Techniques in medical education

Making medical recruitment practices fair

Summary

The fact that in the past each medical student was assured of a post when qualified has led many in medicine to believe that selection for recruitment is merely a formality based on qualification and accreditation. Consequently little thought has gone into developing detailed person or post selection criteria. As a result most recruitment panel members are unclear on what basis to discriminate between equally qualified candidates and invariably plump for 'the face that fits'. This practice discriminates against women, black doctors and those white men not quite acceptable in manner, dress or attitudes. In this article, advice is offered on the development of equality strategies for public sector organisations and on the implementation of fair practices.

Keywords: equal opportunities for doctors, recruitment practice, selection criteria, discrimination in medicine

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Junior doctors may be very demoralised by the *ad-hoc* nature of selection which they perceive as discriminatory. Informal interviews with women doctors in the North West region of the UK in 1993 revealed that the majority of white women doctors suspected that, although they were subject to stereotyping for posts especially at the consultant level, black doctors, especially women black doctors were discriminated against much earlier at senior house officer and registrar levels.¹ Over 50% of medical students are female and a sizeable number belong to ethnic minorities. Yet, even though women have been processing fast through medical school since the 1960s,^{2,3} only 15% of consultants in the UK are women. The Sex Discrimination Acts (1975 and 1986) state that it is unlawful to directly and indirectly discriminate on the ground of sex or marriage. Similarly the Race Relations Act of 1976 (which does not apply to Northern Ireland) states that it is unlawful to directly or indirectly discriminate on the grounds of race, colour, nationality, ethnic or racial origin. In Britain each National Health Service (NHS) Hospital Trust and Health Authority may also have an equality code of practice which sets out local standards and, although these are not legally binding, they may be taken into account by industrial tribunals. The NHS Executive also has targets and guidelines to increase the proportion of women and ethnic minority doctors working at consultant level in the NHS. These recommend that all registrar panel chairs receive training in good practice procedures and interviewing techniques.

Recruitment panel members are now all liable for prosecution under both the Sex Discrimination Act and the Race Discrimination Act, as well as their employers (the hospital or Community Trust). Applicants are rarely sure when discrimination has occurred but if they have been rejected a number of times and not been given an adequate explanation for this they may seek redress through litigation. Both the South West and North West Thames Regional Health Authorities have been successfully challenged for consistently failing to short-list a qualified and competent Asian woman junior doctor for registrar posts, and failing to provide her with any reasonable explanation for this, given that she fulfilled all their stated criteria.⁴

One of the difficulties facing medical staffing personnel is getting medical staff to take recruitment and selection procedures seriously. Medics sometimes think that such procedures are inappropriate and/or too crude for medicine. Clearly the criteria used in selection should be decided by doctors themselves and if procedures are inappropriate then the profession should discuss appropriate amendments, though this is very different from throwing out all procedures. Too often consultants refer to their 'gut instinct' as guiding their personal judgement on the day of the interview - these instinctive judgements may sometimes be sound, but they need to be made transparent and explicable and the covert criteria used acknowledged so that candidates can see why they are selected or rejected. More informed selection will make final decisions less difficult and more explicable to both candidates and other health professionals.

Making assumptions and stereotyping candidates

Discriminating questions are often oblique and suggest that the interviewer has already formed a view of both the candidate and their personal situation. The tendency to stereotype and make assumptions about ethnic minority and women candidates is sometimes blatantly demonstrated by the discriminatory type of questions they may be asked in interviews (box 1). Selectors sometimes assume that black women are more domestically orientated than white women and they are often rejected at the short-listing stage out-of-hand. Asian women in particular are subject to discriminatory questions and are stereotyped immediately as preferring staff grades.

As medical personnel become more aware of the consequences of direct discrimination and of asking direct questions there may be a tendency to bring up

Presumptive or discriminatory questioning

- are you thinking of having children?
- shouldn't you be spending more time with your baby?
- do you think you'll be able to cope?
- do you ever wear western dress?
- I suppose you're likely to move when your husband gets promoted?

