Increasing diversity among clinicians

Is politically correct but is costly and lacks evidence to support it

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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 EMDP and are inaccessible to the conventional applicant. The quest for social justice involves sacrificing equality of opportunity, where all applicants are treated uniformly.[9 12] 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 is it 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.

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Preventing child deaths

New report emphasises the need to review the circumstances of death

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There is no question that preventing child mortality should be a priority for all, and this is indeed so in the United Kingdom.[1] With this objective, the Confidential Enquiry into Maternal and Child Health (CEMACH) has recently conducted a comprehensive review of the deaths of all children aged from 28 days to 17 years and 364 days in Wales, Northern Ireland, and three regions of England (South West, North East, and Midlands).[2] This review pre-empts the mandatory review of all child deaths by local safeguarding children boards in England from 1 April 2008.

The aims of the review were to identify and collect core data on all deaths in the five targeted CEMACH regions for the calendar year 2006, to review a subset of these deaths with a focus on identifying avoidable factors, and to consider a national application of the methods. The review undertook a quantitative analysis of a core sample of 957 child deaths. A subset of 126 deaths was selected for closer scrutiny by a series of 41 multidisciplinary panels. These panels were a crucial and critical component of the review process.

The success of the review was dependent on the collaboration of a large number of people and organisations. In particular, the authors should be commended for their collaboration with young people. Increasingly, child health organisations are consulting with young people to provide greater insights into the nature, causes, and potential preventability of such deaths.

The review identified preventable factors for mortality, but because it was not a case-control study the results cannot necessarily be applied to a wider population. These factors were not detected from the core dataset or from the medical certificates but from the findings of the multidisciplinary panel review. The panel considered relevant information describing circumstances surrounding death. Information from death certificates was inaccurate or insufficient in about a third of the cases reviewed.

The report identified cases of high quality care and cases where, despite the best care and services, the child still died. The most worrying cases were those in which the attending healthcare practitioners did not have the competencies, or systems were not in place, to enable accurate diagnosis or treatment or to facilitate efficient communication. In such circumstances, the inability to identify serious illness in the child and start timely and appropriate treatment were identified as factors in the child's death. The report also found that particular effort is needed to improve the detection and follow-up of children with mental health problems.

The review recommended the development of a mechanism for the national application and review of the common dataset. It emphasised the importance of disaggregating data so that patterns and trends of mortality in minority and socially or economically deprived populations can be identified. It was acknowledged that systems and expertise for the collection and review of neonatal deaths were already in place and should be used in future planning.

The report found examples of both high quality and substandard primary health care and emphasised the importance of ensuring the maintenance of paediatric skills among general practitioners. Primary prevention, in particular timely and complete immunisation, is vital in preventing child deaths and serious illness.

Mechanisms for reviewing child deaths exist in many jurisdictions throughout the world. These mechanisms vary in structure and function depending on the practices already in place, including existing legislative frameworks, cross jurisdictional relations, and collaborative