

Review of the Appointments Process for Consultant Recruitment in Scotland

**Final Report
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Overview

The *objectives* of this project were to:

- Understand best practice global medical recruitment practices to establish sound principles on which consultant appointments can be made.
- Establish how Scotland may differ from other countries in EEA and the rest of UK and specifically, establish how this affects recruitment and retention.
- Present options for relevant changes to current practices in consultant recruitment based on findings from the literature review and key stakeholder consultations.
- Consider how a new, robust, selection system could be implemented, including guidance on practical and feasibility issues.
- Consider how any improvements would be best evaluated.

The *deliverables* of the project are to:

- Report findings from the literature review and present the analysis as a report on best practice principles in recruitment (Phase 1).
- Identify selection criteria for consultant recruitment including an analysis of existing person specifications and relevant documentation.
- Analyse findings and create a draft report based on the outcomes of the literature review and research into best practice; consultation with key stakeholders and review of policy options for consultant recruitment to SEHD (Phase 2).
- Deliver presentations of the project findings to the Health Department Management Board, AAC Review Stakeholder Group and to other groups as necessary.
- Provide the final report with a summary of the review (Phase 3).

Structure of this report

This report is presented in three main parts with an Appendix containing supporting documentation, as follows.

Part 1: Literature and documentation review

Part 2: Consultation with key stakeholders

Part 3: Summary of key issues and implications

Appendix

Part 1 Literature & Documentation Review

The literature review is reported in two sections. Section 1 comprises a review of the *research literature* relating to best practice selection in general. Specifically, implications for consultant recruitment are discussed. Section 2 reviews *existing documentation and reports*, relevant to consultant recruitment in Scotland. An **executive summary** of both reviews is presented here and the full detail is available in the Appendices 1 and 2.

Section 1. Literature Review of Best Practice Selection

The recruitment and retention of consultants in medicine has become a critical issue. The implications of making the wrong selection decision are serious both in human and in financial terms. Hence, developing and implementing recruitment and selection methods that are accurate and fair is crucially important.

The aims of the literature review are to:

- *Briefly outline the principles behind best practice recruitment and selection, with an emphasis on implications for senior level selection.*
- *Establish sound principles on which consultant appointments can be made.*
- *Provide practical recommendations to design and implement a valid recruitment and selection system for consultants.*

The key implications for consultant recruitment are as follows (See Appendix 1):

The selection process

The design and implementation of valid assessment methods starts with a thorough *job analysis* which defines the *selection criteria* required for the post. The existence of selection criteria has implications for issues of *fairness* and *equal opportunities* legislation. In order for the selection process to be fair and objective, candidates should be assessed against the same agreed standards or criteria. When choosing a selection method, issues of *reliability*, *validity*, *feasibility*, *fairness* and *equity* must be taken into account. Selection methods should be developed carefully through piloting and *candidates' reactions* should be taken into account. It is important to conduct validation studies in order to monitor the quality of the selection process and update the process.

Implications for consultant recruitment

When a post arises a carefully prepared Person Specification will enable the recruiter to define the desired candidate skills sets and attributes in an objective and fair manner. A job analysis is needed to define the skills and attributes. This also ensures the selection process operates within the legal framework. Attracting an eligible pool of candidates to select from may be a major challenge in consultant recruitment for some areas.

Organisational Attractiveness

Attracting an adequate number of suitable candidates is the first stage of recruitment and selection. Potential employees do not select organisations on the basis of *job* and *organisational characteristics* alone (e.g. location, and organisational structure). Studies show that the organisation's *image/reputation/identity* plays a vital part in attracting suitable talented applicants (Cable & Turban, 2001; Slaughter, Zickar, Highhouse, & Mohr, 2004; Lievens & Highhouse, 2003). Hence the importance of monitoring and promoting the corporate brand to be more successful at attracting suitable candidates.

Implications for consultant recruitment

The first step in any selection process is attracting an adequate number of appropriate candidates. Job and organisational characteristics such as pay, career progression, location, and opportunities for advancement, are all related to organisational attractiveness. Less tangible factors, such the image/ identity/reputation that candidates ascribe to an organisation, are just as important in making an employer attractive.

Selection methods

The most popular selection procedures used at senior or executive level are: interviews, job-related exercises, and personality measures. These methods are not all equally useful or appropriate in some selection processes:

- **Interviews** are used widely for selection purposes at senior or executive level (Campion, Palmer, & Campion, 1997; Garman, 2005). Research shows that to increase their reliability, validity and feasibility, interviews should be based on a thorough job analysis and selection criteria, they should be semi-structured and scored according to a behaviourally anchored rating scale. Multiple interviews are often favoured over panel interviews, the modality of the interview should be standardised across all candidates, and assessors should be trained (Blackman, 2002; Chapman, & Rowe 2001; McDaniel, Whetzel, Schmidt, & Maurer 1994; Schmidt, & Hunter, 1998).
- **Job-related exercises** can be valid predictors of job performance when designed and conducted according to best practice (Damitz, Manzey, Kleinmann, & Severin, 2003; Lievens, Van Keer, & De Witte, 2005). In order to obtain valid ratings of performance the exercises should be based on competencies identified by job analysis, and scored by trained assessors using pre-defined anchored rating scales. Presentations and written tests are two of the most frequently used exercises for executive or senior level selection. Confidentiality issues often warrant the use of individual exercises.
- **Personality measures** can be used to enhance the decision making process at senior/executive level; to comply with best practice they should always be used in conjunction with other selection methods and never as the sole determinant of a selection outcome.

Implications for consultant recruitment

Selection methods should follow a thorough job analysis and selection criteria to increase their reliability and validity. Interviews can be effective when designed and implemented appropriately. Job related exercises are widely used in other occupational groups and there is evidence of their use within specialty selection. medicine. Other selection tools such as personality measures can be used to enhance the decision making process in selection but evidence for use at consultants level is required. Use of personality measures within selection must be carried out by appropriately trained individuals.

Summary and Conclusions

The principles and issues behind best practice recruitment and selection are summarised in the full literature review with a view to provide evidence that can be used in guiding any future strategy on the selection of consultants. Specific issues around the recruitment and selection of consultants have not been addressed directly as there was little reference in the literature to this. However, the lessons learned from best practice recruitment and selection research in general, and from the assessment of executives more specifically, are transferable to the context of consultants' assessment.

In summary, the following recommendations are made:

- The design and implementation of valid assessment methods starts with a thorough *job analysis* which defines the *selection criteria* required for the post.
- When choosing a selection method, issues of *reliability, validity, feasibility, fairness* and *equity* should be taken into account.
- It is important that the process is seen to be *fair* by all candidates. Research shows that candidates favour selection methods which are *job relevant* and less *personally intrusive*. Applicants also value the opportunity to meet personally with recruiters and have a preference for multiple opportunities to demonstrate their skills. They also tend to prefer selection systems which are administered consistently for all applicants.
- The selection methods should be developed carefully through *piloting* with diverse populations.
- The selection process must be *evaluated* and *reviewed* by monitoring candidates with respect to diversity and subsequent job performance.
- The evaluation of the selection process should lead to improvements aimed at enhancing *validity* and reducing *adverse impact*.
- All individuals involved in assessing candidates during the selection process should have received appropriate *training* (for example in interview skills) and have been adequately briefed about the selection criteria. Assessors should also be aware of unfair discrimination and equal opportunity legislation, two aspects which have a serious impact on the *diversity* of the organisation. Best practice recommends that feedback should always be provided as part of the selection process.

Section 2. Review of Existing Documentation on Consultant Recruitment in Scotland

Recent changes in postgraduate education and legislation in the UK, such as changes in doctors' training, the need for better accountability and improved continued medical education, have increased the demands on senior doctors. Within this context and in view of the shortage of senior doctors in Scotland (Temple, 2004), the recruitment and retention of consultants has become a critical issue. In 2005, the Scottish Executive allocated NHS Boards with new funding to help develop and implement recruitment strategies aimed at consultants. The selection process for consultant posts in Scotland is undergoing a review.

The aim is to briefly outline articles relevant to the appointment of Consultants which have been gathered by the Scottish Government. The articles (See Appendix 2 for a full list) can be categorised under three key headings, as follows;

1. *Background & Legislation*
2. *Fairness & bias*
3. *HR best practice recruitment advice*

Background & Legislation

Several articles review the statutory framework surrounding the appointment of Consultants in Scotland. NHS Scotland has undergone a series of structural changes since the 1999 Health Act.

- The single-system reform, with the creation of 15 single-system NHS boards and the abolition of NHS trusts, is intended to improve service organisation and delivery in NHS Scotland with devolution of decision making to the front-line (Jones, 2003).

Various reports provide recommendations for improving the recruitment/retention.

- In a NES report, McGregor et al (2005) suggest improving the communication and information flow between NES and NHS boards in order that consultant posts can be designed and their advertisement timed to match the output of training schemes. They also recommend the electronic canvassing of trainees' views to take into account their career intentions and a mentoring system that facilitates the transition from trainee to consultant (McGregor, Wakeling, French, & Bagnall, 2005).
- The above recommendations have led to the introduction of an advance appointment scheme (Scottish Executive HD 2006), designed to retain a higher number of SpRs in Scotland as they move to consultant grade. The scheme involves aspiration interviews with current SpRs and funding to assist NHS boards in running with two post holders for a maximum period of 6 months.

Fairness & Bias

The literature review also identified a number of articles on career choice and potential discrimination against women and doctors of ethnic minority origin (see Scottish Executive Workforce Statistics, 2006; RCP 2004; Mavromaras, & Scott 2006; Esmail, 2004; McManus, & Sproston, 2000):

- The majority of consultants (September 2006) are male of white ethnic origin.
- The proportion of women medical students has increased steadily over the years, exceeding 50% in 1991 and reaching 60.8% by 2002.

- The proportion of female doctors and of doctors of ethnic minority origin drops as the seniority level increases.
- There is evidence in some cases of disproportionate promotion that may be interpreted as direct or indirect discrimination. Doctors who graduated in Scotland are more likely to be promoted than doctors who graduated from the rest of the UK or overseas. Female doctors and doctors who work part time are less likely to be promoted to a consultant post.¹

Best practice recruitment (HR perspective)

Best practice recruitment guidelines are available from an HR perspective from the Department of Health (2006). The guidelines outline best practice at each stage of the recruitment process with the aim of ensuring that the process is unbiased and feasible. Some recommendations include:

- *Providing realistic job previews & inductions;*
- *Using valid selection methods such as structured interviews;*
- *Training the recruiters.*

Summary of documentation review

The reports identified by the Scottish Executive on the recruitment and retention of consultants were reviewed. The context and legal framework surrounding the selection of consultants in Scotland is outlined. Articles relevant to the fairness of the current consultant selection process and the related issues of diversity are included. This review also outlines HR advice on best practice recruitment.

¹ There may be several explanations for these findings. For example, the proportion of female doctors in senior posts could reflect medical school intake over the previous decades. Further research is warranted in this area to clarify the causal factors for these findings.

Part 2 Stakeholder Consultation

Stakeholders

Individuals from key stakeholder groups were nominated by SEHD for interview. 33 interviews have been completed and 5 more are due to take place. A full list of interviewees is available drawn from the following stakeholder groups²:

- PG Deans
- Chairs of Boards
- CMO and CDO
- National Panellists
- Academy of Royal Colleges
- HR
- Medical Directors
- NES
- SEHD
- Chief Executives
- Current SpRs
- Newly appointed consultants
- Clinical academics

Methodology

Semi-structured interviews were conducted lasting approximately 60-90 minutes. The majority were conducted face-to-face with a smaller number of telephone interviews. Interview question areas as detailed in the project proposal included:

- *Review of the current system identifying strengths and weaknesses.*
- *Potential or existing barriers to fair recruitment identified by stakeholders.*
- *Identification of the selection criteria for consultant recruitment.*
- *Views and expectations of what makes a valid and reliable selection process. How might evaluation of such a process take place in the future?*
- *Future issues for selection in the context of MMC, global recruitment and diversity eg short-listing and interview methods, scoring mechanisms.*
- *Patient safety implications.*

Emerging themes from stakeholder interviews

A framework of issues consistently emerging from the interviews is presented here. Information can be classified into six key themes. The themes are:

- Theme 1. Recruitment and selection process*
- Theme 2. Professional standards and quality assurance in recruitment*
- Theme 3. Selection criteria*
- Theme 4. Selection methods*
- Theme 5. Fairness and diversity*
- Theme 6. Future perspectives*

² Many of those interviewed were also senior consultants.

Theme 1. Recruitment & selection process

This theme relates to the efficiency and effectiveness of the recruitment process.

1.1 Cost and resourcing of the process.

The resourcing required to run the current process was perceived by some to be excessive and inefficient, particularly for smaller employers. In reviewing current practice, many believed that the size of the interview panel and cost of engaging National Panellists (both in panellists attending in their own region but also in releasing consultants to go to other regions) was expensive, where often the costs were perceived to outweigh the value-added to the process.³ For example, one stakeholder commented *“Most people involved in the process value the external verification of clinical competence, but the numbers [of interviewers] and time involved is costly and doesn’t seem to add a great deal...it could be improved”*. There were some more negative views, illustrated by the comment, *“The whole process needs to shift into the 21st century”*. However, the majority of respondents recognised that consultants on the whole have been appointed effectively for years, but that it could now benefit from a review to optimise efficiency and effectiveness. Some alternatives to reduce costs and resourcing were suggested including reducing the numbers of individuals on the interview panel (e.g. National Panellists, University representatives). For example, one interviewee suggested *“I’m not sure we need to have two National Panellists, we could have a checklist to follow...so we can demonstrate and be sure that the person is ok and on the specialist register”*. Other suggestions included introducing paper-based elements of the process, rather than face-to-face.

1.2 Flexibility of the Regulations.

The regulations were perceived by some to lack flexibility to allow for different local needs. For example, in some areas, consultants may be appointed with a limited, if any, teaching role. In these situations, one University representative on the panel was seen as sufficient. It was reported that this lack of flexibility did not allow HR to make changes to practice in line with their status as an equal opportunity employers. *“Our hands are tied in HR to make any meaningful changes in line with the rest of our recruitment practices. We need changes to the regulations in order to provide us with an impetus for change, otherwise it will remain the same.”* A consistent theme was the current regulations needed a review and updating, illustrated by the comment *“historically it has been professionally driven but now the regulations need a significant review...the Regulations are out of date”*. Many stakeholders welcomed the opportunity to contribute to the review; *“there’s so much that relies on custom and practice so it’s important to have this review”*.

1.3 Logistics & administration of the process.

The logistics of convening a panel with national panellists was viewed by most employers and HR operational staff as difficult. HR representatives reported that while they could engage their own clinicians and non-executives to sit on interview panels, obtaining interview dates from National Panellists was more challenging. This was attributed to a various factors. First, the HR personnel responsible for this task were often junior staff, and it was often perceived that they had insufficient ‘credibility’ with the panellists. HR reported that requests for dates were sometimes ignored. There were clear examples of how departments tried to remedy this. For example, clinical staff in the department that was recruiting would identify the national panellists they wanted to sit on the panel, and

³ Note, that payment to national panellist is only made where the person is carrying out these duties outside of their contracted NHS time. It was reported that the vast majority of panellists get no payment.

using informal contacts, they would agree dates directly with the panellist. HR would then be advised who could be approached and who was available. This was viewed as a practical solution to ensuring attendance of national panellists for interview dates.

