TEACHING AND LEARNING ETHICS

Polemic: five proposals for a medical school admission policy

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Five proposals for admitting better applicants into medical school are discussed in this article: (1) An A level in a humanity or social science would be required, to supplement—not replace—the stringent science requirement. This would ensure that successful candidates would be better "primed" for the medical curriculum. (2) Extra points in the applicant's initial screening would be awarded for an A level in English literature. (3) There would be a minimum age of 23 for applicants, although a prior degree would not be required. This is to ensure that the applicants are mature enough to know themselves and the world better, to make a more informed and motivated choice of career, and to get more out of the humanities components of the curriculum. (4) A year's full-time experience in a healthcare or charity environment would be desirable. (5) Applicants would be given two lists of interview discussion topics to prepare: works of literature and topics in healthcare politics.

As one commentator put it, "just pick the right students and the rest is easy".[1] Who are the most suitable candidates for medical school? Traditionally, the answer in the UK has been: those who do best at science A levels. This is proving more difficult to determine when so many students are getting excellent results, and some schools are relying more on the personal statement to the Universities and Colleges Admissions Service for the UK, on interviews, on common entrance exams such as the Graduate Management Admission Test[2] or Graduate Australian Medical School Admissions Test, or on dubious personality tests.[3 4] In addition, there are debates, similar to those in other public institutions, about the appropriateness of affirmative action for under-represented social groups[5] or of increasing the applicant pool by reducing A level thresholds.[6] I will not be discussing any of these here. Instead, I have five proposals for admitting the right applicants to medical school. The right applicants are those who are both technically proficient and also those who (a) are more capable of understanding the patient and his point of view and thereby providing better treatment and (b) have a greater knowledge of the medical world and of themselves before entering medical school, to increase job satisfaction and therefore performance and longevity of tenure.

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PROPOSAL 1: A COMPULSORY A LEVEL IN A HUMANITIES SUBJECT

Most medical schools presently require two good A levels in science, and that is essential. The stringent science requirement, however, should be supplemented by a good A level (or equivalent) in a humanities subject. The choice of a "humanities subject" is very broad indeed, so even the most scientifically minded student should be able to find something of interest (English Literature, Drama, History, Religious Studies, Politics, Economics, Sociology, Psychology, Philosophy, foreign languages).

It may seem that medical schools have already come a long way in incorporating humanities as compulsory and optional elements into the medical curriculum, and that this has already been recommended in many places.[7 8] The problem with the current arrangement is that the overwhelming majority of students still have a pure-science background both in training and temperament. No matter how many humanities elements are introduced into the curriculum, no matter how compulsory they are made, many pure-science students would not have been sufficiently primed to study the humanities properly, and without prejudice. The result is a lingering resentment of the "soft" subjects, and a widespread belief that their professional training is being compromised by this sop to political correctness. And pure-science students who are, or become, interested in the humanities do not have sufficient time or space to study them systematically because a lower common denominator has to be catered for in provision. This denominator can be raised if the applicants have already understood and appreciated what qualitative research is, what an essay is, and the possible uses and limitations of different kinds of evidence in structured arguments.

Will demanding a humanities A level not put off or exclude some scientifically competent pupils—indeed, some scientifically gifted pupils—resulting in a loss to the medical profession and therefore to society as a whole? I do not believe that one extra A level is such a burden, and it would be a good test of motivation to distinguish between all the high achievers. True, the proposal may reduce the number of scientifically gifted students, but I would suggest that students unwilling or unable to take the humanities A level would be more suitable for a study programme and career in scientific research, and they could contribute to society in that way.

Will demanding a humanities A level not put off students from poorer backgrounds? Not if the humanities A level is their third A level, alongside

chemistry and biology. In combination with one of my other proposals (raising the minimum age limit), the student would also have plenty of time to take A levels after the age of 18, perhaps while in full-time employment during the day.

PROPOSAL 2: EXTRA POINTS FOR APPLICANTS WITH AN ENGLISH LITERATURE A LEVEL

The study of English literature (or indeed literature in any language) has a special place among the humanities, and this should be reflected in the admissions process. Again, I am not discussing the inclusion of literature in the medical curriculum, about which there has already been much discussion;[9] instead, I want to discuss people who are already primed.

