**

They ask who's more likely to survive with the bed, who's more likely to survive without it, and what each patient wants. Beds go to whoever benefits most from them, not to whoever is youngest or most approved of. And they finish by saying that this decision isn't made alone, and not by a student.

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### 4. The hundred-thousand-pound drug

*Should the NHS pay for a drug that costs £100,000 and gives one person an extra six months of life?*

#### **What I'm marking**

Whether you can see that every pound spent here is a pound not spent on someone you can't see.

#### **Where it goes wrong**

There's a phrase applicants reach for here that I'd steer you away from. "You can't put a price on life." It's emotionally true and practically false, and I've heard it forty times by lunchtime. The opposite failure is a cold calculation with no person in it.

#### **What the good ones do**

They name the tension: one identifiable person against many invisible ones, and both are real. They mention that there's a body whose job is to weigh cost against benefit, so that the doctor in the room doesn't decide alone. Then they give a view, with a reason, held lightly.

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## 5. The fifteen-year-old and her mum

*A 15-year-old asks you not to tell her mum something. Her mum is in the waiting room. What do you say?*

### **What I'm marking**

This one tests something applicants don't expect. Not whether you know the rule, but whether you know that a young person can sometimes make her own decisions, that it depends on the decision and her understanding, and where the safeguarding line sits.

### **Where it goes wrong**

Promising secrecy you can't keep. Or refusing to listen until her mum is in the room.

### **What the good ones do**

They set the limit early and honestly: "I'll keep this between us unless I think you or someone else is at risk. Tell me what's going on." Then they have the actual conversation. Why does she not want her mum to know? That's usually the real problem, and she's treated as a person with a reason.

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## 6. The family who want you to lie

*A patient's adult children ask you not to tell their father his diagnosis. "It would destroy him." What do you do?*

### **What I'm marking**

Whose information this is, and whether you can be kind to the family while refusing them.

### **Where it goes wrong**

Agreeing, because they know him and you don't. Or dismissing them, because the rule is clear. The rule is clear and they still deserve to be heard.

### **What the good ones do**

They know the information belongs to the patient, and that he may not want all of it, which is his choice to make. So the first move is to ask him how much he wants to know. To the family they say that they understand the instinct to protect him, that they won't lie to him if he asks, and that they'd rather work out together how to tell him well than have him find out badly.

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## 7. The transfusion he won't have

*A patient bleeding after surgery refuses a blood transfusion on religious grounds. Without it he may die. What do you do?*

### **What I'm marking**

Whether you can respect a refusal grounded in beliefs you may not share, and whether you know to look for alternatives rather than stopping at the refusal.

### **Where it goes wrong**

Treating the belief as a problem to be argued away. Or treating the refusal as the end of your involvement.

### **What the good ones do**

Capacity, then respect: this is a considered position, not a whim. Then work. What will he accept? Many patients in this position accept some products and techniques and not others, and there are surgical and anaesthetic ways to reduce blood loss. Then honesty about the risk, written down, with the whole team involved. His decision, and your best effort inside it.

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## 8. Antibiotics for a cold

*A patient with a viral cold insists on antibiotics. He's angry, he's waited an hour, and he says the last doctor always gave them. What do you say?*

### **What I'm marking**

Whether you can say no to a patient without it becoming a fight, and whether you know why the no matters beyond this one person.

### **Where it goes wrong**

Giving in to end the conversation. Or winning the argument and losing the patient.

### **What the good ones do**

They acknowledge the wait and that he feels awful. They explain, briefly, that antibiotics do nothing to a virus and carry harms of their own, and that resistance is a problem for everyone including him next time. Then they give him something: what will help, what to watch for, when to come back. He leaves with a plan rather than a refusal.

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## Professionalism

Six stations. Applicants ask me about these more than any other kind. In each of them I'm asking whether you act when something is wrong, whether you act in proportion, and whether you stay humane while doing it. The ladder is the same every time: the person, then a senior, then the system. Skipping rungs in either direction loses marks.

