Clinical Medicine 2009, Vol 9, No 5: 410–11

Recruiting physicians to core medical training: how should it be done?

Liz Berkin and Bill Burr

In 2009, the Royal College of Physicians (RCP) undertook the coordination of recruitment to core medical training (CMT) for the first time. Given the recent history of medical recruitment in the UK, this was a high risk and politically sensitive area.

Before 2007, and again in 2008, trainees could make unlimited numbers of applications to individual trusts or deaneries, and there was massive reduplication of recruitment work. In 2007, the Medical Training Application Service (MTAS) was introduced in an attempt to coordinate recruitment, and became synonymous with disaster. Coordinated recruitment has the potential to make much more efficient use of resources, especially the valuable time of applicants, recruitment staff and consultants. With unlimited applications, finite interview capacity results in competent, but 'weak on paper' applicants being excluded by shortlisting, and high-achieving applicants getting multiple interview offers which they do not need and are therefore wasted (up to 40% in 2008). The Department of Health invited bids to pilot nationally coordinated recruitment for 2009, and the RCP responded to this challenge for CMT recruitment, believing there were important benefits for applicants, patients and the service.

Applicants for CMT posts in England applied for Core Training Level One (CT1) posts in January 2009 via a national web-based system (Konetic Powered Recruiting). The system allowed electronic flagging of eligibility issues, which greatly improved the efficiency of longlisting. At this point the intention was to offer a guaranteed interview to all applicants between deaneries, while using an invigilated test (machine marked test, MMT) to move applicants if necessary, to utilise all of the interview capacity. Additionally the MMT would provide a knowledge score to contribute to overall assessment. The proposed MMT was an established test of applied knowledge, problem solving and professional judgement, developed for general practice recruitment (see www.gprecruitment.org.uk/recruitment/assessment_process.htm for further information). The intention was to use the MMT only as a knowledge score, and not for exclusion (historically general practice (GP) recruitment excluded the lower 10–15% on the basis of the MMT result).

In the event, although data collected from CMT applicants who also applied for GP training in 2008 had already shown that the MMT had good predictive value for CMT appointability, the Modernising Medical Careers Programme Board required that the MMT should be used only as a pilot, and that applicants should be allowed to apply to two deaneries. Because of insufficient CMT interview capacity (over 4,000 interviews would have been required to allow all eligible applicants to have two interviews), this re-introduced the unavoidable need for shortlisting. The electronic application system allowed refinement and shortlisting based on applicant selection from drop-down lists. Inevitably, over 40% of applicants were excluded from either their first or second choice deanery and a few were excluded from both choices. This undesirable outcome (of a two application per applicant system where interviews are limited) was predicted.

An article by Patterson *et al* in this issue (pp 417–20) includes the results of the 2008 and 2009 pilot studies and shows that both components of the MMT remain very good predictors of CMT appointability, and perform at least as well in CMT-only applicants as for those who also apply to GP. There were fears that CMT applicants, knowing the MMT mark was to be discounted, would underperform. There is no evidence that this occurred.

The MMT performed better than the shortlisting score (obtained from the application form) in determining appointability as judged by interview. Clearly any method used to select applicants should avoid using a pre-interview hurdle that excludes potentially appointable applicants if at all possible. However, if exclusion is required (in order to match interview capacity) the method used should have the best possible correlation with any subsequent assessment score in the interests of fairness. The interview score is currently the 'gold standard', but interviews alone, particularly when using a single panel, are imperfect. CMT recruiters used a nationally standardised three-station approach in 2009, and added the achievement score to the interview score to obtain the final assessment score.

The future of medical recruitment lies in an assessment-centre approach, where applicants have a number of opportunities to gain independent marks in stations which test a comprehensive range of the required attributes. Clinical knowledge, problem-solving abilities and professional judgement are uncontroversial requirements for a physician, and it has been shown that the MMT can test these adequately. CMT recruitment in 2010 will move to a one-application system. Although the MMT will not be used for CMT recruitment in 2010 for practical reasons, this method is under serious consideration by a wide range of specialties for use in 2011 as a method of

Liz Berkin, Associate Medical Director; **Bill Burr,** Medical Director

Joint Royal Colleges of Physicians Training Board, Royal College of Physicians

matching to interview capacity, and forming a component of the assessment score. It will not replace other forms of assessment, but because it tests important attributes, which are not otherwise assessed, it is likely to enhance an overall assessment score.

Address for correspondence: Dr L Berkin, JRCPTB, 5 St Andrews Place, Regent's Park, London NW1 4LB.
Email: liz.berkin@jrcptb.org.uk