Second, there was a perception that there were a small number of national panellists who volunteered to be on the list for career reasons and because of this were not always committed to attending. For many administering the process, some believed that this explained why there is a long list of panellists, but difficulties in obtaining attendance at interviews. However, from the national panellist perspective, there were concerns that they were given insufficient notice to cancel clinics, so that they could attend the interview. Six weeks notice is the minimum required to ensure clinical work is not disrupted and all panellists interviewed gave examples of being asked to attend interviews at very short notice. Some panellists reported that they do have regular days or sessions that they do not have clinics and could attend interviews on these days within a shorter time frame if this was more widely known.

1.4 Time taken between a consultant retiring or resigning to the appointment of a new consultant.

Even though consultants are required to give three months notice to leave a post, often new appointments are not in place by the time the consultant leaves. Whilst there were various reasons for this, the time taken to set up panels was consistently seen as a significant problem. The process was reported as slow in a number of places, for example in identifying available panellists, obtaining feedback on the job description and in obtaining shortlisting results. Time delays reportedly had an impact in several areas, including:

- i *loss of candidates to other posts*; in some areas if the interview panel is not set up quickly, applicants drop-out as they attend other interviews and are offered posts elsewhere.
- ii *fewer handover opportunities*; if the existing consultant has already left handovers which were viewed as important to the new consultant, the other members of the team and the patients were fewer.
- iii *cost of locums*; some areas have to find locums to fill the post until a new appointment is made, which is not seen as ideal.
- iv *vacant posts*; where locums are not put in, there is disruption to other members of the team and delivery of service while the gap is carried.

1.5 Candidate perspectives.

Delays in setting up panels reportedly cause anxiety and uncertainty in candidates. HR operational staff reported that they regularly deal with calls from applicants concerned about interview dates and whether they should apply for another post coming up. Both current applicants and newly appointed consultants were able to clearly identify areas for improvement in the current process. For example, there was a perceived 'lack of information' for many throughout the appointments process. Many were sympathetic to personnel in HR departments and believed that they were often overstretched or unable to deal with queries appropriately. How candidates are treated through the process, including on visits to the departments, could influence their decision to take a position. As one newly appointed consultant commented, "*I think how you are dealt with throughout each stage can really reflect how they might treat you in the future. I certainly thought twice about a position after how I was treated on a visit*".

For those individuals who are currently applying for posts, there was some lack of clarity regarding what is required of them in the appointments process. For example, they would like more information on what the interview involves so that they can fully prepare themselves. Many valued the opportunity for visits to the department, however some were unsure how this information was used in the process. Some basic information and standardised guidance that clarifies some of these aspects would be welcomed by all.

1.6 Impact of “internal markets” within Scotland for recruiting consultants.

Neighbouring Boards may have vacancies at the same time and are competing for the same candidates. Because of the current pool of applicants and ‘internal market’ conditions, this meant that it was vital to be first to interview and appoint. One national panellist gave an example of this: *“we had set up the panel and done it all by the book...we got interview dates set up and booked our national panellist. However, another region suddenly set up a panel and managed to clear it in a week and we lost out...I’m not sure how but they were cleared to be a national panellist for the day and we lost some really good candidates. I get a feeling that there are rules that sometimes get broken... so we need to make sure it’s all on a level playing field”*.

Ensuring national panellists are independent of a recruiting location is viewed as particularly important in this context.

1.7 Role of HR in recruitment processes.

The role of HR in the process was primarily one of support and administration, ensuring paperwork was available, rooms are booked and candidates and interviewers were looked after. Those undertaking this role were typically more junior. This is illustrated by the comment *“in terms of HR, they are most often treated as the ‘hand-maidens of the process’ and sometimes lack the level of professional influence required...why aren’t Board level HR directors involved”*. Whilst most HR staff were capable to undertake these roles, it was reported that it was a more challenging job for them to be *advisors* to the process. For example, in being able to intervene when best practice was not being followed or when advice was required. Given the level and status of panel members, it was reported that HR representatives would *“need to be very strong to say something to panel members about appropriateness of questions being asked.....or to advise the candidates that they did not need to answer a particular question”*. In most cases, this role was typically taken by the Chair. As such, it requires the Chair to be knowledgeable and motivated to apply best practice recruitment practice.

1.8 Composition and role of interview panel members.

While most were able to describe the rules governing panel composition (as per the Regulations), the specific role of panel members was less clear, other than *“representing”* their stakeholder group. Some suggested a need to see a clearer argument for the ‘value added’ by each member of the panel, with potentially more specific guidance. For example, the role and effectiveness of non-execs was challenged by some, *“People choose non-execs that will go along with the decisions. Some come at the drop of a hat”*.

1.9 Time allocated to the selection of individuals to senior level appointments.

In practice, forty minutes for a panel interview was a common structure. A recurrent theme from stakeholders was that for many, although this had been a reasonably effective approach, there was scope for improvement. Many commented that forty minutes did not seem sufficient for the job level of consultant. *“It seems a short amount of time to examine whether they will be good enough for one of the most responsible, highly paid posts”; “with 40mins, 8 people, and 2 questions each, we barely have time to ask the questions... how can this tell us much about a candidate?”* Stakeholders consistently commented on how this time was spent, with

a focus on the clinical verification of a CV. *“Often we spend 30mins going through a CV where the doctor is just agreeing that they did spend time in x, y and z unit. Surely some of this can be assessed by a paper-based exercise?”*. Others questioned the value of what is uncovered during the interview, *“we have between 8 and 10 people spending the best part of half a day to interview 2 applicants and all that happens is we go through their CV. There must be a better way to use the time to assess them, given that we are about to offer them a job for next 25 years”*. Importantly, all stakeholders believed that the current process does identify appropriate people. However, the vast majority of those interviewed said that the process could be significantly improved.

1.10 Opportunity to assess non-clinical aspects.

It was consistently reported that there was not enough opportunity to assess non-clinical aspects that localities perceive as important (e.g. team working, leadership, motivation, interpersonal behaviour, future plans etc). Most stakeholders felt that this was an area for significant improvement. Some suggested the introduction of a two-tiered process, where clinical competence was one aspect, and the other was the behavioural/attitudinal aspects and fit with the team. This is reported in further detail under selection criteria section (see *Theme 3 Selection Criteria*).

1.11 Consistency of decision-making processes on panels.

In making appointments, the decision making process used by interview panels varied between localities, and even sometimes within the same Board. Where more than one candidate was appointable, some panels decided with a show of hands (ie vote who should be appointed), some had a broader discussion before the Chair summarised, some involved the national panellists, others did not. Decision making processes appeared to have emerged over the years, often depending on the expertise and preferences of the Chair and local practices. There was some interest in understanding the mechanisms that other localities used and whether there was evidence for the effectiveness or efficiency of one approach over another.

1.12 Panel interviews as a networking opportunity for interviewers.

A positive aspect reported of the current system was the additional benefits to participating in the panel that are often not formally recognised. For example, participating in a panel was perceived by some as providing an informal networking opportunity for specialists, some employers and non-executives. It was also reported that there were opportunities to learn from external panellists, to share and cross fertilise ideas, which was viewed as positive.

1.13 Documented evidence of the effectiveness of the current process.

Many stakeholders view the current appointments process as appropriate. Specifically, this is how interviews for consultant level appointments have traditionally been conducted, so that interviewers and applicants are used to the system. *“A lot of this is about custom and practice.....we’ve always done it this way and the regulation has meant that there has been little appetite or flexibility for change.”* Similarly, stakeholders have also noted that although there is no documented evidence to suggest it isn’t working, there are clearly significant areas for improvement. For those who support the current system, they do not see any compelling evidence that any changes to the system would make for a better outcome. There is no documented evidence to say that the wrong people have been appointed, and even though there were anecdotal examples of consequences of poor appointments and consultants moving on, these were not documented in a quantifiable

way to be able to make a full evaluation of effectiveness. Some stakeholders suggested that there should be some primary research conducted in this area so that the results are appropriately documented. All stakeholders were able to clearly identify areas for improvement, even those who supported the current process and structure. In this respect, stakeholders believed that it was not a case for change for changes sake, but there was clearly a case here to make improvements to the current processes. This view is encapsulated in the statement, *“the current selection process obviously works but it really does need modernising and streamlining. As it stands the panels are geared towards assessing clinical competence but there are many other aspects that need attention...we can't ignore this aspect as medicine is changing rapidly and so are the structures that govern it”*.

Key Finding:

The consistent message from all stakeholders is that the current process for consultant recruitment is not working efficiently. There is also evidence to suggest that the effectiveness could be improved, given the personnel involved. This is not to say there are grounds to suggest the wrong people are being appointed, rather that there are lost opportunities in current practice. The *process* by which appointments are made is viewed as bureaucratic and in need of change. Improvements are required to enhance the experience for applicants, interviewers, HR and employers.

Theme 2. Professional standards & quality assurance

This theme relates to the mechanisms used to judge clinical competence, the impact upon patient safety, and the role of the external advisor in the recruitment process.

2.1 Role and remit of national panellists.

For most stakeholders, although there was broad agreement, the *precise remit* and *boundaries* of national panellists was unclear. Most stakeholders clearly described the role as having two key elements. First, in recommending to the Board whether candidates are clinically *appointable/unappointable* for that post, and second the role of an *external reviewer* on the panel, to ensure fair practice and professional standards. However, there were variations in the description of the activities involved in these two areas. For example, the role of panellists prior to, and on the day of, the interview varied in the extent of involvement in reviewing job descriptions, defining interviewing questions and inclusion in the decision making process. There were divergent views on where the boundary and remit should extend. For example, **job descriptions** currently go to panellists to comment on content in advance of the interview. There was some disagreement here regarding the value of this process. Employers were clear that the work plan is the remit of the employers. National panellists and Colleges review job descriptions as an important part of maintaining standards, appropriateness of the job responsibilities and standardisation across Scotland. To illustrate this point one stakeholder said, *“there had to be a safeguard to stop managers over-ruling clinical safety issues. A few years ago, we were trying to appoint 600 new consultants and national panellists had a major role in ensuring that not just anyone was appointed, even through there was some pressure to do so”*.

Some believed that given the cost of attendance at the interview, more should be asked of these external reviewers. *“We have these highly experienced people in the room and we don’t allow them to give their views on the strengths and weaknesses of the candidates. It’s a waste of time and expertise them sitting there”*. Once the panellists have determined whether candidates are appointable, often panellists opinion is sought *“off the record”*. There is no formal channel for this and some suggested that there should be a mechanism for their views to be incorporated into the decision-making process, in a more transparent way. The alternative view was that panellists are not always in the best position to offer a view beyond that of appointable or unappointable, and they shouldn’t be providing views of which of the appointable candidates they believe should get the job. Some already felt panellists sometimes go beyond their remit: *“one panellist wrote to the Executive complaining that we had appointed the wrong candidate. We had 4 candidates and all were deemed appointable by the national panellists, so it was a local decision which of these would get the job. After ranking all of them, we went for candidate 2 but the panellist argued that candidate 1 was “better” and should have been offered the job. We reviewed it but were happy with our decision. They were all appointable and so it was our decision on who would best compliment the team.”* Other examples illustrate the boundaries of the panellist role *“the right person for the post may not always be the highest achieving candidate in terms of publications and other honours. National panellists are not always best placed to make this judgement on how they would fit in the department.”*

2.2 External review role provided by National Panellists

This role is viewed by most stakeholders as important for QA. For example, it is perceived as helpful to ensure against ‘local bias’ in appointments. For example, one stakeholder commented *“You need to have a referee at the appointments panels – decisions can’t be left down to a local cabal who could fix the appointment towards the local guy. We have a similar referee when we conduct the RITA process and I look to the Colleges to provide that person. There must be*

examples of weak National Panellists but on the whole the process of having people to scrutinise the process works”.

Equally, taking a share of the responsibility for decisions to appoint by panellists was seen as helpful in the support against appeals. *“there is a sense of confidence if two or more external panellists are on the appointment committee”.* This reassurance was based on concerns regarding a future increase in challenges and appeals. Panellists were seen as providing defensible independent opinions. *“One example was where a locum was already doing the job for a while and applied for a post when it came upthis was the same job but a permanent consultant position. They didn’t get it and appealed...The Board went back to the national panellists for an independent verdict. The panellists were able to verify the reasons for not appointing and dismiss the claim that it was based on local bias [i.e. interviewers knew the candidate].”* While local clinicians could make similar judgements on appointability, the external review by national panellists was seen as a robust endorsement of process and appointment. While most welcomed and valued a need for an external scrutiny role, some felt that this role could be carried out by **senior doctors** not necessarily on the national panellist list. The need for external scrutiny was supported by all stakeholders. This is illustrated by the comments *“I don’t understand why we need a heavily standardised process, but I do understand the need to ensure QA and patient safety”* and *“External input to the process is necessary to make sure the candidate is appropriately qualified... this is done well on the whole and is a strength in the current process. We need this assessment of clinical competence as a safeguard; in certain specialities it’s increasingly complex”.*

2.3 Process for assessing clinical competence (paper-based v’s face-to-face).

Some stakeholders felt that the CCT defined clinical competence and that this was a ‘given’ if candidates got through shortlisting. As such, some believed that further assessment of clinical competence at interview was duplicating effort. *“It’s very rare for concerns to be raised in the interview. So what is their [national panellists] contribution? Often national panellists are struggling to find things to say in the interview....particularly when the CV is straightforward in the experience gained. It seems a bit of a waste of time sometimes”.* It was recognised that, in theory, for UK trained medics a paper-based assessment of the suitability of their experience and training for the particular post may be applicable and appropriate. Judgements can be made on the basis of the UK training experience. However, for training acquired outside of the UK, a paper-based exercise was not seen as appropriate or sufficient to make this judgement. The national panellists and other interviewers *would not know what it meant* if applicants spent 3 months in a particular place/ hospital/ rotation outside of the UK and how this would relate to the job they were applying for. For most stakeholders, probing this via the interview was seen as the only way to establish the extent of the training experience and in which areas.

National panellist input was viewed by some as important in giving advice on technical aspects particularly in sub-specialist appointments. This was most useful where the local knowledge of board members (e.g. medical director, chairs) was not sufficient to understand the needs of the sub-specialty and where they wanted an opinion beyond the views of their local consultants. Almost all stakeholders questioned suggested that the process could be streamlined by having one national panellist, illustrated by the comments *“as a Panellist, my personal opinion is that National Panellists perform an important role although I can’t fathom out the need for two at every consultant appointment. I suspect that there may be the odd occasion where the input of two national panellists may be required but suspect these instances are few and far between”* and *“one panellist is sufficient - two is overkill”.* However, the College perspective is that they would like to reserve the right to have two panellists in case of dispute or appeal.

2.4 Patient safety and role of CCT.

Patient safety is dependent on fitness to practice and having competent consultants in place. Most of the focus of how this is ensured has been on clinical competence and the role of the CCT and interviewers (including National Panellists/ local clinicians) in assessment. From the stakeholder interviews, it is clear that the CCT provides a different type of assessment of clinical competence than what is assessed at the interview panel (which is often experience and 'fit'). Some stakeholders suggested that there needed to be clarity about the CCT and judgements about a candidate's clinical competence. For example, a national panellist said, *"The concept is that possession of a CCST (dental specialties) or CCT (medicine) automatically makes the individual eligible for every consultant post. However, in some dental specialties appointment to a consultant post requires an additional training period post CCST. Also, possession of a CCST/CCT, whilst confirming clinical competence, may not signify ability to work in particular geographic areas and perhaps the classic example here would be working in remote/rural areas which throw up their own individual challenges"*. A further illustration of the issues is provided in the box below.