In one sense, it is just another humanity, as it deals with the objective study of a text in the same way that historians study the past; it has its own jargon, its own standards of criticism, and there is no essential need to identify with the characters and enjoy the novel, for example. Nevertheless, I maintain that it is a particularly valuable subject for future doctors for three reasons. Firstly, it improves their imaginative understanding of the suffering of individual patients, as opposed to a general understanding of types of patients. The students' scientific understanding deals exclusively in generalisations and types, arranged in causal patterns and correlations, and this is what allows science to progress. It is then tempting for those studying human behaviour to strive for the same scientific credentials by speaking about behaviour types and patterns and causalities—the dread spectre of behaviourism. A grounding in English literature teaches the student to resist the putative completeness of such explanations. Certainly there is room for some generalisations, but there also has to be room for the uniqueness of each human being, a uniqueness that is more than a unique combination of generalisable traits. A sensitivity to such uniqueness calls for a different way of engaging with the patient: not as an object of study (and diagnosis and treatment) but as another subjective point of view on the world. Such engagement is much more than the simplistic notion of empathy that psychologists like to measure, and much more than the simplistic respect for autonomy that many ethicists go on about.

Secondly, and relating to the first point, the study of English literature improves the communication skills of pupils, by encouraging them to be more precise in their choice of words, more sensitive to the resonances of words and phrases and intonation, and more sensitive to the situation and relationship in which the communicators find themselves. It is tempting to reduce such sensitivity to the avoidance of hurting others' feelings by using politically correct language. But for better or for worse, language is far richer than merely a neutral medium to communicate ideas. It is a bearer of culture and identity, an instrument of power and coercion, a key ingredient in seduction and intimacy. With a richer language, the pupil's own experience of the world is richer.

Thirdly, as Nussbaum[10] has argued, reading literature improves a person's ability to discuss complex ethical issues. It is tempting to conceive of ethics legalistically, as a rule book of general guidance that can be consulted and applied without much problem. But, although an ethical judgement often seems to carry the objective force of a legal duty, it is unusual precisely because there is a personal element as well. For the law to work, there has to be a real risk of getting caught; in ethics, however, I can "get away with it" scot-free and yet feel crippling remorse. It is this personal dimension to ethics that requires a personal language in which to express remorse, and such a language can be acquired only by experience, experience that is enriched by the imaginative identification with compelling fictional characters, and by the systematic discussion of the plight of such characters.

PROPOSAL 3: A MINIMUM AGE OF 23

North American medical schools usually require a completed bachelor's degree from all their applicants, and this results in a de facto minimum age of 21 years. There has been some discussion on the advantages and disadvantages of such a policy, compared with the European practice of admitting mainly school-leavers.[11] Some argue that older applicants are more mature and more committed and therefore do better;[12 13] others argue that it is unfair to delay a keen and able school-leaver by forcing him to remain in education 3 years longer. Either way, as Abbasi[14] has argued, current UK practice discriminates against older applicants.

I agree that 3 years of extra tuition fees, living costs and opportunity costs can be burdensome, especially for potential applicants from the lower socioeconomic backgrounds that many schools want to attract. That is why I would have a raised minimum age, but without the degree requirement, so that a person can work full-time for a few years between secondary and tertiary study. Wilkinson *et al*[15] discovered that age accounted for advantages in the case of graduate applicants, rather than the simple fact of having a first degree, and those advantages were "a more understanding approach to patients, better interactional skills, and more diverse skills with which to cope with an increasing range of professional outcomes".

But why not let the keen 18-year-old get on with his studies as long as he meets the competitive academic requirements? For three overlapping reasons, the first is perhaps more controversial than the rest: unlike other university courses, a medical training leads fairly seamlessly into a medical career and the 18-year-old is not ready to make such a momentous decision. Instead, he stumbles onto something under a whole raft of influences, only some of which he is aware of. In many cases, he will discover enough in his original "choice" (the scare quotes are deliberate) that he likes, and his "reasons" (closer to rationalisations, more likely, although not insincere) can be formulated to inquiring parties as and when required along the way. A real risk exists, however, either of dropping out at substantial cost to himself and to the medical school budget, or of being trapped in a training and a profession by sheer inertia, cowardice and lack of imagination. As sincere and enduringly passionate as the applicant may be at 18, it is not a knowledgeable passion. This brings me to the second reason for refusing them.

