Letters

Role of the medical community in detecting and managing child abuse

To the Editor: I thank Oates,[1] and Gwee and colleagues[2] for writing on the role of the medical community in detecting and managing child abuse. I would like to add to the points they make. Doctors have a crucial role in medical follow-up for children in out-of-home care. Many children in out-of-home placements have complex needs, with physical and mental health disorders.[3] Placement breakdowns mean that some children lack consistency in medical follow-up, which can lead to complete treatment drop-out. This is a significant risk factor for children in care.[4]

Keeping the child health passport up to date can help with handover of medical conditions for children changing placements. General practitioners can assist with handover by keeping a log of prescriptions issued, with photocopies of private scripts.[5] A doctor should highlight in the medical record when a patient is a child in care, making note of the name of the person who attends with the child, which organisation he or she works for, and details of the responsible government department and case worker. Such details can be useful to track a new abode for the child, particularly in the context of a missed appointment. Details of the guardian are also valuable when seeking consent for treatment.

Medication safety can be promoted through: carers leaving prescriptions at a designated pharmacy; weekly or fortnightly dispensing; use of Webster-paks; and the safe storage of medications by carers. The medical community can, with documentation and attention to prescribing, assist with the medical management of children in care.

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1 Oates RK. Role of the medical community in detecting and managing child abuse [editorial]. *Med J Aust* 2014; 200: 7-8.
2 Gwee A, Coghlan B, Rayner C, et al. Fortnightly emergency department case-file audit for timely detection of missed cases of suspicious injury [letter]. *Med J Aust* 2014; 200: 23.
3 Tarren-Sweeney M, Hazell P. Mental health of children in foster and kinship care in New South Wales, Australia. *J Paediatr Child Health* 2006; 42: 89-97.
4 Golding K. Helping foster carers, helping children: using attachment theory to guide practice. *Adoption & Fostering* 2003; 27: 64-73. doi: 10.1177/030857590302700209.
5 Hollingworth S, Duhig M, Hall W, Scott J. National trends in the community prescribing of second-generation antipsychotic medications in Australian children and youth: the incomplete story. *Australas Psychiatry* 2013; 21: 442-445. ❑

> “Doctors have a crucial role in medical follow-up for children in out-of-home care”
>
> Beckmann

Removing the interview for medical school selection is associated with gender bias among enrolled students

To the Editor: Wilkinson and colleagues recently presented data showing a reduction in female graduate-entry enrolments in the University of Queensland's medical program,[1] and suggested that this was due to the removal of interviews from the selection process and gender bias in GAMSAT scores.

This explanation is a poor fit for the observed data ($r^2 = 0.586$; see Box 1). The GAMSAT gender bias explains why male students were favoured (and not female), but Wilkinson et al did not explain why removing the interview would directly impact enrolments. Since the magnitude of the GAMSAT bias has remained stable over time, the yearly increase in the magnitude of bias towards male enrolments from 2009 until 2012 remains unexplained.

We present an alternate hypothesis: that the gender bias occurred due to the increase in school leaver pathway enrolments, and the corresponding decrease in direct graduate-entry places offered ($r^2 = 0.956$, Box 2).

LETTERS TO THE EDITOR

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Before 2009, about 130% of the expected intake was shortlisted for interview using GAMSAT score as the ranking criterion. From 2009 onwards, 100% of the intake was selected using GAMSAT ranking only — thereby raising the cut-off score. Given the male GAMSAT bias, this resulted in the small increase in male enrolments between 2008 and 2009.

Data from Wilkinson et al show that since 2010, the school leaver pathway intake has increased substantially but the total domestic enrolment has remained constant. This reduced the number of places offered to graduate-entry applicants, which resulted in higher GAMSAT cut-offs[2] that favoured male applicants due to the underlying GAMSAT gender bias.

We believe that the dramatic bias towards male graduate-entry enrolments in 2011 and 2012 is a direct consequence of the reduction in the number of places offered. To restore gender equity in a GAMSAT-based ranking system, we recommend that the School of Medicine restore the graduate-entry intake in future cohorts to prior levels.

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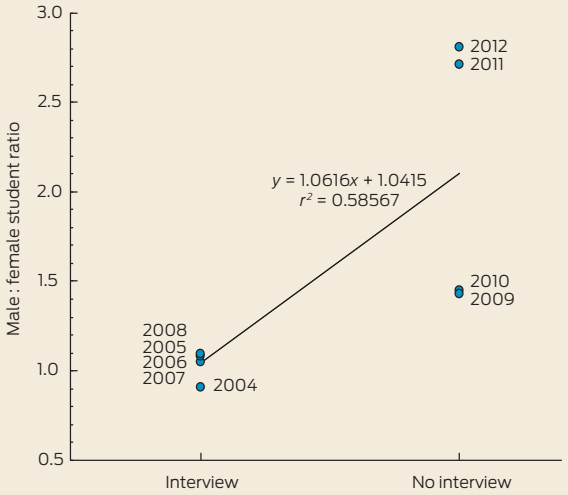
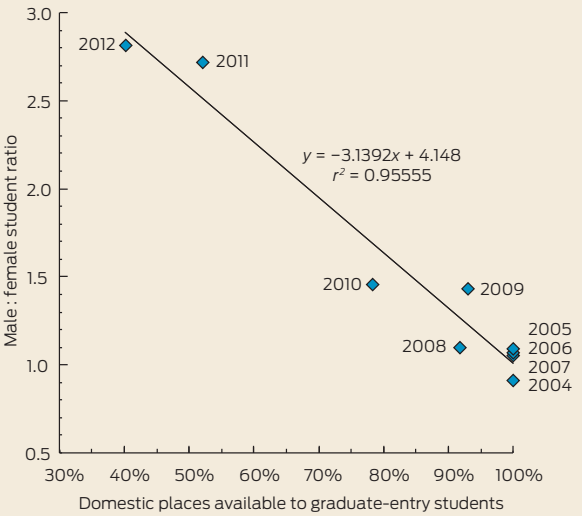
1 Wilkinson D, Casey MG, Eley DS. Removing the interview for medical school selection is associated with gender bias among enrolled students. *Med J Aust* 2014; 200: 96-99.

2 University of Queensland. Doctor of Medicine (MD) - Direct Entry for Graduates. http://www.uq.edu.au/study/?page=189904 (accessed Jul 2014). ❑

1 Gender ratio in graduate-entry enrolments with (2004–2008) and without (2009–2012) interviews in the selection process



2 Gender ratio in graduate-entry enrolments, and the proportion of domestic medical program places available to graduate-entry applicants



In reply: We thank Behrendorff and Liu for their interest in our paper and their insightful comments. We acknowledge the validity of their argument that gender bias may be associated with a decrease in the number of direct-entry, or domestic, graduate places offered at the University of Queensland (UQ) School of Medicine. However, we would counter that the change in numbers across the two domestic entry pathways is another contributing factor, rather than an alternative hypothesis. In our article we point out that the change in gender ratio was associated with the removal of the interview, not that it was caused by the removal of the interview. As with graduate medical student performance in general,[1] there are likely to be a number of interacting factors underlying the change in gender proportions at UQ. For example, the possibility of changing characteristics within the GAMSAT candidate pool is worthy of exploration. Further research is underway to help identify the factors related to the gender differences in GAMSAT performance as well as the underlying causes.

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1 Blackman I, Darmawan IGN. Graduate-entry medical student variables that predict academic and clinical achievement. *Int Educ J* 2004; 4: 30-41. ❑