The 1,345rd Meeting of the Brighton and Sussex Medico-Chirurgical Society took place on 2nd June 2016 in the Audrey Emerton Building:

Speaker: Professor Malcolm Reed
                    Dean Brighton and Sussex Medical School.

Title: What kind of doctors do we want and how do we select them?

The talk started with a discussion of what should be the characteristics of a good doctor. Highlighted characteristic points included knowledge, skills, attitudes, values and behaviours.

Reflective questions addressed to the audience included:
Should our medical workforce reflect the society it is drawn from and serves?
Should potential students of ability have a fair and equal chance of becoming a doctor regardless of background?

HealthWatch East Sussex has assessed what clients expect from a consultation with a doctor and factors such as having an understanding of the patients needs, good communication, empathy and time to listen came as the most important factors. Other than a good command of English there were no concerns from a patient's perspective regarding ethnicity or cultural background. Specifically looking at the medical curriculum this question had divided responses with approximately half referring to the academic qualifications required and schools focusing on delivering a science based curriculum whilst others leaned towards the social /nurture pathways.

Can one teach values and behaviors? One can teach anatomy, pharmacology and you can even teach ethics, you can certainly teach about values and that may will be an important thing to do. However, we need people to own rather than learn their values, and for this reason our responsibility as educators may have more to do with modelling, facilitating and supporting than instructing.It may also entail quite a bit of work up front to ensure that we can fully articulate the values we share, and demonstrate that our actions are informed by and consistent with those values.

The next part of the talk focused on challenges in selection for medical school. This is complex and should ideally focus on the values of being a good doctor. The selective process seems to be skewed against applicants from a lower socio-economic background, with a disproportionate percentage of medical students having a private education (31%, with 50% of state schools not having one applicant over last 3 year period).

Brightmed is a BSMS incentive to nurture and guide prospective students from all backgrounds. It helps in the provision of volunteering or work experience opportunities at the hospital and help in practice interviews.
It also provides a liaison person at BSMS that both students and teachers can address queries to particularly in the clear understanding of selection criteria. It also provides an understanding of other jobs available in the healthcare sector and support for students who would be better suited for these. 'Promotional' events aimed at selected students from years 7 to 11 also helps to introduce the world of medicine to students who might not have considered such a career. A career pathway of a current Foundation doctor was highlighted and how Brightmed had help her in selecting a medical career.

Several reports were highlighted proving the need for a wider socio-economic background in the student selection process. Raw figures of applicants over the last 4 years were highlighted. 58% of current medical students are female, with around 12% having a declared disability. The last intake of 2015 shows that *65%* were from state school / 6th form with 14% from the independent sector; 21% were graduate entry.

Multiple mini interviews is one way forward being introduced from 2017 with a series of 'stations' with one or two interviewers with specific focused topics. It provides consistency in content to current structured interviews but more reliable and current suggests less amenable to coaching

What is Global Health? Understanding the social, political, economic and cultural determinants of health and healthcare. This social discrepancy also includes local geography with a 7 year life expectancy difference between affluent parts of Brighton itself.

Measuring Global Health is a complex issue which could include life expectancy, disability life years, quality adjusted life years and infant and child mortality. Data collection is difficult and data quality is variable but is essential to quantify the problem.

90 % of global burden of disease is in the developing countries where only 10% of health care funds were spent. Globally 35% of risk factors are due to malnutrition, poor water/sanitation and hygiene. Unsafe sex and alcohol account for 7%. In contrast only alcohol accounts for more ill health (9%) with rest of the risks factors in the developed world.

Unfortunately 25% of the total burden of global ill health is in children. Two thirds of these children die within the first 48hours from preventable diseases/care. Mental health accounts for 10.5% of global disease but is a 'neglected disease' with depression accounting for 4% of the total and is on the increase. Intentional and unintentional injuries (road traffic accidents), is a significant contributor with 10% mortality.

The 20th century health revolution was due to improved sanitation, nutrition, housing and education (particularly of women) along with drug development and vaccines. However the 21st century health revolution is due to the Human Genome Project finished in 2003, shift from hypothesis driven to discovery driven research, personalized medicine and the challenge to capitalize on the potential to improve human health and well-being. Unfortunately the health

revolution is not global with diarrhea and pneumonia being a major cause of infant mortality. Lack of health care workers in under developed countries compounds the problem. WHO estimates the need of at least another 4 million of Health care workers to deliver health care globally.

The ten Millennium Development Goals which were due to be delivered by 2015 have not been achieved. Four of these are health related:
- Childhood under 5 mortality rates
- Maternal health as many as 350,000 die annually from preventable complications during pregnancy and childbirth.

Prof Newport highlighted the collaborative research between Brighton medical school and Africa. This is important as most research is targeting Caucasian populations and might not apply to the African population.
Neglected medical diseases account for as much as malaria and tuberculosis but have much less research funds. BSMS has led in genetic research on Podoconiosis, a foot condition in the tropics with collaboration with Ethiopian scientists.
Environment and climate change again affect developing countries disproportionally. Emerging infectious diseases could be due to close human/animal cramped living conditions. Reemerging diseases such as Cholera can affect war/refugee populations. Another area of BSMS research is antimicrobial resistance affecting diseases such as malaria,

In 2006, the Brighton Lusaka Health Link was established with this University teaching hospital. The aim is to provide educational and clinical support for health care workers in Lusaka. The benefit is mutual with Brighton staff broadening their experience with short visits being organized for teaching projects. Examples of collaborative projects include an HIV nurses education project to train the trainers, develop the nurses' role and motivate them so they can make a difference.