Box 1. Assessing Clinical Competence:

CCT, Candidate Experience, Job Context/ Specification

The CCT is identified by most stakeholders as an important indication for clinical competence, signalling the end of training in that specialty. It is viewed as an important measure that is valued. However, while it provides a certain 'stamp' it is viewed that it is not equal in all **contexts/ job applications**. In the appointments of consultants in Scotland, the CCT does provide a basic mechanism to shortlist candidates. That is, without a CCT they would not get to interview. A CCT identifies they have acquired clinical competence to be **considered** for appointment as a consultant. However this does not mean that they would be appointable for **any** consultant job. For example, a candidate's experience in gaining their CCT may be in a very specialist role (eg shoulder surgery). If they applied to a post in the Highlands where it required generalist experience, it is highly likely that they would not be deemed as appointable for that role. If a post came up in a specialties unit in large city hospital, they may well be deemed appointable because of their potential in this area and the future plans of the hospital to specialise in shoulder surgery. As such, the CCT and process of establishing appointability have different roles in the assessment of clinical competence. CCT is minimum requirement and in itself it is not seen as sufficient as it is the breadth of experience that is required for many posts. Similarly some areas may be seeking 'excellence' in applicants, due to the nature of the post/ projections for area, and want to appoint those likely to exceed CCT assessment of clinical competence. Appointability depends on **CCT, experience gained in areas relevant to the job post** and the match to the **context of the job** on offer. Therefore applicants may be deemed **not appointable for a particular consultant job** but this is not the same as saying they are **unappointable as a consultant**.

Case examples below illustrate these points in more detail.

CASE EXAMPLE 1: An example of where the acquisition of a CCT was not sufficient as a selection criteria on its own was illustrated via a post in Obstetrics in Wick. The context of the job was that there would not be any Paediatric back up and so there was a different set of experiences required from the candidate than if the context was Obstetrics in a in city centre hospital. A consultant appointed to this post would need to be able to work immediately without this back up and understand the implications of the decisions they make in the context they are in.

CASE EXAMPLE 2: A second example was provided of a surgical post with no access to CT scanning and no ICU. A CCT would be a minimum requirement but appointable candidates would need to have appropriate experience to be able to deal with this context and have worked independently. They have to understand the context and be independent of thought and not be expecting to be able to ask for second opinions. Risk taking in this context was different as it is dependent on the facilities and context. The appointments process would need to be sure that the candidate understood the facilities of the place and the post and the implication for practice.

CASE EXAMPLE 3: A different example of where acquisition of a CCT was a minimum but not sufficient requirement for appointability was that of a large city hospital looking to develop international expertise in a specialist area. They may want to appoint 'world class' consultants to contribute to their strategy and grow their reputation in particular area. In this example, candidates would have to have clinical competence and potential *beyond* CCT competence. While all applicants may have a CCT, the panel may choose not to appoint if they were not 'excellent' in their field, or did not demonstrate that they had the potential to be excellent.

2.5 Selection and training process for national panellists.

Appointment of panellists was perceived as unclear and "opaque". How panellists are selected, and the level of qualifications required for the role were common questions. "The appointments process for NPs is a bit opaque – there is a nomination via the Royal Colleges, but how the University nominees come forward is really opaque. Improving the transparency of the process would help. The management of the process needs improvement ... it's unwieldy."

National panellists themselves consistently discussed the need for a more structured approach to induction and training for the role. While many may well be experienced assessors and interviewers elsewhere, a clearer, shared understanding of their role and expectations would be welcomed. This is illustrated by a comment by a national panellist who said "National Panellists really must have better training. At the moment it's pretty much non-existent". Another commented, "there needs to be more equality and diversity knowledge, and more on training on employment legislation".

2.6 Training of interviewers.

While many of those involved in the interview process were reportedly experienced interviewers, many commented that there was no provision in place to review interviewing skills or review practice in line with changes to employment legislation or QA issues. As one stakeholder put it, "the trouble with recruitment is that everyone thinks they can do it...the reality is that some can do it better than others". Training was perceived to be growing in relevance for the future, especially regarding employment law. Training for Chairs was seen as particularly important given their roles as guardians of the process. Further clarity on the role of lay panel members would be welcomed. Many believed that NES could have a key role in providing appropriate training and development in this area to optimise the effectiveness of panels.

Key Finding:

Verification of clinical competence of candidates' remains paramount, to ensure patient safety. There were mixed views on whether this needed to be carried out by National Panellists as it currently stands and whether the process could be paper-based, or separated from the interview. While the CCT is an important indicator of minimum clinical competence, alone it does not confirm whether a doctor has the *experience* to safely practice within a particular job context. All stakeholders welcomed a clarification of the role and boundaries of the National Panellists remit, in addition to more structured training for the role. Training of interviewers was also viewed as necessary for the future.

Theme 3. Selection Criteria

The identification of appropriate selection criteria relevant to the consultant role was frequently raised across all stakeholders. What criteria can and should be assessed? The identification and assessment of clinical competence has been the focus of the selection criteria historically. However, the future assessment of non-clinical/'softer' skills was consistently raised.

3.1 Identification of selection criteria, link to interview questions and scoring.

Many reported that the **identification of the criteria** to be assessed through the process, particularly the non-clinical aspects, was not explicit and that the content and focus of questions was variable and could be improved. Our review showed that there had been little if any formal job analysis to identify the selection criteria. Research consistently shows that job analysis is the cornerstone to best practice selection practices. This analysis allows accurate design of the Person Specification and the related selection criteria, guiding design of interview questions. This issue was raised by many stakeholders illustrated by the following comment, *"I'm not sure we often know what we are trying to find out...those applying aren't clear what is expected of them and the questions reflect this lack of focus"*. The actual methods that were reported to be used to score individuals were variable. Our review suggests that more robust scoring mechanisms should be developed to improve the effectiveness, standardisation and transparency of this process. As a result, there could be significant opportunities for giving feedback to candidates.

3.2 Focus on 'attitude' and communication skills as important selection criteria.

This was consistently raised as an issue by almost all stakeholders interviewed. Specifically comments here related to identifying attitude as a critically important selection criterion - an issue that differentiates successful versus potentially unsuccessful consultants. However, further clarity is needed regarding what is meant by the word 'attitude' (i.e. is it personality, motivation etc.) and how it can be assessed fairly, accurately and appropriately. *"We have focused on technical and clinical competence in the past but there is insufficient focus on 'who' we are hiring...especially as modern medicine is more about team based efforts. User/patient expectations are now so much higher...sharing information, acknowledging a team effort, understanding obligations to patient and employees"*.

Most stakeholders consistently said that communication skills were crucial and if a doctor fails, then often this is an issue, illustrated by the comment *"They simply must have the ability to communicate with people at a variety of levels. Obviously the vast majority of consultants do an outstanding job but when there have been problems is usually to do with a break down in relationships...the people side of things"*. Another stakeholder said *"In my experience just about all the complaints I've had to deal with over the years relate to communication. Although it's there in the appointments process there really hasn't been sufficient emphasis on the behavioural and communication aspects when making appointments"*.

3.3 Focus on assessment of 'organisational fit' as important.

Most stakeholders commented on a key requirement for a candidate is to 'fit' into the local context (both technically and in terms of the people aspects). Specifically, local clinicians and employers perceived the need for those appointed to 'fit' the needs of existing teams. Identification of this organisational 'fit' was mentioned by many stakeholders. Some

suggested the use of a presentation to team members, so that the existing local team could have input into the new appointments process. One stakeholder suggested *“I think the academic appointments process has some very positive elements that could be considered. A portion of time is set aside where the candidate visits the department and they give a presentation or seminar, and the department can quiz them on their approach and how they would supervise students...just like asking how they might deal with patients...and do they acknowledge the consequences of not doing it right...views from the department are then represented at the interview panel. I’d really like to see some pilots of some more innovative approaches”*.

3.4 Appropriate identification of other knowledge, skills and abilities.

Whilst the assessment of clinical competence clearly remains paramount, the majority of stakeholders interviewed would like to see more accurate identification and assessment of other selection criteria such as *non-clinical attributes*. This is less clearly defined in the job description and there is little agreement on how best to assess this. Common areas identified as important to assess included *team working* (in particular working in multi-disciplinary teams), *clinical leadership, motivation and intention for development* of special interests (e.g. clinical and non clinical areas), *communication (written and verbal)*. A common belief expressed was that although it was critical that clinical competence is assured through this process, it is these non-clinical attributes that *“make or break successful appointments”*; *“Consultants we have had in the past that were not successful once appointed didn’t fail because of technical or clinical competence it was more often than not related to other aspects [of their behaviour or skills] that we hadn’t pursued at the interview...whether it’s something we could have got to the bottom of in some interview process is another question”*.

Many stakeholders suggested that the selection criteria should be more accurately documented and then investigated thoroughly at interview. This is illustrated by the comment, *“the selection criteria need looking at...the consultant nowadays must be an innovator, a researcher, a teacher, a leader and a manager of people. Consultants for the future must not only embrace change but must be in a position to lead change. The nature of medicine is changing rapidly and so are public expectations. We can’t afford to hold back on progress.”*

3.5 Integration of selection criteria into job description.

Some stakeholders believed that there will be a requirement to identify criteria and job requirements more accurately to enable more robust assessment of these areas in the future. Specifically, this was needed where the consultant role requires them to be more involved in activities outside the clinical group. This might include administration, management activities such as performance management, waiting times, patient experiences, and broader aspects of the job role e.g. engaging with hospital wide delivery. Currently many of these parts of the job role are not clearly featured in the job description and therefore it was not something that panels focused on or explored in any depth in the interview. Many would like to see more effective ways of exploring this and ensuring applicants are aware of this prior to applying for a post. *“When applicants phone me and ask me what is it we are looking for, I say that their technical competence is a given....so long as their experience matches the needs of the department, we are looking for qualities in addition to this that will allow them perform well and get on with the team”*.

Some stakeholders also stated that they would like to see the job descriptions reflect local needs more accurately. For example, one stakeholder said, *“we’ve just appointed a Chief Exec, we had an external assessor, a chairperson and importantly a job description that although it*

was set out in a national format, it really did reflect local needs and requirements too". Another stakeholder suggested, "there should be national and local elements to the job descriptions".

3.6 Quality and usefulness of person specification.

Many stakeholders said that the quality of the Person Specifications could be improved. In particular, the content could contain more specifics relating to non-clinical selection criteria and perhaps reflecting more locally driven requirements. On the whole, stakeholders said there could be more information to help guide choice of questions in interviews and how criteria could be weighted. In particular, one stakeholder said, *"The behavioural aspects haven't been scoped...the stuff beyond the CCT needs to be documented"*. A common view is illustrated by, *"the person specs for jobs don't have anything on what kind of doctor we want to recruit, it really only states the technical and research aspects"*⁴.

Key finding:

Clinical competence is clearly specified on job descriptions. However, all stakeholders believed that improvements could be made to the identification and assessment of other important selection criteria. Common areas include team working, clinical leadership, motivation and intention for development of special interests, communication and organisational fit. Identifying these criteria so they can be effectively assessed was viewed as an area for improvement. There are improvements that can be made to the design and implementation of the panel interview process. However, any improvements must account for the utility and feasibility so as not to reduce the efficiency of the process. Potential improvements have also been identified for the Person Specification.

⁴ The current person specifications do refer to clinical/ technical competence which is crucial

Theme 4. Selection Methods

Here, views on current and future selection methods depended to some extent on stakeholder experiences and knowledge of the contribution and application of selection methods at this level.

4.1 Current strengths and weaknesses of short-listing.

Currently, it was felt that the number of applicants to posts do not create the need to do 'fine grained' ranking at shortlisting (as the selection ratio is low) and so there is little concern over short listing methods. In general, the majority of eligible applicants are invited to interview unless there are identified concerns. For many stakeholders, attracting a pool of appropriately qualified candidates is the main challenge. As such, the short listing criteria is often CCT acquisition, work experience etc, although practices appeared to vary by area and specialty. In summary, this process is aimed more at **selecting out**, rather than ranking individuals. However, many stakeholders recognised that if numbers applying for posts increase and there are more eligible applicants than capacity to interview, short listing methods would need to be improved for the future.

4.2 Current strengths and weaknesses of interviews.

All stakeholders on the interview panel have an opportunity to ask the candidate questions in relation to their relevant stakeholder group interests. Therefore the interview it is perceived by some as **inclusive, and sharing responsibility** on decisions in the interview. This is illustrated by the comment, *"the approach we have is that all the panel members are in this together, including the national panellists."* For many, they believe there is no documented evidence that this approach to interviewing is not working; on the whole, most feel they select the right people from those in the applicant pool. There was no impetus to remove the use of the interview, particularly without any evidence of alternative methods in this context, but there could be ways in which they are improved as a selection method.

4.3 Potential areas for improving selection methods.

Most stakeholders believed that the selection process using an interview worked sufficiently. However, many also believe that there was significant scope for improvement. This is also supported by our audit of current processes. Improvements can be made to the content (questions), selection criteria, timing, structure, and training of interviewers (in advanced interviewing skills).

From an employer perspective, one person said, *"I strongly believe 40 minutes interview is insufficient for the jobs we are appointing to...and often the real selection work goes on outside the interview....either way, we are committing huge resource, millions of pounds...so we need to ensure this process is tight"*. Although clearly most stakeholders believed the interview process had worked well, many stakeholders believed that there was good reason to review the process in light of likely future changes. This is illustrated by the following comment, *"the rate of change in the next 30 years will be substantially higher than the rate of change we have experienced in the last 30 years - to think we can rely in future on a 40 minute interview as it stands is absurd"*. Some stakeholders suggested the use of personality measures to assess the behavioural and attitudinal aspects, and suggested that these processed could be piloted to see whether they could add useful information.

Many stakeholders believed that that the selection methods could be more closely focused to the clinical and on non-clinical aspects. For example, one suggestion was, *“I like the notion of a two-tier system. First there is the clinical competence assessment via CCT/National Panellists etc. Second there is the organisational fit, the behaviours and attitude; these need to be judged by the local team as well as the interview panel”*.

4.4 Using selection methods to identify development needs of candidates appointed.

Some stakeholders stated that often the interview identifies development needs of candidates that are appointed. However, they believed the extent to which these were followed up was variable, or whether they were pursued in any systematic way at all. Of those stakeholders that raised this issue, most agreed that there is a significant opportunity to identify and address development needs for candidates. Many believed that the requirement to do this in the future may be, and should be, more prominent.

4.5 Information from selection methods to aid feedback to candidates, especially if unsuccessful.

Some stakeholders felt that there was insufficient attention paid to providing feedback to candidates, especially those who were unsuccessful in the selection process. Although some recognised that this would take time to achieve, at this level of appointment feedback should be made available. Some stakeholders suggested a feedback sheet could be completed at the end of the panel interview process to help streamline this process.

