Holding a mirror up to society

Professor Peter Crampton
Dean
Wellington School of Medicine
University of Otago

Professor Crampton is a specialist in public health medicine. He has served on numerous advisory panels in a variety of policy areas related to public health, health services and medical education, and has taught both undergraduate and postgraduate courses related to public health, health systems and health services management.

Ideally the make up of medical classes should be equivalent to holding a mirror up to society. The purpose of medical education is to produce a medical workforce equipped to meet the needs of society; this is at the heart of the social contract between medical schools and society. In order to achieve this, the gender, ethnic and socioeconomic composition of medical graduates should roughly reflect the social reality of diverse communities in Aotearoa. The Australian Medical Council recognises this in its guidelines for the accreditation of medical schools (which apply to medical schools in New Zealand):[1]

In Australia and New Zealand, inequalities remain in the health status of various social and cultural groups. Medical schools have a responsibility to select students who can reasonably be expected to respond to the needs and challenges of the whole community, including the health care of these groups. This may include selection of students who are members of such groups. The medical curriculum should also provide opportunities for cultural education programs, and opportunities for training and provision of service in under-serviced communities.

Indigenous health is an area of special responsibility. New Zealand's two medical schools, acting as agents of government, have dual obligations: to honour both the contractual obligations defined in the Treaty of Waitangi and to correct the inequitable health outcomes experienced by Māori populations.

As things stand, the mirror is distorted. In New Zealand and around the world, medical schools struggle to achieve a balance of students which reflects the ethnic and socioeconomic reality of the societies they serve.[2] In sociological and historical terms this is explicable as our elite educational institutions have developed within the context of socially and ethnically stratified public. Furthermore, in spite of best intentions for improvement, there often are inequalities in access to high school educational opportunities for many groups in our population.

Selection policies should, therefore, attempt to counter some of these historical and social forces. Methods of selection are hotly debated. Tests of cognitive ability dominate, but alongside these, other methods such as aptitude tests, psychological tests, student interviews, and random selection have been, and are, used.[3 4]

How does this apply in practice? By way of example, the University of Otago has a common First Year Health Science programme in the first year at university which allows many students to improve their knowledge base in subjects appropriate to the study of medicine. This programme enables students from diverse educational backgrounds to compete equally for places in medical school. The University assists its selection process by identifying students who are believed to have aptitudes (as measured by UMAT) and academic abilities (as measured by grade point average) to successfully complete its long and demanding medical programme.

Amongst students who meet the aptitude and academic threshold, other selection decisions are made: Māori and Pacific students are given priority. Sadly, there still are a few such applicants above the academic threshold to match the demographic make up of society. Various additional strategies have been adopted to redress this imbalance which include a school-leavers' bridging programme for Māori students, and in the future for Pacific origin students.

The graduate entry pathway provides further opportunities for 'selecting in diversity' from a pool of academically able students. Special consideration, as part of a government initiative also, is given to students from rural backgrounds who would not otherwise achieve entry, and there is the ability to provide special entry for those with a demonstrable commitment to pursuing a career in mental health.

This process results in a student cohort at Otago which, in 2010, is comprised of 51.8% female, 27.8% of graduates, 9.0% Māori (compared with a national proportion of 15%), 1.3% Pacific (nationally about 7%), and 20.5% from rural backgrounds. This is not the perfect mirror of society we hope for, and we strive to improve our selection processes within the constraints and limitations of the available selection tools.

If medical schools are to fully achieve their mission to serve the needs of society, ongoing effort is required to refine their medical student selection tools. In addition, the process of selecting medical students must continually adapt to meet the changing needs of society.

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