Learning from their Journey: Black Women in Graduate Health Professions Education

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Learning from their Journey: Black Women in Graduate Health Professions Education

by

Marcia Lynne Parker

A dissertation presented to the Faculty of the School of Education
Loyola Marymount University,
in partial satisfaction of the requirements for the degree
Doctor of Education

2020
Learning from their Journey: Black Women in Graduate Health Professions Education

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by

Marcia Lynne Parker
This dissertation written by Marcia Parker, under the direction of the Dissertation Committee, is approved and accepted by all committee members, in partial fulfillment of requirements for the degree of Doctor of Education.

\[2/4/2020\]

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ACKNOWLEDGEMENTS

First, thank you God for your mercy and for seeing me through so many more milestones than I ever knew I could face.

Thank you to my students, who during the past 13 years of my work as a health professions educator, entrusted me to participate in your academic experience.

To my immediate and extended family, where would I be without you? Thank you for listening, for your support, and for always cheering me on.

To my friends who have stood by me as I have worked and lived in places throughout this country, thank you for being the family I needed so far away from home.

Thank you to my trusted mentors who have graciously offered advice as I navigated so many spaces previously unknown.

To the LMU EdD Cohort 14, I am grateful that we were able to travel this journey together. Can you believe it? We did it!!

To my incredible committee, Dr. Jill Bickett, Dr. Tammy Green, Dr. Elizabeth Stoddard, and Dr. Elizabeth Reilly, thank you from the bottom of my heart. Dr. Bickett, I am so honored that you accepted the challenge of being my chair and that you were there for me every single step of the way. Dr. Green, Dr. Stoddard, and Dr. Reilly, thank you for your time, insight, and encouragement in articulating this work to the world.

Finally, thank you to the women who courageously participated in this study. I am honored for the trust bestowed in me and for the time you graciously took to share your stories. I pray that this dissertation honors your voices and shines a light forward so that your experiences can be a blessing for others.
DEDICATION

To my nieces and nephews, may this work inspire you to pursue your highest dreams.

Love you always—Auntie Marcia.
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ABSTRACT

Learning from their Journey: Black Women in Graduate Health Professions Education

by

Marcia Lynne Parker

While numerous efforts have been made across different educational contexts aimed towards increasing demographic diversity in STEM education, career decision-making content related to the potential pursuit of health professions education has failed to reach all students. Thus, there is a need for a more consistent and targeted sharing of information, including from the graduate level (where students must meet detailed requirements for specific healthcare disciplines), down to the community college and high school levels where students often make life-changing career-direction decisions without sufficient information to inform these decisions. At the other end of the spectrum, the conventional learning experiences in graduate health professions education have failed to adequately adapt to the expanding diversity of the patients they serve or to emphasize the depth and unique insight that students of color can bring to patients, their communities, and to the health professions classroom (Warshaw, 2016).

In this context, this dissertation seeks to understand the experiences of a sample of Black women who have successfully entered or completed a graduate health professions degree program. Using a qualitative methodology, this study will explore and identify factors that first influenced their exploration into a health professions field, what barriers they overcame in their educational process, and how these experiences and meaning can be used by educational leaders wishing to improve access and inclusion for health professions education in the future.
CHAPTER 1
INTRODUCTION

This dissertation will investigate access, perseverance, and reflections of Black women in graduate health professions education. While the vast majority of my professional career has been devoted to providing students with access to health professions education, this topic is not only important to me professionally, it is also important to me personally. Raised by educators, my “village” included my grandparents, aunts, mother, and others involved in shared community activities such as church and my brothers’ athletic events. Although cultural pride was paramount, this pride was juxtaposed against a society where blatant racism was not uncommon and silencing the voices of women was an accepted normality. Despite all of this, in my family, education was seen as the way to emerge from our circumstances and pursue a better life.

Growing up amidst challenging circumstances as an African American female in rural northwest Tennessee, I was raised with the promise that if you study hard and get good grades, everything else, including happiness and financial stability, will take care of itself. However, as I have pursued my own career I have found that advice, while well meaning, was insufficient in its explanation of the way that the world works and what it takes to not only survive but also thrive as an African American woman in our society.

While I was a strong student academically, I fell short in the area of career exposure and had minimal access to the resources needed to explore these opportunities on my own. Perhaps due to the fact that most in my family had not been exposed themselves to professions outside of the K-16 environment, I did not have any particular insight on what “a day in the life” of most careers really looked like. Thus, although, I consistently scored high in subjects such as math,
chemistry, and writing, it was not until I began my professional career in health professions admissions that I was able to discover how these skills could be translated into work that was both challenging and humanitarian at the same time. While health professions careers can be relatively financially lucrative, humanitarian in this sense is defined by having a career where, despite the money, one’s core motivation is improving the human condition.