4.6 Future selection methods.

Although all stakeholders believed the interview was an important part of the process, many suggested additional methods that might improve the process. Various potential selection methods were suggested by stakeholders, but there were mixed views on how these would work, often depending on stakeholder experience and understanding of the methods. Most stakeholders were unsure of how any alternative methods would be received or the evidence for the validity and reliability within this consultant context⁵. All stakeholders believed that new methods could not be introduced without appropriate piloting. Many were keen to find out what other methods could add (e.g. via piloting and validation studies) but would not like to see significant changes without appropriate evidence. Methods suggested by various stakeholders included:

- *Multiple (smaller) split interview panels* focusing on different aspects of performance (e.g. clinical and attitudinal) exploring different aspects of the candidates’ achievements, motivations, capability (e.g. clinical, behavioural etc). etc. Use of scenarios specific to the *context* of the job.
- *Presentations* to team members and/or the panel. Input from the local team/department was viewed as very important as the newly appointed candidate will be working directly with the ‘team’ (not the interview panel).
- *Written exercises* (completed in advance of the interview or during the day): examples of recent achievements, indicating various clinical and non-clinical examples. Submitted prior to the interview and signed off by current employer/referee.

⁵ See the Best Practice Selection Literature Review in this document for a summary of the issues

- **Personality assessment** there was mixed responses to the use of these at this level. Some would not like to see them included *“I prefer to speak to people and find out from themselves what they are like. I’ve taken psychometric tests and I’m not sure what is gained from it”*. Others could see some benefit where they were completed before to inform the interview. *“We have so little to go on in a short space of time. Surely testing can help us focus on key areas”*. Many stakeholders said they would be interested in piloting the use of such measures to investigate whether they could help in the assessment of attitude, in particular.

4.7 Evaluative standards for judging the quality of selection processes.

As the literature review details, there are various best practice standards by which any selection process should be judged. These include *validity, reliability, objective, standardised, fair, cost-effective, feasible and defensible, amongst several others*. Many stakeholders recognised that improvements could be made to the current process but that cost-effectiveness was also an issue. On the other hand, many believed that the process could be made more efficient. If new methods were introduced alongside the interview process, this might increase the resources used. On the other hand, by splitting an interview panel there could be gains in efficiencies. Also if a presentation is introduced for example, there would need to be a clear view on how this would be weighted and scores integrated into the selection decision making process. (i.e. one stakeholder suggested that there is no point having a presentation if the information is not used in decision making).

4.8 Role of references/referees.

Our review shows there is significant inconsistency in the way references are used in the current appointments process. For those that were paper-based and open-ended some panels used them in discussions at the beginning of the interview, others used them once the interview was completed. In addition, many reported the extensive use of informal references requested via networks - depending on ‘who knows who’ - which resulted in low standardisation in the use of references. There was little formal guidance in how reference reports should be best gathered and used.

4.9 Role of visits to departments.

Many stakeholders stated that this process needed to be made more transparent. Specifically, there should be transparency and guidance regarding;

- i whether or not applicants can visit the department in advance;
- ii what information should be made available;
- iii what they should expect to cover in the visit;
- iv who they will see (the team members, etc).

In particular, the opportunities available for candidates to visit units varied considerably. Some candidates were unclear as to whether they were ‘allowed’ to visit and how this might be viewed. By contrast, some stakeholders suggested that some candidates *“expect to see the Chief Executive”*.

Key finding:

The shortlisting methodology is not currently seen as a major issue. Usually, with a relatively small applicant pool, as many eligible applicants as possible tend to be invited to the interview. However, this could change in the future, putting more pressure on shortlisting methodologies. In addition, as described in Theme 1 'The selection process', the logistics of the shortlisting process can incur significant time delays. All stakeholders supported the use of interviews as a method for recruitment at this level. However, many would like to see improvements in the interview (eg number of interviewers, content, criteria, timing, structure, training of interviewers) to help generate more valuable information on candidates, while reducing bureaucracy and workload. Stakeholders would like to see better ways of using information from an improved interview to feed into development activities for appointed candidates, and feedback to unsuccessful ones. There was significant interest in the use of other selection methods (e.g. presentations, work-based exercises, personality measures), but most stakeholders were unsure of the evidence and acceptability for their use in this context. Many would like to see them piloted to generate evidence of the validity, reliability and utility.

Theme 5. Fairness and diversity

This theme relates to fairness and diversity throughout the recruitment process, from advertising through to interviewing and induction.

5.1 Retaining talent and fair recruitment.

It was recognised by many stakeholders that informal identification of future consultants plays a role in the current recruitment practice. This was described by one stakeholder as a “double-edged sword” in balancing the needs of a fair recruitment process, but also in retaining identified talent. As one stakeholder explained, “...we often know who is coming through the system, what they are like and what post they would be well suited to.... When they are good you want to keep them in the system, not lose them elsewhere. Clearly we have to balance this with ensuring a fair and open system”. There was some concern regarding how this manifested itself in practice. For example, stakeholders described how it was not unknown for job descriptions to be created to match identified individuals skills and advertising strategies put in place to meet legislation requirements but enhance the likelihood of appointing the identified candidate. There was no formal documented evidence of this but many recognised that these approaches to recruitment may happen at this senior level in medicine. Most stakeholders would like to see a fair and transparent way of retaining this “talent pipeline” (identifying those coming through with potential and aptitude). However, it was recognised that this must be balanced with open and transparent opportunities for all.

5.2 Attracting a pool of applicants.

A key issue for some stakeholders was the lack of applicants applying for posts, and so attraction is a major issue. This clearly has an impact on the diversity of the pool from which selection is taking place, as the pool is relatively small. There are benefits in ensuring advertising of posts is widespread, in that it can attract applicants that may be better for the post. Many stakeholders reported that legislation around advertising and attraction has a minimal impact on increasing this pool. Most argued that benefits to employers and applicants of wider advertising needs considering. The whole issue of advertising was a recurrent theme. One stakeholder suggested “in some cases posts were only advertised when a panel knew who they wanted to appoint...how else you explain the level of vacant posts? I think we need some clearer policy in this”. Others were keen to ensure that the job descriptions were clear in identifying the core parts of the consultant job and to be clear about the opportunities for work-life balance. As one stakeholder commented, “Advertising should ensure a diverse pool of applicants, wherever possible”.

5.3 Candidate perceptions of fairness.

Recent appointees and future candidates were consistent in wanting more information about posts and the actual appointments process. ‘It [appointment process] seems to be clouded in mystery...it’s really not very transparent. I feel I’ve had to find out by stealth what it is all about and how to beat it. It would help if we were given more information about what to expect’. Another potential candidate said, “It would help if we knew when jobs were coming up, some central database or something. I get to hear about the ones local to me through local meetings or colleagues but there could be ones further afield that I’d be interested in but never get to hear about”. Some commented that in the future, with the introduction of MMC, the end of training will be at a similar time so new consultant posts could co-incide with this.

5.4 Compliance with employment legislation.

Many recognised that the existing appointment regulations were “*out of date*” as employment legislation had moved on. Of those stakeholders who were aware, most assumed they would be updated at some point. In addition, some referred to the Board involvement in the appointment process and suggested that the current processes (in terms of Board involvement) was not compliant with the current regulations.

5.5 Standardisation of selection methods to ensure fairness.

There were mixed views about whether increased standardisation of methods/process increases fairness and effectiveness. For example, in the interview, some felt fairness was ensured by asking the same question of all candidates without deviation. Others however felt this was unrealistic and not helpful when recruiting at this level when informed discussion around key areas was required. One stakeholder said “*Interviews should have some structure but shouldn't be too onerous, they should be semi-structured*”. This is in line with best practice. Some believed that further training of interviewers and Chairs would help to understand how fairness in interviews is enhanced. For example, in using job descriptions and selection criteria to identify *areas* for exploration by interview panel (e.g. communication skills) rather than asking exactly the same question. Appropriately probing of candidates responses was also seen as important at this level and concern that this should not be too formulaic or standardised. Some stakeholders also raised the issue of lay involvement in the interview process. Similarly, many suggested that specific guidance would be helpful in this respect.

5.6 Equal opportunity and diversity training.

Some stakeholders with specific expertise in employment law expressed concerns about the current level of awareness of panels to equal opportunities and employment legislation. Of those with expertise they suggested the need for specific training of those involved in the appointment process. Whilst panel members may have been trained, it was often not clear to what level and how long ago training had occurred. As one stakeholder commented, “*As a Chair of a panel, I'm unsure what training the panel has undergone. Some clearly have, others may have but have either forgotten the core elements or need a refresher*”. Most stakeholders believed that appropriate training in this area would be welcomed and is necessary. Some suggested there were more subtle issues that could be addressed (such as suggesting there may be an indirect gender bias in senior level recruitment). Some stakeholders suggested this issue should be evaluated in particular (perhaps through commissioning primary research) given the increasing numbers of women into the medical workforce.

5.7 Auditing of selection methodology.

Many stakeholders said there should be specific mechanisms in place to audit selection methodologies used for appointments across Scotland. Given that the nature and structure of speciality training has changed significantly, creating processes to plan for the consequential impact on senior level appointments is advisable. Such audit mechanisms could also include processes to monitor information on fairness and diversity.

Key finding:

Attracting an eligible pool of candidates from which to select from was a key issue. Advertising widely clearly helps. However, this strategy alone may be insufficient to ensure an eligible and diverse applicant pool. Tensions between stakeholders wanting to retain local talent with equal ops/fairness/diversity were apparent. Legislation currently requires that there is fairness in the process. However, organisations and departments have developed strategies to meet their own recruitment needs which may not always reflect best practice. In particular, legislation in this area is a necessary but not a sufficient condition to ensure fairness and equal opportunities in the process. Training in equal opportunities, fairness, and interviewing can help stakeholders to better understand the benefits of attracting a wider pool to individuals, departments and organisations.

Theme 6. Future perspectives

All stakeholders were asked to comment on the future of consultant recruitment.

6.1. Applicant perspectives on futures.

There was some concern by applicants that those coming via the new training system based on MMC principles will have their CCT but may have less experience and 'time served' in the specialty. Trainees and other stakeholders felt that through no fault of their own, they may be at a disadvantage to 'experienced' doctors already in the system. Some suggested that there could be posts created that appoint doctors straight from specialty training and then offered structured development to acquire relevant experience. Most of this concern was related to the uncertainty generated by the transitional period and some suggested that those doctors who were less experienced may find it difficult to be appointed until all the *"experienced people were out of the system"*.

6.2. Process improvement (logistics, utility).

A consistent message from all stakeholders was that any change must bring with it less bureaucracy in the process. Anything new introduced must not *"increase the burden"*. As one interviewee put it, *"There must be a method of providing a better experience for all parties... interviewers, HR, panellist and candidates...we must not add to the burden"*. It was clear that stakeholders do not want to see the introduction of a centralised electronic application system, like the MTAS process. Many commented that any improvements to consultant recruitment processes at this time had to be managed carefully given the context and experience of selection by junior doctors. One stakeholder said, *"following recent changes, MTAS, and the impact on the profession, it would be a very brave decision to significantly overturn any of the current processes in consultant recruitment"*. In this respect, any proposed improvements need appropriate consultation with stakeholders.

6.3. Potential impact of 'oversupply' in the future.

Some stakeholders believed that there will be a 'bulge' of qualified specialists exiting training at the same time in the future. One stakeholder commented, *"I'm not convinced there will be a sub-consultant grade as the skill level required should be no different. However, I think we can expect a 'big bulge', and the financial implications need to be thought through"*. Many other stakeholders said that there are likely to be financial and practical implications in the future that need to be addressed now. Specifically, an oversupply of trained specialists would lead to an increase in applications to consultant posts. While this may fit well with current aims for attraction to these posts within Scotland, increased numbers of applications would bring a need for changes to selection practices and processes, in order to deal effectively with the process.

6.4. Opportunities to further improve the appointments system.

Most stakeholders welcomed this review and whilst there were concerns regarding change in the current climate, all interviewees believed that there were opportunities to improve the system in various areas, from advertising through to interviewing methods and provision of development plans to candidates.

6.5. **Feedback to unsuccessful candidates.**

Many stakeholders said they would like to see improvements that lead to enhancing feedback to candidates (especially those that are unsuccessful in the process). Currently, interviewers felt that they often struggled to give meaningful feedback to unsuccessful candidates, while others were concerned about legal implications of how the content of feedback is used. Improvements in identifying the selection criteria and interview methodology could aid and enhance this process.

6.6. **Review of guidance to candidates, interviewers, HR.**

Guidance is available on the appointments process, but many felt that this could be more practical, accessible and available for all stakeholders. Provisions of 'top tips' and guidance on best practice for multiple stakeholders was suggested by many stakeholders.

6.7. **Evaluation of validity, reliability and utility of selection methods.**

While many stakeholders were interested in using other selection methods, perhaps alongside the interview, there was a lack of specific knowledge regarding the evidence for their usefulness (validity, reliability and utility) in this context. Given there is limited evidence in the literature regarding use in this context, there are clearly opportunities to pilot methods in localities or specialties that wish to explore this. In particular, some stakeholders suggested that primary research should be conducted to fully establish areas for ongoing improvements.

6.8. **Impact of new training pathway (MMC) on the next generation of consultants & continuous development of consultants in post**

There were concerns expressed by various stakeholders that the new training pathway means that new appointees (in the future) will necessarily have had less experience in their specialty and in hospitals. However, the MMC pathway suggests that trainees will not progress unless they have acquired the necessary competences. Some believe there is also a need to focus on the development of consultants in post, both in clinical areas but also non-clinical areas. For example, working effectively in teams, attitudes and management development. One stakeholder that illustrates this issue said, *"I'm a senior medical figure and there is a need for 'management development'; it's about attitude and how to behave in organisations. It's an issue that needs addressing"*.

6.9. **Future identification of selection criteria.**

There were consistent messages from stakeholders regarding the selection criteria that are important for current consultant appointments. However, some would like to see further work carried out to specifically identify the criteria for the future consultant role. Given that many stakeholders suggested that the role is changing rapidly, many suggested that it would be apposite to address this specific issue.

Key Finding:

It was clear across all stakeholder groups that improvement is required to the appointments process. Stakeholders differed to the extent of improvements required, and had some concerns about what was possible in the context of changes to junior doctors selection, but most felt that clearly opportunities exist to improve the selection process and pilot selection methods. Given the output from specialty training in the near future, there is a need to plan for this now to ensure a robust system is in place in time.

Part 3 Summary of key findings & implications

The following table summaries the findings in relation to the objectives of this project. In particular the findings identify the key issues arising.

