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Medical Students' Perception of Their "Distance Traveled" in Medical School Applications

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Abstract

Introduction: Within medical school's holistic review of applicants includes a review of their distance traveled to get to this point in their education. The AAMC defines distance traveled (DT) as, "any obstacles or hardships you've overcome to get to this point in your education or any life challenges you've faced and conquered. What medical students consider as their distance traveled has not been explored. The authors sought to identify the factors medical students perceive are important for medical school admissions to consider when assessing someone's "distance traveled" by asking current medical students to share their DT experiences along with the barriers and facilitators they encountered on their medical school journey.

Methods: The authors conducted semi-structured interviews with US medical students through purposeful sampling methods. The Social-Ecological Model framework was used to develop questions to elicit participants' experiences that contributed to their distance traveled. Interviews were conducted in 2021 and ranged from 60-75 minutes. Transcribed interviews were qualitatively analyzed using interpretive description.

Results: A total of 31 medical students from 7 medical schools were included in the study. Overall, participants defined distance traveled as an applicant's hardships (e.g., being the primary caregiver for a family member) and privileges (e.g., having physician parents) they experienced. Three major themes were identified: (1) Individual-level characteristics and factors; (2) Interpersonal relationships; (3) Aspects of the participants' community and society.

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Discussion: Our findings show that medical school applicants considered DT to be a valuable component of a holistic medical school admission process. Participants' experiences of DT were varied and complex. Our research suggests that admissions teams for medical schools should incorporate more comprehensive recruitment practices and inclusive methodological frameworks to accurately capture the diversity of identities and experiences of medical school applicants and to consider the factors which shape their journey to medical schools.

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Introduction

Demographic disparities are present in medical schools globally and are associated with health inequities among patients.[1–3] In response to a wide body of research suggesting that improving the diversity of the physician workforce could alleviate these health inequities, among other benefits, medical schools around the world are trying to improve their admission processes to facilitate a comprehensive review of applicants and increase the matriculation of various under-represented groups.[4–6] For example, United States (US) medical schools are now assessing applicants using a holistic review process in response to the American Association of Medical Colleges (AAMC) release of the Holistic Review Project in 2007 and the United Kingdom now uses "contextual admissions".[7,8] As part of the Holistic Review Project, US medical schools are considering a tripartite of factors including the applicant's demographic factors (e.g., race, ethnicity, socioeconomic status [SES]), personal attributes (e.g., leadership, altruism), and the applicant's lived experience or "distance traveled" (DT).[9]

DT is defined by the AAMC as, "any obstacles or hardships you've overcome to get to this point in your education or any life challenges you've faced and conquered."[10] Similar language, such as the applicants "life story," has been used to define DT in other countries.[11,12] In recent years, medical schools have improved at incorporating an applicant's demographic factors and personal attributes. For example, medical schools in multiple countries have expanded their demographic questionnaires to include more inclusive racial and ethnic identities,

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sexual orientation, and gender information[13,14]; US medical schools are now utilizing socioeconomic disadvantage calculators[15]; and UK medical schools are asking students about their parental education level to understand demographic differences between applicants that may represent disadvantages between applicants.[16] Furthermore, medical schools in the US, UK, Canada, and Australia are incorporating novel interview assessment strategies including Situational Judgement Tests (SJT) or Multiple Mini Interview (MMI) scenarios to assess applicants' personal attributes.[17,18] While some of these interventions have been successful at reducing bias in admission processes and improved medical school diversity[11,17,18], interventions designed to understand applicants' DT have been largely unsuccessful.[19–21] One such mechanism within medical school applications is the personal statement, which has been used as an avenue for the applicant to share elements of their DT. Some medical school applications also include a disadvantaged essay to give the applicant a designated space to share their hardships. However, medical schools have reported being unsure of how to use this information in the overall admissions process.[19,22] A commonly stated barrier is that qualitative questions generate data that can be challenging to quantify.[23–25]

One way to alleviate the perceived barriers of qualitative assessment could be by gaining a foundational understanding of the lived experiences applicants believe should be considered when assessing their DT. To better understand the critical components medical students think are important for medical school admissions to consider when assessing someone's "distance

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traveled," the authors asked participants to share their DT experiences along with key factors, such as the barriers and facilitators, they encountered on their journey to medical school. This information could be helpful to provide essential individual, interpersonal, and community level context into why an applicant may have academic and professional metrics which deviate from traditionally valued application expectations. This knowledge may help generate new metrics to capture essential data to better diversify medical school classes. By building this knowledge, admissions teams may be able to improve holistic review metrics and provide even more equitable and comprehensive medical school applicant selection processes.