Box 1

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Features that make registrar recruitment particularly difficult

- too little thought is given to considering what skills future consultants should possess
- doctors are trained to be individualists and are unused to collective agreement
- in many regions the system for selection of recruitment panels is *ad hoc*. Sometimes the selection panel is different from the recruitment panel, and the panel only meet just prior to the interview
- the lack of transparency and inability to convey what experience, qualities and characteristics are being sought has allowed the system of patronage to flourish

Box 2

Common methods of discarding candidates

- use of age restrictions
- candidates not typing their application forms
- assuming doctors with foreign names are worse doctors or overseas doctors
- candidates lacking research experience and publications

Box 3

Person specification for registrar post in ...

Requirements	Essential	Desirable
Qualifications		
professional		
general		
Experience		
clinical		
specialty		
subspecialty		
Training		
specialist		
management		
Academic		
research		
publications		
Skills		
leadership		
patients		
team working		
management		
Other		
as necessary		

Box 4

domestic and marital arrangements in the discussion at the end of the interview. This is also discriminatory. Those interviewing who are party to such stereotyping should point out to the other committee members that these assumptions are probably misguided, and very likely completely wrong.

Evidence of racial discrimination

In 1990 it was reported⁵ that 13% of ethnic minority senior house officers had to wait over two months for their first post whereas only 5% of European graduates had such a wait; similarly, 21% of ethnic minority doctors had a substantial wait for a registrar appointment compared to only 10% of European doctors. The researchers concluded that discrimination against black people was more likely to occur at the short-listing stage for both senior house officer and registrar posts. This was reinforced by the findings of the Kings Fund Task Force⁴ in 1989 which demonstrated that whilst the short-listing and appointment of white doctors is proportionately higher than their application rate, the situation is reversed for black doctors (see table).

Evidence of sexual discrimination

The discrimination faced by women doctors tends to be more indirect and involves an assumption that all women have overwhelming domestic commitments and consider work secondary.¹⁻³ Although women have been trained as doctors for many years in Britain the gender culture within medicine in the UK remains highly traditional. Women are assumed to be domestic partners first and foremost, not doctors. Although there are exceptional women doctors who defy traditional expectations, women medical students continue to report a strong but subtle pressure on them to avoid certain specialities and follow suitable (female) career routes.¹ Isobel Allen's research² showed that cultural expectations of women doctors led them to choose staff grades, part-time work and certain specialities. Although general practice is seen as a desirable career track for women doctors, women and ethnic minority doctors constitute the majority of general practice locums and retainer scheme candidates, while men dominate as general practitioner principals.⁶

Difficulties in establishing criteria for selection

One of the most inhibiting factors in changing medical attitudes to candidates is the belief in medicine that human nature is natural, immovable and responsible for all problems. As no agreement is possible between medics on criteria, *laissez-faire* attitudes are therefore justified. Time and time again consultants will say: "It's only human nature to choose who you like" (Manchester recruitment seminar for medical recruitment chairs, 1995), and "We don't know how to choose and even if I worked it out my colleague wouldn't agree with me. In addition we just haven't the time to discuss the procedures" (Mersey medical recruitment training seminar, 1995). The latter is an honest assessment of the registrar recruitment procedures, which are at present made more difficult by the factors listed in box 2.

The majority of junior doctors experience patronage as being very strong in the UK and yet consultants report it to be waning in influence. Whichever is the case, the reality for junior doctors is that women and black doctors suffer from a lack of patrons. Although the British Medical Association (BMA) has come out firmly against patronage,⁷ candidates with sponsorship from established surgeons and physicians are still perceived as preferred candidates. Patronage is likely to persist until more explicit criteria for selection are developed within medicine and made public to medical candidates. Relying on respected colleagues for informal reinforcement of recruits can be a fall-back when detailed information on candidates is lacking. In the past being 'a good chap' was enough to secure a post but in the 1990s, within the changing NHS, this is no longer a good enough qualification and choosing a candidate on that basis is dis-

Table Kings Fund Task Force findings, 1989⁴

	Black*	White	Other**	Not known	Total
Applied	25 (13%)	416 (42%)	149 (15%)	29 (30%)	980 (100%)
Short-listed	16 (6%)	199 (81%)	31 (13%)	–	246 (100%)
Appointed	2 (3%)	65 (84%)	10 (13%)	–	77 (100%)

