Every clinical teacher loves to tell students about significant events in his or her career, and the students seem to enjoy it. Yet we are frequently admonished for blathering on with ‘war stories’ that are more about our desire to be heard than the students’ need to learn.

Quaintance and colleagues from Missouri appear to be giving us permission to tell our stories so long as we do it properly. Clinicians modelling active reflection by talking about their experiences can be an excellent way of teaching professionalism. In this study, clinicians were interviewed by students about instances of positive professional behaviour in which they had been involved (or had witnessed). Stories covered a broad range of professionalism principles: humanism, accountability, altruism and excellence. Students wrote the stories up and reflected on them. Occasionally, they missed the point or just skated over the surface. At other times they gained deep insights, especially into what it means to ‘go the extra mile’ as a professional. Importantly, most students were able to internalise the concepts embedded within the clinicians’ stories, and to empathise with the emotions expressed. So clinical teachers should feel free to reflect on their professional behaviours in front of their students, and to encourage students to do the same.

Selection into medical school remains a topic of keen interest for clinical teachers. After all, the people who go into medical schools eventually emerge as our trainees, assistants and future peers.

The University of Newcastle in Australia has been at the forefront of medical selection for decades. In this very accessible paper, Bore, Munro and Powis present a model of selection that takes the best available techniques to ‘maximise the probability of making accurate, defensible and fair selection decisions’.

Their process begins before candidates even apply for selection by providing enough vocational guidance for potential applicants to make an ‘informed self-selection’ about their suitability for medical studies. Academic achievement – inevitably and appropriately – is next. The authors note that setting the bar too high excludes those from lower social and economic backgrounds, although it does tend to guarantee students’ academic success during the course.

Measuring general cognitive abilities (rather than the specific ones currently measured, such as verbal ability, reasoning, etc.) is suggested as the next step to ensure an applicant pool that is full of very able but still diverse individuals. Personality testing remains contentious, but the results have been shown to have predictive validity for the eventual work role. Moving on from the traditional ‘Big 5’ the authors propose four essential non-cognitive criteria for medical
In practice: ‘Involved with’ rather than ‘detached from’ or ‘manipulative of’ others; ‘emotionally stable’ and ‘resilient’, rather than ‘overly emotionally reactive’ or ‘unpredictable’; ‘self-controlled’ and ‘conscientious’, rather than ‘impulsive’ and ‘disorderly’; and being neither too judgemental nor too permissive in one’s moral or ethical values. How the scores from these tests are combined with the other measures to create an interview pool is complex, but the key is setting a separate desirable range for each variable.

The face validity of the personal interview – whether single or ‘multiple mini’ – is hard to ignore, despite the cost and potential for ‘gaming’. So long as they are structured, rate only observable, important behaviours and are conducted by trained raters, they have value. Medical schools will continue to struggle to select the best students from the mass of applicants: using a research-informed method that is transparent, defensible and equitable is a good start.

Bore M, Munro D, Powis D. A comprehensive model for the selection of medical students. Med Teach 2009;31:1066–1072.

The UK Clinical Aptitude Test (UKCAT) is one example of a test of cognitive abilities mentioned by Bore and colleagues above. It was introduced to medical school selection processes throughout the UK in 2006 in the hope of offsetting some of the limitations of relying solely on academic tests, such as those used in the final year of secondary school (‘A levels’, which tend to miss many applicants’ desirable characteristics, and are influenced by school - background and other socio-economic factors).

The outcome of this study by Yates et al is that it did show a modest correlation between A level and UKCAT scores (and so UKCAT is a suitable proxy before the A level results are released), but that favourable bias persisted towards male applicants, and those from higher socio-economic backgrounds or independent or grammar schools. This does not augur well for increasing the diversity of the medical workforce.

James D, Yates J, Nicholson S. Comparison of A level and UKCAT performance in students applying to UK medical and dental schools in 2006: cohort study. BMJ 2010;340:c478.