The 18-year-olds cannot know what they want because most of them have not left home yet. Leaving home requires the definition of many aspects of their adult selves. They have to deal with money and with rent, they have to balance work and play, they have to handle a new kind of aching loneliness, and the uncertainty so typical of a future that is not just open, but wide open. They have the sharp ethical experiences of dealing with a bullying boss or a clinging colleague and of negotiating longer-term romantic liaisons. They have to go through the sex, drugs and booze phase. Above all, they have to learn to live with freedom. All of this will change them in unpredictable ways, will reveal affections and aversions, will strengthen and weaken them in different aspects of their personality.

It may be thought that their youth is an advantage because it means they can be moulded more easily into good doctors, whereas older students are more likely to have entrenched ideas and prejudices. To this, I would argue that there is nothing inherently wrong with having entrenched ideas and prejudices if they are desirable ideas and prejudices, entrenched firmly enough to resist the pressures of the "hidden curriculum", for example. (The hidden curriculum is

a pejorative term for the more traditionalist aspects of informal teaching during a hospital placement. For example, although the importance of patient autonomy is being taught in the medical school, the principle of "doctor knows best" may be, if not taught, then at least demonstrated in the hospital.) If the admissions process works well, the medical school can discover these ideas and select accordingly: with older applicants, we know better who we are getting.

My chosen threshold of 23 years is fairly arbitrary. The idea is that it forces even the university graduate to work for a couple of years in the real world, the main point being, the older the better. At the very least, the onus should be on those younger than 23 to show somehow that they have the required maturity.

One extension of this point is that those doing badly in their A levels at 18 years, including those from under-privileged backgrounds, would be able to retake them without losing time.

The third reason for not letting them into medical school at so young an age is because they will not get much out of the non-scientific aspects of the course. They may end up doing well on the humanistic exam questions, but only in the same cram-and-regurgitate way that has proved to be so successful in their scientific studies until now. But the humanities are fundamentally about human lives and human societies, and the full meaning of many of the concepts used cannot be grasped in the abstract: here, understanding requires more than study, it also requires experience of using those concepts in ordinary situations in our own life. (And such experience is complemented by the study of literature.) For example, the word "vulnerable" is often used by sociologists to describe certain types of people in certain situations; but for this word to be more than an arbitrary taxonomic label, it has to mean something real to the student, and this requires some experience as a vulnerable adult. More broadly, the student has to understand something about his own relationship to the society in which he lives to begin to understand something of the patient's relationship with the same society.

To conclude this section, I would say: yes, this 18-year-old is bright and keen. But he is just too ignorant of what medicine and a medical career entails; he is ignorant about himself and what he wants, and he is ignorant of the wider context of human life. And however good he may be at 18, just think how much wiser and more knowledgeable he will be 5 years later. During this time, if he loses interest in medicine, so much the better for the medical profession in that he discovered this before wasting anybody's time; if he still has interest in medicine, then how much deeper this interest will be, and how much better a student, and eventually a doctor, he will be. This would more than make up for the 5-year loss of service. Anyway, why think of it as a loss? Why think of the 18-year-old as penalised? Put simply, what is the rush? Medicine is unlike any other university course precisely in that it ultimately requires a special kind of commitment to people. A 12-year-old prodigy can study mathematics or music or philosophy or medical research at university, partly because there is no necessary connection with people, and especially with vulnerable people. There are certain things about our patients that we cannot understand unless we have lived a little.

PROPOSAL 4: A YEAR'S FULL-TIME EXPERIENCE IN A HEALTHCARE OR CHARITY ORGANISATION

In their personal statements, the 18-year-olds will typically claim to have shadowed a general practitioner for a couple of weeks and gone to the MEDSIN conference. This is a ludicrously brief and contrived exposure to the environment in which they claim to want to spend the rest of their working lives. And yet it is hardly surprising, as they do not have the time during their secondary school studies. What they need is a full year to gather enough experience to make a more informed decision. Again, such an experience may put the prospective applicant off the profession, but, equally, it may reinforce his initial interest: here, the profession benefits from attracting the knowledgeable rather than the starry-eyed and keen.