My sense of responsibility in my role as a health professions educator has deepened as I have grown professionally, where the charge to recruit the next generation of nurses, pharmacists, and physical therapists occurred alongside alarming experiences witnessing family members struggle to find practitioners able to deliver culturally competent care. As I progressed in my career, I began to realize even more deeply how issues such as unconscious bias and stereotype threat in a health professions educational environment could affect the very students I was responsible for recruiting (Ackerman-Barger, Valderama-Wallace, Latimore, & Drake, 2016). I distinctly recall being approached more than once by my Black students with complaints about examples provided in class of patients who were gunshot victims or ethical cases with patients who were known to have stolen something. In these cases, the students’ complaints stemmed from the coincidence that these scenarios were often presented assuming a Black person was the perpetrator of the crime. Further, while on the outside, successful Black female clinicians appear to achieve career and educational triumphs, on the inside these same women may simultaneously cope with disrespectful encounters from disinterested outsiders far too willing to remain uneducated on the importance of culture to the patients they (as future health care providers) have sworn to serve.
In my culture, they often say “and a child will lead you.” While my research interests have always been firmly committed to exposing students of color to health professions education, the calling to focus my dissertation on the journey of Black women came in the form of a young girl who spoke truth to the story I knew had to be told. At a march calling for increased school safety in Washington D.C. in 2018, 11-year old Naomi Wadler had the courage to raise her voice in the midst of a national tragedy. In her speech, she eloquently articulated the importance of highlighting the voices of African American girls and women. Shortly after taking the podium, Wadler boldly stated “I am here today to acknowledge and represent the African American girls whose stories don’t make the front page of every national newspaper. . . . I represent the African American women . . . who are simply statistics instead of vibrant beautiful girls full of potential” (NBC News, 2018; See Appendix A). It was after hearing her words that I realized that I have the context and the opportunity to focus my research on the unique experiences of Black women, helping to bridge the gap for a group that remains largely unheard in many spheres, including the sphere of health professions education.

**Consideration of Terms Identifying Those of African Descent Living in the United States**

Given the historical context surrounding women of African descent living in the United States, it is important to discuss and honor how this group will be described in my research. In Collins’ (1991) pivotal work, *Black Feminist Thought*, Collins consistently used the terms “Black” and “African American” interchangeably. While this work was initially written more than 20 years ago, Collins has consistently utilized this same style of interchange between “Black” and “African American” in more recent publications as well (Collins, 2015, 2012, 2010). Others who have used Black feminist thought as a theoretical framework have also
included a declarative statement that, for the purposes of their literary work, Black and African American will be used as similar terms (Reid, 2009). That said, it is critical to note here that the effect of American slavery cannot be underestimated. Those of African descent whose relatively recent lineage has been directly subject to the dignity/identity robbing effect of American slavery might have vastly different generational oppressions than those whose ancestors did not suffer from these experiences.

One of the central tenants of Black feminist thought is allowing for the freedom of each individual within the Black female experience to define herself (and associated terms) in the manner that best fits her preference. When considering the approach to take with this paper, the question becomes challenging. The diversity of those of African descent currently living in the United States is extremely broad, and any attempt to streamline it runs the risk of diluting an aspect of each person’s pride and identity. There are some who associate the term “African American” with a specific set of individuals, whose descendants were most likely brought to the United States as slaves, and accordingly potentially inherited the associated sense of psychological enslavement that does not trap the psyche of those whose parents, or they themselves, came to this country more recently, of their own free will. Others associate the term Black with either a higher degree of inclusivity or with a history of mistreatment, solely based on the color of a person’s skin, whereas African American, on the other hand, could be seen to have a deeper reach, speaking to culture, a concept broader than skin color (Agyemang, Bhopal, & Bruijnzeels, 2005). The unity movements of “Black Girls Rock” and “Black Lives Matter” embrace the solidarity of pride and protest, related to strength and experiences born from a shared racial identity. These movements have taken place during the same timeframe as the
opening of the groundbreaking Smithsonian National Museum of African American History and Culture which uplifts the power of the term African American in its mission to represent “Americans of African descent affected by the historical American experience” (Forson, 2018).

One of the chief goals of this study has been to illuminate the voices of the participants, allowing each woman the freedom to self-define or be free of restriction to any single definition at all. For this reason, strict lines generally were not drawn between the terms Black and African American. This centered the study on the holistic experiences of the women who courageously participated in the study and aligned with the precedence set in Black Feminist Thought, which served as the theoretical foundation for this paper. The spirit of this work has been to identify themes of commonality and unity in the lives of a marginalized group and this was reflected in the dialogue of the study, both individually and in group form. That being said, the sample of women who were recruited for this study have spent the majority of their academic careers (grade school and beyond) in the United States and thus, this context (whether overtly or subliminally) may affect the manner in which the women articulated their experiences. These factors are important ones to address and are included in the discussion and analysis found in Chapter 5.

**Statement of the Problem**

The World Health Organization (WHO) maintains that “the highest attainable standard of health [is] a fundamental right of every human being” (World Health Organization [WHO], 2018). Robillard, Spencer, and Richardson (2015) called attention to related remarks by Booker T. Washington, a pivotal figure in the post-slavery era, who noted “of all the forms of inequality, injustice in health is the most shocking and inhumane” (p. 94). If you have ever been
significantly ill, you know that when you are sick, nothing else matters. What is even more disturbing is when you suffer from a condition that is not common amongst the dominant population and thus the treatments and mechanisms for living with a particular illness are less known than are other diseases or conditions. Lack of programmatic emphasis on conditions that disproportionately affect women of color has directly affected members of my own family who have bravely faced illnesses rare in the dominant population with minimal providers properly trained to address their conditions. Given this, increasing inclusion of Black women and the issues pertinent to their communities is critical to ensuring health equity and adequate clinical training going forward (Sullivan Commission, 2004).