Objectives	▪ Key Findings	▪ Issues Arising
<p>1. Understand best practice global medical recruitment practices to establish sound principles on which consultant appointments can be made</p>	<ul style="list-style-type: none"> ▪ Robust evidence is available in the literature of best practice approaches to recruitment and selection in non-medical contexts. Specifically in how to effectively carry out job analysis and define selection criteria to assess teamworking, leadership potential, personality, attitude towards work etc. ▪ In the medical context, at <i>entry</i> into UG and PG medical training, there is some evidence of the value of identifying criteria and piloting relevant selection methods. For example, how to identify and assess <i>potential</i> for attaining clinical competence and non-clinical attributes, given that these are viewed as important criteria for the successful completion of training/future performance. ▪ There is little national or international documented evidence of senior level medical recruitment practices, nor indeed the criteria for selection. ▪ There is no evidence of any systematic analysis of job requirements and limited evidence of whether or how non-clinical criteria have been assessed within consultant selection. ▪ However, stakeholders consistently identified criteria important to assess at this level, although there is no published evidence of the most effective ways of assessing this in this context. 	<ul style="list-style-type: none"> ▪ While extensive academic literature exists on best practice recruitment and selection in other sectors, there is limited evidence of practice in medical recruitment, especially for consultant recruitment. ▪ Lessons can be learnt from other sectors, but given the unique medical context, care must be taken in application of selection methods within this context. ▪ Significant opportunities exist for Scotland to be the first to identify relevant selection criteria and methods for consultant recruitment, establishing Scotland's consultant recruitment practice as 'leading edge'. ▪ The development of appropriate person specifications (reflecting specialty differences and non-clinical criteria) is essential. ▪ Piloting and validation of methods prior to implementation is essential.
<p>2. Establish how Scotland may differ from other countries in EEA and the rest of UK and specifically, establish how this affects recruitment and retention.</p>	<ul style="list-style-type: none"> ▪ Scotland needs to attract candidates to apply to posts to improve selection ratio and fill rate of consultant posts. ▪ Scotland operates a different appointment process to the rest of the UK in that clinical competence is assessed via Royal Colleges in England, not National Panellists as in Scotland. ▪ One of the future challenges for Scotland is that doctors will exit training earlier and potentially have less experience in their specialty. Those applicants applying straight out of completing their CCT and medical training within Scotland believe they may not be as competitive with those who have held a CCT for years and are already in the system. The challenge is to ensure fair recruitment and selection for all groups. ▪ A clearer development plan following appointment may be required in the future. Whilst this currently happens in some appointments, given changes to the training of doctors in Scotland, formalised development opportunities identified at interview and feeding this into appointments may be necessary. 	<ul style="list-style-type: none"> ▪ An appointments process and system is required that is attractive to candidates and fits with their needs. In particular in managing perceptions and expectations regarding fairness in appointments and development opportunities post CCT. ▪ Widening the applicant pool is critical. Advertising is one method, but alone may be insufficient to ensure a wide applicant pool. Improving the accuracy of job description and person specifications can also be beneficial. ▪ It is possible that the selection ratio may change and so Scotland will need to 'future proof' any process and method of selection to this level.

3&4. Options for relevant improvements to current practice based on literature reviews and stakeholder consultation. A means by which a new robust selection system would be implemented including guidance on practical and feasibility issues

Theme 1: Recruitment and selection process

- Stakeholder consultation makes clear that the *process* by which appointments are made is viewed as bureaucratic, inefficient and in need of improvement. There is also evidence to suggest that the effectiveness could be improved. This is not to say there are grounds to suggest the wrong people are being appointed, rather that there are lost opportunities in current practice.

Theme 2: Professional standards and quality assurance in recruitment

- There were mixed views on whether National Panellists needed to carry out clinical competence verification and how this is carried out. What is clear is that while the CCT is an important indicator of minimum clinical competence, alone it does not confirm whether a doctor has the *experience* to safely practice within a particular job context. All stakeholders would welcome a clarification of the role and boundaries of the National Panellists remit, in addition to more structured training for the role. Training of interviewers was also viewed as necessary for the future.

Theme 3: Selection criteria

- Clinical competence was clearly specified on job descriptions. However, all stakeholders believed that improvements could be made to the identification and assessment of other important selection criteria. Common areas included teamworking, clinical leadership, motivation and intention for development of special interests, communication and organisational fit.

Theme 4: Selection methods

- Shortlisting methodology is not currently a major issue as most eligible applicants are invited to interview. All stakeholders support the use of interviews as a method for recruitment at this level. However, many want improvements to the interview (eg number of interviewers, content, criteria, timing, structure, training) to help generate more valuable information on candidates, while reducing bureaucracy and workload. Stakeholders want improved ways of using selection information for development activities for appointed candidates and for feedback to unsuccessful ones.
- There was strong interest in the use of other selection methods (eg presentations, work-based exercises, personality), but most stakeholders were unsure of the evidence and acceptability for their use in this context. Many would like pilots to generate evidence of the validity, reliability and utility.

- Improvements are required to the practicalities and feasibility of the appointments process to reduce bureaucracy and enhance efficiency. There are opportunities to improve effectiveness of the process.

- Clinical competence still needs to be assessed beyond CCT. If National Panellists continue to carry out this role, clarification of their remit, training and added value beyond that of local consultants or senior doctors is required.
- Training of interviewers, particularly Chairs could be improved.

- Work to identify the selection criteria for consultants, particularly non-clinical knowledge skills and abilities is required.

- Consistent view that the interview could be improved to obtain better information on candidates and utilise panellist time better.

- Interest exists in exploring the use of other selection methods, but evidence is required to gain acceptance/ confidence that alternatives will be an improvement on current methods.

	<p><i>Theme 5: Fairness and diversity</i></p> <ul style="list-style-type: none"> ▪ Attracting an eligible pool of candidates from which to select from was a key issue for many employers. Advertising widely clearly helps, but alone this strategy may not be enough to ensure a suitable applicant pool. Tensions were apparent with stakeholders wanting to retain local talent through the process. Legislation provides requirements to ensure the process is fair, but clearly practice has developed to work around this for organisational and departmental needs. Most recognise that legislation in itself will not change some of this practice. <p><i>Theme 6: Future perspectives</i></p> <ul style="list-style-type: none"> ▪ It was clear across all stakeholder groups that improvement is required to the appointments process. Stakeholders differed to the extent of improvements required, and had some concerns about what was possible in the context of changes to junior doctor selection. However, most felt that clearly opportunities exist to improve the selection process and planning is required now to ensure a robust system is in place to deal with future output from specialty training. 	<ul style="list-style-type: none"> ▪ Evidence is required to convince many stakeholders of the benefits of ensuring posts are attractive to a wide group of applicants. Detailed and accurate person specifications and job descriptions can enhance this. ▪ Training in equal opportunities, fairness, and interviewing can help stakeholders to better understand the benefits of attracting a wider pool to individuals, departments and organisations. ▪ There is considerable support for improvements but it is clear that any improvements to current practice need to be considered in the context of the current climate following the changes in selection of junior doctors.
<p>5. Consider how improvements might be best evaluated particularly if the statutory basis is removed</p>	<ul style="list-style-type: none"> ▪ Evaluation of the effectiveness of any appointments process must consider factors other than whether the right person was appointed, whether they are effective in post and are retained. Evaluation of the <i>process</i> is required from multiple stakeholders (eg applicants, HR, interviewers, employers etc) in order to judge success. ▪ Design of evaluation is important if any improvements take place. This must be agreed in advance with regular reviews and checkpoints to the process. ▪ Monitoring of selection process is required and reviewed regularly by key stakeholders to ensure best practice is adhered to and to ensure improvements made on basis of evaluation. 	<ul style="list-style-type: none"> ▪ An evaluation design is required if improvements are made. Best practice shows this should include multiple empirical assessments including measures of validity, reliability and the utility of methods and processes.

Appendix

Appendix 1 *Research Literature Review of Best Practice Selection*

Appendix 2 *Summary of Existing Documentation and Reports*

Appendix 3 *Stakeholder Groups*

Review of Best Practice Consultant Recruitment

*Research Literature Review of Best
Practice Selection*

Introduction

There have been many changes in medical education and training in the UK in the recent past. Within this context, the recruitment and retention of senior doctors in post are central issues. The implications of making the wrong selection decision are serious both in human and in financial terms. Hence, developing and implementing selection methods that are accurate and fair is of crucial importance.

This document presents a review of the existing literature relevant to the selection of consultants. The review also spans practices in different countries and in other professions at senior/executive levels. The **aims** of this review are to:

- understand best practice global medical and senior level recruitment.
- establish sound principles on which consultants appointments can be made.
- provide practical recommendations to design and implement a valid selection system for consultants.

Three main information sources were targeted including (i) existing *reports* (published via the SEHD, MMC, PMETB and others, e.g. media releases & reports); (ii) current *research* literature in 'best practice'; and (iii) reports from existing good practice in the medical selection context. Information from each source has been integrated into this report and each section draws out some implications for consultant recruitment.

2. The Selection Process

The key stages of the selection process, from job analysis, to assessing candidates, to validating the selection methods, are summarised in Figure 1.

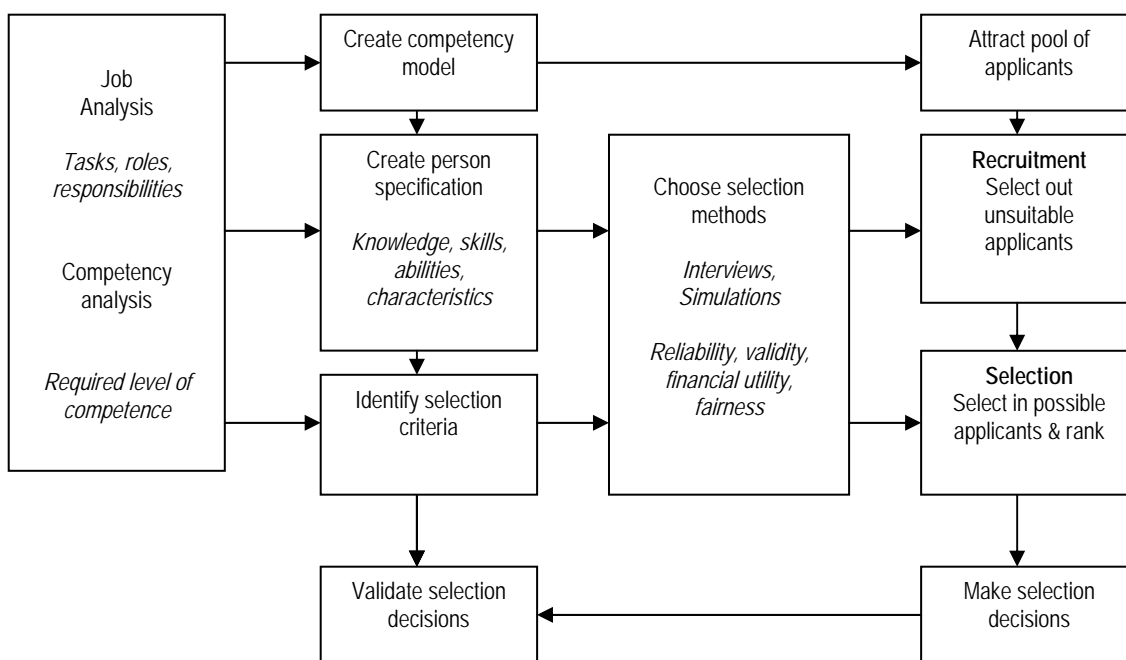


Figure 1. Overview of the selection process illustrating best practice

The first stage is a thorough job analysis, the process of collecting and analysing information about the *tasks, responsibilities* and *contexts* of jobs. There are a range of job analyses techniques and procedures available (Morgeson & Campion, 2000). A thorough job analysis usually involves the use of a range of reliable and systematic techniques and informants to ensure that there is a clear picture of the job.

The output from the job analysis should provide information about the *tasks* and *responsibilities* in the target job and also provide information about the particular *behavioural characteristics* required of the job holder (Patterson et al, 2000). The job analysis also forms the basis of a *job description* and of a *person specification*, which outline the *selection criteria* (competency model) that will form the basis of selection decisions. The selection criteria include the qualifications, skills, experience, knowledge and other attributes a candidate needs in order to perform effectively on the job. The selection criteria are used to guide the choice of selection methods.

The existence of a competency model or selection criteria has implications for issues of fairness and equal opportunities legislation. In order to be fair and objective, selectors should be able to assess candidates against the same agreed *standards* or *criteria*. If candidates know what *criteria* they are being assessed against, selection is seen to be fair and transparent. The existence of selection criteria allows

employers to justify a short-listing procedure, the way they conducted an interview, or the criteria they used for selection (or promotion).

The next stage in the process is the choice of selection method(s) (e.g. interviews, work simulation exercises, psychometric tests) that can be used to detect whether candidates display the required competencies. These methods are then used to assess candidates and hiring decisions can be made. Attracting a pool of applicants could be a challenge for job roles that require high-level 'niche' skill sets. Finally, it is important to conduct validation studies in order to monitor the quality of the selection process. Results from validation studies can be used to improve and update the selection process.

Implications for consultant recruitment

When a post arises a carefully prepared Person Specification will enable the recruiter to define the desired candidate skills sets and attributes in an objective and fair manner. A job analysis is needed to define the skills and attributes. This also ensures the selection process operates within the legal framework. Attracting an eligible pool of candidates to select from may be a major challenge in consultant recruitment for some areas.

Organisational Attractiveness

Before candidate selection takes place it is important to attract a good number of appropriate candidates. The importance of applicants' attraction is likely to vary from firm to firm but in today's economic conditions well qualified candidates are often in short supply and it is often candidates who select organisations. Under these circumstances, appropriate attraction strategies need to be developed and implemented. The term "war for talent", which was coined in the 1990s, describes a situation where companies compete to attract and retain high calibre candidates. The concept of organisational attractiveness has recently received much attention with several articles published in the business press (Lloyd, 2002; Sherry, 2000; Ritson, 2002), in communication and marketing journals (Ambler, 2000; Bergstrom et al, 2002), and in the area of applied psychology (Collins & Stevens, 2002). In this section, two key questions related to organisational attractiveness will be briefly addressed:

- (1) What makes an organisation attractive?
- (2) Which marketing, communication, and public relation principles can organisations rely upon to successfully "market" themselves to the right applicants?

After describing the theory behind organisational attractiveness, a practical approach to medical recruitment and retention in a rural under-serviced area is provided.

2.1. What makes an organisation attractive?

Studies have traditionally looked at some of the more tangible aspects of a job and organisation that make a firm attractive to applicants. Several studies for example have shown that applicants' perceptions of a *job* or of *organisational characteristics*, such as pay, location, opportunities for advancement, organisational structure or career programmes, are all related to organisational attractiveness (Cable & Graham, 1999; Highhouse et al, 1999; Lievens et al, 2001; Lievens & Highhouse, 2003). In addition, the literature on applicants' reactions to selection procedures has shown that applicants who hold a negative perception of the *selection process* (based on recruiter's

friendliness or competence for example) are less attracted to the organisation than those who hold a positive view (Kohn & Dipboye, 1998; Ployhart & Ryan, 1998).

The *person-organisation fit* literature suggests employees select organisations on the basis of their perception of “fit” with the organisation’s values. In other words, the more they identify with an organisation, in terms of perceived similarity in *values, interests, and personality*, the more likely they are to be attracted by the organisation (Cable & Judge, 1996; Judge & Bretz, 1992; Judge & Cable, 1997).

2.2. Marketing principles and organisational attractiveness

The awareness that, in the future, competing for employees may become as difficult as competing for customers, has led HR researchers and practitioners to bring in the lessons and principles from marketing and from *product branding* specifically to recruitment practices (Sartain, 2005).

Researchers are borrowing the language of marketing and communications to describe the intangible aspects of a job or organisation that make an employer attractive. A plethora of fairly new marketing-related terms have entered the realm of recruitment practice. Figure 1 summarizes some the key marketing-related questions and concepts that are linked to the way an organisation is perceived by potential applicants.

Cable and Turban (2001) developed a model of *employer knowledge* based on *brand knowledge*. According to this model, *employer knowledge* is made of three dimensions: *employer familiarity*, *employer image*, and *employer reputation*. Cable and Turban suggest that potential employees select organisations on the basis of these related dimensions. The first dimension, *employer familiarity*, relates to the level of awareness a candidate has of an organisation. The more familiar an organisation is, the more attractive it is perceived to be (Cable & Graham, 2000; Gatewood et al, 1993; Turban, 2001; Turban & Greening, 1997). The second dimension, *employer image*, refers to the beliefs that candidates have about objective aspects of an organisation or a job. These include organisational procedures or policies, pay, location, and benefits. The third dimension refers to the organisation’s *reputation* or to the organisation’s *public evaluation*. Cable and Turban (2001) incorporate the person-organisation fit approach in their model; they suggest that the applicants’ values and needs moderate the impact that employer knowledge dimensions have on organisational attractiveness.

