Increasing diversity among clinicians
Is politically correct but is costly and lacks evidence to support it

UK medical students tend to come from higher socioeconomic classes,\(^1\) perhaps not surprisingly, as social class correlates with intellectual ability.\(^2\) As part of the UK government’s widening participation initiative, there is a push to increase the proportion of students from lower socioeconomic classes (as well as mature students, those from minority racial groups, and disabled people) in higher education. Two underlying principles exist for medicine in particular. The first, social justice, aims to ensure fair access to a degree course that is the gateway into the medical profession.\(^3\) The second is the belief that a diverse population of doctors can better serve a diverse population of patients.\(^4\) To help promote widening participation, the Higher Education Funding Council for England and the Department of Health have provided funding to medical schools for projects such as outreach schemes at local schools and innovative degree programmes.\(^5\)

In the accompanying article, Garlick and Brown describe the six year extended medical degree programme (EMDP) at King’s College London.\(^6\) The first two years of the conventional medical curriculum is spread over three years, which allows for more academic and pastoral support. It is open to students from low achieving state schools in inner London. Most of these schools have exam results below the national average, so the authors argue that A level results may not be an accurate reflection of the true academic potential of these students. However, that ignores the large detailed study by the Higher Education Funding Council for England, which found that the aggregate performance of a student’s school performance does not predict a student’s subsequent university performance.\(^7\) Successful applicants were given a standard offer of CCC at A level, after going through an extended interview and a mental agility test. However, a recent paper found aptitude tests to be less useful than A levels as university selection tools, with no added value for the UK context.\(^8\)

Nevertheless, the EMDP selection process has resulted in a more diverse student population. Only 31% of EMDP students are from middle class families compared with 76% on the conventional course at King’s College London, and 91% of EMDP students are from ethnic minorities compared to 51% of “conventional” students. These figures provide evidence that widening participation to some extent achieves wider access, although white working class students are still notably absent. The diversity of this population of medical students should also translate into a more diverse population of doctors—the EMDP’s overall retention rate is 90%, and its first cohort graduated successfully in 2007.

The logical next step is to question the second assumption underlying the widening participation initiative. Can a more diverse population of doctors better serve a diverse population of patients? At the very least, the assertion that patients require or expect doctors of the same ethnicity, sex, and social class as themselves (white patients demanding white doctors would probably prompt claims of racism) is an uncomfortable one. Widening participation targets narrowly defined segments of society—lower socioeconomic groups and people who are geographically disadvantaged (those who live in inner city or rural areas). Do patients from these populations have better health outcomes when they are cared for by doctors with similar backgrounds? Are they more satisfied? We do not know.

Even if, through faith, we accept that a more diverse population of doctors better serves a diverse patient population, the awkward question of whether doctors selected through the widening participation initiative will end up serving disadvantaged patient populations remains. The best way to investigate this would be to follow the career paths of graduates from the widening participation scheme.\(^9\) An alternative is to look at the current population of doctors to see whether doctors from disadvantaged backgrounds are more likely to serve disadvantaged populations. Using this method, a study in the United States found that black doctors cared for more black patients than other doctors and Hispanic doctors cared for more Hispanic patients.\(^10\) Black and Hispanic doctors also cared for poorer patients.

This raises a potential conflict between the two premises of widening participation. If social justice in the form of fair access into the medical profession is the primary concern, no one should complain if widening participation graduates end up in private practice. But this would also mean a failure of the second premise, as disadvantaged patients are not benefiting.

Garlick and Brown conservatively estimate the total costs of the EMDP to be £190 000 (£240 000; $375 000) each year. Is this money well spent? They conclude that “widening participation students need considerable extra academic and pastoral support if they are to be successful,” and the pass rate is still lower than for conventional entrants. Their study has no control group, however, so it does not show that the extra support is needed.

A recent study from St George’s, University of London, suggests the contrary.\(^11\) Thirty five “adjusted criteria” students (with A level grades between BBC and ABB) performed as well as conventional students (given the standard A level offer of AAB). The adjusted criteria students did not receive additional support, but the comparison is limited because the average A level grades of EMDP students are lower—CCC in the first four years of the scheme and BBC in the recent two years—and small sample sizes mean that statistical power is low.
Intangible costs must also be considered. A quota system has effectively been set in place at King’s College London. Four hundred medical school places are available each year; 50 are reserved for the EMFD and are inaccessible to the conventional applicant. The quest for social justice involves sacrificing equality of opportunity, where all applicants are treated uniformly. This may be noble as we cannot afford to be complacent about injustice. But in seeking to understand unfairness we need to admit that it will never be eradicated from society, and an elite will arise in lower socioeconomic groups. So it is worth our while to widen participation, particularly if this risks reducing standards? Political ideology says yes, but the evidence is pending and the costs are rising fast.