In the United States, certain designations within the health professions arena require a graduate degree for entry into the field. Examples of these include Medical Doctor (MD), Pharmacist (PharmD), Physical Therapist (DPT), Nurse Practitioner (DNP or MSN), Physician Assistant (PA) and so on. Particularly in the case of these professions, the lack of representation of people of color finds its origins well before a student reaches graduate school. The activity of pursuing a health professions career is a very long one, requiring years of preparation at the college and high school level to even be ready to enter a health professions program (Sullivan Commission, 2004). There is a lack of exposure, role modeling, and mentoring regarding the breadth of health professions careers open to students and the pre-matriculation training required to pursue these fields (Padula, Leinhaas, & Dodge, 2002). This deficit, particularly for students of color, starts at a young age (Sullivan Commission, 2004). For families of color, including African Americans, a lack of access to financial capital further complicates the situation given that capital deficiencies affect self-confidence and risk taking, both of which are required to
pursue graduate level health professions education (Shapiro, 2017). Current recruitment efforts fall short in reaching these students early enough to formulate the academic, financial, and other support resources needed to pursue health professions education at the graduate level. The recruitment mechanisms that do exist fail to assess what motivates these students as well as what challenges they face after enrolling in or graduating from a graduate health professions program (van Ryn et al., 2015).

The problems with achieving diversity in health professions education do not end at recruitment. Researchers have documented that students of color experience micro and mega aggressions even in the midst of their classroom and clinical experiences (Latimore, 2018). Studies have also shown that Black student success (or lack of success) in science, technology, engineering, and math related professions is often due to the presence (or lack of) ability to cope with biases, racism, and stereotypes (Fries-Britt, 2017). Perhaps most importantly, patients (the ultimate benefactor of graduate health professions education) are affected by the extent to which clinicians are able to address issues of implicit bias and whether the interactions these clinicians experience with others from diverse groups are sufficient to improve the quality of care they provide. Van Ryn et al. (2015) addressed this in their work exploring how exposure to Black fellow students and/or physicians benefits all students and has the potential to increase their knowledge and comfort interacting with Black patients.

For Black women, issues with voice and representation in graduate health professions education are especially poignant. Following a long history of oppression both inside and outside and of the home, the plight of Black women has been subsumed as secondary to the plight of men and to that of other women (Taylor, 1998). Facing issues such as the “superwoman schema”
(Woods-Giscombe, 2010, p. 1) and an ideology of having to be “twice as good” (Kusimo, 1999, p. 5) to earn the same level of respect, Black women undergo a set of dynamics unique to their lived experience. Particularly in the case of education with such high stakes as the health professions, the voices of Black women, disproportionately impacted by both race and gender, have not been heard (Siple, Hopson, Sobehart, & Turocy, 2015).

**Significance**

While previous studies have examined the intersectionality between career theory and Black feminist theory (Reid, 2009), limited research exists that specifically frames this within the context of health professions. Health professions, in particular, reflect a practical manifestation of what have become, at times, overly popularized conversations surrounding education in Science, Technology, Engineering, and Math (STEM) (Lohr, 2017). This study has the potential to propel the STEM movement beyond buzz words into tangible, explorable, and employable career options for students and their families. Likewise, few if any studies have utilized Ford’s Female Achievement Model for Excellence (F²AME) to link the academic, gender, and cultural pride of Black girls to the success of graduate and professional Black women (Ford, Harris, Byrd, & Walters, 2018). This study spoke to the power and self-confidence of an entire generation of female leaders, so that we might celebrate and encourage the aspirations of students to come.

The results of this work have the potential to impact both research and practice. First, while this study focused on women who have progressed to the graduate level in the health professions, it can inform curricula and programming for middle, high school, and undergraduate students as well. As noted earlier in this chapter, preparation for graduate health professions
education begins long before a student reaches college. Years of academic preparation are necessary in order to adequately compete for one of the few coveted seats available at the graduate level. By identifying how the women in this study first gained exposure to the health professions, measures can be taken to spread this experience to more students. Identifying how to expand these early methods of career exposure can contribute to a greater pool of potential health professions students of color in the future.

In addition to impacting exposure for students, this research can impact professional development for teachers and counselors as well. Currently, students receive career advice, and in particular advice on health professions pathways from a variety of sources (Carroll, Rogers, Schwartz, Stutz & Tsipis, 2017). However, while educators (and current pipeline programs) provide general awareness of medicine as a profession, little funding has been dedicated to informing students about careers in atypical health professions, such as pharmacy or genetic counseling (Health Resources and Services Association [HRSA], 2016). In addition, the structure of career and academic advising is different at all levels. At the college level, a national organization known as the National Association of Advisors for the Health Professions helps to inform undergraduate academic advisors and science instructors about steps and preparation needed to pursue health professions education (National Association of Advisors for the Health Professions [NAAHP], 2018). What does not openly exist, however, is a clear linkage between educators and counselors practicing with students at varying stages of development. Secondary schools often revolve around meeting requirements of the common core with no clear indication of whether these requirements are actually linked to what our students will face when they enter the workforce or graduate/professional school (Vybornova & Dunaeva, 2007). By retracing the
steps of students who matriculated to health professions careers in a variety of specialties, this will provide further insight for educators to pass along this knowledge to their students. Moreover, the historical reflections of these students will inform what types of early interventions and influences were necessary for them to successfully pursue their health profession of choice.

