Choosing tomorrow's doctors

A lottery may be the best way

The national debate on medical school selection criteria continues. The underlying assumption at a recent gathering of students, patients' representatives, the chief medical officer, and admissions deans from Britain and abroad at St George's Hospital Medical School in London was that we are getting it wrong. But are we? Just what do we want from the doctors of the future? To what extent are we achieving it now, and how, if at all, will selection criteria help us improve things?

The only clear answer was that, with 2.8 applicants for every medical school place in Britain, we do need to select. We currently use academic achievement, in the form of A level grades, as a filter—a requirement of three "A" grades, or two "A"s and a "B", reduces numbers sufficiently to make individual interviews practicable. Average A level grades among medical school entrants have increased over the past 10 years,¹ even though selectors themselves agree that these academic requirements far exceed what is needed to be able to complete the course. Whether driven or followed by selection policy, being good at science is now far more likely to be quoted as a reason for applying to medical school than in 1966.²

Is academic achievement at 18 too blunt a discriminator? It is certainly unfair, since it excludes people who are able but educationally disadvantaged,³ but there is no evidence to support other, more tenuous, notions—for example, that academic criteria may select for the "wrong" kind of person ("narrowly scientific") or even fail to select for the "right" kind ("caring communicators"). While there is no research to suggest that A level grades correlate with any useful endpoint, such as clinical skills or patient satisfaction (as opposed to the ability to pass exams during the preclinical course),¹ there is no evidence to the contrary. It may well be neither necessary nor desirable to choose on purely academic criteria, but we need to be clear about why not and what alternatives there are.

Are there, then, any core attributes central to becoming a good doctor? Addressing the question of what patients want from their doctors, Sally Greengross, director general of Age Concern, appealed on her clients' behalf for doctors who are flexible, self motivated, cooperative, broad minded, community oriented, informative, intelligible, accessible, generous with time, good communicators, and holistic. Amen, said everyone—yet how far this list addresses the problem of medical student selection is questionable. It is unclear to what extent these characteristics are discernible at school leaving age, even less clear how to select for them. Their presence in doctors may well owe more to "nurture" in the form of the now reforming medical school curriculum than to selection for the "nature" of the relatively unpreconditioned 18 year old. Perhaps it is appropriate that most research has focused less on whom we choose than on what we do to them.^{2,4} And, as Dr Chris McManus from St Mary's Hospital in London pointed out, even if we were clear about the priorities, the more criteria we use for selection the less power each individual criterion has. If we select on everything, ultimately we select on nothing.

Some useful attempts have been made to identify early predictors of good doctoring. An Australian cohort study published in the *Lancet* last year examined premedical exposure to the humanities, and found that it correlated well both with completing the medical course and with competence at intern level as judged by a clinical supervisor.⁵ Of the 104 medical school graduates followed up, those with a strong background in both humanities and science at secondary school level performed significantly better in areas such as initiative and reliability, and in clinical, diagnostic, managerial, and communication skills than did interns who had a strong background in science alone.

McManus on the other hand invokes learning style as a predictor of levels of clinical experience. The "deeper" a student's learning style, the more likely he or she was to score highly on clinical experience at a later stage, whereas "superficial" learners or those purely oriented to examinations tended to acquire less clinical experience. Interestingly, he found no correlation between study style and A level grade or preclinical exams results.

Much was said about maturity. With heavy financial burdens, domestic commitments, and huge opportunity costs, mature students are in general highly focused individuals, argued Baroness Blackstone, president of Birkbeck College, London, an institution for mature students. Those "studying the tough way" both demand and contribute a great deal to their courses, she explained, and their motivation, tenacity, and commitment are unrivalled by younger students. In her ideal world, medical schools would admit a greater proportion of mature students and relax some of the "overly rigid" regulations which stand in their way. Is she right? The value of mature students certainly seemed to strike a chord in the floor debate. Perhaps an American style model of medicine as a graduate programme would weed out those who drift into medicine without conviction, only to regret it later. Perhaps life experience would be a cost effective selection criterion, eking out tight medical education budgets and saving precious teaching space on crowded curriculums. It is, after all, easier to select for experience than to teach maturity.

The difficulty of fairness has been tackled by just a handful of models. The University of Newcastle (Australia),⁵ Auckland (J Collins, Choosing Tomorrow's Doctors conference), and McMaster University² have all confronted gender and racial discrimination head on, using medical school entry criteria which strive to reflect the composition of the society they will serve. Britain still falls far short in this regard, as a glance at the demographic profile of our entrants will show. If women and Asians are now well represented, Afro-Caribbeans and students from poorer backgrounds are still conspicuously absent. Dwindling grants and rising fees will not help.

Medicine is a wide umbrella with space for clinicians, academics, politicians, planners, and many others. The notion of "a good doctor" must surely be equally pluralistic. The practical aptitudes necessary in a surgeon and the psychological insight required in a psychiatrist can never replace one another; scientists need intellectual rigour; politicians need passion. We cannot expect every virtue from every doctor, even if that were theoretically desirable, and who can say that what we want from today's doctors will be acceptable in tomorrow's? How, then, are we to choose tomorrow's doctors? Finding the right balance between an obviously inadequate academic criterion and a hopelessly unwieldy shopping list will require wisdom and a deal more evidence, but find it we must. Perhaps a lottery of those fulfilling the minimum academic criteria would be the fairest way.

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