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### 9. The colleague who smells of alcohol

*You're a medical student. A doctor on your ward smells of alcohol at eight in the morning. What do you do?*

#### **What I'm marking**

That the patient comes first, said early. Then proportion.

#### **Where it goes wrong**

Doing nothing, because it's not your place. Or going straight to the regulator, which skips every sensible step in between.

#### **What the good ones do**

They speak to the doctor privately if they can, and to a senior regardless. They make sure he's not seeing patients today. And they hold two things at once: this person needs help, and this person can't work today. Both are true, and a good answer contains both.

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### 10. The wrong patient

*On placement you see a nurse give a tablet to the wrong patient. Nobody else noticed. What do you do?*

#### **What I'm marking**

Applicants usually know what to do here. What they often don't know is how, and the how is what I'm marking.

#### **Where it goes wrong**

Saying nothing. Or saying something in front of the patient.

#### **What the good ones do**

They tell the nurse, now, quietly: "I think that might have been Mr Ahmed's." Most errors are caught in exactly this way. If it's not put right, they tell someone senior. And the ones at the top of the band add that this is what incident reporting is for. The point is the next patient, not the blame.

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## 11. The friend who wants to know

*Your friend's mum is on the ward you're placed on. Your friend texts: "Is she okay?" What do you reply?*

### **What I'm marking**

Confidentiality under pressure from someone you care about.

### **Where it goes wrong**

"I can't tell you" is correct, and on its own it's worth about half the marks.

### **What the good ones do**

They acknowledge the friend, explain why, and say what the friend can do instead: ring the ward, ask her mum directly. Then they notice the second problem. They're on her mum's ward and they know the family. Someone on the team should know that, because they're now a conflict of interest themselves.

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## 12. The photo

*A fellow student posts a photo from the ward on Instagram. A patient is visible in the background. What do you do?*

### **What I'm marking**

Whether you act on a colleague's mistake with the proportion you'd want applied to your own.

### **Where it goes wrong**

Reporting them before speaking to them. Or deciding it's harmless because the patient is blurry.

### **What the good ones do**

They message the student now, ask them to take it down, and assume it was thoughtless rather than malicious. If it comes down, that's probably the end of it, though the patient's dignity was still breached and they might say so. If the student refuses, it goes to the placement lead. I'm marking whether you can treat a colleague as you'd want to be treated while still protecting the patient.

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### 13. Your own mistake

*On placement you told a patient her scan was clear. You had the wrong patient's results. What do you do?*

#### **What I'm marking**

Whether you can own an error without minimising it or collapsing under it.

#### **Where it goes wrong**

Hoping nobody notices. Or apologising so much that the patient ends up comforting you.

#### **What the good ones do**

They tell a senior immediately. They go back to the patient with that senior, apologise, correct it, and answer her questions. They report it so the system learns. And then, separately, they ask what allowed it to happen: why were those results in front of them at all? That last question is the one that tells me someone will be safe in five years' time.

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### 14. The gift

*A patient's family gives you a bottle of wine on their last day. Do you take it?*

#### **What I'm marking**

A small station, and I've learned a lot about candidates from it. I'm marking whether you know why the rule exists, not whether you know the rule.

#### **Where it goes wrong**

Refusing so rigidly that you wound people who are trying to say thank you.

#### **What the good ones do**

They know that small gifts freely given after care has ended are usually fine, and that refusing can hurt. Anything that could look as though it buys different treatment isn't fine. They ask what and when: chocolates for the ward after discharge isn't the same as cash before a decision. And they say, unprompted, that the family who gives every week worries them more than the one who gives once at the end. Judgement, not rules.

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## Communication and role play

Six stations, some with an actor. Actors are briefed to escalate if you defend, explain, or rush. What I'm marking is nearly always the same three things: did you listen before you spoke, did you pitch it at the right level, and did you check they understood.