For those involved in graduate school education, administration, and educational policy, the significance of the study extends over a number of domains. Recruitment and admission professionals can utilize this research to better reach students of color earlier in the educational pipeline. Retention practitioners as well as faculty can utilize this study to better support students during their classroom and clinical experiences. For participants who have graduated and entered practice, this study may have peeled back the curtain regarding often unspoken challenges (such as compassion fatigue) experienced by health professionals after they enter field (Jablow, 2017). In the realm of policy, influencers such as clinical licensing organizations, special interest groups, and community organizations have a vested interest in increasing the representation and improving the experiences of these students. Thus, there is the possibility of influencing policy touched by these organizations at the national, state, and local levels. The political importance of this topic has reached prominence amongst those charged with representing Black American interests in Congress as well, as evidenced by the Congressional Black Caucus Foundation’s panel, *The Impact of the Decline of African Americans in the Medical Profession* featured at their 47th annual conference in 2017 (Congressional Black Caucus Foundation [CBCF], 2017; See Appendix A).
Each stage of the study has been further informed by insight into the perspective and context of Black women in these careers. By calling out the unique challenges faced by those experiencing the duality of oppression by race and gender, this brings compassion and insight to help future Black women and girls cope with the challenges they face, or, ideally, prevent these barriers from occurring in the first place. Moreover, exploring the passion behind what propels these women to pursue education so that they may ultimately serve others can influence venues outside of education, particularly as it relates to the ways patients are treated in clinical practice.

**Research Question**

This study focused on the following research question:

What are the experiences of Black women who gain entry to and/or complete graduate education in the health professions?

**Purpose**

The purpose of this study was to explore the experiences of Black women who had gained entry to or completed graduate education in the health professions, to demystify the pursuit of these fields, and to provide freedom of reflection and expression for the study’s participants. Not only can this study inform the work of leaders practicing in graduate health professions education but also those working in K-16, who hold the responsibility of exposing and preparing students to make informed choices at the graduate level.

**Theoretical Framework**

This dissertation found its theoretical foundation in the tenants of Black feminist theory, facilitating a specific focus on experiences in health professions education through the history and resilience of Black women. Drawing upon the work of Patricia Hill Collins (1991) and
others, this study revealed the unique perspective of Black women who chose to pursue graduate education in the health professions, a perspective that cannot be fully articulated by either the experiences of Black men or by those of other women. This research provided space for the participants to critically reflect on their lived experiences, as a woman, as a person of African descent, and as a human being engaged in the emotional and physical rigor of working in a health profession. While acknowledging challenges, this study also celebrated the tremendous value that Black women bring to health professions education, both within the classroom and, ultimately, to the patients they will serve.

After establishing the theoretical foundation, the study expanded through the lens of two theoretical branches: social cognitive career theory (SCCT) and Ford’s Female Achievement Model for Excellence (F²AME) (Lent, Brown, & Hackett, 1994; Ford, Harris, et al., 2018). Lent, Brown, and Hackett’s (1994) social cognitive career theory examined the intersection between interest development, career choice, and performance. By beginning with the approach utilized by Lent and colleagues, the current study investigated what types career modeling the participants had in their early years of development. What factors first influenced their exploration into a health professions field? Were there any environmental barriers they had to overcome to make such a choice? Known as the career development interpretation of Bandura’s (1986) social cognitive theory, Lent et al. (1994) posited that students model what they see and that environmental factors such as “differential opportunities for task and role model exposure; emotional and financial support for engaging in particular activities [etc.]” significantly contributed to career choices for students (Lent, Brown, and Hackett, 2000, p. 40).
The third theoretical lens, completing the branches of this work, was the Ford Female Achievement Model for Excellence (Ford, Harris, et al., 2018). Dr. Donna Ford, author of the model, was, as of 2020, a distinguished professor in the College of Education and Human Ecology at The Ohio State University. Inspired by her own educational experiences as well as by challenging encounters trying to find quality gifted education for her son, Dr. Ford has spent years in scholarly search of ways to properly support Black gifted students (Vanderbilt University, 2018). Her model, abbreviated as F²AME, is one of the few works that specifically speaks to the excellence and needs of Black females. This model, as explained in her co-authored article discussed in Chapter 2, formed part of the tools used to analyze the data collected in Chapter 4 as well as served as a resource for transforming the data into recommendations for action in Chapter 5.

**Research Design and Methodology**

The research design for this study was phenomenological in nature. Specifically, this study aimed to understand and learn from the experience that Black women have with gaining entry to and completing a master’s or doctoral level health professions program. By documenting the narrative of their experience in their own words, this research served justice to the lifetime of sacrifices made by these women and by their circles of support.

While this study was not designed to provide an extensive technical analysis of admissions processes or the detail the clinical requirements for post graduate residencies, it utilized a combination of demographic questionnaires, semi-structured interviews, focus groups, and reflections to gather information and address key timeframes within the journey of a graduate health professions student. After collecting participant background information, key
timeframes were assessed including: the journey to admission to a graduate health professions program, experiences while in the program, and experiences upon graduation from the program. The study also included a self-reflection by the participants as well as the author upon completing the study. Each segment not only examined the structural factors contributing to the participants’ journey but also involved a self-assessment of the impact of race and gender on the participants’ lives.

Participant Selection

The participants in this study were derived from a purposeful sample of graduate health professions students from across the United States. As identified by scholar Patricia Hill Collins:

All African-American women share the common experience of being Black women in a society that denigrates women of African descent . . . [however] the existence of core themes does not mean that African-American women respond to those themes in the same way. Diversity among Black women produce[s] different concrete experiences.

(Collins, 1991, p. 23)

By exploring experiences in varying parts of the country, this celebrates the right of Black women to critically analyze the common core of their existence while acknowledging the effect of context on how and why these experiences unfold.