Methods

Study design and theoretical framework

This exploratory qualitative study utilized the social-ecological model (SEM) framework to develop the interview guide, organize data, create a codebook, and identify themes.[26] SEM is a theory of human development consisting of a microsystem, containing interactions and relationships with immediate surroundings; a mesosystem, which includes one's community and social networks; a macrosystem, which includes societal, religious, and cultural values; lastly, the chronosystem which represents time and historical context.[27] This study was conducted from October - December 2021 and was deemed exempt by IRBMED (HUM00203993). A semi-structured interview guide was designed by BE, a medical student, and three expert qualitative researchers (GS, MB, JE). The finalized guide can be found in Supplemental Table 1. To allow

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for the exploration of themes most important to participants, iterative modifications to the guide were made, a standard qualitative technique.[28]

Participants and setting

Medical students were sampled via a purposive sampling method.[29] A recruitment email describing the details of the study (e.g., study purpose, interview process, analysis plan) was sent to medical school admissions offices at seven US medical schools, with requested to be distributed to medical students. The schools were selected based on messaging on their websites that DT part of their holistic review process. Prospective participants provided contact and demographic information (e.g., age, year in medical school, first generation status, and underrepresented in medicine (URiM) status) via a Qualtrics (Provo, Utah) survey. A tiered approach was applied to schedule interviews with participants. Preference was given to students who answered "yes" or "unsure" if they identified as URiM and then to first-generation medical students. This selection strategy was used to maximize the demographic representation of students and ensure the achievement of information power.[30] Information power occurs when no new information is identified within the data sample indicating sufficient depth of information and sampling.[31] Interview participants were compensated $25.

Interview procedures

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Interviews with participants were conducted via phone call or video conferencing (Zoom Video Communications) with study team members BE or JE. Verbal consent for participation was obtained. The average interview duration was 60 minutes. All interviews were audio-recorded, then transcribed and de-identified. Interviewees were invited to check and approve any illustrative data used in this manuscript, through a member-checking process.[38] Only participant approved illustrative data was included. For all illustrative quotes, participant names have been replaced with pseudonyms.

Data organization and analysis

Methodological Approach

Interpretive description (ID) was used for qualitative analysis. ID was chosen as the analytical approach due to its theoretical flexibility and ability to address experiential questions. ID enables researchers to identify themes and patterns within the context of subjective phenomena.[39] This methodology provides for the interpretation and explanation of human experiences with the goal of developing useful knowledge and actionable direction for implementation in applied settings.[40]

NVivo12 (QSR International 2022; Melbourne, Australia) was used for data management, structure, and analysis.[41] All transcripts were manually coded to identify conceptual, semantic, and latent content by one of 2 researchers trained in qualitative

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methodology (BE and QS).[42] Conceptual data coding is the first and most abstract coding in the structuring process. It is used to define, describe, organize, and present data elements and their relationships with little detail.[43] Semantic data coding is a method of organizing data that both reflects the basic meaning of data and the relationships among them.[43] Latent data coding enables the capture of the interpretation of information's symbolic meaning.[44] Researchers used principles of reflexivity to guard against methodological bias from the influence of personal perceptions.[45] The codebook was finalized through discussions between researchers and any divergent codes were deliberated until an agreement was reached. The SEM framework was used to sort codes into themes; however, researcher were open to novel factors found within the data in addition to the SEM framework. Uniformity and relationships between codes allowed for codes to be clustered into subthemes. After the finalized codes, themes, and subthemes were developed, a random sample of transcripts were reviewed again by GS and JE to confirm these themes were supported by the data.[46] A record of the reconciliation and how it was achieved was maintained.[47]

