Using a competence framework to select future medical specialists

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Postgraduate deans in one UK region have developed a competence framework for selection of specialist registrars. This paper describes the process by which this was developed and adapted to 62 specialties. Evaluation demonstrated high levels of acceptability for applicants and to a lesser extent for selectors. An external review confirmed that the process was in keeping with good employment practice.

INTRODUCTION

The reforms of specialist training in the UK (Department of Health, 1993) removed the previous hurdle between the registrar and senior registrar grades. They also aimed to link the numbers in the new unified specialist registrar grade to predicted consultant employment opportunities. Thus those appointed to specialist registrar programmes could expect to become consultants in time. These changes gave much more significance to the process of selecting registrars from the pool of senior house officers. In effect, this was the point where each specialty's future consultants were being identified.

The reforms also made specialist registrar recruitment the responsibility of the postgraduate deans and required recruitment to training programmes, not individual posts. To reflect these changes, a radical rethink of the previous system of recruitment was required. This traditionally involved short-listing from curriculum vitae, interviewing by a panel, and checking references. There had been anxieties that the traditional system lent itself to racial discrimination, lobbying and patronage (Esmail and Everington, 1993).

Recognized good recruitment practices in professions outside of medicine needed to be used within medicine to help address these issues (Gatewood and Field, 1990). Following the reforms, postgraduate deans were strongly motivated to develop a process that was fair, open and accountable, and that properly discriminated between candidates to identify those that were most likely to make good consultants in the relevant specialty. This paper describes how the postgraduate deans in one region set about the task, and the outcome in terms of acceptability to applicants, selectors and an external expert in employment studies.

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THE PROCESS

The competence framework

In 1998 the North Thames Deanery sought to develop and implement a selection and recruitment programme for specialist registrars that began with identification of the attributes required for future consultants in the NHS. Five stakeholders' focus groups were developed to consider the attributes and competencies of future UK consultants. Invitations to participate in these groups were sent to individuals who were involved either in training or service delivery. Forty-seven individuals participated in the process.

The five stakeholders' groups were:

1. Hospital doctors (medical directors from teaching hospitals, district general hospital and community hospitals) and GPs
2. Trainees from a range of specialities
3. General managers from trusts and health authorities
4. Patients (representatives from community health councils and lay chairs of appointment panels)
5. Other professional groups (nurses, midwives, professions allied to medicine).

The five groups met separately over a 6-week period and were each facilitated by the same occupational psychologist with a particular expertise in recruitment issues. Each 2-hour session was divided into four parts:

1. A brainstorming session on what currently makes an effective consultant
2. Consideration of consultants who are thought to be 'successful' and what makes them so
3. Consideration of consultants who are thought to be 'failing' and why this might be the case
4. The characteristics required of the consultant of the future.

The proceedings were carefully documented and then drawn together into a competence framework (*Figure 1*). Eleven major competencies for the future consultant were identified. Most of these are also reflected in the General Medical Council's *Good Medical Practice* (General Medical Council, 2001), which sets the standards for the professional practice of doctors in the UK. The key characteristics of these, as described by the stakeholders, have enabled a clear statement within the person specification of the aspects of each attribute that needs to be evaluated within the specialist registrar recruitment process.

The person specification

The person specification is at the heart of the recruitment process (Attwood and Dimmock, 1996). It defines for candidates and for the selection com-

mittee the attributes against which applicants must be assessed. The generic person specification for specialist registrars presented here was derived directly from the competence framework and reflects those characteristics that a prospective candidate must present evidence for to the selec-

Figure 1. Specialist registrar competence recruitment framework (continued overleaf).