Employer reputation has been the subject of much research in recent years. Several studies have shown that applicants assign *traits* to organisations (e.g. “trendy” or “prestigious”) which describe the organisation subjectively. Slaughter and his colleagues (2004) found that the traits potential applicants ascribe to organisations are related to the organisation’s attractiveness. Moreover, the greater the sense of similarity between the applicants own personality traits and the organisation’s traits, the greater the sense of attraction becomes. Lievens and Highhouse (2003) found that trait inferences about a Belgian bank (e.g. innovativeness) predict the attractiveness of the bank as an employer over and above job and organisational attributes.

Fig. 1: Key marketing-related questions and concepts (adapted from Balmer & Geysler, 2003)

<i>Key question</i>	<i>Key concept</i>
What are the corporation’s distinctive attributes?	Corporate identity
What is the corporation’s promise or pledge?	Corporate branding
What are organisational members’ affinities, or “who are we”?	Corporate identity
How are we perceived as time goes on?	Corporate reputation
How are we perceived right now?	Corporate image
To whom and what do/should we communicate?	Corporate communication

In summary, there is substantial evidence that the image/culture that potential employees ascribe to an organisation is linked to the organisation's attractiveness. Therefore it is vital to monitor and promote the image/identity/ brand that potential applicants have of an organisation to be more successful at attracting, recruiting and retaining talented employees (Martin & Hetrick, 2006).

2.3. The medical perspective: an example from rural Canada

The recruitment of appropriately educated and trained doctors is a growing concern in many healthcare organizations across the world. In the US and Canada for example it is often a challenge to identify and recruit qualified doctors, especially in the more deprived and isolated areas. In the UK, the medical recruitment and retention crisis is a fact and it is likely to continue, so urgent measures are now required. Although the literature search did not provide many examples of how different countries and health authorities are tackling the issue of filling consultant posts, the experience of Alberta, a rural and isolated Canadian province, is reviewed below.

In 1992, a multi-stakeholder working group was established in Alberta to develop a plan of action to recruit and retain rural physicians (Wilson et al, 1998). The plan focuses on professional and lifestyle issues of three distinct groups: undergraduate medical students and postgraduate physicians, physicians practising in Alberta, and rural communities and health authorities. The programme is based on research literature which shows that maximising students' exposure to rural practice and rural living can effectively improve recruitment of physicians in rural areas (Wetmore & Stewart, 2001). Research also shows that graduates often base their decision to practice in remote areas on lifestyle issues (Rabinowitz et al, 1999). One of the objectives of the programme is to encourage undergraduate and postgraduate students to take up rural practice by providing positive experience in rural medicine and by developing the skills necessary for rural practice. In order to improve the recruitment and retention of physicians practicing in rural communities the workgroup addresses professional issues. Other initiatives are aimed at helping rural communities and regional health authorities to identify and meet physician resource needs. Examples of initiatives for the three groups are included in figure 2.

Fig. 2: Examples of initiatives aimed at recruiting rural practitioners in the Alberta province (adapted from RPAP Evaluation Report, 2005)

Target group	Initiative
Undergraduate and Postgraduate medical students	<ul style="list-style-type: none"> • Mandatory 4-week rural rotations for medical students and residents • Student loan remission programmes after 2 years rural service in an approved under-served community • Rural tours, shadowing programme and mentoring initiative for medical students • Student summer experience programme for medical students • Matching signing bonus for practice
Currently practicing rural physicians	<ul style="list-style-type: none"> • Medical Information Service • Virtual library • Royal College re-entry positions • Rural physician retention/innovation grant programme • Award of Distinction programme • RuralNet
Rural Regional Health Authorities and their Partner Communities	<ul style="list-style-type: none"> • Recruitment fairs • Recruitment expense reimbursement programme • Community Development and Partnership grants • Rural Health Week

The example from Alberta shows how one specific medical community is tackling the recruitment and retention issue. While the effectiveness of the action plan has not been fully evaluated (RPAP Evaluation Report, 2005), researchers and practitioners generally agree that policies such as offering financial incentives to enter given specialties or to delay retirement, may be of limited success. The lessons from the literature are that physician recruitment and retention in rural areas is related to several driving forces which include lifestyle issues, rural background and exposure, and socio-cultural integration and identity (Cutchin, 1997; Cutchin et al, 1994).

Implications for consultant recruitment

The first step in any selection process is attracting an adequate number of appropriate candidates. Job and organisational characteristics such as pay, career progression, location, and opportunities for advancement, are all related to organisational attractiveness. Less tangible factors, such the image/ identity/reputation that candidates ascribe to an organisation, are just as important in making an employer attractive.

3. Best Practice Principles

Two of the most important criteria that should guide the selection of an assessment method are *reliability* (relevance) and *validity* (accuracy).

Reliability

Reliability refers to how dependably and consistently a selection instrument/test measures a characteristic. If a person takes the assessment/test again, will he or she get a similar score, or a much different score? A test/assessment that yields similar scores for a person who repeats the test is said to measure a characteristic reliably.

Validity

Validity is the most important issue in choosing a selection method, it refers to:

- 1) The degree to which an assessment method is measuring a job-related competency or characteristic.
- 2) How well the selection method measures that characteristic.

Validity also refers to the relationship between performance on an assessment and performance on the job. A selection method is valid to the extent that it is relevant to job in question and that it predicts something useful.

Key Principles

When judging the suitability of a selection method, it is also essential to ensure that the method is *valid, reliable, objective, standardised*, administered by *trained* professional(s), and *monitored*. Validating a selection process is important to make sure that selection methods are *fair, cost-effective, feasible* and *defensible*. Patterson and Lane (2007) emphasise that paying attention to best practice criteria for designing selection methods is essential. They suggest 12 key issues that should be reviewed when designing and implementing a selection system, as follows:

1. *Establishing reliability and validity of the tool*
2. *Positive employee/candidate reactions*
3. *Ensuring ease of interpretation*
4. *Ensuring generality of use*
5. *Minimising costs and maximising value*
6. *Practicality*
7. *Expertise required for analysis & interpretation of information generated by the tool*
8. *Utility*
9. *Fairness perceptions*
10. *Educational impact/value*
11. *Generates appropriate feedback*
12. *Procedures are in place for ongoing validation, evaluation and renewal of assessment tools*

4. Selection Methods

Although there are a variety of personnel selection methods available to use in organisational settings, research shows that not all the methods are equally useful or appropriate in some selection processes. This section describes the main selection procedures that are used at senior or executive level in the UK and abroad. Three of the most popular selection methods for senior/executive selection: interviews, job-related exercises, and personality measures; are described. The section outlines;

- *how well these selection methods predict job performance,*
- *how they are perceived by candidates, and*
- *relative fairness and equity.*

Implications for the recruitment of consultants are highlighted.

4.1. Interviews

Interviews are used widely in a variety of industries for recruitment and selection purposes, both at entry and at senior or executive level (Campion et al, 1997). They are the single most used assessment method for higher level positions (Garman, 2005). They are likely to be used at different stages of the selection process, either as the sole method, or in conjunction with other selection methods.

Interview format

There has been considerable amount of research undertaken into the selection interview. Recent studies have shown that when evaluating the reliability and validity of selection interviews, it is important to consider that interviews can take many forms and that different types of interviews may have different validities. Interviews may vary in terms of the purpose of the interview (recruitment, selection); duration of the interview; the medium used to conduct the interview (telephone, face-to-face, video conference); the number of interviewers (one to one, panel); and the amount of structure of the interview (unstructured, semi-structured, structured).

Interview structure

Recent studies suggest that structured or semi-structured interviews, which are based on thorough job analysis, selection and scoring criteria, tend to have much better criterion-related validity than unstructured interviews (Campion, Pursell, & Brown, 1988; Goho & Blackman, 2006; McDaniel et al, 1994). Meta-analytic research shows that structured or semi-structured interviews are often reliable (Conway et al, 1995) and that they are valid predictors of job performance (Huffcutt & Arthur, 1994; McDaniel et al, 1994). Recent meta-analyses suggest that semi-structured interviews can have incremental validity over cognitive ability tests (Cortina et al, 2000; Schmidt & Hunter, 1998) and that they generally yield much smaller ethnic group differences (Bobko et al, 1999; Huffcutt & Roth, 1998). Adding structure to an interview may also increase the chances of an organisation successfully defending a lawsuit.

Past-behaviour versus situational interviews

Recent debates in the interview literature have centred on two broad themes: the type of interview most suited to the specific selection circumstance and applicants' reactions to different interview

formats. Interviews may differ in terms of the type of questions asked: situational interviews (e.g. "Assume that you were faced with the following situation...what would you do?) and past-behaviour interviews (e.g. "Can you think of a time when...what did you do?) are the two most commonly used structured interview types for selecting employees. Situational interviews are based on the premise that goals are immediate precursors to actions, whereas past behaviour interviews are based on the notion that past behaviour will predict future behaviour. Both past-behaviour and situational interviews are predictive of job performance when the interviews are designed and conducted according to best practice. However, there is some empirical evidence that the past-behaviour approach is a more valid predictor of job performance for higher level positions and leadership roles (Huffcutt et al, 2001; Pulakos & Schmitt, 1995).

Panel versus individual interviews

In terms of interview format, the use of individual versus panel interviews continues to be the source of much debate. Panel-format interviews, involving the use of multiple interviewers simultaneously, continue to be used in many organisations, particularly in the public sector. Research evidence suggests that, contrary to popular belief, multiple individual interviews are preferable to panel interviews, both in terms of quality and feasibility, as long as they are designed according to best practice (Garman, 2005).

Interview modality

The medium used to conduct the interview (e.g. telephone, face-to-face, video) has been shown to influence interviewer judgements (Blackman, 2002; Chapman & Rowe, 2001; Silvester et al, 2000; Strauss et al, 2001). Therefore, modality of interview used should be standardised across candidates applying for the same job role.

Candidate reactions

Applicants generally react positively to interviews and that they tend to prefer them over other selection methods, such as personality tests and biodata (Hausknecht et al, 2004). However, they prefer multiple opportunities to demonstrate why they are the best person for the job. Formal training of the interviewer tends to result in heightened candidates' perceptions of the interview and in a better rapport between interviewer and applicant (Gatewood et al, 1989). There is evidence that structured or semi-structured interviews are preferred to unstructured interviews (Campion et al, 1997; Gilliland & Steiner, 1999), mainly because candidates value job-relatedness when evaluating the fairness of a selection process. Although little research is available on trends in candidates' reactions at senior/executive level it is fairly safe to assume that applicants at senior/consultant level will equally endorse job-relatedness.

Practice in executive assessment

There is little academic evidence describing the current stage of practice in executive assessment. Evidence to date suggests that the majority of executive or senior level recruitment is carried out through the "head-hunter route". Candidates are often identified and short listed by a head-hunter from CVs and then interviewed by the organisation. Unfortunately, the criteria used at these stages are rarely based on a thorough job analysis. Unstructured interviews are still widely used for selection in a variety of industries, despite their low predictive validity and their lack of legal defensibility in numerous countries (Klehe, 2004; Terpstra et al, 1999; Williamson et al, 1997). Unstructured interviews are prone to potential biases and errors (e.g. stereotyping, first impressions, halo, and leniency) that are likely to distort candidates' ratings (Edwards et al, 1990). Whenever selection is carried out in an unstructured way, there are also clear dangers in terms of equal opportunities and diversity. At senior level the legal implications of unfair selection are the same as at

any other level. However, the importance of ensuring diversity is perhaps especially important at this level if the need for diversity is going to be encouraged and managed throughout the organisation.

Practice in medicine

In medicine, use of selection methods based on CVs and unstructured interviews continue to be followed for the appointment of consultants or consultant staff in several countries.

However, some medical schools are making innovations in how they select at entry level. Awareness of the biases associated with unstructured interviews has led some medical schools to develop structured interviews to select students. Searle and McHarg (2003) developed a structured interview for selection of medical undergraduates at the Peninsula medical school in the UK. Although evidence for the interview predictive validity is not currently available, the interview showed face validity. In the US, Patrick and his colleagues (2001) describe the development of a structured interview for the admission of students at the University Of Iowa College of Medicine. The structured interview displayed good reliability and low-to-moderate correlations with other admission criteria such as cumulative GPA and MCAT scores. The predictive validity of the structured interview approach used by the University of Iowa is still to be determined. Similar attempts to develop a structured interview approach for medical school selection have been carried out in Canada and Australia, where medical schools often used a combination of structured interview, academic criteria and psychometric assessment (Turnbull et al, 2003). Monash University in Australia for example, has developed and piloted a structured interview for selecting medical school applicants. Results show the structured interview used at Monash University has concurrent and predictive validity (Tutton, 1993; 1997).

The use of interviews for postgraduate medical selection is widespread, but again, the type of interviews used varies, with inconsistencies throughout the world and indeed within individual countries. Although unstructured interviews are still commonly used, there is an awareness that the selection process needs to be refined. In the UK, the NHS advocates the use of structured interviews for entrance into specialty training (DoH, 1998).

Implications for consultant recruitment

Interviews should be based on a thorough job analysis and selection criteria. They should be semi-structured and scored according to a pre-determined, standardised scale. Past-experienced questions might be favoured over situational questions, but this needs further piloting and investigation in the context of a specific job role. Interviewer training is essential and will enhance perceptions of fairness and interview validity. The modality of interview (face-to-face, telephone, or video-conferencing) should be standardised across all candidates applying for a given post. Multiple interviews might be favoured over panel interviews to increase reliability, validity, and feasibility. This needs further piloting and investigation.

4.2. Multiple selection methods

Job-related exercises

Interviews are often used at a senior level in combination with other selection techniques such as job-related exercises, simulations and personality inventories. Individual exercises are more commonly used than group exercises for recruiting into senior or executive positions because of confidentiality issues. Experience suggests that candidates for higher level positions are not keen on attending group exercises, where other candidates are likely to be known to them. The preservation of candidates' identities and confidentiality are important for the exercises to be perceived favourably. Presentations

and/or written tests are two of the most frequently used exercises for senior level selection. Best practice indicates that the exercises must reflect job performance criteria or competencies that have been identified previously with a thorough job analysis (Algera & Grueter, 1989; Pearn & Kandola, 1993). Scoring of the exercises should be directly linked to the competencies and the information gathered should be interpreted in context by appropriately trained assessors. Meaningful feedback must be provided and the process must be monitored.

When these exercises are well designed and when results from at least two different exercises are combined (e.g. presentation and interview), they have a good track record for both validity and fairness. Research shows that they can be highly effective at *predicting job performance* across a wide range of occupations (Damitz et al, 2003; Lievens et al, 2005; Schmidt & Hunter, 1998; Schmitt et al, 1984); that they can have *incremental validity* over cognitive ability tests and that they tend to be *viewed positively* by candidates (Macan et al, 1994; Rynes & Connerley, 1993). Research also indicates that the **combination of several exercises are better predictors of performance than interviews alone** (Bobrow & Leonards, 1997; Harel et al, 2003; Hough & Oswald, 2000; Salgado, 1999). The use of a selection system based on multiple assessment reduces the possibility of biased judgements being made, is seen to be fair to all candidates, and is thus legally defensible.

