CHILDREN OF IMMIGRANTS TO BRITAIN

Edwin de H. Lobo

Hodder and Stoughton London (1978)

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Growing up between two cultures, often in an impoverished environment, is one of the reasons given that children of immigrants have particular health and social problems. Dr de Lobo, a consultant paediatrician in Luton, gives an easily read account of the traditional cultural background for four ethnic groups, Asian, West Indian, Chinese, and European, and explains how this background influences the present difficulties of children of immigrants in Britain today.

One of the underestimated problems is the stress and psychological trauma to which such children are subject. Differences in language, diet, family structure, and cultural roles produce great conflicts of self-identity for the child—within the family, at school, and at work. Changes in cultural behaviour, illiteracy, and poor housing exacerbate the medical problems. For example, the decline of breast feeding and altered weaning habits have led to a reported incidence of dietary iron-deficiency anaemia in 24 per cent of three-year-old Asians in a Luton study. Diseases such as rickets which have a higher incidence among immigrants are also discussed.

This minority group, of unstated size, has medical and social needs which are probably not being met. An awareness of these problems may be a step towards their recognition in general practice, and this short descriptive book provides an interesting introduction to the problem for both general practitioners and paramedical staff. The description of how to record Asian family names rationally is well worth reading for any general practitioner who has Asian immigrants on his list.

CLARE RONALDS

REPORT

Conference on the selection of medical students

UNDER the auspices of the Education Committee of the General Medical Council, a conference was held in London on 22 February 1979 to consider various aspects of selection of medical students. The President welcomed over 100 delegates from medical schools and other interested organizations.

Pre-selection of applicants

Mr Mark Smithies, National Union of Students, discussed the various influences operating *before* students applied to medical schools, including the disproportionately high number of applicants from doctors' families, the design of the public school curriculum, and bias against women and the lower social classes. In addition, financial disincentives operated against some mature students.

Motivation

Mr R. M. Blackmore, House Master, Oakham School, gave results of a survey involving 1,255 students in medical schools in the UK. The most popular reason for choosing medicine as a career was to help the distressed, and this was followed closely by an interest in exploring physiological and biological phenomena. Least often chosen from the list of seven reasons offered was good social standing. Most respondents found it difficult to say exactly why they wanted to enter medicine, and there appeared to be little idea of what medical education entailed. Most thought that a decision to enter medicine had to be made at about 13 to 15 years.

Academic criteria

Discussing the present criteria for choosing applicants, Dr T. S. L. Beswick, University of Manchester, highlighted the shortcomings of the present system of relying on O level grades with predictions of A level grades, but felt that in the absence of other criteria this had to do at present, although other criteria, such as headmasters' reports, were useful adjuncts for selectors.

Personal qualities

Dr W. D. Wylie, St Thomas's Hospital, spoke on assessment of motivation and suitability of applicants for medicine. He believed that high academic achievement did not necessarily correlate with the production of a good doctor; even when combined with good personal qualities it was not possible to place many otherwise suitable applicants. He believed that medical education played a greater part in the production of the doctor than did the selection process. He drew attention to the shortcomings of procedures used in other countries, such as the medical college's admission test (MCAT), the McMaster process of screening by assessing letters written by applicants, and the structured interview. He felt this process might be more feasible in schools which had limited objectives, such as those in Pennsylvania and Negev, where the output of the school was geared specifically to the primary care needs of the community. While information gained in non-structured interviews, used by 21 out of 31 medical schools in the UK, might have low predictive value, it could be helpful to supplement information or redress a balance in doubtful cases.

In presenting a non-medical parent's view, Mr G. M. Tibbs, London, compared selection procedures in different professions and pointed out that the Armed Services, the Church, and the Civil Service often used laymen. Dr D. C. R. Lincoln, Headmaster at Charter House, listed the qualities he looked for, including positive motivation, altruism, good memory, and 'character', but agreed these were not easy to assess.

Discussion

In discussion, attention was drawn to the need to develop a more realistic public image of the doctor and to create amongst undergraduates an awareness of the wide range of careers in medicine. Dr R. D. Lowe, St George's Hospital, indicated that his medical school used interview procedures to sift out applicants who appeared unsuitable on personality grounds.

Considerable discussion focussed on the bias against women and those from the lower social classes, and it was generally agreed that the situation was changing, though there was room for further research. The experiences of some European countries who had bowed to political and social pressures and opened their doors to all who wished to study medicine were felt to be unfortunate. The composition of admissions committees was discussed. The new medical school at Nottingham indicated that the contributions from general practitioners and the lay public in decisions about applicants had been found to be helpful.

The need for action research based on information already available to the medical schools was discussed, and the value of careers guidance in helping students with poor levels of communication.

Professor Henry Walton, University of Edinburgh, challenged the view that the education process was more important than selection and felt that while the selection process did indeed contribute to outcome, there was need for further research. Sir John Walton considered that while selection was necessary to maintain the high standard of medical education, a certain level of academic achievement was also necessary to ensure that the applicant could get through the course.

