



David Geffen School of Medicine at UCLA

Demystifying the Application Process

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2004 Applicant Pool

■ Total applicant pool	5,418
■ Male	2,767
■ Female	2,651
■ Supplemental requests	2,358
■ Supplemental received	2,063
■ Invited to interview	758
■ Interviewed	726
■ Total accepted	245
■ Total matriculated	121

Class of 2008

■ Total matriculated:	121
■ Males	55
■ Females	66
■ Demographic data	
■ Oldest	33
■ Youngest	20
■ California residents	102

Class of 2008

■ Academic profile

- Avg BCPM 3.71 (3.65)
 - Avg Cum AO 3.70 (3.73)
 - MCAT
 - Verbal reasoning - 9.80 (9.69)
 - Physical science - 11.1 (10.93)
 - Biological science - 11.4 (11.17)
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Class of 2008

■ College Statistics

■ UCLA	33
■ UC Berkeley	12
■ UCSD	9
■ UCI, USC	6
■ Stanford, UCD	5
■ Harvard, MIT, Pomona	4
■ Cornell University-EC	3
■ Brown, Duke, Princeton, U of Penn, Yale	2
■ 20 Other schools	1

Class of 2008

■ Major

■ Biochemistry	17
■ Biology, Human Biology	30
■ Molecular Biology	15
■ Chemistry, Physiology	7*
■ Neuroscience	3
■ Other sciences (other biology)	10
■ Microbiology/bacteriology	2
■ Psychobiology	3
■ Non-science	25

Class of 2008

■ Subcommittee E

■ Total applied	873
■ Supplemental requests	450
■ Supplemental received	407
■ Invited to interview	150
■ Interviewed	142
■ Admitted	54 (F - 31)
■ Matriculated	37 (F – 22)
■ Deferred	1

Class of 2008

■ Academic profile for Disadvantaged Applicants

■ Avg BCPM 3.30 (3.65)

■ Avg Cum AO 3.50 (3.73)

■ MCAT

■ Verbal reasoning - 8.23 (9.80)

■ Physical science - 9.81 (11.1)

■ Biological science - 9.87 (11.4)

Criteria for Determining Socioeconomic Status

■ Financial

- Per annum income below accepted federal government poverty level
 - Parents income if under parental support
 - Applicants income if self-supported
 - Number of siblings (over 6) and status of their education (none in college)
 - Applicant worked at least 40 hours/week to support self in college
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Criteria for Disadvantaged Status Consideration

- Education level of parents
 - Deprivation of background (qualitative)
 - English as 2nd or 3rd language in home (assuming U.S. citizenship)
 - Physical handicaps
 - Mental handicaps (learning disability, treated psychological disorder)
 - Economic deprivation in formative years
 - Geographic (lower socioeconomic neighborhood, medically underserved area, gang infested neighborhood, rural, etc.)
 - Member of historically medically underserved population
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FAQ

- **What are you looking for in a medical student applicant?**
 - **What makes an applicant competitive, desirable for admission?**
 - **Do I have to do research to gain admission to medical school?**
 - **How much do MCAT scores count for admission?**
 - **How much do extracurricular activities count?**
 - **How much clinical exposure is necessary?**
 - **I have a low GPA and high MCAT scores - will medical schools consider me for admission?**
 - **My MCAT scores are low, but my GPA is high - should I apply now or wait and retake the MCAT?**
 - **Does the committee have preferred schools?**
 - **Is there a preference for California residents?**
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Web Sites

- **David Geffen School of Medicine at UCLA**
 - <http://dgsom.healthsciences.ucla.edu/>
 - **AMCAS**
 - <http://www.aamc.org/students/amcas/>
 - **Association of American Medical Colleges**
 - <http://www.aamc.org/start.htm>
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David Geffen School of Medicine at UCLA

Why We Need Minority Doctors

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Why we need minority doctors

- **Some facts you should know:**
 - **Overall health care of the American population has improved over the past few decades.**
 - **All Americans have not shared equally in these improvements.**
 - **Among non-elderly adults**
 - **Report that they are in only fair or poor health**
 - **Hispanics – 17%**
 - **Black Americans – 16%**
 - **White Americans – 10%**
-