It may be difficult to find employment in the NHS for a year if the local hospital has enough auxiliary nurses and porters. But I would allow any paid or voluntary work that comprises 40 h a week of looking after people in need. Sometimes the pay will not be enough to live on, but there would still be the option of living within a voluntary community in return for room and board.

Is this not unrealistic for an applicant from a poorer background who has to work and save up for medical school, and indeed for an applicant who has to work to feed and house a family? It is true that a year of voluntary work may end up delaying a person's first application to medical school, but, in partial response, I would suggest that the benefits of that year (test of motivation, learning about caring) would outweigh this cost. The important thing is that medical school should not be seen as something that one should be in a hurry to enter and get over with.

Voluntary work is more than a matter of discovering one's motivation and suitability for this kind of work; it would also be an important lesson in working as part of a team, in discovering the less glamorous (but arguably more important) side of medicine and even in acquiring some humility. It is bad enough that medical students do not have to graduate through basic nursing skills, such as bathing patients and wiping their bottoms, but they are also surrounded by an aura similar to that projected on to fully-fledged doctors. Without a year of humility, they may well learn to walk the walk of the Big Consultant without a sense of perspective.

Finally, the year in healthcare would provide something meaty to discuss in their personal statement to the Universities and Colleges Admissions Service for the UK, as well as in their interview.

PROPOSAL 5: THE INTERVIEW

Interviews are sometimes criticised for being too inconsistent and expensive,[16] and for discriminating against those from lower socioeconomic backgrounds.[5] I believe that interviews are important, but do not have the space to argue for them here. Instead, I want to suggest how an existing interview format can be improved. All applicants would be asked to prepare several topics from two lists advertised well in advance on the school's website: one list would comprise works of literature (with a medically relevant theme) and the other would comprise issues in healthcare politics.

The interviewers would obviously have to prepare all the topics from both lists, but would only discuss one from each, chosen randomly. Importantly, the discussion would not be a dry academic exercise in textual analysis, but the starting point for a less formal conversation that could go in many different directions, depending on whether, for example, the student can relate the literary topic to aspects of his own life.

The political topic would be something that has recently been in the news—for example, the general practitioner contract, the Human Tissue Bill or the criticisms of New Labour's Health Policy by the Conservatives. Again, the applicant can study the facts and prepare certain things to say, but the discussion could go in many different ways, and this would test the applicant's wider political knowledge, awareness and sensitivity. Some may object that politics is—or at least should be—irrelevant to healthcare and all that they want and need are people with the requisite technical

and interpersonal skills. But surely this is no longer true. Doctors today require a political sense not only to find their feet within the hospital hierarchy but also because they cannot avoid political opinions on the many management and government decisions that affect their work and environment—and their patients and social circumstances. Finally, doctors as a social class are enormously influential in shaping societal attitudes, and they have a special responsibility to keep informed. I am not suggesting that the best doctors will lean to the left or to the right; all I am asking is that they be the type of people who think and care about political issues, in healthcare and elsewhere, and who are willing and able to defend their corner.

One potential problem here is the differing degree to which applicants can be helped and coached in their preparations for the interview. The advantage of an unseen topic is that everyone can approach it on a level playing field. It is already bad enough, some may argue, that applicants from private schools are typically better coached in interview techniques than applicants from state schools, and having a prepared topic would surely exacerbate that.

This question is part of a wider ongoing debate on whether to have interviews at all. What I can say for now is that preparing a topic is different from training a technique. The preparation for a topic does not necessarily require help from a guidance counsellor or secondary school tutor. It is enough that the students read and engage critically with what they read, in a way that could be shown by a discussion on the above topics. I would imagine that socioeconomic origin probably still has to be taken into account, however.

CONCLUSION

Medical schools have come a long way towards improving the curriculum by increasing the content of humanities subjects and communication skills in the past decades. It is not clear how much further such improvements can go with the raw materials at hand. The 18-year-old pure-science pupil is no longer suitable for medicine.

Competing interests: None.

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