Reflexivity statement & Risk mitigation

The authors' GS, QS, and SB identify as racially/ethnically minoritized individuals. BE identifies as a socioeconomically disadvantaged individual. Individually and collaboratively, all the authors have engaged in advocacy and research work that seeks to enhance more equitable opportunities for minoritized and marginalized individuals. The members of the study who

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conducted interviews had no personal relationship with the participants. BE shared the identity of being a medical student and may have related to some of the challenges the participants voiced as salient components of their DT.

Results

A total of 31 medical students from 7 different medical schools were interviewed. The median age was 25 (IQR, 24-27), 13 (42%) identified as URiM, while some participants were unsure if they qualified as URiM (10 [32%]). Most study participants, 27 (87%), were first-generation medical students (Table 1). All participants reported that an applicant's DT should be considered as part of the medical school admissions review process. Participants highlighted that DT has the potential to create a more inclusive student body by admitting individuals with a greater diversity of experiences. Participants shared that broader communication of DT and how it lends itself to a more holistic admissions approach is needed.

Participants cited multiple factors which are important for medical school admissions teams to consider when they are assessing an applicant's DT. There was a notable variation in the experiences of each respondent and the effects these circumstances had on their DT. Although each student had their own unique background, three major themes across participant experiences were identified. Theme definitions, representative codes, and illustrative quotes are represented in Tables 2, 3, and 4.

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Theme 1. Individual-level characteristics and factors

Theme 2. Interpersonal relationships

Theme 3. Aspects of the participant's community and society

Theme 1: Individual-level characteristics and factors

This theme includes traits and personal contingencies voiced by participants as important components of their DT experience. We have organized these factors into three subthemes, which include personal traits and characteristics, the intersectionality of marginalized identities, and socioeconomic status (SES).

Personal traits and characteristics

Participants described intrinsic qualities and personal characteristics they identified as crucial to their ability to weather hardships and overcome adversity. They described themselves as "motivated," "goal-oriented," or "resourceful," as well as, "self-aware," "open-minded," "optimistic," "courageous," and "kind." One participant shared their concern about how their distinctive personal characteristics might not be compatible in the current culture in medical education.

> *"I think I'm friendly and kind, and I think I'm quiet and humble. I think it's unique in medicine to be that way. But it's also a bad thing, because when you get into third year and fourth year [of medical school], it's hard to come from a culture that values humility*

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and discourages being self-centered. I feel like to succeed in clinical rotations, you have to be boastful and you need to speak up. It's been very hard for me to step over that line that culturally; I don't feel it's okay to do. But in medicine, I have to. (Celia, M4)

Nearly every participant mentioned the importance of resiliency. Participants described rebounding from a variety of setbacks, including the death of a loved one, criminal prosecution, illness, financial ruin, gatekeeping, or failure. Participants reported that enduring adversity increased their confidence and made it easier for them to face future challenges.

"I think the biggest [characteristic] is my resiliency. I'm not some special human who's resilient. I just think that you build resiliency through trauma after trauma after trauma and just having to keep moving forward?" (Margo, M4)

The intersectionality of marginalized identities

Many of our participants occupied more than one marginalized group, experiencing the complexities of discrimination and disadvantage across social categorizations. Race, class, and gender identities were interconnected with sexual, immigrant (both documented and undocumented), and disability identities (including those with chronic illnesses). For example, several participants who identified as ethnic minorities also had immigrant statuses. Participants with marginalized gender identities were sexual minorities, as well. Many participants who identified as URiM additionally had low SESs. As a result, individuals experienced overlapping

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and interdependent systems of discrimination or disadvantage, which made it more challenging to complete the necessary requirements to develop a strong medical school application (e.g., studying, volunteering, conducting research, leading student organizations). For example, multiple students served as caregivers for chronically ill family members. For other students, English was not their first language, which required additional studying or tutoring. Some students discussed how experiences associated with their intersecting identities made it difficult to even explore medicine as a career path.

