Selecting for CME: Making the Right Choice

Jocelyn Lockyer, PhD

For two and a half years, I have had an opportunity to serve as Chair of our Admissions Committee, in addition to my work in CME and Professional Development. Where previously my role has been to consider how the University can support all physicians who practice medicine, my mind had to turn to how we choose people for a career in medicine. I immediately stepped into a very different world. Picking people for medicine involves selecting certain people, while declining others. It means trying to determine who will succeed in medical school and residency followed by participation in lifelong learning.

It bears noting that some of the people we select for the class of 2011 will work as physicians through to 2050. That in itself is a sobering reality. Decisions made today will affect the people of Canada and the healthcare system for decades.

It is impossible to know what medicine will entail over a physician's career. The role of medical expert is clearly on the table as it has been for centuries. It is likely that the competencies embedded in CanMEDS will continue to guide expectations for many years. But how will the roles of professional, communicator, manager, scholar, advocate and collaborator play out over four decades? Will some of the CanMEDS roles become more important while others shift to lower priority? How will specialties, patients, healthcare institutions and governments decide upon the roles that physicians play?

It is an important job to select people who have the aptitude for medicine and who can sustain their interest and their competence throughout their professional life. It is a task that the profession and the medical schools take seriously. Many resources, generally *pro bono*, go into the selection of the members of each class. In our school alone, 20 people will spend 80 to 120 hours reviewing files to select those applicants who will proceed to the interview. Another 108 will dedicate a full day from their busy lives to interview applicants. Committee and staff work is on top of that.

Currently, every medical school in North America has a different perspective on the "best" applicant for their curriculum. Generally, schools look at applicants against two templates predetermined by the Faculty:

- cognitive ability and
- non-cognitive attributes.

However, the details of what admissions committees look at can be quite variable as can the weighting

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that is assigned between and within the various components.

It is widely acknowledged that cognitive ability can be determined by the student's grade point average and their Medical College Admission Test (MCAT) scores.[1] Some medical schools will assign more weight to those who go to university longer (*e.g.*, those with honours or master's degrees) compared with those who have been in university for only two years. Other committees will consider the school of graduation or type of university program differently, believing that graduates of some programs and some universities provide a higher quality of education. Similarly, schools may use all or part of the MCAT results in conjunction with grade point average. Some schools do not require the MCAT. There are many formulae that determine how much grades are worth in comparison to the MCAT.

Non-cognitive attributes (*e.g.*, reliability, responsibility, team work, communication skills) are also subject to different perspectives and different scoring. Some schools depend on a student's autobiographical and essay data to inform the process. Other schools, challenged by data that suggests some students do not prepare these documents independently, may minimize or exclude these data in their decision-making. Reference letters can be difficult to interpret and may tell the committee more about the writer than the applicant. Weight provided to extracurricular and work history can be variable and usually needs to consider the applicant's age.

Recently, the role and format of the interviews has undergone scrutiny as it has become clearer that interviewer idiosyncratic perspectives and synergy between the interviewer and interviewee can skew scores. In Canada, most medical schools have adopted the mini medical interview (MMI), pioneered by the DeGroote School of Medicine (McMaster University).[2] With the MMI, applicants will have eight to 14 short interviews (eight to 10 minutes), each at a different station (room). Each mini interview will assess a different trait or attribute. There may be both face-to-face and written stations. Training of interviewers helps to assure that this group understands the goals of the medical school, the nature of the station and the scoring system.

When finally done, it is not unusual for Medical School Admissions Committees to use eight or 10 variables in reaching decisions about who will be offered a position and whose application will be declined. The potential to be a lifelong learner and the ability to adapt to changes in the practice of medicine, will be, at best, a small component of the selection process.

However, unlike the selection for medical school and residency, everyone who completes their training gets admitted to professional development. Working at this end of the medical education continuum, my colleagues and I must now consider how we can sustain and continue to enhance the skills and knowledge of those who graduate from medical school and complete residency programs to ensure that Canadians have physicians who embody both the medical expert role and the other roles inherent in CanMEDS. This is an equally daunting task. Identifying group and individual learning needs, developing curricula and evaluating outcomes are all part of the challenge.

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