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THE NEXT GENERATION

Currently, Australia is in the business of making more doctors. We will soon have 19 medical schools producing well over 2000 graduates per year — a worthy endeavour in the current doctor drought, but this rapid expansion is creating some interesting challenges.

One problem is how to select the best candidates for medical school entry. Different schools have had different approaches but, currently, applicants to nine Australian graduate medical schools sit for the GAMSAT (Graduate Australian Medical School Admissions Test), a written test of basic science knowledge, problem solving, critical thinking and writing. It's a big, stressful and expensive hurdle for both the would-be-doctors and the selectors, and there is conflicting evidence about whether GAMSAT, or the interview process that often accompanies it, predicts the quality of the final "product". On *page 120*, Groves et al add to the available information with their finding that GAMSAT and interview results have little bearing on examination results in Year 2, or specific tests of clinical reasoning administered in Years 2–4. Part of the problem in the selection process, say McManus and Powis (*page 118*), is that the outcome measures that characterise a good doctor are difficult to define:

"*In medical school and beyond, most measures of competence assess knowledge, whereas being a competent, safe and effective doctor probably depends to an equal extent on behaviour, attitudes and approaches*".

They add that, in order to resolve our questions about medical school admission, we need to lift the quality of the evidence, despite the usual objections. After all, "*If RCTs are ethical when assessing the effectiveness of drugs given to patients, they are surely also ethical for assessing the efficacy of tests used for selecting the doctors giving those drugs to patients*".

Having gained admission, medical students find themselves in the equally evidence-poor zone of medical education. Hays (*page 110*) describes medical schools as "*two-team institutions*", in which the researchers power ahead collecting evidence in the biomedical and clinical sciences, while the teachers teach quietly in the background, relying mainly on "*experience, opinion and rumour*". For those sceptical of this harsh assessment, Hays provides a convincing list of evidence gaps, which strengthens the argument that "*… it is time for medical education research to enter mainstream research agendas and become a research priority for universities*".

Medical education does not end at graduation: doctors in their early postgraduate years need ongoing training. In recognition of this, the Confederation of Postgraduate Medical Education Councils has recently launched the draft Australian Curriculum Framework for Junior Doctors. Gleason et al (*page 114*) applaud this initiative, but caution that it needs to be "*well resourced and implemented in an effective manner with substantial input from junior doctors*". Educationalists Lake and Landau agree (*page 112*) and add that junior doctors "*… also need to understand their responsibility in this partnership of learning*". Assessment is one sticking point, but this could be less contentious if it were aimed at assisting rather than blocking progress.

OUTSIDE THE SQUARE

Much of the material published in the *MJA* is based on, and adds to, a firm foundation of earlier work. Studies such as that of Cugati et al, which estimates incidence of diabetes and impaired fasting glucose in an older Australian population (*page 131*), are important because they quantify a known problem, while those of Thomas and Nestel (Management of dyslipidaemia in patients with type 2 diabetes in Australian primary care, *page 128*) and Calver et al (Stimulant prescribing for the treatment of ADHD in Western Australia: socioeconomic and remoteness differences, *page 124*) provide feedback on current practice. The Journal also has a role in helping authors to express dissent, put forward new ideas or report the unexpected. For those who enjoy a mind stretch, Patel (*page 136*) tracks the recent history of meningococcal disease in Australia and suggests that, while monitoring the effect of vaccination initiatives on the evolving host–microbial ecology, "*… we must also find ways to optimise our coexistence with microbes*". Keks et al (*page 142*) acknowledge that, in the past, co-prescribing different antidepressant medications was extremely hazardous. This approach is still not evidence-based, but, with a wider range of drugs now available, it may sometimes be appropriate under specialist supervision. Gibson et al (*page 152*) impart the important message, learned from five deaths in Australia, that it is possible for a patient with a naltrexone implant to die from an opioid overdose. And, in *Letters* (*page 156*), where dissenting voices most often hold sway, Lawlor and Billson explain how the practice of encouraging people to register their wishes about organ donation may have actually reduced organ donation rates in NSW.

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ANOTHER TIME … ANOTHER PLACE

I have often asked myself why it is that medical education is so discussed by the profession, why this never-ceasing upheaval. We do not see the education in law, we do not see the education in theology, a matter of constant dispute and agitation … The agitation is but a sign of the unrest in medicine we see everywhere.

Jacob M Da Costa, 1893