1. Technical expertise	Is technically qualified and competent with in-depth expertise in at least one specialist field	Possesses a range of clinical knowledge, skills and expertise with in-depth knowledge where relevant
		Is concerned to maintain and develop this knowledge
		Displays sound professional judgment
		Sees patients within a holistic context
		Exercises sound clinical risk management
2. Intellect and education	Shows an approach based on critical enquiry and evidence-based medicine	Analytical and scientific approach to problem-solving; clear, logical thinking
		Interest in research and development
		Embraces evidence-based practice and audit
		Shows breadth of awareness and a range of problem-solving skills
		Prepared to challenge
		Willing to supervise juniors, spots talent and nurtures it
		Able to operate within a teaching/training culture
		Encourages ongoing learning and an educative culture, both for self and others
3. Organization and planning: both personal and departmental	Ensures that everything that needs to be done by self or others happens on time	Possesses sound enough business understanding and at least some business skills
		Displays management and financial competence
		Understands resources and resource limitations
		Is able to operate effectively in a committee; contributes to strategic decision-making
		Understands issues of risk management and of operating within a litigious and complaints culture
		Is well prepared, reads notes, familiarizes self with the issues
		Shows self-discipline, e.g. regarding record-keeping and legibility
		Is able to juggle a large number of demands by setting priorities and planning effectively
		Is able to manage conflicting and unpredictable demands
4. Communication	Is able to communicate clearly, avoiding jargon, with a range of different people; reads people well; is convincing	Explains clearly and honestly
		Is readily intelligible to patients and families as well as to professional colleagues
		Uses language effectively and appropriately
		Is able to advocate/influence/persuade when this is required
		Is an effective negotiator
		Listens carefully, checks understanding
		Builds rapport
		Is able to liaise with others
5. Ability to operate within a wider context	Aware of the issues affecting current and future NHS practice, is not blinkered	Understands the NHS system: nationally, regionally, locally
		Recognizes the resource management implications affecting practice
		Has some organizational 'nous'
		Shows reasonable political awareness
		Has an overview, can set things into broader context, e.g. social context
		Is able to operate within the umbrella of the organization, not in isolation
		Understands the concepts and principles of clinical governance
		Recognizes the implications of information technology developments
6. Decisiveness and accountability		Is able to justify decisions
		Recognizes clinical constraints and the realities of rationing of care
		Is able to take responsibility/make decisions/take well-judged risks
		Is able to make and share ethical decisions
		Is able to exert authority when appropriate
		Is prepared to tackle difficult issues, e.g. disciplinary problems
7. Partnership with patients	Sees patients as individuals, not purely a collection of symptoms	Will negotiate treatment plans with patients
		Manages patients' expectations
		Empathic, able to see things from the patient's perspective
		Reassuring, shows respect for the patient
		Recognizes the increase of 'patient power' and able to accommodate that in practice

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8. Managing equals/ interpersonal skills	Builds a strong and effective relationship with patients, families and colleagues; gains their confidence and trust	Operates through developing partnerships, not dependent on hierarchy
		Collective decision-making, often less autonomy than in past
		Is able to lead, where appropriate; is able to follow; delegates appropriately
		Is cooperative; operates comfortably in climate of multidisciplinary teamwork
		Can motivate, coordinate, give direction; creates a climate in which people thrive
		Is accessible and open towards others
		Displays flexible team skills and implements change
		Shows humour and a lightness of touch
9. Flexibility and resilience	Ability to cope with considerable pressure as well as to adapt to constant change and new demands	Shows willingness to change practice as appropriate
		Is able to adapt to rapidly changing circumstances
		Is able to live in an environment of change and uncertainty
		Shows resilience and strength under pressure
		Exercises self-discipline when confronted by hostility or failure; remains composed
		Is self-aware; recognizes own limits and knows when and who to ask for help
		Shows 'maturity' in making reasonable demands of others; exerts patience
		Is aware of the pressures that others may be under and acts appropriately
		Has 'survival skills'; develops strategies to handle difficult situations
		Is open towards others and not defensive; has a secure sense of self
10. Drive and enthusiasm	Demonstrates purposeful energy, enthusiasm and initiative in pursuing the highest standards for patients, juniors, other colleagues and the organization	Is a self-starter; self-motivated with clear personal goals
		Is keen to learn; aware of personal strengths and development needs
		Shows curiosity; is open to change and to new ideas
		Shows commitment and purposeful application to work
		Displays an appropriate sense of urgency
		Displays creativity and energy; inspires and motivates others
11. Professional values	Displays honesty, commitment, probity and integrity	Inspires respect
		Treats patients as people, not pathology
		Recognizes the ethical implications of technology

