Equal opportunities to all ethnic groups: from aspiration to reality

Ethnic and gender variations in university applicants to United Kingdom medical and dental schools
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Aim
To explore ethnic and gender variations amongst applicants to undergraduate United Kingdom medical and dental schools.

Method
Retrospective analyses of University and College Admissions Services (UCAS) data on all students applying to study pre-clinical medicine and dentistry, during the academic years 1994/5, 1995/6 and 1996/7. Information for each medical and dental applicant included age, gender, social class and ethnic group.

Results
Of all applicants, just over half (50.2%) were male, though a greater proportion of applicants to dentistry were male (54.1%) than for medicine (49.3%) (OR=1.21, 95% CI=1.15, 1.28). Over one third (36.4%) of all students were from minority ethnic groups, a larger proportion of which were dental students (48.3%) than were medical students (33.8%) (OR=1.83, 95% CI=1.73,1.94). There were also marked differences between medicine and dentistry when the ethnic groups were examined separately. The largest number of applicants from minority ethnic groups came from the Indian community, and this group increased in size annually by 4.1% ($P<0.05$) for medicine, and 29% ($P<0.05$) for dentistry.

Conclusions
Significant inter-ethnic and gender differences are observed amongst applicants to medicine and dentistry. Dentistry appears to be relatively more attractive to minority ethnic applicants.

In Brief
- Dentistry appears to be relatively more attractive to minority ethnic applicants than medicine
- The Indian community form the largest minority ethnic group applying for medicine and dentistry
- There are clear inter-ethnic differences in those applying to study medicine and dentistry.

Comment

This paper about the ethnic and gender variations in university applicants to the UK medical and dental schools raises many interesting and compelling points worth further consideration. Ethnicity is difficult to define. Self-identification with cultural traditions may be the best way to provide a meaningful social and racial identity. Unlike the 1991 census, the ethnicity data collected by the University and College Administration Services (UCAS) were based on self-identification rather than the country of origin (more than 50% of the ethnic minority groups today are born in the UK and the proportion is on the increase). It is assuring to note from Bedi and Gilthorpe's findings that medicine and dentistry are attractive to minority ethnic youth, though to some and not all groups. The achievement of those from Indian origin is impressive.

It is well recognised that minority ethnic groups are not homogenous but diverse with different cultural, religious and social background.[1] They have different aspirations. Some of them managed to break the cycle of disadvantage and inequality. Many others are still trapped in it with more evidence of social and economic exclusion.[2] Achievers or not, the issue most feared by all minorities is racism and in particular institutional racism and discrimination by the majority. It increases inequality and injustice, contributes to social exclusion, restricts ambition and equal opportunities, and increases anxiety, insecurity and ill health. Building on the experiences of some of the well-established minority groups (for example the British Jews), the British South Asians community found the route of education is the best to break the cycle of disadvantage. Others still have much work to do and in particular the British Black, Chinese and Bangladeshi. However, despite a steady rise annually, the gender difference among certain group (Pakistanis in this paper) which could be attributed to the interpretations of the religious codes, is quite worrying.

Bedi and Gilthorpe's mixed message did not go far to explain the reasons for these differences between groups and gender. It did not tell us also whether the increased applications are linked to specific universities where minority ethnic groups tend to concentrate (for example London, West Midland, West Yorkshire and Manchester): areas of more cultural diversity and cultural competencies by the majority population. They did not tell us the reasons for the drop in percentages among those commencing pre-clinical medicine and dentistry compared with the application to study the two subjects. Furthermore the authors did not give us any hints or suggestions for solutions. Acheson in his report on inequalities in health have highlighted some of the possible measures to reduce poverty, address inequalities, improve safety and living standards of the some of the disadvantaged ethnic minority communities.[2]

We hope that some of the evidence provided by Bedi and Gilthorpe will be part of a process of natural justice and fairness in a society which gives every one the opportunity to contribute on the basis of ability rather than ethnic origin, gender, colour of skin or social status. However, we need to develop a reliable and robust system to monitor ethnicity in all aspect of daily activities. The achievement of equality and social justice will be measured not only in number of applications but also in the number of those given the same opportunity to do the same jobs in medicine and dentistry, for example,[3] opportunity for senior position in professional and public appointments and less racial harassment and attacks. While Bedi and Gilthorpo are right in exploring the educational attainments of various ethnic groups in the UK, what is important is translating it to equal opportunities for all irrespective of colour, culture, religion, social status, country of origin or gender. I believe, that without political commitment these goals will continue to be aspirations for many ethnic minority groups.

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1 Rawaf S, Bahl V (eds). *Assessing health needs of people from minority ethnic groups.* London: Royal College of Physicians, 1998.
2 Acheson D (Chairman). *Independent Enquiry into Inequalities in Health Report.* London: The Stationery Office, 1998.
3 Esmail A, Carnall D. Tackling racism in the NHS: we need action not words. *Br Med J* 1997; **314**: 618-619.