Limitations

While this study revealed potential impact for both research and practice, it was not without limitations. First, the study did not represent an exhaustive list of participants and thus could not be presumed to represent the opinions of all Black women. Second, given the vast range of options in the health professions and that this was a purposeful sample, it should be
noted that the experience with one health profession does not automatically replicate to another health profession. Finally, the range of perspectives may have been impacted by differences in generation, class, parental background, geographic location, etc. that might further contribute to variation in participant responses.

**Delimitations**

By focusing on Black women in graduate health professions education, the author intentionally focused the study in a number of ways, indicating several delimitations. First, the focus on the study was on health professions careers that required either a master’s or doctoral degree as the minimum degree necessary to enter clinical practice. Examples of professions that require this level of training included physician, pharmacist, dentist, physical therapist, nurse practitioner, physician assistant and so on. This in no way took away from the importance of health professions that did not require this level of training for entry such as practical or registered nurses, emergency medical technicians, medical assistants, etc. Second, as referenced earlier in this chapter, the author, by virtue of her professional experiences maintained a commitment to seeing all students fulfill their academic and career potential. At the same time, the author’s personal experiences grounded her in the ongoing struggle for equity for students of color and for women. Moreover, the author specifically chose to focus her dissertation work on the lived experiences of Black women. This delimitation did not create a divide in the struggle for equity, but instead highlighted the importance of taking time to examine the unique journey of each group therein.
Definition of Key Terms

*Black/African American:* these words are used interchangeably to represent individuals of African descent living in the United States.

*Didactic:* courses taken primarily through classroom instruction.

*DPM:* this is the designation earned by those who have graduated from a Podiatry program.

According to the American Association of Colleges of Podiatric Medicine (2020), a podiatrist is “known also as a podiatric physician or surgeon, qualified by their education and training to diagnose and treat conditions affecting the foot, ankle and related structures of the leg.”

*Graduate Health Professions Education:* education, typically occurring at masters or doctorate level, representing the minimum education necessary to enter a particular health profession.

*MCAT (Medical College Admission Test):* an exam that students must take as one of the requirements to gain entry to many of the medical schools in the United States and in the Caribbean.

*MD (Medical Doctor):* a designation earned by those who have graduated from a school focused on allopathic medicine. Allopathic medicine is defined by the National Cancer Institute (2020) as “a system in which medical doctors . . . treat symptoms and diseases using drugs, radiation, or surgery.”

*PharmD:* this is the abbreviation earned by those who have graduated from a Doctor of Pharmacy program.
Rotations: forms of education performed through hands-on learning, usually in a hospital or other setting involving interaction with patients or licensed healthcare providers.

Organization of Dissertation

This dissertation began by examining the current state of diversity in graduate health professions education and how issues, such as implicit bias, can affect the treatment of patients in clinical practice. This examination is followed by a literature review in Chapter 2 through the lens of Black feminist thought, social cognitive career theory and Donna Ford’s Female Achievement Model for Excellence (Ford, Harris, et al., 2018). This literature review continues with an exploration into the freedom of reflection for Black women and additional factors contributing to Black girls’ selection of healthcare as a career choice. Subsequent to the literature review the research design of the study in Chapter 3 is discussed including participants and techniques for data analysis. Chapter 4 represents the data and findings of the study and Chapter 5 summarizes and analyzes the findings and suggests next steps for further research.
CHAPTER 2

REVIEW OF RELEVANT LITERATURE

Chapter 2 addresses several important considerations in the experiences of Black women in graduate health professions education. First, the chapter begins with an extensive analysis of diversity and inclusion in graduate health professions education, including the complexity surrounding why challenges in this area continue to exist. Next, it identifies and explores the three theories (Black feminist thought, social cognitive career theory, and Ford’s female achievement model for excellence) that comprise the theoretical foundations and associated branches of this work (Ford, Harris, et al., 2018). Finally, the chapter ends by discussing additional elements that must be addressed in order to facilitate the liberation of Black women and girls going forward.

Diversity and Inclusion in Graduate Health Professions Education

Issues with diversity in graduate health professions education run both broad and deep. Given the extensive time and dedication required to complete a clinical professional degree, any substantive analysis of these experiences must acknowledge the historical context as well as the multi-layered approaches being taken to address them. Furthermore, although this dissertation is written in the context of a School of Education, basic concern for health and the human condition requires a serious look at how challenges with diversity in health professions education affect the significant life and death realities faced by patients who are the benefactors of its graduates.

While educators at various levels (secondary, undergraduate, and graduate) may, at times, function in isolated self-consumed circles, the resulting adults who graduate from these systems are human beings who deserve our multi-level, diligent professional collaboration. Issues such as
geographic restrictions, access to proximate role models, and resources one does (or does not) have access to have very real consequences for the adults charged with earning a meaningful wage or, moreover, making a meaningful difference as a working professional. The first part of Chapter 2 explores the often-unrevealed complexity surrounding lack of diversity in graduate health professions education and provides insight on efforts currently being employed to address this.

**Historical Context**

While this study aimed to provide space for students to articulate their personal experiences with gaining entry to and completing health professions education, it is important to identify historically, systemic issues that are the source of barriers to such pursuits. The following section provides a brief historical context of diversity within health professions education as well as background on why representation and voice for Black women in this area is critical, not only within an educational context but also in ensuring equitable and quality patient care.