Figure 1. Specialist registrar competence recruitment framework (continued from previous page).

tion panel. The 10 domains of the person specification have been divided into those elements considered to be essential for candidates to demonstrate evidence of and those that are desirable. The domains are explicit, described in detail and customized for each specialty (*Figure 2*). Perhaps the most distinctive element about the person specification is the requirement to explicitly identify the point in the appointment process at which the candidate will be evaluated for that characteristic. In the generic specification, this is from the application form (AF), at the interview (I) or from the structured reference (Ref) document. These are not, however, exclusive evaluation strategies. The use of presentations to offer evidence of attributes, such as teaching skills or analytical thinking, or of observed or videoed interactions in simulated scenarios to assess interpersonal behaviours, such as communication skills, have been introduced by some specialties.

The evidence used to evaluate candidates

Applications and short-listing: In accordance with good recruitment practice, CVs are not accepted in the application process (Weston, 2000). There is a standard application form that again has been customized to reflect the requirements of each specialty. The application document (Gatrell and White, 2001) is supported by a number of statements concerning the Rehabilitation of Offenders Act 1974, police checks for children, a statement concerning potential conflicts of interest, equal opportunities statements and monitoring requests, as well as a reminder to applicants about General Medical Council (2001) guidance on rules around accepting appointments.

The short-listing score sheet reflects the elements of the person specification which are assessed from the application form. It has been laid out to reflect the order of information in the application form for each element that is scored and identifies where in the application evidence supporting an attribute is likely to be found.

Essential and desirable criteria are both scored using a range of 0–2: a score of '0' indicates that there is insufficient or no evidence of the attribute offered; a '1' means that evidence of an attribute is given; a '2' means that an 'abundance of evidence' for the attribute has been presented. Some specialities have chosen to score essential attributes '0' or '1', indicating that evidence for the attribute is either present or absent. Other specialties have, however, chosen to use the wider score range or 0–2 in order not only to indicate that an essential attribute is present, but also to give it an increased weighting.

The short-listing score sheet indicates the minimum number of points which must be achieved to be considered for short-listing. It is made available to candidates, along with the person specification. It reminds candidates that achieving this minimum

