Research Note

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Exploring Equity in Canadian Undergraduate Medical Education Admissions

The diversity in the Canadian population is not reflected in the intake of medical students or the physician population. Although there is greater gender balance than in the past, other underrepresented groups are not making the same strides. This note reports on the preliminary steps in a five-year plan to provide evidence for modifying undergraduate medical student selection processes that support equitable access to medical programs for underrepresented groups using the principles of inclusive education.

Historically, white, middle-class men held the overwhelming majority of seats in Canadian medical schools (Blishen, 1991). Despite the so-called feminization of medicine in Canada, the United States, the United Kingdom, and elsewhere (Notzer & Brown, 1995; Paik, 2000), female students, like their male counterparts, tend to be a socially privileged group (Bellaire, Malhotra, Mrkobrada, & Touw, 2002; Bickel, 2000, 2001). Canadian undergraduate medical students are disproportionately white, urban, middle-class women and men with advanced educational preparation, and with well-educated parents who hold professional or high-status jobs, and live in neighborhoods where the median family income is in the top quintile of the Canadian population (Dhalla et al., 2002). Black and Aboriginal women and men, gays and lesbians, the differently abled, and those from rural and socially or financially disadvantaged backgrounds are among those who continue to be underrepresented in Canadian medical programs.

A complex web of reasons explains why some groups are underrepresented in medical schools. Often cited are financial obstacles that are intimately linked to other social, geographic, and educational disadvantages (Bellaire et al., 2002). To support students from recruitment through to successful completion of their program, academic medical centers have responded in a variety of ways. For example, recent attention has focused on establishing preadmission schools (Searle, 2003; Strayhorn, 1999, 2000), using innovative recruitment strategies (Curran & Rourke, 2004; Frankl, 2003), hiring diverse faculty who model values and attitudes of equity and social justice (Frankl, 2003; Mclean, 2004), deeply incorporating diversity into the curriculum (Baez, 2004), and warming chilly classroom and clinical climates (Beagan, 2001). Collectively, such examples form the basis of inclusive education.

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Inclusive education provides an action-oriented framework for thinking through a multifaceted response. Inclusive education recognizes the qualitative value of justice, the importance of sharing power and decision-making, and the need to expand mainstream knowledge to include the knowledge, experiences, and concerns of all social groups (Dei, 1996, 1998; Vlachou, 2004). Inclusive education is concerned about curricular content, faculty composition, classroom climate, teaching and learning strategies, and, important to this study, access to educational institutions.

Those who support inclusive medical education identify five reasons for diversifying the intake of undergraduate medical students: quality medical education, better health care, improved health outcomes, advances in medical research, and enhanced business outcomes (Cohen, 2003; Lakhan, 2003; Reede, 2003).

Addressing the underrepresentation of marginalized groups is also a time-sensitive issue. Many immigrant, Aboriginal, northern, isolated, and rural communities will for the foreseeable future need an influx of qualified physicians. Second, medical education is a protracted process. Although credentialing foreign-trained physicians is one important solution, a long-term plan is required to achieve greater and sustained change. Taking stock of and modifying current undergraduate admissions procedures is a practical step toward resolving the underrepresentation of historically marginalized groups in medicine.

Canadian medical school admission procedures are bound by many institutional texts that operate at and beyond each local context. Extralocal texts such as accreditation standards, professional medical regulations, and the Human Rights Code of Ethics regulate how schools create and administer selection processes with regard to sex, race, disabilities, and other categories of difference. To date, there are no published studies that examine how and under what conditions Canadian medical schools interpret these extralocal texts in constructing admission policies and procedures.

Studies indicate that medical schools in the US, UK, and Australia have responded to judicial, political, and public calls for equity by implementing quota solutions. Affirmative action, for example, is a tool used by many US universities to promote racial diversity in the student body. Debate is ongoing about the value and effectiveness of race-conscious policies (Berliner, 2001; Bollinger, 2003; Bowen & Bok, 1998; Clawson, 1999; Cohen, 2003; De Ville, 1999; Reede, 2003; Thernstrom, 1997). Focusing on a single category of difference does not, however, take into account the interconnectedness of race with other categories of human difference such as sex, religion, sexual orientation, and place of birth or residence. Moreover, strategies that "add on" race do not get at the deeply embedded relational practices of inclusion and exclusion in the admission procedures.

The first phase of this research provides a baseline survey of the kind and quality of expressed commitment to equity and the various criteria used in ranking applicants to Canadian medical school programs. Data were collected from two sources: (a) equity policies on student admission from the central administration Web sites of all Canadian universities with a medical school;

and (b) medical school application packages and other related Web-based materials available to potential applicants.

Data are being sorted and put into a searchable database using Microsoft ACCESS. Coding and analysis draw from the findings of a US national survey of admission practices in nonmedical health educational programs (Agho, Mosley, & Williams, 1999). This survey found that programs use a combination of cognitive and noncognitive factors in selecting students for admission. Higher priority was placed on cognitive factors (e.g., overall GPA and GPA in foundation courses) than on noncognitive factors (e.g., desire to work in an underserved area) in rank-ordering applicants. These rankings provide insights into the institutional beliefs and assumptions about what constitutes the ideal candidate.

Analysis of the current data will generate working theories about the points of disjuncture between the expressed commitment to equity and the under-representation of some groups in medical school admissions. These findings together with literature on institutional ethnographic studies of the relational processes will lay the essential groundwork for mapping the admission processes. The goal of the larger project is to provide the basis for a politically literate understanding of the medical admissions processes, the mechanisms and practices of inclusion and exclusion, and the conditions for change.

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