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### 15. The four-hour wait

*An actor plays a daughter whose father has waited four hours in the emergency department and nobody has spoken to her. You're the student.*

#### **What I'm marking**

This is the station applicants dread, and I've scored a lot of them. I'm marking whether you can be useful when you can't fix anything.

#### **Where it goes wrong**

Explaining how busy the department is. Saying "I understand" in the first ten seconds.

#### **What the good ones do**

They let her finish. Then they acknowledge specifically: four hours, nobody has spoken to you, and your dad is unwell. That's not acceptable and I'm sorry. Then one concrete thing. Find out where he is on the list, find the nurse in charge, come back in ten minutes. And they actually come back.

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### 16. The injection

*Explain to a ten-year-old why they need an injection they don't want.*

#### **What I'm marking**

It sounds like the easy station. It's one of the more revealing ones. Level, honesty, and whether you check.

#### **Where it goes wrong**

"It won't hurt." It will, a bit, and the child knows it, and you've lost them.

#### **What the good ones do**

No jargon and no baby talk. It'll sting for a few seconds. They give the child a job: hold the cotton wool, count to three. Control is what the child is frightened of losing. Then they check, and "can you tell me what's going to happen?" is a check. "Does that make sense?" isn't.

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## 17. The car

*You borrowed a friend's car and scraped it. The actor is your friend. Tell them.*

### **What I'm marking**

Breaking bad news, in miniature. The structure is the same one you'll use for the rest of your working life.

### **Where it goes wrong**

Building up to it for a minute, so they know something is coming and start to panic. Or blurting it out and then flooding them with excuses.

### **What the good ones do**

A warning shot: "I've got something to tell you and it isn't great." Then the fact, in one plain sentence. Then silence, and they let the friend react. Then ownership, and what they'll do about it. No excuses unless asked. If the friend is angry, the friend is allowed to be.

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## 18. The patient who doesn't speak English

*You need to explain a procedure to a patient who speaks very little English. Her teenage son is with her and offers to translate.*

### **What I'm marking**

Whether you know why family interpreters are a problem, and whether you can decline the offer kindly.

### **Where it goes wrong**

Accepting, because it's quicker and he's right there.

### **What the good ones do**

They thank him, and explain that they need a professional interpreter so that his mother hears everything accurately and can ask whatever she wants without worrying about him. A son shouldn't have to translate his mother's diagnosis, and she may not say certain things in front of him. They use the telephone interpreting service, and they speak to her, not to the interpreter.

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## 19. What a stroke is

*Explain to someone with no medical knowledge what a stroke is and why time matters.*

### **What I'm marking**

Whether you can teach. Structure, level, and one image that stays.

### **Where it goes wrong**

Showing how much you know. Every extra term costs a mark.

### **What the good ones do**

One sentence: a stroke is when part of the brain loses its blood supply, usually because of a blockage. One image: a hosepipe kinked, and the plants at the end start to die within minutes.

Why time matters: there's a treatment that can unblock it, and it only works in the first few hours. Then the signs to know. Then they check what the person took from it.

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## 20. "Am I going to die?"

*You're a student sitting with an elderly patient. She asks you, quietly, "Am I going to die?"*

### **What I'm marking**

Whether you can stay in the room with a hard question you aren't qualified to answer.

### **Where it goes wrong**

"Don't be silly, you'll be fine." Or leaving to fetch someone before she's finished speaking.

### **What the good ones do**

They don't answer it. They ask it back: what has made you think about that today? And they listen. In my experience most people asking this aren't asking for a prognosis. They're asking whether anyone is going to talk to them about it. Then honesty about the role: I'm a student and I don't know, but I'll find someone who does and come back with them. And they come back.

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# You, and why medicine

Five stations. These are the five stories from earlier, asked in different words. I'm marking specificity. One moment, described precisely, is worth more than any list.

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## 21. Why medicine, and not nursing?