Generic Person Specification for Specialist Registrar

	Essential	When evaluated	Desirable	When evaluated
Qualifications	Eligible for registration with the General Medical Council	AF		
	MB BS (or equivalent), MRCP, MRCS/FRCS or FRCA or equivalent	AF	BSc (or other intercalated degree), other degrees/qualifications	AF
Clinical experience	Relevant post registration experience, e.g. senior house officer post in chosen field	AF	Experience in other related specialties	AF
Clinical skills	Specific clinical procedures Good manual dexterity and hand/eye coordination	AF, Ref	Defined procedures	AF
	Understanding of clinical risk management	I		
	Competent to work without direct supervision where appropriate	I, Ref		
	Clear, logical thinking showing an analytical/scientific approach	AF, I		
		I, Ref		
Knowledge	Appropriate level of clinical knowledge	Ref	Demonstrates breadth of experience and awareness in and outside specialty/medicine	AF, I
	Shows knowledge of evidence-informed practice	I	Demonstrate use of evidence-informed practice	I
	Shows awareness of own limitations	I, Ref		
Organization and planning	Ability to prioritize clinical need	Ref	Understanding of NHS, clinical governance and resource constraints; management/financial awareness, experience of committee work	I, AF
	Ability to organize oneself and own work	I, Ref	Active involvement in audit	I, AF
	Evidence of participation in audit	AF	Information technology skills	AF
	Experience and ability to work in multiprofessional teams	AF, I, Ref		
Teaching skills	Evidence of teaching experience	AF	Enthusiasm for teaching; exposure to different groups/teaching methods	AF, I
Academic/ research	Understanding of the principles of research	I	Research experience, presentations, publications, prizes and honours	AF, I
Career progression			Progression of career consistent with personal circumstances	AF
Start date			Available to start on post start date	AF, I
Personal skills	Communication and language skills (ability to communicate with clarity and intelligibility in written and spoken English; ability to build rapport, listen, persuade, negotiate)	AF, I, Ref	The ability to produce legible notes	AF
	Decisiveness/accountability (ability to take responsibility, show leadership, make decisions, exert appropriate authority)	I, Ref		
	Interpersonal skills (see patients as people, work cooperatively with others, empathize, open and non-defensive, sense of humour)	AF, I, Ref		
	Uses a non-judgmental approach to patients and colleagues regardless of their sexuality, ethnicity, disability, religious beliefs or financial status	Ref		
	Flexibility (ability to change and adapt, respond to rapidly changing circumstances)	I, Ref		
	Resilience (ability to operate under pressure, cope with setbacks, self-aware)	I, Ref		
	Thoroughness (is well prepared, shows self-discipline/ commitment, is punctual and meets deadlines)	I, Ref		
	Shows initiative/drive/enthusiasm (self-starter, motivated, shows curiosity, initiative)	AF, I, Ref		
	Probity (displays honesty, integrity, aware of ethical dilemmas)	I, Ref		
Physical requirements	Meets professional health requirements	pre-employment health screening		

Figure 2. Generic person specification. AF = application form; I = interview; Ref = reference.

score does not mean candidates will be short-listed automatically since the short-list will need to reflect the number of applicants applying and the number of posts available for a particular recruitment episode. A candidate who does not offer evidence for an essential characteristic is not considered further, but an individual member on the appointment committee must receive support from the short-listing panel that such evidence is lacking.

The interview and structured reference: The interview panel is set up in accordance with guidance set out in the *Guide to Higher Specialist Training* (Department of Health, 1998). The panel uses the interview to further assess candidates for elements of the personal specification. A scoring range of 0–2 is again used, with the attributes being assessed in four main areas (*Figure 3*). Interview panel members attend equal opportunities training and

Interview score sheet

	Notes	Candidate's score
Clinical experience, knowledge and skills		
Competent to work without direct supervision where appropriate		
Awareness of own limitations		
Knowledge of evidence-based practice		
Experience of clinical risk management		
Breadth of awareness in and outside specialty and medicine		
Organization, planning and clinical governance		
Ability to organize own workload and to prioritize clinical need		
Experience of clinical audit		
Experience of working in multi-professional teams		
Management experience		
Knowledge of clinical governance		
Academic, research and teaching		
Research experience/principles of research		
Presentations, publications		
Teaching – exposure to different groups/teaching methods		
Personal skills and career intentions		
Communication skills		
Interpersonal skills		
Demonstrates clear logical thinking/analytical approach		

Maximum score for each criterion is 2 (range 0–2)

Figure 3. Interview score sheet.

a number also attend deanery-supported programmes in good interview techniques. Supporting notes are supplied to members of the panel giving guidance on interview techniques, including examples of how to ask open questions (North Thames Postgraduate Medical and Dental Education, 1999).

The structured reference used to support this appointment process was developed to offer evidence for specific elements of the person specification that could not be readily obtained from elsewhere. Of the three references required, one must be from the present or most recent educational supervisor or consultant. The structure of the reference is very specific and directly relates to the attributes of the person specification, especially those related to interpersonal skills. Examples of the types of questions asked are shown in *Figure 4*. Referees are also invited to write a statement on their professional opinion of the candidate. The chairman and a clinical lead read references before the interview. The purpose of this is to enable the panel to address any concerns with the candidate that may have been raised in the references. It gives an opportunity for the candidate to respond to those concerns and for his/her response to be heard by the panel.

