

Recruiting the wrong students

Medical schools are still failing to recruit a broad spectrum of students

There are still huge barriers to studying medicine for a large proportion of society. Many studies have shown that people in lower socioeconomic groups have an increased morbidity and are more likely to use healthcare services.¹ But for many years the socioeconomic distribution of doctors has been skewed in the opposite direction. In 1984, 83% of medical students admitted to St Mary's medical school were from social class I and II.² In some cases, such a mismatch in background between patients and doctors may result in difficulties in communication and bias in the treatment offered. For instance, young doctors from affluent backgrounds are unlikely to understand why patients of their own age group resort to illegal addictive drugs.



Not likely to make it to medical school

The Higher Education Funding Council for England recently produced its first set of performance indicators on student participation from different parts of society.³ Three medical schools are counted as separate Higher Education Institutions and so have their performance made explicit: the Royal Free Hospital School of Medicine; UMDS Guy's and St Thomas's Hospitals; and St George's Hospital Medical School. These three presented some of the worst participation results of all the 175 institutions being measured. The proportion of students they admitted from state schools were 40%, 48%, and 48% respectively. These were the worst, third worst, and fourth worst respectively, out of the 175 institutions. Of students with parents in manual occupations they admitted only 13%, 10%, and 12%. Of students from low participation neighbourhoods they admitted only 2% (worst), 4%, and 8%. This last statistic is particularly interesting as it may be the measure the Funding Council uses to target funds to institutions that increase participation. It is quite possible that other medical schools have similarly bad figures masked by the overall figures for their university.

Different secondary schools' exam results are becoming increasingly diverse, in line with the continuing polarisation of sectors of society, and this is only making the problem worse.⁴ In short, the chances of a child from a poor or even average neighbourhood entering medical school are falling in relation to the chances of children from more affluent neighbourhoods as exam results diverge. Without targeted funding by the Funding Council to encourage medical schools to change their ways they are likely to remain at the bottom of these league tables. However, funding also needs to be targeted at encouraging students from more varied backgrounds to apply. Such students may simply not consider medicine a financially

viable option. The introduction of tuition fees is a huge addition to the already large expenditure medical students must cope with during their course. For many students rent bills exceed their student loan,⁵ and medical students embark on a longer course with shorter holiday periods in which to find employment. There are many other additional expenses such as books and equipment that the student must meet, while the current government loan does not take into account a longer academic year for most medical courses.

Another reason for this mismatch is bias in the selection criteria. This is always going to be a controversial area since the number of able applicants exceeds the number of places.⁶ The evidence suggests that this process is often arbitrary, with undefined selection criteria.⁷ At present medical schools assume that the greater the number of applicants the higher the marks threshold needs to be set to limit entrance.⁷ We know that more restrictive criteria for eligibility and rising tuition fees have changed the profile of students in state colleges in America.⁸ Fewer students from families of the working poor are enrolling, and a higher academic and social class profile has been created among those who qualify for admission.

Therefore it's time to rethink the criteria for admission. John Dunford, general secretary of the Secondary Heads Association, said recently that universities in the UK need to look further than the A level and rethink what they want from prospective students. Deciding on these qualities and finding ways of identifying them will take considerable time and effort.

A simpler method to increase participation is for medical schools to receive greater funding for students from lower participation neighbourhoods. Bursaries could encourage these students to embark on such an expensive course. Faced with two applicants of equal merit it would then be in the financial interest of the medical school to take the poorer student.

Almost 1000 extra places for medical students will be created in the UK by 2005. As Michael Whitehouse, vice principal of undergraduate medicine at Imperial College said recently, "Routes into medicine are standard. If someone happens not to have the right qualification at the right time, it blocks their entry. The risk is that we exclude those who would make good doctors." There are no easy solutions to this problem. Poverty, social class, and exam success may be inextricably linked, making it naive to believe that one day medical students will have the same social class distribution as the general population.⁹ However, the extreme mismatch between patients and their doctors deserves further scrutiny. It cannot get any wider and surely needs to begin to narrow.

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