Recalibrating US Medical School Admissions With an Equity Lens
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In 2020, the collision of COVID-19, police violence, and racism in the US ignited attention to the widespread structural violence against racial and ethnic minority groups and other disenfranchised communities.1 In response to COVID-19, the Association of American Medical Colleges (AAMC), which oversees the largest number of US medical school applications annually and administers the Medical College Admission Test (MCAT), expanded its Fee Assistance Program (FAP) and shortened the MCAT length by nearly 25% for students applying in 2020. Many medical schools also provided greater flexibility in admission requirements. In parallel, academic medical centers, medical schools, and national organizations such as the AAMC realigned their missions with a greater focus on fostering diversity, equity, and inclusion. In this context, the number of first-time applicants increased by 21.2% from 2019 to 2020, contributing to a record number of applications.2 Students matriculating in 2021 also represented the most diverse US medical school class to date, including 12.7% who identified as Hispanic, Latinx, or of Spanish origin and 11.3% who identified as Black or African American, up 0.7 and 1.8 percentage points from 2020, respectively.2

Despite these gains, the pathway to medical school does not yet align with renewed commitments by the AAMC and medical schools to overhaul recruitment processes and learning environments to ensure inclusion and equity for students from marginalized communities.3,4 In this Viewpoint, we consider unresolved barriers in the pathway to medical school matriculation and offer tangible solutions that we believe should not be delayed while waiting for other structural issues to be addressed. Here, we let the term underrepresented in medicine (URiM) be more expansive than its current AAMC definition5 by including individuals who are from socioeconomically disadvantaged backgrounds, from rural backgrounds, have a disability, or are LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other sexual and gender minorities). To adopt such an expansion, the AAMC should first address remaining demographic data collection gaps related to these groups as part of their strategic plan to “diversify tomorrow’s doctors.”6

Although medical schools and the AAMC have tried to increase the diversity of the physician workforce, many barriers persist.7 During secondary education, URiM students may be deterred from pursuing higher education or becoming a physician as a result of limited resources, unfair punishment or bullying at school, insufficient culturally appropriate curricula, and lack of mentorship. Consequently, some URiM individuals pursue other career pathways, whereas those continuing with their education may not be aware of the preparation needed for medical school or may lack access to capable advising.7 To address these barriers, medical schools and undergraduate institutions have implemented educational enrichment and pathway programs but they have not been as effective as anticipated.7

Another barrier to diversifying the physician workforce is application costs.8 For qualifying applicants from low-income backgrounds (11% of MCAT examinees in 2020),9 the AAMC FAP offers many benefits, including free access to the official MCAT preparation bundle, reduced MCAT fees, and waived American Medical College Application Service (AMCAS) expenses for up to 20 medical schools. To be eligible, applicants must have a permanent US address and a family income up to 400% of the federal poverty level. Parental tax forms are required for applicants aged younger than 26 years, creating barriers for applicants in some families. Applicants may submit a parental estrangement form, but approval is not guaranteed.

At the time of application, students encounter additional procedural hurdles, which may disproportionately burden URiM students. Students must complete the common AMCAS application...
in which they indicate their selected schools. Applicants then complete a secondary application for each medical school mutually interested in them, although these are often initiated on the basis of metrics and without close review of applicants’ attributes, lived experiences, and academic growth. Each secondary application comes with a steep cost, which medical schools are not required to waive for FAP recipients, and most schools ask similar questions to gauge applicants’ inter- and intrapersonal competencies.

To recalibrate medical school admissions with an equity focus, we propose several policy changes. First, Congress should maintain federal funding and budgetary increases for Title VII health workforce programs, including the Health Careers Opportunity Program that supports the education of “individuals from disadvantaged backgrounds”—often beginning in high school. Through strategic partnerships sustained by federal dollars, a broader network of academic organizations supportive of URiM students may be attainable that includes role models and enrichment opportunities.

Second, to ensure sufficient advising of URiM students, under an expanded AAMC definition of URiM as described earlier, we propose that use of the AAMC Medical Minority Applicant Registry be broadened to connect students to advisers. Given the limited capacity of advising services from the National Association of Advisors for the Health Professions, the AAMC should institute its own advising program for URiM students. Students who self-identify as URiM should also be permitted to join this registry—at the time of their choosing and without needing a MCAT score—to allow URiM students to be connected to an adviser and accustomed to the AAMC procedures sooner.

Third, we recommend modifications to the FAP. The process for determining parental estrangement in the FAP should include consideration of personal factors such as domestic violence, parents unsupportive of an individual’s sexual orientation or gender identity, and housing instability. In addition, FAP benefits should be expanded to include full coverage of MCAT fees, because even the reduced fee of $130 may still be prohibitive for some students.

Fourth, the AMCAS should be redesigned to eliminate the need for secondary applications to individual schools. The AAMC could model its application service after the undergraduate Common Application or the Schools of Public Health Application Service, whereby applicants complete a few additional school-specific questions for each selected school. Common essay questions in secondary applications could be incorporated into the AMCAS.

Fifth, medical school applicants should only be allowed to apply to 20 schools. Although doing so may seem to impede their chances of acceptance, instituting a cap on the number of schools to which applicants may apply would eliminate the opportunity for students with greater financial means to apply to a greater number of schools. In addition, a cap would (1) reduce application expenses for students who do not meet the FAP income requirements but still need financial assistance and (2) encourage all applicants to conduct more meaningful research to formulate their school list.

Sixth, we caution against reversing constructive changes introduced at the onset of the COVID-19 pandemic. In 2022, for example, the AAMC resumed charging MCAT rescheduling fees, which had been waived since 2020. Full cancellation refunds have also been terminated. Within 10 days before their examination date, examinees may submit an emergency refund request, which provides at most a partial refund subject to AAMC discretion. Finally, although in-person interviews provide additional opportunities for recruitment, medical schools should conduct virtual interviews permanently to safeguard the elimination of interview travel costs.

Despite a renewed focus on equity, barriers persist in the pathway to medical school for applicants in historically marginalized groups. The policy changes we propose can be readily implemented while more deeply rooted issues that limit URiM student access to medical education are addressed.
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