Appointment outcomes

Once the appointments panel has concluded interviewing candidates most specialities calculate the scores for each candidate using a ratio of 70:30, interview to short-listing scores. The rationale for this is that certain elements of the evaluation of the candidates take place only during the short-listing process and not at the interview. In order for the person specification to be fully considered in the appointment process, both elements should be taken into account in the final evaluation. The scores are therefore calculated and the candidates are ranked. There is then an open discussion, led by the lay chairman of the panel, as to whether the outcome 'makes sense'. The scores are indicative and in most cases, the ranking is used to agree the final outcome. However, in some circumstances the scores are identical or extremely close and therefore discussion is required. The rankings can be changed but only after full and open discussion in which the panel reaches agreement and fully documents the proceedings.

The specialty perspective

The work around the development of the competence framework, person specification and application documentation could only have a context if it was developed and customized for the specialities using it. Detailed work was undertaken with each of the deanery higher specialist training committees to develop the generic approach for the specialty. Further work was undertaken with each of the committees to talk through the implementation of the new recruitment process.

OUTCOMES

The evaluation process used to assess these changes to the recruitment process considered it from the users' perspective. The short-listing panel and appointment panel members as well as those applicants invited for interview were asked their views of the process through three separate but similar evaluation questionnaires. To ensure a high response rate, participants were asked to complete the questionnaires before leaving the short-listing or interview panels. Responses from 10 specialities, representing those with the largest number of applicants, as well as a spread of different specialties (accident and emergency, anaesthetics, cardiology, child and adolescent psychiatry, general psychiatry, nephrology, obstetrics and gynaecology, orthopaedics, paediatrics and respiratory medicine) were analysed from recruitment episodes between January 2000 and May 2002.

Shorting-listing panel evaluations

Across 41 short-listing panels, averaging five members on each panel, 159/209 responses were received, i.e. a

response rate of 76%. Most of the respondents (89%) agreed that the person specification reflected the requirements of the specialty and that the information from the application form was adequate to make an assessment of the candidate for short-listing purposes. However, fewer than half of respondents thought that the scoring system was sensitive enough to support the process. Sixty per cent of respondents thought that this process of short-listing was fairer than using CVs.

Figure 4. Examples of issues explored in the structured reference document.

Clinical experience and skills

1. **Do you have any concerns about this applicant's level of knowledge compared with other doctors at this level?**

   I have no concerns

   I have some concerns which relate to

2. **Do you have any concerns about the applicant's overall clinical competence compared with other doctors at this level?**

   I have no concerns

   I have some concerns which relate to

3. **Do you have any concerns about the applicant's awareness and insight into knowing when it is necessary to seek help/advice?**

   I have no concerns

   I have some concerns which relate to

4. **Do you have any concerns about the manual dexterity of the applicant?**

   I have no concerns

   I have some concerns which relate to

Personal skills

5. **Interpersonal skills (ability to see patients as people, empathize, work cooperatively with others)**

Do you have any concerns about the applicant's ability to demonstrate interpersonal skills which promote good teamwork and which contribute to patient care?

   I have no concerns

   I have some concerns which relate to

6. **Equal opportunities (dealing with patients and colleagues non-judgmentally)**

Do you have any concerns about the applicant's ability to deal with patients and colleagues in a non-judgmental way regardless of their sexuality, ethnicity, disability, religious beliefs or financial status?

   I have no concerns

   I have some concerns which relate to

7. **Resilience (ability to operate under pressure, cope with setbacks, self-aware)**

Do you have any concerns about the applicant's ability to demonstrate resilience in day-to-day work?