Why we need minority doctors

- **Some more facts you should know:**
 - **Primary care is the under pinning of the health care system.**
 - **Having a usual source of care increases the chance that people receive preventive care.**
 - **30% of Hispanic Americans (lack a usual source for health care)**
 - **20% of black Americans**
 - **16% of white Americans**
 - **Hispanic children are 3-times less likely than non-Hispanic children to have a usual source of health care.**
 - **African Americans and Hispanic Americans are far more likely to rely on hospitals or clinics for their usual care than white Americans (16 and 13% respectively, versus 8%)**

Why we need minority doctors

■ Unequal treatment:

- There is a significant variation in the rates of medical procedures by race, even when insurance status, income, age and severity of condition are comparable.
 - Racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health care services.
 - Minorities are less likely to be given appropriate cardiac medications, undergo bypass surgery, receive kidney dialysis, or transplants.
 - Minorities are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions
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Why we need minority doctors

■ Unequal treatment:

■ Breast cancer:

- The length of time between an abnormal screening mammogram and the follow up diagnostic test to determine whether a woman has breast cancer is more than twice as long in Asian American, black and Hispanic women as in white women.

■ Asthma:

- Among preschool children hospitalized for asthma, only 7% of black and 2% of Hispanic children, compared with 21% of white children, are prescribed routine medications to prevent future asthma-related hospitalizations.

■ HIV infection:

- African Americans with HIV infection are less likely to be on antiretroviral therapy, less likely to receive prophylaxis for pneumocystis pneumonia, and less likely to be receiving protease inhibitors than other persons with HIV.
-

Why we need minority doctors

■ Unequal treatment:

■ Heart disease:

- African Americans are 13% less likely to undergo coronary angioplasty and one-third less likely to have bypass surgery than whites

■ Nursing home care:

- Asian American, Hispanic, African American residents of nursing homes are all far less likely than white residents to have sensory and communication aids, such as glasses and hearing aids.
-

Why we need minority doctors

- **Beyond income and insurance**
 - **Important, but not the only factors**
 - **Hispanic Americans with a usual source of care – 80% in 1986 declined to 70% in 1996.**
 - **Insurance coverage has also declined.**
 - **Hispanic men – 37% have no health insurance**
 - **Declines in insurance coverage explained only one-fifth of the change in access to a usual source of care.**
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Why we need minority doctors

- **Beyond income and insurance**
 - **Quality of care (as measured by physician review and adherence to standards of care)**
 - **For hospital patients with CHF or pneumonia**
 - **No difference for patients from poor communities compared with other patients, after adjusting for other factors.**
 - **African American patients received lower quality of care than white patients.**
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Why we need minority doctors

- **Beyond income and insurance**

- **Physician decision making**

- **Study of physicians' decisions about whether to refer patients for cardiac catheterization using actors portraying similar backgrounds.**

- **Black women – significantly less likely than white men to be recommended for referral, despite reporting the same symptoms.**

- **Differences for other groups were not significant.**

Why we need minority doctors

- **Beyond income and insurance**

- **Hospital characteristics**

- **Quality of care for African American patients was lower in non-teaching hospitals than in teaching hospitals.**
 - **White patients were more likely than Hispanic and African American patients to receive invasive cardiac procedures in hospitals performing high volumes of such procedures.**
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Why we need minority doctors

■ Fact

- Patients who are members of minority groups may be more likely to consult physicians of the same race or ethnic group.
 - What about the relation between patients' race or ethnic group and the supply of physicians or the likelihood that minority group physicians will care for poor or black and Hispanic patients?
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Why we need minority doctors

- *The role of black and Hispanic physicians in providing health care to underserved populations.* Komaromy M, Grumbach K, Drake, M, et al. (N Engl J Med 1996 May 16; 334(20): 1305-10).
 - Analyzed data on physicians' practice locations and the racial and ethnic makeup and socioeconomic status of communities in California
 - Surveyed primary care physicians from 51 California communities and examined the relation between their race or ethnic group and the characteristics of the patients they served.
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Why we need minority doctors

- *The role of black and Hispanic physicians in providing health care to underserved populations.* Komaromy M, Grumbach K, Drake, M, et al. (N Engl J Med 1996 May 16; 334(20): 1305-10).
 - Communities with high proportions of black and Hispanic residents were 4 times as likely as others to have a shortage of physicians regardless of community income
 - Black physicians practiced in areas where the percentage of black residents was near 5 times as high, on average, as in areas where other physicians practiced
 - Hispanic physicians practiced in areas where the percentage of Hispanic residents was twice as high, on average, as in areas where other physicians practiced