**The Flexner Report.** The challenges relating to diversity in health professions education date back several decades, experiencing what some feel was a poignant setback with the issuance of the Flexner Report in 1910 (Duffy, 2011). During that year, at the request of the Carnegie Foundation, Abraham Flexner issued a report that led to medical schools being divided into tiers. Schools not meeting the standards of the tier system were closed and those that remained were bestowed with philanthropic gifts to support physician faculty being involved in research and teaching only, with no time devoted to maintaining an independent practice of patient care. This division was labeled as a scientific approach to medicine, with little to no focus on the humanism
and empathy needed to address patient suffering. While there were positive aspects of the report, such as insistence upon adequate medical training facilities and ensuring a standard level of training across schools, critics maintain that the report unfairly disadvantaged minority serving medical schools and setback advances that had been made in the admission of women to the profession. All but two of the seven minority serving medical schools in existence at the time closed, and by 1930, only one medical school devoted to the education of female physicians remained in the United States (Duffy, 2011).

Critics of the model fashioned after the Flexner report continued to voice their concerns, even amidst significant financial backing from the elite to maintain the newly established medical school status quo. Not only did growth of minority and female serving medical schools come to an abrupt halt after 1910, parallel issues such as a lack of empathy for physical pain, thoughtless experimentation by doctors, and an insensitivity to patient ability to pay contributed to a growing distrust of physicians and their ability to equitably treat all members of society (Duffy, 2011). While the Flexner study was focused on medical practice, the report’s effect on diversity reached far beyond medical school (into other health professions) and ultimately led to the passage of significant legislation responding to disparities that the Flexner report, and the surrounding environment, helped to create.

**The Comprehensive Health Manpower Training Act of 1971.** In 1971, Congress passed the *Comprehensive Health Manpower Training Act* of 1971 (known as Public Law, or P.L., 92-157). P.L., 92-157, which included specific language about increasing enrollment of “minority or low-income students” (Kline, 1971, p. 35) and banning sex discrimination in admissions. P.L. 92-157 was one of the most significant pieces of legislation affecting health professions
education since the passage of the Flexner Report in 1910 (Garcia, Nation, & Parker, 2004). Prior to P.L. 92-157, only 3% of medical students nationwide were students of color and most were enrolled in one of two Historically Black Colleges or Universities (HBCUs): Howard University in Washington, DC, and Meharry Medical College in Nashville, Tennessee (Garcia et al., 2004). Following the passage of P.L. 92-157, the call for diversity in health professions education resulted in the establishment of “Offices of Minority Affairs” in medical schools, led by pioneers such as Astrid Mack, PhD, at the University of Miami and to the opening of a third minority serving medical school, the Morehouse School of Medicine, led by Louis W. Sullivan, MD (Morehouse School of Medicine, 2018; University of Miami, 2018). Dr. Sullivan went on to serve as U.S. Secretary of Health and Human Services and to chair the commission responsible for the 2004 seminal work that represents our most recent comprehensive assessment of health professions diversity in the United States, the Sullivan Report.

**The Sullivan Report.** In 2004, the Sullivan Commission on Diversity in the Healthcare Workforce published “Missing Persons: Minorities in the Health Professions.” This work represented an urgent call to bring diversity of the health professions on par with the increasing diversity of the country. At the time of its publication, African Americans, Hispanic Americans, and American Indians comprised almost 25% of the nation’s population, however collectively they made up less than six percent of physicians, five percent of dentists, and nine percent of nurses (Sullivan Commission, 2004). Per the Sullivan Commission, “the lack of minority health professionals is compounding the nation’s persistent racial and ethnic health disparities” (p. i). These disparities could not be more prevalent than in the Black community, and, in particular, within the context of Black women.
Examining the Effect of Diversity and Inclusion

Issues surrounding diversity and inclusion in a health professions educational setting can have long-term effects on both students and patients. Students who experience a lack of support or inability to locate a trusted academic or emotional outlet may face a delay in reaching their goals (Rainey, 2001). Insufficient interaction with fellow students or faculty of color may decrease clinicians’ future ability to treat diverse patients. The ripple effect of these issues is complex and will be discussed in further detail in the sections below.

Effect on graduate student retention. Accreditation standards in graduate health professions programs hold retention of students in extremely high regard. Perhaps this is due to the “stakes” under which health professions students are being trained. This high level of accountability for retention starts at the point of admission where health professions schools, such as schools of pharmacy, are required to uphold “admission criteria, policies, and procedures [which] are not compromised regardless of the size or quality of the applicant pool” (Accreditation Council for Pharmacy Education [ACPE], 2016, p. 11). Partially due to the fact that health professions schools train individuals who will quite literally hold the vitality or fatality of the general population in their hands, standards for progression and “early detection of academic and behavioral issues” are directly tied to a school being allowed to remain open or (at a minimum) continue to operate without a probationary or other adverse accreditation status (ACPE, 2016, p. 12).

According to Rainey (2001), health professions schools have a fiduciary duty to only graduate clinicians who are competent in their field. Likewise, health professions schools have a duty to only admit students they feel can graduate. Even with this underlying obligation,
However, underrepresented minority medical students are three times more likely to experience a delay in progressing to graduation (Rainey, 2001). In his study, Rainey (2001) contended that the underlying reasons for academic struggle or graduation delay within medical school programs are vastly underreported. He suggested that improvements should be made in at least five areas of the medical school experience including: Admissions, Faculty, Curriculum, Remedial Strategies, and Support Services. Similar to what we see in the F²AME model, factors not directly measured by grades such as having a vision, goal (or future) orientation, and sense of cultural and psychological belonging are all important in retaining underrepresented minority health students (Tucker, 1999). Moreover, concrete tools for educators, such as helping students realize their most effective learning strategies to structuring faculty reward strategies around effective teaching should be considered when working towards most effectively supporting minority students in their educational pursuits (Rainey, 2001).