*Why do you want to be a doctor rather than a nurse, a paramedic, or a physiotherapist?*

### **What I'm marking**

Do you know what the job actually is, and have you tested yourself against it?

### **Where it goes wrong**

When applicants practise this with me, the first answer is nearly always "I want to help people". So do nurses, teachers, paramedics, and social workers. The question is why this, and why you.

### **What the good ones do**

They start with a specific moment: a patient, a shift, a conversation they watched on placement. Then what's different about the doctor's part in it: the uncertainty, the decisions, carrying responsibility for the plan. Then a cost. Something they saw about medicine that they didn't like, and why they still want it. Wanting it isn't evidence. Having looked at it properly and still wanting it is.

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## 22. Work experience

*Tell me about your work experience.*

### **What I'm marking**

Not the placement. What you noticed, and what it changed.

### **Where it goes wrong**

I'm often asked whether a particular placement is good enough. It's the wrong question. A list of places scores nothing, and two weeks with a surgeon is worth less on my sheet than one afternoon in a care home, if the afternoon is the one you can talk about.

### **What the good ones do**

What I saw, what surprised me, what it means for the doctor I want to be. The healthcare assistant who knew every resident's tea order, and what that told you about the job that the surgeon's list didn't. If nobody would give you a placement, say so, and talk about what you did instead. That's a better answer than a padded one.

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## 23. A time you failed

*Tell me about a time you failed.*

### **What I'm marking**

Whether you can say "I got that wrong" without disguising it. Doctors who can't are dangerous, and this question exists to find them.

### **Where it goes wrong**

About half of the candidates I've interviewed give the same answer, which is a success in disguise. "I got 89% and I wanted 90%."

### **What the good ones do**

A real failure. Something that went wrong because of them and cost something. Ten seconds on what happened, and fifty on what they did next, what they learned, and what they do differently now. The failure is the setup. The aftermath is the answer.

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## 24. The team that didn't work

*Tell me about a time you were in a team that wasn't working.*

### **What I'm marking**

Whether you can describe a team problem without making yourself the hero or everyone else the villain.

### **Where it goes wrong**

A story in which you fixed everything. Or one in which it was all someone else's fault.

### **What the good ones do**

What was actually going wrong, in a sentence. What their own part in it was, including anything they got wrong. What they did, and whether it worked. If it didn't, they say so, and say what they'd do now. Medicine runs on teams that aren't quite working, and I want people who can be in one without pretending otherwise.

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## 25. What will you find hardest?

*What do you think you'll find hardest about being a doctor?*

### **What I'm marking**

Realistic insight. Whether you've looked at the job properly.

### **Where it goes wrong**

"I care too much." A strength dressed as a weakness, and I've heard it.

### **What the good ones do**

Something true and specific. The hours away from people they love. Not knowing. Telling someone a thing they don't want to hear. Being the most junior person in the building at three in the morning. Then how they think they'll manage it, honestly, without claiming to have solved it. Insight is on the sheet. Having no weaknesses isn't.

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## The NHS

Two stations. Applicants ask me how to handle these, and usually what they mean is which side to take. That's not what's being scored. I'm marking whether you can describe the strongest version of both sides.

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### 26. Free at the point of use

*Is a health service free at the point of use still affordable?*

#### **What I'm marking**

Whether you can hold a large question at the right size, and give each side its best case.

#### **Where it goes wrong**

Arriving with a position. "The envy of the world" or "it's broken", delivered with certainty.

#### **What the good ones do**

The issue in one sentence: demand and cost are rising faster than funding, and the principle is that nobody is turned away for money. The case for the principle: it protects the poorest and the sickest, and countries with charges don't spend less overall. The case against: money is finite and rationing already happens, just invisibly. Then a view, with a reason, held lightly.

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### 27. The topic of the week

*What do you think about [whatever the NHS story in the news is that week]?*

#### **What I'm marking**

Whether you've read anything serious, and whether you can be fair to people you disagree with.