Job-related exercises are increasingly used in combination with other methods of selection for entry-level positions, such as selection of graduates, in a variety of settings (CIPD, 2004).

In medicine, awareness of the limitations associated with single method selection processes, and changes in the medical curriculum have recently led some medical schools to consider the introduction of job-related exercises for medical school selection. For example, a group exercise, video based interview, and written exercise aimed at selecting graduate applicants have been developed recently. The exercises target core competencies that have been identified by job analysis. Two UK medical schools implemented the exercises for graduate selection in 2006 (Kerrin et al, 2005; Patterson, Petty-Saphon et al, 2005). At undergraduate level, some UK medical schools are considering the introduction of problem-solving tasks and group work in addition to the interview process for medical selection (Parry, 2006). Similar selection processes are being designed in other countries (Cate & Smal, 2002).

At postgraduate level, job-related exercises are slowly gaining in popularity for assessment of medical trainees into different specialities. In the UK, competency based exercises have been used to select candidates into training in General Practice and have shown good predictive validity (Patterson et al, 2000; Patterson, Ferguson et al, 2005).

Evidence for the use of job-related exercises at senior level in medicine is scarce. In other settings, some corporations are making breakthroughs in how they select their leaders. Shell for example has introduced job-related exercises for the selection of their global leaders. The Shell global leader selection process consists of two interviews, and of an individual presentation/discussion exercise where candidates present an example of some of their best work and then engage in a discussion with assessors. The exercises are designed to elicit several competencies that have previously been identified by a job analysis. Trained assessors score the different exercises according to pre-set criteria.

Implications for consultant recruitment

Job-related exercises based on core competencies identified by a thorough job analysis can be valid predictors of job performance at consultant level. Trained assessors should aim to score candidates on the selection criteria according to a pre-defined anchored rating scale for the ratings to be reliable and valid. Confidentiality issues warrant the use of individual exercises for senior appointments, perhaps using multiple job-related tools. Candidate feedback should always be provided.

Personality measures

The last fifteen years have seen a substantial increase in the use of personality and related tests in personnel selection for a broad spectrum of jobs (Ones & Anderson, 2002). The recent enthusiasm for personality assessment in selection is based on developments which occurred in the 1990s. After years of research, the personality field approached consensus on a general taxonomy of personality traits, the Big Five model, which is based on five factors or traits: Extraversion, Emotional Stability, Agreeableness, Conscientiousness, and Openness to Experience. Meta-analytic findings have shown that small but meaningful relationships exist between measures of personality and job or academic performance (Barrick et al, 2001). This is particularly true for the personality traits of conscientiousness (Dollinger & Orf, 1991; Schmidt & Hunter, 1998; Wolfe & Johnson, 1995) and integrity (Murphy, 2000).

Nevertheless, the use of personality measures to assess some of the characteristics of job applicants is still controversial. Critics argue that the predictive validity of personality traits for job performance is often low and badly understood (Tenopyr, 2002; Tett et al, 1999), that personality tests used by organisations are often poorly chosen (Murphy & Dzieweczynski, 2005), and that faking can compromise the validity of personality tests (Birkeland et al, 2006; Rosse et al, 1998; Scarpello et al, 1995).

In medicine, the use of personality measures to explore career choice into different specialties is increasing. Research findings indicate that individuals with different personality types tend to choose different specialties (Gilliland et al, 1990; Stilwell et al, 2000). Defining the competencies that are important at each stage of medical selection and for different specialties is a primordial step in designing an appropriate selection process. In the UK, a thorough job analysis has been conducted to define the competencies required for performance as a general practitioner (Patterson et al, 2000). This information is useful to explore career choice preferences and personality.

Personality inventories are often used for senior/executive level assessment in a variety of settings. They are mostly used to provide information over and above that obtained from more traditional assessment methods, often as a final check on a chosen candidate's suitability. Research shows that when they are used appropriately, (i.e. used to guide probing questions at interviews, for example) personality measures can enhance decision-making. In order to be of any value and to comply with best practice, personality measures should always be used in conjunction with other selection methods and never as a sole determinant of a selection outcome. Particular care should be taken to ensure that the choice of personality measures is based on the core competencies identified by job analysis and that the tests do not indirectly discriminate unfairly between certain groups. Personality measures must be used and interpreted by appropriately trained individuals, who are also required to give appropriate feedback to candidates.

Implications for consultant recruitment

Personality measures can be used to enhance the decision making process for the selection of consultants. However, piloting and validation is required before it should be used in this context. Personality measures can be used to guide further probe questions in an interview with the candidate. They should always be used in conjunction with other assessment tools, such as semi-structured interview and job-related exercises. Best practice shows that personality inventory results should not be used to 'score' candidates on specific dimensions. The choice of personality measures should be based on the competencies identified by the job analysis. The use and interpretation of personality measures must be carried out by appropriately trained individuals. Feedback can be fed into the interview process.

5. Summary & Recommendations

This report has reviewed the research literature on best practice senior level selection, focusing on issues that are particularly relevant to the selection of consultants. The report has provided practical recommendations based on research evidence for the selection of consultants. Specific literature around the selection of consultants is scarce; however, the lessons learnt from the literature around best practice assessment, at senior level especially, should be transferable to the senior level medical recruitment context. In medicine, some universities are making changes in the way they are selecting their medical students and selection into postgraduate training is also introducing multiple methods. It is likely that given these changes, trainees coming through this system in the future may have very different expectations of the selection methods for consultant posts.

In summary, the following recommendations have been made:

- The design and implementation of valid assessment methods starts with a thorough *job analysis* which defines the *selection criteria* required for the post.
- When choosing a selection method, issues of *reliability, validity, feasibility, fairness* and *equity* should be taken into account.
- It is important that the process is seen to be *fair* by all candidates. Research shows that candidates favour selection methods which are *job relevant* and less *personally intrusive*. Applicants also value the opportunity to meet personally with recruiters and have a preference for multiple opportunities to demonstrate their skills. They also tend to prefer selection systems which are administered consistently for all applicants.
- The selection methods should be developed carefully through *piloting* with diverse populations.
- The selection process must be *evaluated* and *reviewed* by monitoring candidates with respect to diversity and subsequent job performance.
- The evaluation of the selection process should lead to improvements aimed at enhancing *validity* and reducing *adverse impact*.
- Individuals involved in assessing candidates during the selection process should have received appropriate *training* (for example in interview skills) and have been adequately briefed about the selection criteria. Assessors should also be aware of unfair discrimination and equal opportunity legislation, two aspects which have a serious impact on the *diversity* of the organisation. Feedback should always be provided as part of the selection process.

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Appendix 2

The Recruitment & Retention of Consultants

*Summary of existing documentation
and reports*

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1. Introduction

Recent changes in postgraduate education and legislation in the UK, such as changes in doctors' training, the need for better accountability, and improved continued education, have increased the demands made on senior doctors. In view of the shortage of consultants in the whole of the UK, the recruitment of consultants has become a critical issue. In 2005 the Scottish Executive allocated NHS boards with new funding to help them develop and implement recruitment strategies aimed at consultants. The selection process for consultant posts in Scotland is currently under review.

The aim of this document is to summarize a list of articles relevant to the recruitment and retention of consultants in Scotland. Most of these articles were gathered by the Scottish Executive. The articles (see Appendix) can be categorised under three key headings, as follows:

1. Background & legislation.
2. Fairness and bias.
3. HR best practice recruitment advice.

2. Background & legislation

2.1. Structural framework: Single-system working

- NHS Scotland has undergone a series of structural changes since 1999. These include:
 - *Health Act 1999*. Reduction of NHS Trusts from 46 to 28. Repeal of fund holding. End of purchaser-provider split. Creation of local healthcare cooperatives (LHCCs).
 - *Scottish Health Plan, Our national health, December 2000*. From October 2001, health boards become unified NHS boards; trusts integrate into single local system but remain separate legal entities.
 - *Community Care and Health (Scotland) Act 2002*. Legislation allows NHS/local authority pooled budgets for community care services. Creation of joint Futures shared management bodies for community care services.
 - *Partnership for Care, Scotland's health white paper 2003*. Proposals for removing barriers in local NHS systems, including the final abolition of NHS trusts by April 2004 and the creation of 15 single-system NHS boards, with devolution of decision-making to front line. LHCCs to evolve into community health partnerships.
 - *Single-system working 2003*. The guidance, published by Trevor Jones, Head of Department and Chief Executive, NHS Scotland, includes proposals for changes to the governance arrangements for local NHS systems. The single-system working is a way of working to improve service organisation and delivery throughout NHS Scotland. Health Department Letter HDL 2003(11) deals with the duties which had been placed on NHS Boards to improve integration, decentralisation, service redesign and patient focus. The intention is for the NHS to function at local level as a single organisation with shared aims, a common set of values, and clear lines of accountability. Traditional barriers in the system, such as between acute and primary care, are removed.

2.2. NHS Boards

- There are 21 NHS Boards in Scotland. 14 are *territorial Boards*, responsible for care and services in their areas and 7 are *Special Health Boards*, which provide national clinical and non-clinical care and services.
- The 14 territorial boards - the mainland is covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three - are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. Boards work together in regional planning arrangements for those services which require that wider perspective.
- NHS *operating divisions* are committees of an NHS Board, with schemes of delegated authority setting out their operational responsibility for the delivery of care and services. Operating divisions came into being after the abolition of NHS Trusts.

- *Community health partnerships* (CHPs) have a statutory basis and a key role in the future of primary care and community based services. CHPs are part of the move to single system working in which NHS Boards maximise their ability to support integration across health and between health and other agencies such as social services. CHPs are committees of an NHS Board with schemes of delegated authority setting out their operational responsibility.

2.3. Consultants recruitment & retention

2.3.1. Number of consultants and doctors in training in Scotland

A chart from the NHS Scotland Workforce Statistics shows that the number of consultants and doctors in training in Scotland increased steadily between September 1995 and September 2006.

In Scotland, between September 2005 and September 2006, the number of doctors in training increased by 4% and the number of consultants increased by 3.6%.

2.3.2. The Temple report

- Concern over the recruitment of SpRs trained in Scotland to Consultant posts and their retention is an important issue in relation to the Scottish Executive's current drive to increase consultant numbers.
- In 2004, the *Temple report, "Securing future practice"* published the results of information gathered from consultants, GPs, SpRs, and GP registrars who left NHS Scotland the preceding year. The data was based on a small sample because of low response rates (32 SpRs and 21 consultants). However, the Temple report highlighted some of the main issues:
 - Reasons for leaving included: lack of suitable posts in their specialty; career aspirations better served by leaving; headhunted by other NHS employers; advice given on personal career management; only intended to train in Scotland.
 - Factors that might have persuaded them to remain included: a redesigned job; better facilities and working conditions; improved training and development opportunities; career advice and management.
- The report concluded that strategies to recruit and retain might include:
 - flexible career and employment packages;
 - family friendly policies (e.g. better childcare);
 - financial rewards;
 - improved working conditions and better career advice and counselling.
- Temple stated his intention to increase the consultant population by 600. It was hoped that this workforce expansion would be achieved by September 2006 but a fairly recent article in *The Herald* (16th September 2005) reported that recruitment was significantly behind schedule.
- A recent report in the *BMJ* (MacDonald, 2005) highlighted that approximately 35% of graduates from Scotland's four integrated medical schools leave the country to work elsewhere. In addition, only 38% of international doctors who complete their undergraduate training in Scotland remain in the country. Approximately one third of SpRs who gain their Certificate of Completion of Specialist Training (CCST) from training programmes in Scotland do not take up substantive consultant appointments in Scotland.

2.3.3. The McGregor et al report

- In a report written for the NES (NHS Education for Scotland), McGregor and his colleagues (2005) studied the career intentions of 198 SpRs across four regions in Scotland, already in or entering

their final year of training. They used e-questionnaires and structured interviews (based on focus groups with SpRs one year senior). Response rate: 75%.

- Findings:
 - The majority of trainees would prefer to remain in Scotland but they leave because job opportunities are not available in the short time frame SpRs are available for consultant appointments.
 - Some SpRs leave because posts appear more attractive elsewhere for a variety of reasons. These include: the perception that the new consultant contract is detrimental to recruitment in Scotland; a lack of opportunities for flexible work or part-time consultant posts in Scotland compared with the rest of the UK.
- The report provides a list of recommendations for improving recruitment and retention of consultants in Scotland:
 - need to improve the communication and information flow between NES and the NHS Boards in order that consultant posts can be designed and their advertisement timed to match the output of training schemes;
 - career intentions of trainees need to be taken into account and electronic canvassing of their views is suggested to gain this information;
 - a mentoring system may facilitate the transition from trainee to consultant.

2.3.4. The Advance Consultants Appointment Scheme

- The Scottish Executive has recently introduced an advance appointments scheme (2006) to assist the transition from SpR to consultant grade. The scheme is aimed at retaining a higher number of SpRs in Scotland as they move to consultant grade.
- The Scottish Executive Health Department (SEHD) have recently commissioned work from NES aimed at managing and matching SpRs at the end of their training to consultant posts in Scotland.
- Characteristics of the scheme:
 - The matching scheme will identify the career aspirations of current SpRs, with aspirations interviews.
 - The career wishes of SpRs will be matched to current and potential future consultant vacancies.
 - The SpR will then be able to apply for the identified post but will have to go through the normal open competition process (including formal AACs) and will have to have gained CCT before taking up the post.
 - In circumstances where there is an overlap between the SpR obtaining their CCT and the consultant vacating the post, then funding will be available, on successful application, to assist the NHS Board in running with two post holders for a period of between 0 and 6 months.

3. Fairness & bias

3.1. Career choice & discrimination: official statistics

- The NHS Scotland workforce statistics table B5 shows that the majority of consultants in Scotland at end of September 2006 were male (71%), working for the major part on a full time basis. Most part time posts are taken up by female consultants. Interestingly, there are more female senior house officers (foundation year 2) than male equivalent (51% versus 49%). At registrar level the number of female drops and it drops even further at consultant level (Fig. 2).

Fig. 2: NHS Scotland workforce statistics table B5 (summary)

Group	Male	Female	Total
All doctors in Scotland	6,292 (56%)*	4,911 (44%)	11,203
Consultants	2,720 (71%)	1,127 (29%)	3,847
Part time doctors	536 (33%)	1,071 (67%)	1,607
Part time consultants	63 (19%)	262 (81%)	325
Registrar group	917 (56%)	729 (44%)	1,646
SHO/F2	1,453 (49%)	1,540 (51%)	2,993

* Official table does not include percentages. These were calculated separately.

- Another official table from NHS Scotland workforce statistics includes the number of HCCHS medical and dental staff by gender and ethnic origin in Scotland at the end of September 2006. The table shows the breakdown for all specialties and levels (Consultant, Registrar group, Senior house officer, etc). The data indicates that ethnic minority doctors tend to be under-represented at consultant level – 90% of consultants, 75% of registrars, and 62% of senior house officers are of white origin (Fig. 3).

Fig. 3: HCCHS medical and dental staff statistics by gender and ethnic origin (summary)

Group	Male	Female	Total	Ethnicity Total
All specialties	6,243	4,686	10,929	77% white origin 17% other ethnic 5 % not known
Consultants	2,658	1,066	3,724	90% white origin (29% female) 8% other ethnic (18% female) 2% not known
Registrar group	1,695	734	961	75% white origin 21% other ethnic 3% not known
Senior House officer	1,403	1,358	2,761	62% white origin 30% other ethnic 8% not known

* The HCCHS data does not include any percentages. These were calculated separately. The official table also includes data on other medical grades such as House officer, Associate Specialist, Staff grade, Senior clinical medical officer, Clinical assistant, Clinical Director, medical adviser, etc.

