

Multiple Mini Interviews vs Traditional Interviews: Assessing Reliability and Equity in Medical School Admissions [Response to Letter]

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Dear editor

We appreciate the opportunity to respond to the recent letter regarding our article, “Multiple Mini Interviews vs Traditional Interviews: Assessing Reliability and Equity in Medical School Admissions”. We are grateful for the engagement with our work and welcome the thoughtful critique. Scholarly discourse is essential for advancing practices in medical education.

The letter to the editor raises a concern about including the Casper test in our broader discussion of admissions tools. The Casper test, a situational judgment test, is not a direct comparator to the MMI, but both are designed to assess interpersonal and intrapersonal competencies aligned with the qualities we hope to see in future physicians (eg, social intelligence, advocacy, respect, collaboration, and ethical responsibility). These tools offer behavioral evidence of such characteristics, complementing applicants’ written materials and addressing gaps that traditional cognitive metrics or supplemental essays may overlook.

Although concerns have been raised about demographic differences in Casper scores, it is also important to highlight that recent research has demonstrated Casper’s ability to predict performance in Objective Structured Clinical Examinations (OSCEs) and clinical settings, above and beyond GPA in other healthcare professionals.¹ Furthermore, using Casper in admissions processes is associated with reduced professionalism concerns,² which remain challenging for medical schools to define, assess, and evaluate.³ These findings suggest that, despite its limitations, Casper can serve as a meaningful component of a holistic admissions process aimed at identifying candidates with the potential to thrive in the practice of medicine.

Additionally, we acknowledge that while the effect sizes in our study were modest, they were consistent across multiple cycles and measures of reliability. We intentionally highlighted these small but meaningful findings to underscore the incremental nature of progress in admissions reform. Large effect sizes are rare in a field as complex and multifactorial as medical school admissions, and small yet consistent differences can still inform policy and practice. Structured coaching is a promising strategy to support applicants from lower socioeconomic backgrounds. However, in the US, such interventions are increasingly scrutinized for potentially conferring unequal advantages. Moreover, offering coaching to all applicants may exceed most admissions offices’ logistical and resource capacities.

It is also important to clarify that our study was not designed to promote MMIs over traditional interviews or to suggest that either format is superior. Instead, our objective was to empirically assess whether MMIs, often proclaimed more structured and objective, actually translate into reduced demographic disparities compared to more conventional

interview formats. Our results suggest that both formats exhibit similar patterns concerning equity-related metrics. This finding invites a more nuanced view of how we define and measure fairness in admissions.

Lastly, we appreciate the concern regarding our recommendation to reconsider the weight of academic metrics such as the MCAT, GPA, and Casper in favor of more holistic tools like the MMI. To clarify, we do not advocate for universally diminishing the role of academic indicators but rather emphasize that the relative weighting of these measures should be tailored to each institution's curriculum, support systems, and remediation capacity.

2019–2021 matriculants with MCAT 502–505 (52nd to 62nd percentile) and GPA ranging from 4.0 to 3.8 achieved a 92% first-time pass rate on USMLE Step 1.⁴ Furthermore, matriculants with lower MCAT and GPA ranges (498–501; 3.0–3.19) yielded first-time pass rates of 94% on USMLE Step 2, which is more closely aligned with clinical knowledge and readiness. These findings suggest that a rigid reliance on high academic cutoffs may not be necessary to ensure strong performance in medical school in the US. This data provides a compelling opportunity for US medical schools to address systemic inequities by adopting more evidence-informed admissions practices. Our goal is not to compromise the predictive validity of admissions decisions but to advocate for fair and attainable thresholds that better account for the structural barriers faced by qualified applicants from disadvantaged and underrepresented backgrounds.

We agree with the letter writer's assertion that further research is needed—particularly research that investigates interview formats and the broader ecosystem of admissions processes, including holistic review, application screening, and unconscious bias mitigation strategies. We also welcome future studies that explore qualitative dimensions of applicant experience, the interaction between interviewer training and format, and long-term outcomes beyond admission, such as retention, performance, and professional identity formation. The potential of these future research endeavors is promising and gives us hope for the future of medical education.

In conclusion, we thank the author for engaging with our work and hope our response clarifies the intent and implications of our study. Our goal remains the same: to contribute to a more equitable and evidence-informed admissions process in medical education.

Disclosure

The authors report no conflicts of interest in this communication.

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