> *"There's a couple of factors. I have an anxiety disorder. After we moved to the US, it put me at a disadvantage in the sense that I wouldn't talk to people for the longest period of time. To overcome that versus other people being able to just not have that played a role. But the bigger thing for me was the immigration system. Migrating back to the US my family was broken. My dad, who is struggling with multiple health issues, couldn't come. Then my mom had to choose between me and my dad. That's a constant struggle, and even to this day my performance is affected by it." (Aarna M1)*

It was difficult for participants to judge the appropriate level of personal disclosure. Participants shared that it was important for medical school admissions teams to be more transparent with applicants about how much personal information to share, what is relevant, and when to disclose during the application process. With new application requirements and recommendations being added each year, applicants continue to be uncertain about the process.

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Additionally. some participants did not feel comfortable sharing this information. Some participants reported that their DT could be viewed negatively by admission members. Furthermore, participants reported that advice on disclosure is highly variable. This leads to inconsistent messaging and frustration for applicants.

> *"I thought about writing my challenges as an LGBT person or my own disability since these experiences are what drove me to medicine, but I didn't know what they were going to do with that information. I've talked about this with my classmates. I was jealous that other students' mentors helped them insert more of their distance traveled into their application. I just didn't have that type of mentorship." (Megan M1)*

Socioeconomic status

Participants' SES was the most discussed factor contributing to their DT. Participants who grew up in low-SES households faced extraordinary challenges throughout their journey to medical school, such as the financial burdens associated with the application process, tuition, post-graduate placement, and training. Students shared stories of their family's financial ruin from accruing debt, which lead to increased anxiety at the thought of obtaining debt. They discussed the significant amount of time spent researching and applying for scholarships. Some students reported experiencing food or housing insecurity. Other participants were required to work to financially support themselves and their families. These obligations left minimal time for

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studying and extracurricular activities that would make their applications more competitive (e.g., research, volunteering).

> *"In college, I would have basketball practice from 7:00-9:00 AM. I would work 12:30-3:25 a.m. in the morning to have enough money so I could just live. I didn't really share with medical schools about how that impacted my ability to study. I felt like I was making excuses." (Regina M2)*

Yet, many attributed those experiences as motivating factors for becoming a physician. Some students saw becoming a physician as a way to improve the health of their communities as well as lift themselves and their families from poverty. This drive fueled the participants to overcome obstacles.

> *"I think seeing my parents struggle financially and seeing them work multiple jobs was a wake-up call. It was a very strong motivator that I need to work hard, and be successful so that my parents don't have to struggle years down the road... I wanted to show other kids in my community that becoming a physician was possible. I think that helped me overcome hardships and difficult tasks. (Aera M2)*

Many students did not know if they should share or how they should share their challenges with poverty. The medical school primary application required them to report their family income, but many students did not feel they had an opportunity to share how their SES

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affected them. Some participants communicated worry that writing about their SES in their personal statement could be viewed as "poverty pornography" or that it could negatively affect the applicant. Students reported reticence in using the disadvantaged essay which requires you to identify yourself a "disadvantaged applicant." For example, Tiffany reported,

> *"I wasn't sure where I stood compared to other applicants. I knew I was on the lower end, but I wasn't sure what was considered "disadvantaged" because the application was vague. They asked us if we considered ourselves disadvantaged or not, but they didn't put any criteria. I didn't want to take advantage of that option, because I felt there were other students who are much more financially disadvantaged." (Tiffany M2)*

Theme 2. Interpersonal relationships

The interpersonal theme holds the personal relationships participants voiced as contributing to their DT. These interpersonal factors centered around two broad types of support. First, support networks comprised of people who invested in the participant's success, including family members and academic members (e.g., mentors, coaches, sponsors). Secondly, the was the financial support which gave the participant access to more opportunities.

Support network

The quality of a student's support network was a key factor impacting their journey to medical school. Students without proper support networks doubted their ability to be a physician.

