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Family Medicine

LETTER TO THE EDITOR

Reconsidering Virtual Interviews and Preference Signals in Residency Recruitment

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TO THE EDITOR:

We appreciate the article by Snellings et al regarding the future of residency interview formats and the use of preference signals in family medicine recruitment.[1] Their work highlights the need for our specialty to reflect critically on postpandemic recruitment structures and to better understand the role of preference signals. As educators and family medicine program leadership, we interpret these findings through a balanced lens that acknowledges both their promise and their limitations.

The authors demonstrated that many programs are using fully virtual interview formats and are increasingly likely to continue doing so.[1] Virtual interviews undoubtedly reduce the financial burden on both applicants and programs and may level the playing field for applicants facing geographic or travel-related barriers. However, multiple studies across specialties have described limitations of fully virtual formats. Applicants have reported difficulty assessing intangible program qualities such as culture, resident–faculty interactions, and overall fit.[2] Programs similarly have reported diminished confidence in evaluating applicants' professionalism, communication skills, and interpersonal dynamics in virtual contexts.[3] Concerns also exist regarding inflated interview volumes due to the lack of travel constraints, which may limit opportunities for other applicants, lead to late cancellations without financial disincentive, and ultimately contribute to programs entering Match Week with unfilled positions.[4,5]

With respect to preference signals, while we agree that signals hold value, we believe further exploration is warranted. The authors note that programs across interview formats favored the use of five signals.[1] In a virtual model, signals help triage interest within a large applicant pool; however, for in-person formats, travel itself may serve as an implicit signal of interest. Importantly, data from the first match cycle after the introduction of signals showed no improvement in fill rates, with more programs failing to fill than in prior years.[4] Future research should examine whether the impact of signals differs among in-person, hybrid, and fully virtual models, and how signals influence applicant behavior and match outcomes.

Importantly, applicant preferences also warrant careful consideration. While virtual interviews are widely valued for reducing financial burden and improving flexibility, national survey data have demonstrated that many applicants prefer in-person or hybrid models when feasible.[6,7] In a multiinstitutional study published in *JAMA*, applicants reported substantial cost savings with virtual interviews but indicated that in-person experiences better allowed assessment of culture and fit.[6] Similarly, data in the *Journal of Graduate Medical Education* indicated that although applicants supported continued virtual options for equity reasons, a significant proportion favored hybrid structures moving forward.[7]

Thus, decisions regarding continued virtual interviewing must be examined through the lens of mission alignment and the ability to meaningfully assess mutual fitness assessment that may not be fully achievable in a virtual format.

This year, our program returned to in-person interviews, which received overwhelmingly positive feedback. We acknowledge that this feedback represents a self-selected group of applicants who chose to participate in an in-person interview process and therefore may not reflect the perspectives of those who prefer virtual formats. Faculty found it easier to gauge applicants' interest in

family medicine, interpersonal qualities, and program fit compared to virtual interviews. Applicants appreciated the clearer understanding of our program's ethos, resident culture, and training environment through direct interactions and hospital/clinic tours. Ultimately, the decision to pursue virtual, in-person, or hybrid interview structures will depend on departmental priorities and institutional graduate medical education leadership guidance.[8]

Location consistently remains a top factor in applicants' ranking decisions.[9] While geographic preferences were not explored by the authors, existing evidence has demonstrated that these preferences meaningfully shape applicant decision-making and should continue to be considered within the recruitment process.[10] The essence of family medicine lies in building relationships, fostering community connection, and committing to the populations we serve. Fully virtual interviewing limits an applicant's ability to observe program culture, witness authentic interactions among faculty and residents, and explore the community in which they may ultimately train and live. For programs serving rural or underserved communities, an in-person visit is often crucial in helping applicants understand lifestyle considerations and community needs. For programs in resource-rich environments, observing faculty–resident collaboration and clinic dynamics may help applicants meaningfully differentiate among training sites.

As Lochner noted, "Recruiting and matching students into programs in ways that best meet the needs of all involved parties is critical to the creation of a well-educated and skilled workforce to meet the health care needs of our country."[11] As family medicine educators, we recognize that recruitment decisions shape the future of our workforce. While the pandemic accelerated the adoption of virtual interviewing and technological innovation, our continued decisions about recruitment must remain evidence-based, grounded in equity, and rooted in our specialty's long-standing values rather than driven solely by convenience.

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