3.2. Career choice & discrimination: journal articles

3.2.1. Promotion to Consultant posts

- In a BMJ article, *Mavromaras & Scott (2006)* examined the role of several factors associated with the promotion to NHS consultants in Scotland. Focused on the role of sex, country of qualification, hours of work, and the nature of training. Controlled for years of experience.
- Method: analysis of NHS data from the medical and dental census between 1991 and 2000; sample consisted of registrar, senior registrar and specialist registrar who could potentially have been promoted to consultant between 1991 and 2000.
- Findings:
 - Doctors who graduated in Scotland were more likely to be promoted to consultant than graduates from the rest of the UK and from overseas.
 - Women were less likely to be promoted than men, even after controlling for experience and part time working.
 - Doctors who worked part time were less likely to be promoted than doctors who worked full time. NHS boards in non-metropolitan areas were more likely to offer promotions than NHS boards in metropolitan areas.
 - Having an honorary contract before promotion was positively associated with a higher probability of promotion to consultant.
- Limitations: the measure of years of experience used (years since graduation) does not account fully for accumulated experience (that may be different for men and women). The fact that women are less likely to be promoted may in part reflect this.
- Mavromaras & Scott's (2006) article elicited a number of criticisms:
 - The study looked at all registrars, senior registrars, and specialist registrars, many of whom would still be in training and not eligible for applying to a consultant post (Mokhtar, 2005). Trainees are only eligible for appointment to a consultant post in the last year of training (Lack, 2006).
 - Some of the doctors, particularly those who have graduated outside Scotland might have been promoted outside Scotland and not been accounted for in this study (Mokhtar, 2005).
 - Women doctors are more likely to do part time training and this might explain the lower promotion rates found in this study (Mokhtar, 2005).
 - The number of female and male applicants is not taken into account (Lack, 2006).
 - The authors did not make the distinction between "promotions" and "appointments" to consultant posts.

3.2.2. Gender & ethnic discrimination in hospital medicine

- *McManus & Sproston (2000)* assessed from official statistics whether there is evidence that the careers of women doctors in hospitals do not progress in the same way as those in men.
 - Method: assessed the proportion of female hospital doctors overall (1963-1996) and career intentions and preferences of pre-registration house officers, final year medical students and medical school applicants (1966-1991).
 - Findings: analyses of career preferences and intentions lead authors to conclude that disproportionate promotion of male doctors versus female doctors cannot be explained by a differential choice by women.
- *Lambert et al (2004)* analysed a database of consultants eligible for distinction awards (2002) in England and Wales.
 - Findings: historical under-representation in award winning by women and doctors from ethnic minorities was partly explained by time spent as a consultant. Recent awards showed no under-representation of women and no appreciable under-representation of

ethnic minorities. However, doctors who trained abroad remained under-represented for B awards.

- Note: a new award scheme was introduced in 2004.

3.2.3. Discrimination in the NHS

- *Esmail (2004)* suggests that despite good intentions, discrimination in the NHS is rife. He argues that research has shown that ethnic minority doctors, who form nearly one third of the workforce of the NHS, are:
 - disadvantaged when they apply to medical schools or for hospital jobs at both junior and senior levels;
 - more likely to be suspended if concerns are raised about their performance; (Commission for Racial Equality, 1996; Esmail et al, 1993; McManus, 1998);
 - more likely to be disciplined by the General Medical Council (Esmail, 1994);
 - paid less and disadvantaged in the allocation of discretionary payments (Esmail, 2003; Royal College of Nursing, 2004);
 - more likely to face bullying and harassment from both patients and staff;
 - overwhelmingly over-represented in the more junior rank of staff in the NHS (DoH, Tackling racism in the NHS, 2000; DoH Medical Workforce Statistics, 2004).
- Esmail asks why ethnic minority doctors are over-represented in the lower grades of the profession. He questions whether admission policies are operating equally and whether present curriculum teach all students about cultural sensitivity and awareness.
- The author concludes that with virtually no ethnic minorities in influential positions, and with only 1% of trusts' chief executive from black and ethnic minorities, the challenges are huge, even if intentions are good.

3.2.4. Diversity at senior level in the NHS

In a report for the Health Foundation, *Esmail and his colleagues (2005)* report on a project to assess and evaluate different strategies for increasing the diversity of the workforce at senior levels in the NHS.

- Context: Black and minority ethnic (BME) groups make up 7.9% of the population in the UK and about 8.4% of the NHS workforce. However, the distribution of the workforce is concentrated mainly in the lower levels of the organisation with only 1% of chief executives and 3% of executive directors from BME groups. The differences are even greater within professional groups, for example doctors, where BME groups make up nearly 30% of the workforce.
- The reasons for this lack of diversity at senior level are not clear-cut:
 - Ethnic monitoring data about the existing workforce within the NHS is not sufficiently detailed to map out the reasons why some staffs are able to gain promotion and others are not. The lack of accurate information about promotions combined with a career progression system that is based on informal methods of assessment (such as belonging to peer networks) ensures that certain groups are excluded from senior posts.
 - Numerous reports, many commissioned by the DoH, have painted a variable picture of lack of senior management commitment, poor accountability, widespread bullying, and a deep felt perception among BME staff that the NHS does not value their contribution. Nearly two-third of cases in the Employment Tribunals are from the NHS and nearly 80% of these are related to allegations of racial discrimination.
- The NHS recognises that it needs to embrace diversity as a central facet of its business plan:

- The Health Foundation, as part of its Leadership Programme, has stated that one of its priorities is to develop and support a greater diversity among those in leadership positions in the NHS.
- The need to improve senior management diversity has been recognised by the Chairman of the Commission for Racial Equality, Trevor Phillips (Carvel, 2003). He used the term “snow capping” to describe how the NHS in England looks. Quoted in the Guardian newspaper on 30 April 2004 he said, when describing the NHS: “It is a mountain of an organisation. At the base among its 1.3m employees, there is a wide ethnic diversity. People from black and minority ethnic communities make up 35% of its doctors and dentists, 16.4% of nurses and 11.2% of medical staff. However at the top of each NHS organisation, the boss is almost always white. There are more than 600 NHS trusts, health boards, local health boards and health and social services boards in England, Scotland, Wales and Northern Ireland, and less than 1% of them have a black or minority ethnic chief executive. The contrast between snow-capped summit and the mountain base could hardly be more stark”.

The report recommendations include:

- monitoring staff progress;
- identifying talent;
- incorporating management training for diversity.

4. HR best practice recruitment

4.1. Recruitment research & its implications

- *Mianzo* reviewed research in the area of recruiting and published a research paper aimed at assisting HR managers in recruiting qualified applicants. HR managers are finding it increasingly difficult to recruit and retain qualified employees. This shortage of qualified employees implies that HR managers need to maximise their efforts in order to recruit the right candidates for the jobs.
- After briefly reviewing the research literature on candidate reactions to various selection methods; the validity of interviews; and the importance of the “recruitment message” (i.e. realistic job preview); the author gives a series of recommendations:
 - View recruiting as a two-way process.
 - Market the organisation to potential recruits.
 - Do not under-estimate the importance of the recruitment message.
 - Take proactive steps to improve the interview process: use highly structured interviews based on well defined job descriptions; use behaviourally-anchored rating scales and complete the rating as soon as possible after the interview; use more than one interview; use information from interviews in conjunction with information from other sources.
 - Train and educate recruiters.
 - Choose recruiters carefully: they need to be friendly, personable, and knowledgeable. Candidates react better to line managers than HR managers.
 - Develop pre recruitment activities, such as mailings, interest sessions, employee recruitment programmes, open houses, and socials.
 - Tailor recruitment efforts to individual applicant needs.
 - Invest time and money in the recruitment process, plan ahead and keep up-to-date with research and trends.

4.2. HR High Impact Changes: an evidence based resource

- Published by the DOH Workforce Directorate, this document is designed as a resource to support the 10 High Impact HR Changes outlined in “A National framework to support local workforce strategy development” (DOH, 2005).
- The 10 HR High Impact Changes - areas where HR interventions can make a difference in terms of cost, quality, patient care and efficiency - are:
 - 1) Support and lead effective change management.
 - 2) Develop effective recruitment, good induction and supportive management.
 - 3) Develop shared service models and effective use of IT.
 - 4) Manage temporary staffing costs.
 - 5) Promote staff health and manage sickness absence.
 - 6) Promote job and service re-design.
 - 7) Develop and implement appraisal.
 - 8) Involve staff and work in partnership to develop good employee relations.
 - 9) Champion good people management practices.
 - 10) Provide effective training and development.

- The resource includes a summary of research evidence and case studies designed to support HR directors and staff in the development of local HR approaches. The aim is to share good practice.
- Research evidence demonstrates that best practice recruitment (i.e. use of valid selection methods, realistic job previews, formal induction processes, supportive managers) has been linked to reduced turnover, improved labour productivity and organisational performance.
- One case study (case study 3) shows how United Bristol Healthcare Trust appealed to the future workforce and promoted career opportunities implementing a one-week work experience placement for a small group of College students. Another case study (case study 4) shows how centralising recruitment processes at one Trust improved quality and reduced costs by reducing turnover of Health Care Assistant staff.

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6. Further reading

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7. Appendix

	Article	Topic area	Type of document	Summary
1. BACKGROUND & LEGISLATION	*Jones (1993)	Single-system reform (Scotland)	NHS Scotland Guidance	Guidance includes proposals for changes to the governance arrangements for local NHS systems. They are intended to improve service organisation and delivery in NHS Scotland. Proposals include the abolition of NHS trusts by April 2004 and the creation of 15 single-system NHS boards, with devolution of decision-making to the front line. New duties are placed on NHS Boards to improve integration, decentralisation, service re-design and patient focus.
	*NHS Scotland Workforce Statistics	Number of doctors in training and consultants (Scotland)	Chart	Shows the trend in the number of doctors in training and consultants in Scotland between September 1995 and September 2006 (steady increase). From September 2005 to September 2006, the number of doctors in training increased by 4% and the number of consultants increased by 3.6%.
	Temple (2004)	Consultant recruitment and retention (Scotland)	Scottish Executive Report	Reviews the reasons why trainee doctors leave NHS Scotland. Recommends strategies to improve recruitment and retention including: flexible career & employments packages; family friendly policies; financial rewards; better career advice & counselling; improved working conditions.
	*McGregor et al (2005)	Consultant recruitment and retention (Scotland)	NHS Education for Scotland (NES) report	Provides a list of recommendations, based on the study of career intentions of SpRs (n=198) in the final year of training, for improving the recruitment and retention of consultants in Scotland. These include: <ul style="list-style-type: none"> - improving the communication & information flow between NES and the NHS Boards in order that consultant posts can be designed and their advertisement timed to match the output of training schemes. - taking into account the career intentions of trainees by electronic canvassing of trainees' views. - a mentoring system to facilitate the transition from trainee to consultant.
	*Scottish Executive. Health Department Workforce Directorate (2006)	Consultant retention (Scotland)	Letter & Annex	Introduces an advance appointments scheme designed to retain a higher number of SpRs in Scotland as they move to consultant grade. New arrangements under the scheme include: <ul style="list-style-type: none"> - aspiration interviews with current SpRs to match the career wishes of SpRs to current and future potential consultant posts - availability of funding to assist the NHS Board in running with two post holders for a period of between 0 and 6 months in circumstances where there is an overlap between the SpR obtaining their CCT and the consultant vacating the post.
2. FAIRNESS & BIAS	*NHS Scotland Workforce Statistics	Medical and dental staff by gender, contract type, grade, region and NHS board in Scotland	Table (B5)	Shows that the majority of consultants in Scotland at the end of September 2006 were male (71%), working for the major part on a full time basis. Most part time posts are taken up by female consultants. There are more female senior house officers (foundation year 2- 51%) than male equivalent.
	*NHS Scotland Workforce Statistics	Medical and dental staff by gender & ethnic origin in Scotland	Table	Data from the end of September 2006 shows that ethnic minority doctors tend to be under-represented at consultant level - 90% of consultants, 75% of registrars, and 62% of senior house officers are of white origin.

	*Mavromaras & Scott (2006)	Fairness of promotions to Consultant	Journal article	Analysed data from medical and dental census (1991-2000) in Scotland. Found that doctors who graduated in Scotland were more likely to be promoted than doctors from the rest of the UK and overseas. Female doctors and doctors who worked part-time were less likely to be promoted. Used “years since graduation” as a measure of experience.
	Lack (2005)	Fairness of promotions to Consultant	Journal letter	Highlights some of Mavromaras & Scott’s (2006) limitations. The authors failed to: - distinguish between “promotions” and “appointments” to consultant posts; - realise that trainees are only eligible for appointment to a consultant post in the last year of training; - check the number of female and male applicants.
	McManus & Sproston (2000)	Gender discrimination in hospital medicine (UK)	Journal article	Assessed from official data the proportion of female hospital doctors (1966-1991) and the career intentions of PRHO, final year medical students and medical school applicants (1966-1991). Concluded that the under-representation of female doctors in hospital medicine cannot be explained by their differential aspirations.
	Esmail (2004)	Prejudices against ethnic minority doctors	Journal article	Research shows that ethnic minority doctors are disadvantaged when they apply to medical schools and to hospital jobs (Commission for racial equality, 1996; McManus, 1998). Questions whether admission policies are operating equally in view of the vast under-representation of ethnic minority doctors in the upper grades of the medical profession.
	Esmail et al (2005)	Diversity at senior level in the NHS	Report for the Health Foundation	Questions why Black and ethnic minority (BME) groups are excluded from senior posts in the NHS. The NHS recognises that it needs to embrace diversity. Quotes Trevor Phillips, Chairman of the Commission for Racial Equality, who described the NHS: “people from black and minority ethnic communities make up 35% of its doctors and dentists (in the NHS).However at the top of each NHS organisation, the boss is almost always white”. Some of the report’s recommendations include monitoring staff progress; identifying talent; and incorporating management training for diversity.
	Gray (2005)	Discrimination & fair interviewing	Journal article	The author, who is a medical director at a UK Foundation trust suggests that “Discrimination is tiger country. It is human nature to prefer people who are similar to our own tribe. There is published evidence of racial disadvantage, and the BMA has consulted recently on tackling racism in medical careers (Central Consultants & Specialists Committee, 2003)”. He adds that valuing diversity training is invaluable.
3.BEST PRACTICE RECRUITMENT (HR PERSPECTIVE)	*Mianzo	Best practice recruitment advice	Student research paper	After briefly reviewing research on candidates’ reactions, interviews’ validity, and job previews, the author gives recommendations on recruiting and retaining talent. Some of the recommendations include: providing realistic job previews and induction; using structured interviews; training recruiters.
	*DH Workforce Directorate	10 High Impact HR changes	HR guidance	Includes summary of research evidence and case studies designed to support HR directors and staff in the development of local HR approaches. The 10 High impact changes include: change management; effective recruitment; shared knowledge; job satisfaction; job design; appraisal; employee relations; good people management; training & development; managing temporary staffing costs.

* articles sent by the Scottish Executive

Appendix 3: Key Stakeholders Consulted via Interviews (N=38)