*African, Asian and Caribbean. **Greek/Turkish, Irish and other non-UK origins

Registrar selection: possible sources of information

- specify what they want to know from referees and draw up detailed guidelines on what is required within a reference
- ask specifically about the demonstration of particular skills from appraisers and referees. The development of appraisal schemes in all specialties should point out to both doctors themselves and selectors their strengths and weaknesses relating to clinical and management responsibilities
- ask doctors to do specific tasks at or prior to the interview

Box 5

The model selection process

Step 1 Person and post specifications
Each appointment procedure should be determined by a person and post specification. This should apply to all posts except very temporary ones or house officer placements for which there are few applicants. For instance, psychiatry is short of training-grade applicants and proactive work needs to be done in medical schools to encourage students to take up this specialty.

Step 2 Advertising
All posts should be advertised.

Step 3 Selecting the panel
Panel chairs and members should be decided on annual basis so that they can be made aware of their legal responsibilities and of how and why discrimination occurs.

Step 4 Short-listing
Short-listing should be done on the basis of the criteria specified above by either medical staffing or the same medical personnel as involved in the interviewing. If done by the chair and medical staffing, panel members should agree the criteria developed in their absence. The grounds on which applicants are accepted or rejected at short-listing should be recorded and kept by medical staffing for at least 6 months. This is crucial as most discrimination cases are from doctors rejected at the short-listing stage. The reasons for rejection may be called as evidence. 'Yes' and 'no' are not adequate explanations, recorded reasons must be given - against the agreed criteria as stated above. Those candidates not short-listed should be given the reasons why they were unsuccessful - and in some cases it is suggested that the Dean's office should support junior doctors with guidance on CV writing and interview techniques.

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criminary. More sophisticated interpersonal and patient skills are required by health services which rely on collaborative practices.

Organising the selection and recruitment panel

In the UK, the Postgraduate Deans within the regional medical schools organise the recruitment of registrars with the support of medical staffing personnel and medical training committees. Where communication between medical recruitment panel chairs and administrative staffing personnel is poor, then the moves made by personnel departments to standardise procedures tend to be misunderstood and often fail. Often these moves are attempts to ensure common practices to make processes more visible to candidates, yet because medical staffing personnel are fearful of doctors they do not discuss or liaise with panel chairs. The more discussion takes place the more likely procedures will not be sabotaged. It is unreasonable to expect busy consultants to recruit fairly, when they have not been involved in agreeing the selection criteria and were invited onto the recruitment panel at a late stage, often only a week before the interview. In addition, the number of registrars being interviewed will determine the manner in which selection can realistically take place. Interviewing 20 people in one day for two or three posts is onerous and confusing. There needs to be better coordination between the Postgraduate Deans, medical staffing and medical chairs of selection panels to see that the recruitment process is more controlled.

The difficulties involved in short-listing

Many of the fair-practice procedures which follow in this article and which are now recommended by the BMA refer to the actual interview.⁸ However, most discrimination occurs not at the interview but during short-listing. Short-listing again should be decided on agreed criteria, not on traditional ways of discarding candidates (box 3).

Often these methods of rejecting candidates indirectly discriminate against doctors who have not followed the traditional career routes. For instance, rigid age barriers are shown to discriminate against female doctors.^{2,3} The expectation that career advancement in medicine should follow rigid and set patterns which link medical grade with age and therefore career achievement is in itself indirectly discriminatory; this rigidity does not allow for doctors to take career breaks, work overseas or have children. Recruitment committees need to consider whether, for instance, they always need candidates with research experience; there are many other skills required. If the medical training committee and panels have agreed detailed short-listing criteria, there is no reason why short-listing could not be done independently of the panels by administrative staff, although there are dangers in this if the process and criteria are not reviewed regularly.

Developing and agreeing person specifications

The Unified Training Grade is going to make short-listing even more important. Once rejected, a doctor will find it more difficult to apply again. This is going to have a very significant effect on doctors from the ethnic minorities who have been shown to be consistently rejected at the short-listing stage. Specialty committees need to start discussing what talents, roles and skills they consider will be necessary at consultant level given future health service needs within their specialty. After agreeing priorities, it then becomes possible to formulate a person specification which can be used for all short-listing. An example of a person specification form is given in box 4.