   I have no concerns

   I have some concerns which relate to

8. **Probity (displays honesty, integrity, aware of ethical dilemmas)**

Do you have any concerns about the applicant's probity in the approach to patient care and in dealing with colleagues?

   I have no concerns

   I have some concerns which relate to

Interview panel evaluations

Across 64 interview panels in the 10 specialties, 384/447 responses from interview panels with an average number of six members/panel were received, i.e. a response rate of 86%. Although 60% of respondents thought that the scoring documentation was easy to use, only 43% felt that it was sufficiently sensitive to distinguish between candidates. Forty per cent of respondents said that the system was an improvement on the previous, while 21% said that it was not.

Applicants' evaluations

Five hundred and five responses were received from short-listed applicants from 46 recruitment episodes across the 10 specialities. All short-listed candidates who attended for interview were asked to complete the confidential evaluation form while waiting to be seen and return it in a sealed envelope after the interview was completed. Candidates were explicitly told that neither completion of the form nor the response made had any influence on the outcome of the recruitment process. Almost all participants returned the evaluation.

Sixty-seven per cent of respondents thought that the process was fairer than short-listing by CV. Applicants from ethnic minorities were more likely to feel this way than white applicants (69% *vs* 64%, $P<0.05$). Fifty-nine per cent of applicants also felt that the process enabled candidates to demonstrate their strengths better than using CVs. There was no attempt to seek the views of those who had not been short-listed.

External review

Since this whole process represented a radical change from previous recruitment processes, and since the authors were aware that many consultants were unconvinced of the merits of the change, the postgraduate deans commissioned an external review from the Institute of Employment Studies (IES). This included interviews with a selection of consultants who had written in expressing strong views about the process, both positive and negative, as well as a review of all the paperwork. The report (Stebler, 2001) confirmed that the process was in keeping with good employment practice. By and large users found this new approach acceptable, although concerns over the ability of the limited score range to distinguish clearly between candidates were raised by some panel members. The external review supported this narrow range as being more accountable

than wider score ranges. The major reason for using a small score range is to try to ensure that professional views about candidates are clearly accountable – based on the evidence presented, the attribute is insufficiently demonstrated, clearly demonstrated or demonstrated in abundance. The employment report also indicated that panel members were concerned over the length of time it took to short-list applicants from the application document, an issue which has been raised previously in the literature (Wood, 1999).

CONCLUSION

This paper describes the development of a recruitment process designed to be fair, open and accountable and, in accordance with good employment practice, select the best qualified candidates. It has been externally validated through review by a report from the IES and has been offered as an example of good practice by the British Medical Association (2000) and others (Gatrell and White, 2001). Approximately two-thirds of individuals involved in both short-listing and applying for appointments found the process to be fairer than the previous process that relied on applying with CVs.

Evaluation by applicants, consultants involved in selection, and an external expert in employment studies have all supported the changes, although with reservations. Each recruitment episode is undoubtedly more time-consuming than in the previous system, although central recruitment to a unified grade means that episodes are fewer. Recently where the narrow scoring has created too many difficulties, half-scores have been introduced. Each specialty has had the opportunity to adapt the person specification and scoring after each episode, to fine-tune the documentation to meet its needs. There is no evidence that the changes have resulted in the selection of a different type of applicant from the previous system – and no evidence that they should. However, the deanery can now respond positively to queries about why certain applicants were or were not selected. In an NHS that is increasingly committed to openness and fairness in all its activities, this must be the way forward. HM

KEY POINTS

- Recruitment to the specialist registrar grade is a key process in identifying those individuals destined to become consultants in the NHS.
- The process used to recruit specialist registrars must be fair, open, and accountable.
- Focus groups were used to develop a competence framework for future NHS consultants.
- The process included a person specification, a structured application form, and a scoring system that is made available to applicants for specialist registrar appointments.
- Those involved in using this appointment system found it to be fairer and most preferred it to appointing using curricula vitae.

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