**Effect on health equity.** According to a 2016 article by Belgrave and Abrams, “African American women fare worse than women in other racial/ethnic groups” across nearly every health indicator (p. 723). From experiencing more severe effects of lupus to increased morbidity from obesity and cervical cancer to a higher rate of adverse birth outcomes, the need to improve the health and care of Black women could not be more urgent (Belgrave & Abrams, 2016; Moncrieffe & Tillery, 2015). While biological or inherited factors may account for the prevalence of some conditions, this by no means explains the unbalanced extent of Black women’s suffering relative to their counterparts from other groups. When translating disparities in healthcare to the health professions classroom, some may ask, how does diversity in the classroom ultimately affect equitable treatment in practice? As alluded to in Chapter 1, there
were several references in the literature connecting diversity in health professions education to
the quality of care received by underrepresented groups. For the purposes of this review, I will
focus on three of these areas: 1) reducing implicit bias, 2) increasing trust, and 3) encouraging
cultural humility.

**Defining and decreasing implicit bias.** Van Ryn et al. (2015) defined implicit bias as
“automatic and unconscious negative attitudes towards African Americans as compared to
Whites” (p. 1748). While this definition is specific to African Americans, the harm of implicit
bias has certainly been found to affect other oppressed groups (Blair et al., 2013). While those
working in healthcare typically oppose explicit bias as being “at odds” with their call to serve,
“healthcare providers, like other members of society, may not recognize manifestations of
prejudice in their own behavior” (Institute of Medicine [IOM], 2003, p. 162). These
manifestations could be subtle, such as refusing to look a patient in the eye, or hidden, such as
assuming that Black patients are less intelligent than their White counterparts (IOM, 2003; van
Ryn & Burke, 2000). While additional research is needed to establish the degree to which
implicit bias directly affects patient outcomes, “minority patients are less likely than Whites to
receive the same quality of healthcare, even when they have similar insurance or . . . ability to
pay . . . [and, tragically] . . . this healthcare gap is linked with higher death rates among
minorities” (National Academies of Science, Engineering, and Medicine, 2002, p. 2).

Given the power that healthcare providers have in the type of treatment their patients receive,
finding ways to avoid these subliminal influences is critical. In their article, van Ryn et al. (2015)
identified three main factors that can change cognitive habits of aspiring physicians: 1) formal
curricula, 2) informal curricula, and 3) favorable interracial contact. Formal curricula refers to
what is specifically taught in the curriculum such as exercises that address caring for Black patients or discussions/assignments involving cultural humility with these patients. Informal curricula is described as “hidden” or suggested messages in the types of assignments that are provided in class (van Ryn et. al, 2015, p. 1749). Examples of hidden curricula include faculty or supervising clinicians making negative remarks about Black patients or weak efforts on the part of the health professions school to meaningfully address racial climate within the program (p. 1752).

Perhaps the most telling evidence of the need for an increase of Black women in the health professions is the concept of interracial contact. Interracial contact refers to the type of interactions one has with those from another ethnic group. In their study of 3,547 medical students, van Ryn et. al (2015) found that “students who reported having had highly favorable contact with African American faculty had decreased racial bias, while those who reported unfavorable contact had increased racial bias” (p. 1754). While these results primarily focused on faculty, there is a need for increased studies regarding the interactions with Black medical students, especially given the low percentage of medical students who identify as students of color. The very presence of Black women in the classrooms of health professions schools can contribute to positive interaction amongst their peers, thus expanding the numbers of aspiring physicians who have a foundation for increased empathy for future patients they will serve.

While significantly understudied, issues of implicit bias extend to the ways in which clinicians and trainees are treated by patients and supervisors as well. A recent study in the New England Journal of Medicine documented that 16.6% of surgical residents surveyed experienced discrimination based on race and 65.1% of the female residents surveyed reported discrimination
based on gender (Hu et al., 2019). Patients were found to be the number one source of gender and racial discrimination. Verbal abuse from attending surgeons was also a frequent concern and sadly, 4.5% of residents recalled having suicidal thoughts within the last year. Furthermore, as explained by Steele (2010) in reference to discrimination’s physiological effects, those who reported such occurrences were more likely to suffer from symptoms of burnout. Above all, women were the most likely to report these symptoms.

**Increasing trust.** Historical events have long documented a distrust by African Americans in the healthcare system and, due to a number of reasons, this phenomenon continues to exist. A 2003 study published in Public Health Reports showed that “African Americans were less likely to report trust in their physicians than their White counterparts” (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003, p. 363). Consistent with the findings of Peek et al. (2013), healthcare providers can increase trust by demonstrating medical skills and knowledge and by improved interpersonal communication. Both of these factors have a higher likelihood of occurring if individuals have had favorable interactions with other Blacks in a variety of settings, including the classroom (van Ryn et al., 2015).