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"Growing up I had two parents that weren't interested in me. I had to learn, 'how do I exist and how do I live my life without parents that care about me?' My life was spiraling downhill until I found someone who believed in me. Until then, there was no way I could have gone to medical school." (Shanice M4)

Having a strong support network streamlined and simplified the journey. Educators and mentors provided guidance and resources, while family members provided emotional and logistical support that freed time for the student to focus on their academics.

Strong support networks also affected participants' motivation to pursue a career in medicine. Some students had no physicians in their community. Others, who were told it would not be possible for them, became self-motivated to prove to themselves and the naysayers that it was possible. Multiple students had younger siblings that motivated them. While some participants were comfortable leveraging social capital, many had not learned this skill as this practice was uncommon in many participants' upbringings. Participants expressed frustration at the disadvantages that accompanied not learning these skills, as Aarna described.

"Growing up an immigrant and living in poverty, I was taught that asking for help was a sign of weakness. Luckily, I didn't follow this advice, I made good connections with people. I always had confidence in myself; I knew if it was within my limit, I could do it. But I eventually learned that if it is not within my limit, that's where I could utilize my connections. Once I learned that there was nothing that could stop me." (Aarna M1)

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Participants without sufficient support networks found the journey to medical school more challenging. These participants had difficulty navigating the circuitous pathway through medical school preparation and admissions. One participant described how vexingly opaque the medical school system is in the US.

> *"The medical system in the US has a completely different entrance system versus internationally. In other countries, you graduate from high school, take the entrance exam, and go to medical school. Here, it's not the case. And to know what exactly goes into it is so difficult if you don't have connections. There are certain unspoken rules that if you don't know, then you won't get into med school. (Frank M3)*

Financial support

Participants reported financial support was essential in providing the freedom to pursue opportunities that could bolster their application. Participants without financial support described how it limited their ability to participate in essential activities including volunteering, shadowing, or research. Financially supported students did not have this burden. They were able to hire tutors to assist with test prep or consultants to help prepare their applications. Students who were financially supported understood those resources put them at an advantage.

> *"A clear advantage for me was I was able to afford cool experiences. I went abroad to volunteer in health clinics. And obviously, because it's volunteering, you didn't need*

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good grades or test scores to do it, just the money to afford it. Those experiences showed up in my personal statement and they were key talking points in interviews." (Celeste MD/PhD)

Having financial support was not always related to the student's SES. The distinction between the two was important as each contributed differently to the student's DT. Students with low SES often did not have their basic needs met (e.g., food, shelter), while students with low-financial support did not have the resources to support costly but beneficial academic endeavors. For example, there were students that identified as coming from a low-SES background but were financially supported to pursue academic endeavors through external sponsors and scholarships. For some, financial support at all levels of education was key.

"I just hadn't considered being able to afford college with my parent's income. I was very fortunate that I applied and received a four-year full ride, and that kind of changed everything." (Levi MD/PhD on research time)

Theme 3. Aspects of the participant's community and society

The final theme encompasses the aspects of the participant's community, as well as the cultural norms of society that contribute to their DT. Participants identified being a part of athletic, educational, religious, neighborhood, and cultural communities. Group and social norms

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within these communities shaped their experiences, both advancing and inhibiting their journeys. Within this theme, subthemes included role models and gatekeepers.

Role models

Students frequently mentioned the importance of having role models – people who could be admired or served as an example to emulate. Examples of role models included classmates, parents, physicians, and professors. Participants who were surrounded by productive, caring role models explained how it helped them become cultivable students. Being surrounded by peers who were college-bound, becoming physicians, or other college-trained professionals motivated the students to work towards similar goals. Many students mentioned that seeing and interacting with physicians in their communities who shared similar upbringings or demographic factors showed students that becoming a doctor was a realistic possibility.

> *"Something that was hard for me was I didn't see anyone doing well that was Black. Black people in my community were very low-income. It was hard for me to envision myself being successful. My mom ended up sending me to a fancy boarding school that was all Black, and that increased my confidence in my identity. I finally saw people who looked like me and were successful." (Regina M2)*

Students without strong role models reported delays in emotional development, lack of early academic success, difficulty establishing strong study habits, and challenges building social

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capital (e.g., social relationships that have productive benefits).[48] Lack of connections with professors and physicians resulted in lackluster research opportunities, volunteering, or shadowing experiences.