Some specialty training committees are already developing more detailed person specifications for registrar training posts. For instance, in the North West Region of the NHS, the local training committee for surgery is investigating and formalising criteria for assessing registrars (L de Cossart, personal communication). However, it appears that where moves are being made to formalise procedures this is because of the commitment of individuals to standardise practices. In general, improving selection procedures appears to be difficult because responsibility for registrar recruitment falls between the specialist training committee, the Postgraduate Deans and the medical staffing officers.

At consultant level the process of selection is simpler. The medical and clinical directors can decide on clinical and non-clinical post functions, such as developing the directorate, research requirements and management roles, all of which will determine which non-medical skills are necessary to include in the person specification. Too often, in the past, it has been assumed that all consultants require the same experience, qualities and research interests, irrespective of the actual post.

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Step 5 Advice to short-listed candidates

Listed candidates should try to visit the hospital for their own benefit and if they cannot do so they would be wise to inform the Clinical Directorate why not. All candidates should seek information and details about the post concerned but they should not enquire about who will interview them or seek out panel members; neither should close associates, sponsors or backers of the candidates.

Step 6 The interview - advice to interviewers

Panel members should all agree the basis of selection prior the interview. The chair should inform all panel members that lobbying is banned, that discriminatory questions are contrary to the law and that good practice involves probing for potential and looking for the best candidate for the post advertised. The chair should also make it clear that overseas doctors have passed their residency requirements and are available for work. Interviewing can be exhausting and no panel should sit for more than 2 hours at a time. Make each candidate feel welcome as interviews can be intimidating.

Step 7 Communicating the decision and keeping records

Each candidate should be informed of the decisions made and of the reasons behind them. All decisions should be recorded and kept for at least six months.

Step 8 The complaints procedure

Should a candidate make a formal complaint about the procedures this should be investigated immediately and the procedures explained to the complainant - if complaints are handled promptly and the individual doctor feels that medical staffing is actually taking notice of their complaint they are much less likely to take further action.

Box 6

Difficulties in obtaining evidence of suitability

Once selection criteria are established for person and post, the next problem for recruitment committees is how to establish whether individual candidates actually possess the skills and qualities required. The reason why many in management look to a battery of tests for assessing candidates is because they want to find ways of assessing how candidates manage in problematic situations, as well as what they know. However, psychometric testing is not a good way of finding out how people will manage; such tests usually identify personality types - a skill many doctors already claim to possess without resorting to testing.

Registrar selection panels may seek out information on candidates from a number of sources (box 5). The process of selection will never be perfect, requirements and thinking will change, as will organisational pressures, but it is possible to make both the process and the broad criteria visible to both candidates and staff. The model given in box 6 is an attempt to provide a starting point because, at present, too often recruitment in medicine is not transparent and appears rather to be dependent on 'clubability'.

Such procedures attempt to make it easier for selection panels to identify doctors possessing the skills and qualifications required of consultants and demonstrating the potential to be able to deliver quality health care in a changing and developing NHS. They are not designed to encourage positive discrimination, although in the past positive discrimination has been offered to white male doctors. This has to be rectified.

In some instances positive discrimination will occur because the post specification in hospital may require a well-qualified female doctor precisely because the patients demand it. In obstetrics and gynaecology there are still units employing three male doctors when the patients are 100% female and a sizeable percentage of them would prefer a woman consultant. The particular circumstances of a post and hospital trust may make it necessary to seek out, for example, a woman surgeon or a male psychiatrist.

Being clear what is required protects both candidates and selectors - criteria for consultant posts will change depending on the changing nature of the service. Blanket criteria are often discriminatory - balance is required in medicine as it is in other professions.

Until there is more open debate about the future role of doctors in the NHS, recruitment will continue to be an onerous task. Poor recruitment practice can result in financial loss. Litigation can be very expensive and is also a waste of valuable time. Good practice is cheaper, fairer and results in patients having greater confidence in medicine.

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4 King Edward Hospital Fund for London. *Equal opportunities task force*. 14 Palace Court, London W2 4HT: Kings Fund, 1989.

5 McKeigue P M, Richards JDM, Richards P. Effects of discrimination by sex and race on the early careers of British medical graduates during 1981-87. *BMJ*, 1990; **301**: 961-4.

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7 BMA. *Patronage in the medical profession*. Working paper, London, BMA, 1993.

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