Modernizing medical school admission processes: a European perspective

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Dear editor

We read with keen interest the commentary by Eltorai and Daniels1 wherein they suggested a streamlining of the current US medical school admission process, through the development of a common application system called the National Medical School Matching Program (NMSMP). This, the authors argue, would not only improve the efficiency by centralizing the application process, reducing the number of futile interviews and the need for superfluous documentation, but also significantly reduce the costs to both the applicant and the medical schools.

We agree with the authors of the commentary, that the current US medical school admission process appears unnecessarily arduous and costly for all parties, and that an overhaul such as the one described would be hugely beneficial. Specifically, we note the huge cost that an applicant is likely to incur, estimated at $7,655.50, as especially problematic, as it may exclude applications from those of poorer backgrounds, worsening their accessibility to the profession. Moreover, the lack of a centralized system, such as University and Colleges Admissions Service (UCAS)2 used in the UK, places an unnecessary burden on the applicants, and increases the paperwork for all involved.

The proposed solution would bring the application process more in line with the current UK system, for which we wish to share our experience and views. Additionally, we hope that by comparing and contrasting with another European country also recognized for its high standard of medical education – Sweden – that this may be informative, and further strengthen the case for change in the US.

Unlike in the US, the UK applicant would submit her application, consisting of a personal statement, academic reference, educational history, aptitude test scores (UKCAT or BMAT) to the centralized application system, UCAS, along with a choice of maximum four, from the 33 medical schools.3 Promising applicants are interviewed, and those successful are given conditional offers (guarantees of acceptance if specified grades are achieved). Those with multiple offers rank one as their “firm” offer and another as their “insurance” offer, with the latter being withdrawn if the conditions of the former are met.

We would argue that the UK application system is superior, primarily based on the lower costs for the individual applicant, and the existence of a centralized application platform, limiting the number of medical course applications to four. The only costs for a UK applicant are a UCAS application fee (£24),4 aptitude tests fees (UKCAT
£65, BMAT £45), optional preparatory courses (approximately £280), and any travel and accommodation expenses associated with interviews, bringing the total to a negligible sum in view of the US figure. One could, however, argue that the comparatively low number of applications allowed, is overly restrictive for the individual applicant, and that it may deter some from applying to their dream school out of fear of wasting an application on a highly competitive institution. On balance, we maintain that this system forces students to be more focused in their application, without adversely affecting their chances of being admitted, given that the ratio of applicants to places should, in theory, remain unchanged. Furthermore, this reduces the administrative load on medical schools.

Interestingly, the application system in Sweden differs significantly from those described earlier. In Sweden, applicants rank medical schools in order of preference. They apply using a centralized system, through which there are three admission routes, each constituting approximately a third of the total intake:

(1) Academic – high school grades.
(2) Swedish Scholastic Aptitude Test (SweSAT).
(3) University specific – personal letters, aptitude tests, and interviews.

Up until the recent introduction of the university-specific admission component, the Swedish system was unidimensional, exclusively assessing the academic prowess of applicants. However, the third route is similar to the UK system, taking a more holistic approach, by determining not only the applicant’s predicted ability to progress through a demanding medical degree, but also one’s suitability as a medical professional. While the minimal cost to the applicant (only £40 for those wishing to go through the SweSAT route) is strongly appreciated by the authors, the increased efficiency of a largely academic-based application system does not justify the lack of a global view of an applicant’s qualities.

In conclusion, after reviewing two European medical school application processes, a move by the US toward a system more aligned with the one in place in the UK, such as the NMSMP, would indeed increase the efficiency and reduce the costs to both applicants and medical schools.

Disclosure
The authors report no conflicts of interest in this communication.

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**Authors’ reply**

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**Dear editor**

We appreciate the commentary provided by Karlsson and Elmqvist in comparing a potential National Medical School Matching Program (NMSMP) to extant medical school application systems in the UK and Sweden. Key learnings from these processes provide a context with which to refine parameters for a NMSMP.

There appear to be four primary factors leading to increased efficiency and decreased cost in the UK system: 1) reduced primary application costs, 2) reduced costs associated with standardized testing, 3) lack of secondary, school-specific applications, and 4) a maximal limit on the number of applications per individual. Addressing the former three factors, it is yet to be determined whether or not implementation of a NMSMP in the US would result in reduced primary application and standardized testing costs (factors 1 and 2), and our prior articulation of a NMSMP involved an elimination of secondary applications. As a result, if a NMSMP is implemented, administrators should monitor for this trend and be prepared to consider limiting the maximum number of applications.

The Swedish system provides interesting contrast to a NMSMP. While utilizing a centralized application platform, there exist several, highly differentiated pathways for Swedish applications. We concur with Karlsson and Elmqvist in favoring a holistic approach to evaluation over permitting support of an application solely based on aptitude test scores. Of note is that the average US medical school applicant in 2015 was 23–24 years old, whereas Swedish and UK medical schools accept students immediately following secondary education. It is therefore reasonable for US medical schools to consider a wide breadth of factors when evaluating potential students, given greater divergence of experience in the postsecondary years. Commensurate with a more aged applicant population, adoption of a NMSMP would also allow for “couples matching” (similar to the current NRMP system). This function may be increasingly vital as the average US medical student applicant age continues to rise.

In summary, comparison of a NMSMP to UK and Swedish medical school application systems allows for refinement of proposed approach. Most notably, the UK...
experience suggests that an upper limit on applications per applicant may be required to realize the full efficiency potential of a US NMSMP. However, the efficiency benefits of such a proposal should be carefully weighed against restrictions of choice. The most direct beneficiaries of increased application efficiency will be applicants and admissions offices and if, on balance, these stakeholders would prefer greater freedom over increased efficiency, their perspectives should be heavily weighted before imposing such a limit.

**Disclosure**
The authors report no conflicts of interest in this communication.

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