> *"I didn't have mentors in college. I think I was just a number. I didn't have anyone to guide me, except my mom. I think that was a significant barrier. After I failed the MCAT the first time, I think I went through a lot of psychological lapses. I had issues with losing and I lost a lot of confidence." (Regina M2)*

Gatekeeping

Not all communities provided positive environments for participants. Gatekeeping was experienced by many. Gatekeeping involves controlling, limiting, or discouraging practices by community members that inhibited the participant from pursuing a career in medicine. This experience was frequently described by participants who identified as female, racial or ethnic minorities, immigrants to the US, or members of the LGBTQ+ community. A student who identified as transgender shared how one professor who was supposed to write them a letter of recommendation refused after they announced their use of gender-neutral pronouns. Multiple female students shared experiences where it was recommended they would be better suited for a career like nursing. Students reported these interactions added stress and created barriers to pursuing a career as a physician.

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"It's undeniable that in this country there is a history of structural racism. There's a history of classism. There's a prejudice against immigrants. And the gatekeepers to the healthcare system in this country continue to mostly be rich white men. Until that changes and we get more women, minorities, and immigrants in positions of power in healthcare, I think the healthcare system will continue to discriminate against others, whether unintentionally or maliciously." (Sudhu M4)

Discussion

In this study, the authors make the first attempt to understand key factors medical students think are important to consider when assessing an applicant's DT. Participants shared a variety of components that contributed to their DT, along with the barriers and facilitators they encountered on their journey to medical school. These individual, inter-personal, and community features of their lived experiences revealed salient elements from an applicant's life story that could inform and improve medical schools' evaluation of applicants' DT.

These findings highlight a need to better understand individual-level dynamic, interrelated, and multifaceted characteristics within the application process. Importantly, the deficit framework (e.g. hardships, obstacles, challenges, and disadvantages), which has been used extensively by medical schools to capture the inequities experienced by prospective medical students, does not measure the full complexities inherent in an applicants' DT.[49–51] Our

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participants reported "disadvantaged" labels may cause applicants to question if they qualify. As a result, it inadvertently influenced participants in our sample to not share their hardships. This is in keeping with previous research which points to the internal struggle that medical school applicants face with identifying themselves as disadvantaged. [20] Participants reported being reluctant to share their hardships for fear of being perceived as inadequate, pandering, or deficient rather than showing resiliency and the drive to pursue medicine.[20]

These findings support previous literature which has shown that medical students are inhibited from disclosing their hardships (e.g., mental or physical illnesses) for fear of stigma.[52–54] However, studies have shown that medical school admissions members do not negatively reduce their scoring for applicants who share hardships in the application process.[55,56] Clarity on how inequity narratives contribute to a holistic admission process could be more broadly communicated by medical schools within the US and abroad. Confidentiality considerations for applicants sharing this information also must be addressed in these communications. The vulnerability of this student population needs to be at the fore when collecting such intimate information. Better guidance and more transparency in this process will allow for greater applicant engagement.

The measurement tools medical schools are using to understand an applicant's DT do not provide a complete picture of the situational complexities applicants experience.[57,58] Personality

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traits that help enable applicants to be high achievers can be collected with reliable validated measures.[59,60] In a study of desirable physician attributes identified by expert practitioners across specialties, they identified integrity, empathy, lifelong learning, tolerance of ambiguity, and recognition of one's limitations.[61] Integrating methodologies that include the collection of these noncognitive characteristics may lead to greater diversity in applicant selection.