Overseas applicants

Professor Eric Cruickshank, Postgraduate Dean, University of Glasgow, outlined the changes that had taken place over the last 40 years as British Colonies had become independent and the Commonwealth evolved. The Goodenough Report (1944) had suggested that the primary obligation of medical schools in the UK was to applicants who were born in the UK but that a small proportion of places should be reserved for overseas applicants. In addition, medical schools should be developed in the colonies and UK medical schools could help by educating selected overseas postgraduate students. In implementing these recommendations, the Colonial Development Welfare Scheme set up schools in various former colonies. The Todd Report (1968) had recommended an overseas intake of between seven per cent to 10 per cent per school, and had highlighted the dangers of 'deculturalization' of overseas students. Countries too small to support their own medical schools would have to continue to export their students for medical education. In addition, greater emphasis had been placed in the training of medical auxiliaries in developing countries.

In a recent survey of the medical schools, Professor Cruickshank had found the following factors to weigh the balance in favour of applicants: the presence of racial or political discrimination in the overseas country; absence of facilities for medical education in the overseas country; UK nationality and the family background; those living overseas but educated in this country (UK); those who were completing their higher education in the UK. The last criterion was criticized during discussion because of its possible discrimination in favour of the wealthy. However, from this survey and from a review of the situation in his own medical school, Professor Cruickshank felt that the present criteria seemed reasonably uniform and fairly applied.

Mature students

Professor Whelan, Vice-Chancellor, University of Liverpool, reported briefly on a survey he had carried out in 1978, concerning applicants aged 21 and over, both graduate and non-graduate. While all medical schools took mature students, there was no consistent pattern or trend. The average number of students per school was eight, though Scotland and the London schools were lower than the mean. The proportion of graduates to non-graduates was two to one. The situation appeared to be static. About one in six applicants gained admission (cf. one to four of all applicants). Characteristics of the successful applicants were that they were unmarried, aged less than 24, and possessed a degree in biological sciences.

Asked why mature students were included in their intake, medical schools replied that they provided "balance in the class", that they "worked better", and that in their later careers medicine would benefit from their first degree.

It was possible to challenge each of these assumptions, and Professor Whelan felt there was room for further study.

Accelerated courses

Dr J. Anderson, University of Newcastle upon Tyne, examined the implications of recent proposals to replace A levels with N and F levels. He felt that unless medical schools took a more liberal approach to their entry criteria, the new proposals would create difficulties for applicants. However, it appeared unlikely that there would be changes in the A levels in the foreseeable future. Although there was evidence that some schools

would be willing to shorten their courses for science graduates to four years he believed that the realities of curriculum design, the move towards an integrated approach in medical teaching, cutting across departmental approaches, and influences of the examination structure, all operated against the concept.

Discussion

The discussion which followed centred on the problems of mature students. Opinions varied about the influence they had on the student body and about their subsequent performances, and also about the help available over economical and financial problems peculiar to this group of students. The special position of dental graduates was discussed: many medical schools were reluctant to admit such applicants to medicine unless they showed a clear commitment to oral surgery, and the nation's needs might be met by only one such admission per school per year. Professor W. I. N. Kessel, from the GMC Education Committee, reminded delegates that selection procedures not only selected medical students but influenced (he believed adversely) sixth-form education. Delegates would realize that however many overseas applicants and mature students were admitted, this proportion was of a finite number and could be interpreted as excluding otherwise appropriately qualified UK born students who would work longer as service doctors within the National Health Service.

Comment

It was clear that many delegates shared a sense of inadequacy in the face of the complexity of the issues involved. It was generally felt, however, that given the inherent problems of current selection procedures, selection was carried out fairly and with great care. The need for research into subsequent student performance and performance as a doctor were clearly desirable. The actual administrative structure for the selection process was not discussed but informal discussion revealed that decisions would be taken by as few as one or two individuals or as many as a large complex committee structure allowed. Most medical schools were aware of the need to keep the situation constantly under review.

J. D. E. KNOX
G. R. TUDHOPE

References

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OBITUARY

C. J. Swanson, OBE, MB ChB, FRCGP

C. J. SWANSON practised for 46 years from Aberfeldy, a Scottish small town rural practice. A founder member of our College, he expressed his enthusiastic faith in the value of independent general practice by giving his time to yet another cause, although he was already fully extended.

His unfailing defence of general practice and its *Caritas* was invaluable; he chose the medico-political area, the BMA, and the Scottish and United Kingdom General Medical Committee, from which to further its cause and attained many of their highest offices.

He was the wise and outspoken touchstone for all our medico-political affairs, and the Scottish Office, as well as his Scottish colleagues, practitioners and specialists alike, all missed him greatly when he finally retired a few years ago. His hand in developing many special features which make perhaps the Scottish National Health Service Act a bit more pliable will be clear to future historians. Yet he remained a rugged general practitioner, gaining the affection of his patients and the local community. His sense of fair play made him an excellent chairman; he was hard-hitting in debate and always put the care of the patient first.

His stamina in being able to sustain extensive travelling and hard work on behalf of patients and profession was a byeword, as was his courage in remaining unruffled during landings in rough weather at Turnhouse Airport.

We were fortunate that he was still able to attend some local College meetings in his retirement, when he was full of interest and with his own contributions to make. He will remain more than life-sized in our memory.

E. V. KUENSSBERG

Mervyn Stuart Patterson, MB, Ch.M, FRACGP

ON Christmas Eve, 1978, there died, in Queensland, in his 94th year, Dr Mervyn Stuart Patterson, one of the oldest and most respected general practitioners in Australia.

Qualifying in medicine in 1908 at the University of Sydney, he practised for 61 years in Ipswich, one of the largest provincial towns in Queensland. When he graduated it was usual for general practitioners to undertake all the surgery in their practices. Mervyn Patterson was dextrous with his hands and was skilful