Nobody denies that selecting medical students solely on the basis of A Level grades makes no sense. But Chris McManus and Lesley Southgate, professors at the same medical school, propose different changes to the system

Recently, the Council of Heads of Medical Schools published guiding principles for the admission of medical students. The first of these says selection for medical school is also selection for the medical profession.

This is an important proposition because it implies the primary purpose of medical schools and faculties is to educate and train doctors — doctors who will usually practise in the UK, and frequently in the NHS. While this may seem self-evident, audit of the use of resources in schools and the recognition of excellence in teaching as a criterion for promotion reveals a different priority.

It has been established by studies and confirmed by complaints about doctors that patients want doctors to be competent and humane. Patients expect doctors to diagnose and carry out practical procedures, and behave reasonably while doing so. In particular, they expect a doctor to listen, explain and show understanding of the anxieties of the patient. It follows that when we select people for medical school, we should look for those who are capable of becoming competent and humane. However, there are very few characteristics that reliably predict these qualities, especially if selection is to be made at the age of 18.

> 'Teachers in medical schools should be made into role models for competence and humanity'

There is another way. Perhaps the teachers and other academics in medical schools should be made into role models for competence and humanity, and the schools should help staff achieve these aims. Many academics do not feel supported in this way in the current mix of cut-throat competition, poor funding, stifling hierarchies and cliques, which can still be found in many institutions.

A commitment to openness and an acknowledgement that schools have a responsibility to society would be a good start. The curriculum should be relevant to the health needs of the country, with emphasis on quality, access and cost-effectiveness of healthcare. Healthcare delivered by the school and its associated institutions should be characterised by the highest professional standards.

If a school structures its activities according to these values, it could attract applicants who share them. If the faculty provides powerful role models, perhaps those admitted with a lesser commitment will come to share its values. In time, the school would establish an assessment framework that would identify those unsuited to medicine.

One remaining problem, however, is the uncertain ability of an 18-year-old to make a judgement about values. Some feel school-leavers should attempt to find out about the medical profession through work experience. But some students are more fortunate than others in that they attend schools or come from families that can open doors better — it is revealing that the BMA only recently issued guidelines about patient consent and confidentiality with regard to these young people.

All this makes a powerful case for graduate entry. The academic standard can be kept high providing some students can reach it through access courses and part-time or distance-learning degrees. It keeps the window of opportunity open longer and lets those mature enough to know their own values identify schools that share them. ■

Lesley Southgate

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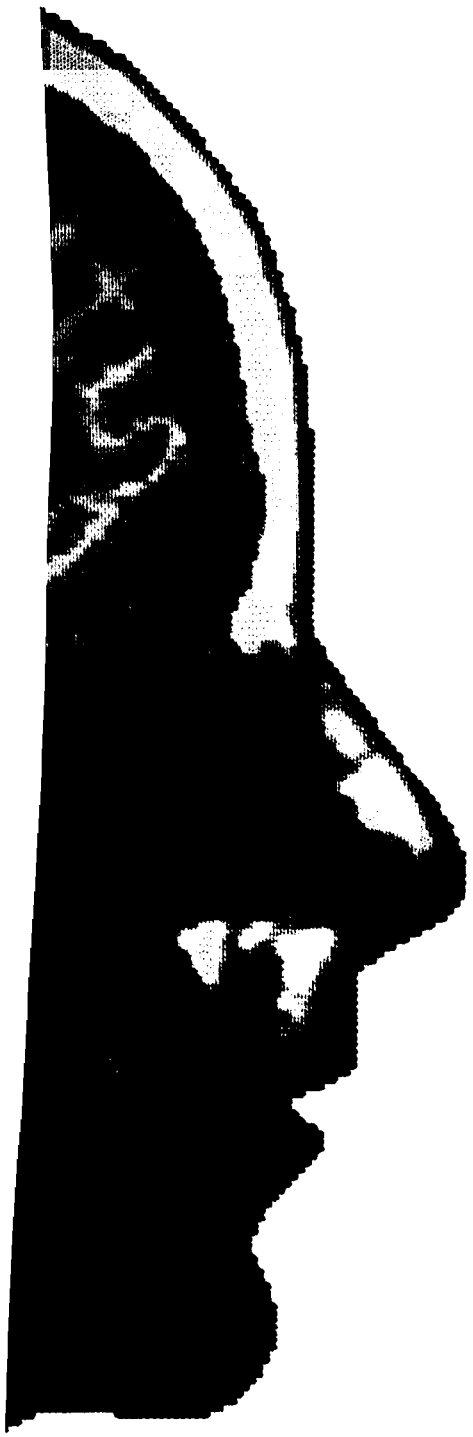
Head2Head

Unnatural selection



Chris McManus

How do we know we are selecting medical students properly? There have been almost no long-term prospective studies of selection and its outcomes.

In the age of evidence-based medical care, student selection is still in the era of phlebotomy, leeches and the clyster. Primarily, we need good data, which must include randomised controlled trials of selection.

This suggestion is often received with the response: 'But these are people's lives,' which is strange considering so many drug trials are the difference between life and death. If RCTs are good enough for patients, they are good enough for us.

We do know a little about student selection, but not enough. In practice, selection is usually determined by A Level grades. These do correlate with performance in medical school exams, but the link is not a strong one, and the sensitivity and specificity would be unacceptable for any screening test in clinical practice.

The worry is that A Levels predict little about being a doctor and everything about passing exams set at a lower cognitive level, instead of assessing the deeper thought processes required for university and professional examinations.

Fortunately, there are enforced limits on selection. Despite prevalent myths, there are not dozens of applicants for every place — about half the applicants are accepted and some of the rejects were never serious contenders.

This means selection can only be a blunt instrument of policy. In contrast, education and training are powerful, keen-edged tools for affecting behavioural change. That we overemphasise selection at the expense of educational process mostly tells us about our collective defence mechanisms.

Our present selection process is one-dimensional, based as it is almost entirely on A Level grades. It at least has the advantage that A Levels are examined in a fair, reliable, professional way by disinterested, well trained examiners. In practice, however, this is devalued because the majority of applicants apply pre-A Level and rely on 'estimated A Level grades' — in other words, a poor and biased guess.

A broader perspective is surely desirable. Intellectual ability, which is reflected in part at A Level stage, is of course part of the picture — and doctors surely cannot be too intelligent. But being a good doctor does not depend only on IQ. Personality is also important, with characteristics such as conscientiousness, motivation and communication skills relating to good medical practice. There is therefore a strong argument for basing selection around evidence of these abilities. At present, selection depends so strongly on A Levels that we cannot allow for anything else.

> 'A Levels predict little about being a doctor and everything about passing exams'

If we believe non-academic factors are important skills for a doctor, we have to reduce our dependence on A Levels and include formal, validated personality assessments in selection.

That is what we should be trying at the moment — not because students selected that way will definitely become better doctors, but because they might. ■

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