In the US applicants can report their SES, parents' or guardians' level of education, family participation in public-assistance programs, residence in an underserved area, and the applicant's contribution to family income.[62] However, these questions provide incomplete information about the applicant[63,64]; they are missing a crucial component, the story behind the statistic. For example, participants in this study described how the application process allowed them to report their family's income, but the applicants did not feel they had enough space to describe how their family's financial situation affected them. Given the uniqueness of each applicant's story, it suggests these factors should be elicited via more open-ended prompts, such as optional essays focusing on positive factors of lived experiences or additional personal history statements as a space for self-advocacy. The collection of these data may empower the applicant to provide context surrounding what they have achieved with respect to their level of resources, opportunities, and barriers. Additionally, it is essential for admissions teams to allow individuals with other marginalized identities to be made visible in medical school applications, including caregivers (of children and/or adults), immigrants or children of immigrants (both documented

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and undocumented), individuals across the gender spectrum, and individuals with disabilities (including those with chronic illnesses).

Our research also found that interpersonal relationships contribute consequentially to an individual's DT. Strong support networks and targeted financial support provided students with essential resources that buoyed them through their undergraduate education, medical school preparation, and medical school application cycles. The most predictive factors for acceptance to medical school, GPA, MCAT score, undergraduate institution, research productivity, and medically related volunteering and shadowing, can be bolstered by privilege.[65-67] Quality mentors, tutors, and access to medical experiences can be more readily activated by individuals with stronger support networks. Having financial support to cover one or more medical school application cycles is essential as there are primary application fees, secondary application fees, college service fees, and exam fees. There are numerous other costs, including travel, appropriate interview attire, and the purchase of medical school application tools, guidebooks, and subscriptions.[68] To truly make the medical school admission process more inclusive, medical schools must actively engage with prospective students through outreach and pathway programs to connect and fortify support networks. For example, many medical schools have created post-baccalaureate and Masters' degree bridge programs which allow learners to build skillsets, find mentors, and conduct research.[69] Many of these programs are able to offer admission to their doctoral programs upon successful completion. Investing in financial support, through no-cost

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programming and grants, can give prospective students equitable access to opportunities.[69] It is essential to note, expanding educational offerings and significantly augmenting financial support requires high-level institutional commitment to diversity planning and strategic development with advancement offices to identify funding resources.[69]

Lastly, participants shared how community identification and the social norms affected their DT. Community role models advanced their goals, while gatekeepers inhibited their progress. Medical schools have the power to advance diversity through modeling and promoting diversity within and surrounding medical education communities. The lack of role models and mentors for URiM students has been identified as a barrier to success.[70] In the recruitment and application process, medical schools should include a diversity of voices and inclusive representation in admissions committees, student interviewers, and admitted student participation. Medical school admissions are historically viewed as gatekeepers for students and as a contributor to the relative lack of diversity in the student body entering medical professions.[71,72] To interrupt unconscious or implicit bias, medical school admissions teams should engage in regular anti-bias education. Medical school admissions teams should build opportunities for personal interaction between applicants and faculty, students, and administration. Schools also should strive to maintain regular personal contact with their diversity pool.[68] Dedicated institutions have developed pre-college programming, summer camps, and admission outreach events to build connections and bolster interaction with

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traditionally excluded students, families, and communities.[69] These strategies require time and capacity to development strong institutional-community partnerships with local leaders and educational organizations.[73]

This study has some limitations. The study cohort only includes current medical students. This specific study population limited the perspectives on how applicants and schools are currently understanding and evaluating DT. We recognize that self-selection bias may be present in this dataset, as the decision to participate in a study was up to individual participants. The perspectives of those who volunteered to take part in this study may be different in terms of motivation or demographics from those who did not. Additionally, since participants were asked to provide perceptions over a multiyear period, recall biases may be present. Lastly, we cannot rule out bias from demand characteristics as idealized perceptions of medical student characteristics could shape how these participants responded.

Conclusion

Medical student experience of DT are varied and complex; they include individual, interpersonal, and community-level factors which shape their journey to medical school. DT was considered an important component of the medical school holistic review process, yet many students struggle to communicate these highly personal stories within the current DT framework. Our research suggests that medical school admissions teams could incorporate more

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comprehensive recruitment practices and inclusive methodological frameworks to accurately capture the diversity of identities and experiences of medical school applicants. While the finish line for each applicant may be medical school acceptance, each applicant does not have the same starting line and their journeys vary greatly.

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