#### **Where it goes wrong**

An opinion with no summary. The candidate who gives me two fair summaries and a question scores more than the candidate who gives me a take, and it's not close.

#### **What the good ones do**

The same structure every time. What the issue is, in a sentence. What each side wants, and why that's reasonable. Their own view, one reason, held lightly. Before the interview, they've read one long article on each live topic, not a clip, and can say what it argued.

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## Reasoning

Three stations. Nobody has the answer, and that's the point. I'm marking the method. This is what clinical reasoning is. You never have the number. You have a way of getting there.

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### 28. The estimate

*How many GP appointments happen in the UK in a year?*

#### What I'm marking

Applicants sometimes tell me they froze on a question like this. Nobody knows the number, and I don't need you to. I'm marking whether you can build an answer from things you do know, out loud, and say what would change it.

#### Where it goes wrong

"I don't know." Full stop. That scores nothing.

#### What the good ones do

Population, roughly 67 million. How often does a person see a GP? A few times a year, more if older or with a long-term condition, less if young and well. They multiply, and say each assumption as they make it. Then what would move it: children, the very old, the people who never go. The number they land on matters much less than my hearing every step.

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### 29. The graph

*Here's a graph. You have thirty seconds. What does it show?*

#### What I'm marking

This one catches able candidates, because they start with the conclusion. What I'm listening for comes before that.

#### Where it goes wrong

Jumping to the story you want. And the graph is sometimes built to punish it: a truncated axis, or a correlation dressed up as a cause.

#### What the good ones do

They say what the axes are, out loud. Then the shape: rising, falling, a change at some point. Then the numbers that matter, roughly. Then, and only then, what it might mean, and what else could explain it. The ones who spot the truncated axis or the missing confounder score at the top of the band.

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### 30. The better hospital

*Hospital A has a higher death rate than Hospital B. Why might Hospital A be the better hospital?*

#### **What I'm marking**

Whether you can resist the obvious reading of a number and ask what produced it.

#### **Where it goes wrong**

Defending the number. "Maybe it's badly run." That's the reading you were handed, and the question is asking you to doubt it.

#### **What the good ones do**

They ask who goes to Hospital A. If it's the specialist centre, it receives the sickest patients from everywhere else, and more of them die because more of them were going to. A hospital that turns away hard cases will have a very reassuring death rate. So they want to compare like with like: the same kinds of patients, adjusted for how ill they were on arrival. A raw death rate tells you who walked in, not how well they were treated.

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## The night before

My own interview for medicine was in 2008. These are the things I'd say to myself the night before.

- No new material. Anything you learn tonight you'll half-remember tomorrow, and half-remembered is worse than absent.
- Read your five stories once, out loud. Then close the notebook.
- Check the practical things: the route, the login if it's online, the time zone, the clothes laid out. Wear what you'd wear to meet a patient's family, not a suit you're wearing for the first time.
- Sleep. Reasoning is the first thing tiredness takes, and reasoning is where the top band lives.
- In the morning, read the school's published values once. That's the marking scheme.
- Take the water when it's offered. Drinking is a legitimate five seconds to think.
- After a bad station: one slow breath in the corridor, say the next station number to yourself, and treat it as the first station of the day. Stations are scored on their own. The next interviewer doesn't know and doesn't care. What I've noticed over five years is that the recovery decides the interview more than the bad station does, and the replay is what costs you the next one.

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## About

I'm Chief Resident on a Surgical Emergency Unit in Oxford, and I tutor Oxford medical students at Keble College. I've sat on medical school interview panels for five years, I've been helping applicants get in for ten, and I sat my own interview in 2008. I can't tell you the questions. I can tell you what's marked, which is what this is. Through the season I post one station a day at @drnathanspence on TikTok and Instagram, and I read what people write underneath. If something in here is unclear, that's where to ask.

This guide is free. Send it to anyone who needs it. Nothing in it is a real question from any school's interview bank, and nothing in it replaces reading what your own schools publish about how they assess. Do that first.