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When I say...fairness in selection

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Is a fair society one where everybody of the same ability has the same probability of success? Or where those of equal potential have equivalent opportunities? Or where those who have most to contribute to society have the best chance of making this a reality?

Over the years there has been an impressive drive to improve the perceived fairness of medical selection at all career stages. Yet, even with legal, societal, ethical and financial imperatives for doing so, evidence suggests this drive has had a mixed impact, at best. We wonder if one reason for this is that 'equality' itself is a highly contested concept. What do we mean by equality? Which of the opening suggestions, if any, are most fitting? Do you (the reader) have another view of equality? Indeed, should the term 'fairness', when used in conjunction with student selection, be placed in [air] quotes to highlight its subjectivity? [1] More broadly, '*people who praise [equality] or disparage it disagree about what they are praising or disparaging*'.[2]

Over the centuries various philosophical traditions have informed our thinking about equality. Reflecting our opening quandary, we briefly discuss three of these. Two are well-established ways of thinking, reflected in the many papers on selection and widening access to medicine. The third is the way that we believe the term "equality" should be used.

In libertarianism the concept of proportional equality suggests that those in society of equal ability should have the same probability of success. However, libertarianism itself can clothe itself in both the politics of the left and right. How one achieves the ability that one's potential dictates is often shaped by the society that one is born into. Left-leaning Libertarians would promote access to high-quality state funded, non-selective, education in order to achieve this. Those on the right tend to reserve the best educational opportunities for those with the resources to pay for them, although philanthropy is also encouraged, where those who have grown wealthy through capitalism may choose to support less advantaged members of society ('the deserving poor'). To some extent this thinking is echoed in the creation of 'widening access' or "pipeline" courses and schemes intended to increase access to medicine to the brightest students from disadvantaged or 'non-traditional' backgrounds.

The position of 'moral equality' asserts that everyone of equal potential has the same probability of success in society. This idea comes from the concept of 'human equality', which became increasingly widespread within political thinking from the 17th century. It is most famously enshrined in the United States Declaration of Independence which asserts that '*all men are created equa*l' and '*endowed… with certain inalienable rights*'. The 'veil of ignorance' is a well-known method for determining the ethics of policies from a moral equality perspective. This is a thought experiment whereby one is invited to imagine being born into a society without knowing one's circumstances, *a priori*.[3] In essence, it is a way of attempting to purge personal interests and prejudices from the policy creation process. That is, it encourages policy makers to think more broadly about the potential impact of a policy on all members of a society. Where marked demographic differences occur on key variables it raises questions about whether selection is indeed equitable from a moral equality perspective. For example, in the UK it is well known that 80% of the enrolled medical students are supplied by 20% of the country's schools.[4] This implies that medical selection in the UK may not withstand the "veil of ignorance" test- that is, merely the fact of being educated in a certain high school is likely to greatly enhance or diminish an individual's opportunity to access medical education. In practice, moral equality can be frequently

challenged in cultures, such as the United States, where the 'first language' is that of individualism, and themes of interconnectedness, community and interdependence are relegated to a 'second language'.[5]

More recently the 'capability approach' has been put forward by Sen.[6] Sen proposed five components in assessing capability, one of which is concern for the distribution of opportunities within society. Capabilities denote an individual's opportunity and ability to generate valuable outcomes, accounting for personal characteristics and external factors. The approach has informed the way that, internationally, we estimate the development of a country (e.g. the Human Development Index, which takes into account educational opportunities such as adult literacy and school enrolment). Within this framework an equitable society is one where people are free to realise their potential. Although the philosophy is focussed on the individual we propose it can be extended and combined with elements of utilitarianism to argue that those with the potential to most benefit society should be provided with the greatest opportunities.

Bringing this discussion back to the case of medical selection, who has the potential to most benefit society? Is it the applicant from a good school with high grades, or is it those applicants most likely to eventually work in medically underserved areas? To illustrate how these principles may be implemented consider an example. In Australia, remote, rural areas are medically underserved. Medical school applicants from rural backgrounds, on average, perform less well on selection measures. However, they are more likely than those from urban backgrounds to eventually work in remote areas, where there is a desperate need for doctors.[7] However, saying 'yes' to such a candidate is, in effect, saying 'no' to another applicant- possibly one who achieved higher scores on the selection metrics and could claim 'unfair' treatment. This situation has been legally challenged in the US. The Courts subsequently ruled that such 'positive discrimination' was justified where it was proportionately implemented *"…with the goal of achieving the educational benefits of a more diverse student body…"*.[8] In this case, 'educational benefits' could be assumed to also represent the more general rewards for society of a diverse student intake. This leads us to challenge the predominant discourse in medical selection,[9] often subtly (and not so subtly) echoed in the language used around selection. A linguistic analysis of interviews with UK-based Admissions Deans reported a recurrent emphasis of the 'otherness' of under-represented applicants.[10] For example, one lead for admissions was quoted as follows: "*it's more* ***people with, who come from sort of, you know, socio uh, poorer, more deprived socioeconomic groups, in terms of their families, or their communities, or their own origin,*** *and that and that somehow, success will be defined when you have greater numbers from* ***those backgrounds."*** . The phrases in bold highlight where language is used to group together and stress the 'otherness' of a set of individuals, defining their characteristics through generalizations about their 'different' social and economic backgrounds. More subtle examples of problematic language have been reported in separate qualitative research focussed on high school teachers. It was observed that teachers in UK state schools, unused to having students successfully apply to medicine and perceiving admissions as particularly long and difficult, may only weakly endorse a student's aspirations to apply to medical school, and thereby subtly discouraging them. For example, in this quote a teacher talks of her reaction when students reveal their aspiration for medicine: "*I don't think I've ever been in the situation where I've felt it was my job to say,* ***well perhaps you won't,*** *I just keep it all very factual: this is what you'll need to do this, this is they kind of skills they're looking for, and then they go away and make up their own minds*". Again, the words in bold

reveal the immediate assumption that a medical career is not likely for students from that school. Such 'factual' or 'realistic' responses were well intentioned - seeking to protect a student from disappointment - but nevertheless may work against the widening access agenda.[11]

Every culture and country will also have its own definitions of equality and history shaping the groups of particular interest, as well as underserved populations. However, the principles of a capability approach combined with utilitarianism would seem applicable across different contexts. This can be summarised as taking a 'reverse engineering' approach to selection- where the selection processes are designed to optimise a mixture of entrants most likely to meet the medical workforce needs of the host country. This is not straightforward and there will inevitably be questions about who funds any additional costs for such equitable selection policies.[12] However, without taking a more radical approach to equality in selection it is difficult to see how any significant progress in widening access or in meeting the needs of medically underserved populations will be made.

In conclusion, 'when we say fairness/equality' we mean the triple consideration of fair/equal to the individual applicant, to the varied patient groups to be served, and to the needs of the profession overall.

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Conflicts of interest

None declared