

Reflections on Otago Medical School in its 150th anniversary year

Peter Crampton

Medical schools are beautifully complex. They sit at the intersection of numerous and only partially reconcilable competing interests. Here I reflect on some of these competing interests as they play out at Otago Medical School (OMS) and on the ongoing evolution of OMS over coming years. Primarily, OMS exists to produce graduates who are equipped to provide healthcare to our diverse and evolving communities with skill, compassion, empathy and cultural safety using diagnostic and treatment technologies that are, like the health system itself, ever evolving and changing. In addition, it is an engine room of research and innovation. Importantly, OMS is embedded in the wider health system on which it depends and which it serves. It contributes to the quality agenda, to health and social policy, to civil society and to broader social movements.

A social contract underpins the operation of medical schools in New Zealand. They are publicly funded in large part. Unlike many degrees where graduates may end up choosing diverse career options, we expect that the large majority of medical graduates will practice medicine and fulfil their part of the social contract by choosing to practice where and how they are needed. Is that expectation fair or realistic? Will it endure? Medical schools have little or no say over graduates' career choices and where they work and certainly no say over the burden of debt that graduates face that might influence their choices. Already OMS selects medical students using a set of approaches that ensure they come from a variety of backgrounds on the grounds that their own backgrounds, rural for example, will influence their future career choices. But is this enough? Should we as a society revisit the social contract, and place clearer and more specific expectations on medical graduates while at the same time removing from them the burden of mortgage-sized student debt?

Medical schools are bound by laws, regulations and rules. They work within a strict and constraining regulatory environment, where the quality of education, clinical safety and cultural safety are paramount considerations. At the same time,

medical education is reliant on wide networks of literally hundreds of community-based organisations and hospitals that host medical students and provide a large component of their education. In all these settings patients and whānau have a right to be safe and to feel cared for when they interact with medical students. The safety and quality of patient care and of students' learning is reliant on trust, professionalism and the strength of relationships between the medical school and its myriad partners. What does the future hold? As the number of medical students and other professionals being trained increases, the pressure to find training places will become more intense. The social contract with the public health system includes the education and training of future generations of health professionals, but what if the health system is pushed towards increased privatisation of service delivery? The social contract won't apply and commercial considerations will most probably take precedence over training. It is hard to predict the consequences of any such shift, but they may include increases in medical student fees and the prospect that some aspects of training will be increasingly limited to working with the stratum of society that can afford private healthcare.

Medical schools are equally blessed and cursed with the burden of the social desirability of medicine as a career. The intense competition to enter medical school is partly a consequence of this social desirability. It is a blessing that medical schools attract highly motivated, bright and altruistic students. However, because of the focus on academic achievement at secondary school, medical schools also face pressures to accept students who have had the benefit of the "right" educational pathways to the exclusion of similarly capable students who may not have had the same educational opportunities. Otherwise highly suitable Māori, Pacific and rural background students were turned away from medical school entry for far too long. This is less the case now because of affirmative selection policies. These policies increase the diversity and representativeness of medical classes through raising the participation of members of

population groups that have been historically excluded or under-represented, while at the same time complying with the academic requirements for entry into medical school. While affirmative policies continue to be contested, they are one of our most effective tools for recognising and correcting systemic barriers that disadvantage students from less privileged backgrounds.

It is a fact of medical school life that their parent universities have clear expectations of them to attract high-quality staff, to tap into rich seams of research funding, to bring international recognition and prestige to the university and to attract large numbers of aspirant first-year students. The challenge of medical school leadership—one might say the paradox—is to meet the needs of the university while still ensuring the sense of social purpose of the medical school is preserved. In particular, the medical school must continue to be responsive to society's changing expectations and needs, ensure ongoing innovation and adaptation of the curriculum and meet regulatory and accreditation requirements. These objectives must be achieved within universities that face their own internal and external pressures and sometimes don't understand medical education very well. Hence, the old cliché goes that there are two types of university—those that don't have a medical school and wish they did, and those that do have a medical school and wish they didn't.

Medical schools are critically important, and expensive, social infrastructure. It is safe to assume there will be a third medical school in New Zealand at some point in the future if the population grows as expected. At the time of writing, the decision on the Waikato medical school has not been announced. My experience working with Australian medical deans over many years is that even though a new medical school may be born out of a tawdry political process that had little to do with society's needs and more to do with a marginal seat, once the decision is made then neighbouring medical schools and their health provider partners work together in a collegial and constructive way to make everything work. In the New Zealand context, this would mean medical schools working together with hospitals and general practices to ensure adequate training placements for increasing numbers of medical students. If the Waikato medical school does not go ahead, OMS will

need to decide at some point in the future when it believes it is at or beyond its optimal size for quality and logistical reasons, and advocate for a sound process to develop a third medical school.

It is very disturbing to see the current United States (US) administration's attack on its universities. Universities there appear to be under pressure to suppress African American histories, contributions and participation, and to acquiesce to other demands of the administration. Given that US culture wars have already found expression in New Zealand, how should OMS prepare for the hopefully unlikely eventuality that it comes under political pressure to take its focus off Māori participation and relegate the place of hauora Māori in the curriculum? I hope that wider society will swing in behind the university to support its commitment to Te Tiriti o Waitangi and equity of participation for Māori. I hope too that wider society will recognise and support the social and health quality dividends that result from proportionally representative participation of students from Pacific, rural, low socio-economic and other under-represented communities.

Also on the political agenda are debates about the definition of what it means to be a woman and a man and about gender diversity. Regardless of the political debates, OMS has an obligation to provide a welcoming and safe work and learning environment for all its staff and students. Despite the long history of misogyny and sexism in medicine and more generally in healthcare, over the past 30 years the proportion of females in medical classes has increased from about 50% to now being about 57%.¹ This trend is positive and helps to redress historical under-representation of women in medicine. Over the same 30-year period the proportion of female students in the University of Otago as a whole has gone from about 56% to about 62%.¹

I love all this complexity. I look at the new generation of leaders in the University of Otago and the medical school and the strong representation of Māori and women, and I believe that OMS is well positioned to celebrate 150 years of achievements and to tackle with confidence the opportunities, complexities and challenges that lie ahead. I feel immensely privileged to have had the opportunity to work with medical school colleagues and students over many years. I wish the OMS ongoing success.

COMPETING INTERESTS

PC was Pro-Vice Chancellor of the Division of Health Sciences and Dean of the Otago Medical School over the period 2011–2018 and led the introduction of the Mirror on Society affirmative selection policy.

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