Why we need minority doctors

- *The role of black and Hispanic physicians in providing health care to underserved populations.* Komaromy M, Grumbach K, Drake, M, et al. (N Engl J Med 1996 May 16; 334(20): 1305-10).
 - After controlling for racial and ethnic makeup of the community, black physicians cared for significantly more black patients and Hispanic physicians for significantly more Hispanic patients than other physicians.
 - **Conclusion: Black and Hispanic physicians have a unique and important role in caring for poor, black, and Hispanic patients in California.**
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Why we need minority doctors

- **California Civil Rights Initiative - Article I, Section 31 of the California Constitution**
 - **"The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting."**
 - **November 5, 1996**
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Why we need minority doctors

■ Strategies

- Support evidence-based decision making
 - Improve the clinicians' abilities to apply the results of previous research to minority patients whenever relevant research exists.
 - Support patient decisionmaking
 - Develop Spanish-language publications that provide patients with survey based assessments of consumer satisfaction with their health care
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Why we need minority doctors

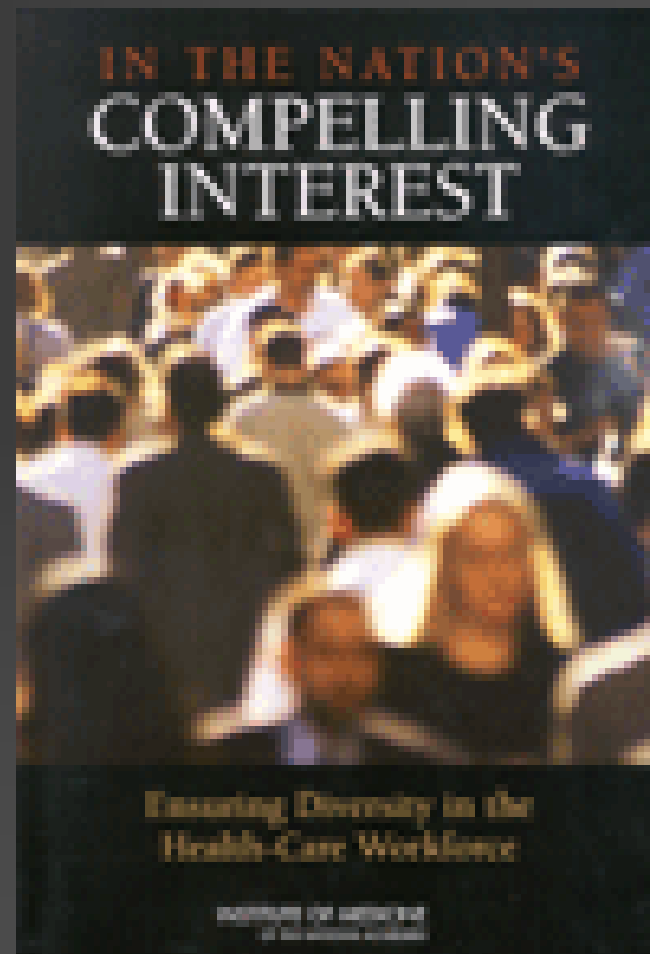
■ Strategies

- **Develop better strategies for quality improvement**
 - **Funding for “centers of excellence” to develop practical tools for eliminating racial and ethnic disparities.**
 - **Supporting research that involves partnerships between academic researchers and community health care providers.**
 - **Supporting training for minority health services researchers to address the priorities identified in the President’s Initiative to Eliminate Racial and Ethnic Disparities in Health.**
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Why we need minority doctors

■ Strategies

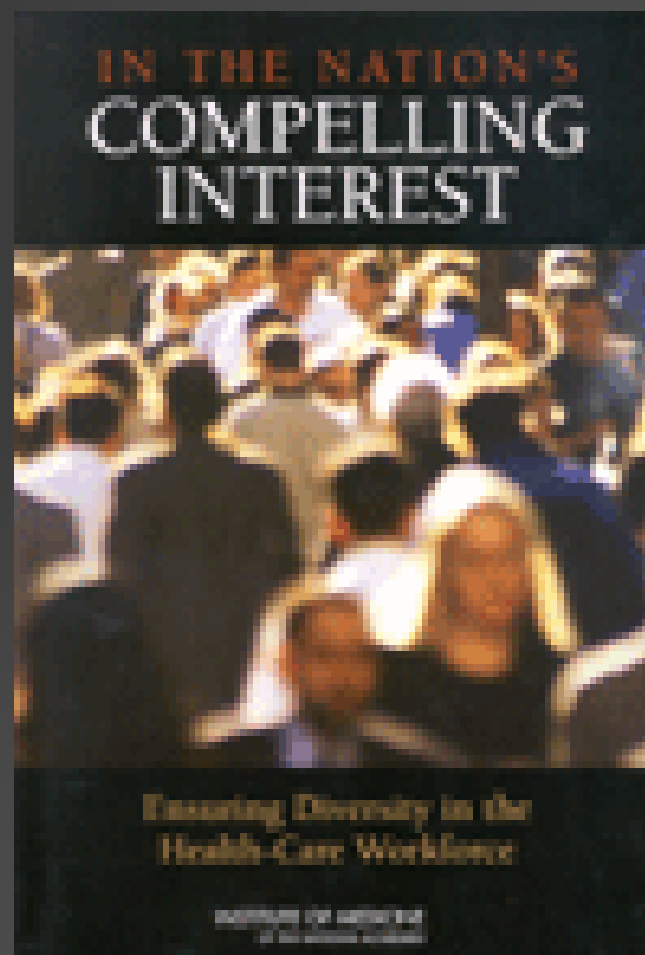
- **In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce**
 - Admissions policies and practices of health professions educational institutions;
 - Public sources of support for health professions training;
 - Standards of health professions accreditation organizations pertaining to diversity;



Why we need minority doctors

■ Strategies

- **In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce**
 - The “institutional climate” for diversity at health professions educational institutions; and
 - The relationship between Community Benefit principles and diversity.



Resources

- **Institute of Medicine (IOM)**
 - <http://www.iom.edu/>
 - **Agency for Health Care Research and Quality (AHRQ)**
 - <http://www.ahrq.gov/>
 - **Association of American Medical Colleges**
 - <http://www.aamc.org/start.htm>
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UC Medical Schools

■ First-Year Enrollments, 2001 - 2002

■ Total URM & Other Hispanic

■ Fall 2002

■ UCD	14 (93) – 15.1% (+6.5)
■ UCI	10 (92) – 10.9% (+1.3)
■ UCLA	32 (121) – 26.4% (+10.7)
■ UCSD	12 (122) – 9.8% (+0.7)
■ UCSF	26 (141) – 18.4% (+3.5)

2003 Applicant Pool

■ Total applied:	5,155
(F=2,561) (CA=3,106)	
■ Invited to complete supplemental & letters	2,292
■ Supplemental application received	2,001
■ Screened applicants	1,738
■ Total invited for interview	750
■ Interviewed	728
■ Applied for disadvantage consideration	973
■ Interviewed	141
■ Total accepted	262
■ Total matriculated	121 (F=55)

Class of 2007

■ Total matriculated	121
■ Males	66
■ Females	55
■ Demographic data	
■ Average age	24
■ Oldest	37
■ Youngest	18
■ California residency	102 (85%)

Class of 2007

■ Academic profile

■ Avg BCPM	3.66
■ Avg Cum AO	3.70
■ MCAT	
■ Verbal reasoning -	9.86
■ Physical science -	11.26
■ Biological science -	11.46

Class of 2006

■ College Statistics

- UCLA 24 (37)
- UC Berkeley, UC Davis, UC Irvine, UCSD, UCSC 27
- Stanford 20
- Brown, Cornell, Yale 6
- Harvard 4
- University of Pennsylvania 3
- USC, University of Arizona, California Institute of Technology, MIT 3 *
- BYU, Northwestern, Occidental, Pomona, U of Chicago, U of Michigan 2 *
- 13 Other schools 1 *

Class of 2007

■ Major

■ Biochemistry	11
■ Biology	36
■ Molecular Biology	13
■ Human Biology	8
■ Physiology	5
■ Neuroscience	2
■ Other sciences (other biology)	15
■ Microbiology/bacteriology	3
■ Psychobiology	2