Since illnesses such as lupus, morbid obesity, and cervical cancer disproportionately affect women of African descent, it is reasonable to posit that members of this group have a higher likelihood of having personal or familial experience with such diseases. As referenced in Chapter 1, members of my own family have encountered difficulty with insufficient treatment by clinicians who lacked familiarity with diseases predominantly affecting women of color. While any treatment plan is made with a degree of uncertainty, “when faced with patients who are from different racial or ethnic backgrounds, doctors may find that their uncertainty about the patient’s
condition and best course of treatment is even greater” (National Academies of Science, Engineering, and Medicine, 2002, p. 3). In their study of the behaviors that Black women wanted to see in their providers, Black female participants in Dale, Polivka, Chaudry, and Simmonds (2011) stated a desire for clinicians to lean in, explain/involve them in what they were doing, and speak to them with respect. Women in the study commented that they could tell when a provider was comfortable versus uncomfortable with them (as a Black woman) and that this comfort affected their assessment of the provider’s willingness and/or capacity to adequately treat their condition. In addition to body language and respect, participants specifically expressed a desire to be listened to and for the provider to be responsive, positive, and thorough in his or her patient/provider exchange.

**Encouraging cultural humility.** Cultural humility is also critically important for increasing health equity, yet there is still significant work to be done to effectively situate cultural humility in the context of clinical practice (Davis & Hook, 2013). Broadly, cultural humility represents being open and humble to the beliefs and values of others (Hook, Davis, Owen, Worthington, & Utsey, 2013). Demonstrating cultural humility means maintaining an interpersonal exchange that is other-oriented (rather than self-oriented) and a respect for others reflected in a lack of superiority (Davis & Hook, 2013). In their study, Davis and Hook (2013) recommended the following in regard to therapists’ interactions with clients:

[Therapists should] not assume that they understand the client’s cultural background or experience based on therapists’ prior knowledge, experience, or training . . . This attitude of humility may be especially important to the development of a strong working alliance with a client who is culturally different. Furthermore, engaging a culturally diverse client
with an interpersonal stance of humility may attenuate the tendency for therapists to overvalue their own perspectives and worldviews, instead of joining with the client to explore the client’s perspective and worldview. (p. 361)

In the context of health professions education Loue, Wilson-Delfosse, and Limbach (2015) suggested that increasing opportunities for medical students to self-reflect could not only contribute to student awareness but also to their comfort in working with diverse patients. Even when students perceive themselves as culturally competent, the reality may reflect that students actually view others with a closed approach (Isaacson, 2014). Cultural humility calls for clinicians to be attentive when listening to others and possess sufficient humility to self-critique the effectiveness of their interactions with those different than themselves (Isaacson, 2014).

**Current Efforts towards Increased Diversity in the Health Professions**

After the historical chain of events from the Flexner Report of 1910, to the Comprehensive Health Manpower Training Act of 1971, to the Sullivan Report of 2004, recognition of the need to increase diversity in the health professions is growing. However, even with efforts dating back to 1910, the deficiency in diversity in health professions education in the United States still exists. Part of the divide, in terms of whether students are prepared with the requisite exposure and accompanying academic preparation for health careers, historically has been due to the separation of programming at the federal level between what is offered by the Department of Health and Human Services or private health related funders versus what is offered through the Department of Education. The following section describes a brief history of programming available under each of these entities as well as the limitations of each.
U.S. Department of Health and Human Services and private health related funders.

The Department of Health and Human Services (HHS) is responsible for “protect[ing] the health and well-being of all Americans” and is the starting point for governance of practicing healthcare clinicians (U.S. Department of Health and Human Services [HHS], 2018). In keeping with its mission to be inclusive in its service to all Americans, HHS has long offered programming aimed towards diversifying the socioeconomic demographics of the healthcare workforce. Even with great intentions, however, Area Health Education Centers (AHEC) formed in 1971 and other grants awarded by the Health Resources and Services Association (HRSA) dating back to 1982, have been unsuccessful in reaching all students (Area Health Education Centers [AHEC], 2018a; HRSA, 2018). According to their website, 15% of the counties in the United States do not have an AHEC center despite its mission to “improve the supply and distribution of healthcare professionals” in rural, frontier, suburban, and urban areas (AHEC, 2018a, 2018b). In addition, much of the language relating to AHEC focuses on operations housed at medical, or in some cases nursing schools, with generalized references to allied health schools and no prominent emphasis on other health professions requiring graduate preparation such as physical therapy, occupational therapy, genetic counseling, etc. (AHEC, 2018b).

To fill gaps not satisfied by HHS, private funders such as Robert Wood Johnson created programs like the Summer Health Professions Education Program (SHPREP) which, since 1989, has provided funding devoted to summer experiences for college students to gain exposure to health professions (Summer Health Professions Education Program [SHPREP], 2018). As in the case with AHEC, SHPREP primarily focused on medicine for the first 17 years of its existence, expanding to dentistry in 2006 and to other health professions in 2016 (SHPREP, 2018).
Recognizing this deficiency, private advocacy organizations such as the American Association of Colleges of Pharmacy and the American Pharmacists Association began their own efforts, housed in graduate schools focused on other health disciplines, to try to spread awareness campaigns to professions beyond the practice of medicine (Pharmacy is Right for Me, 2018).

At their core, grants and/or programs of this nature housed in colleges/schools of medicine, nursing, dentistry, pharmacy, etc. have the capacity to provide a specified set of students with experiences facilitated by practicing health professionals and/or administrators housed within these schools. Given that they are administered by entities that are intimately connected with clinical practice, they are very much tied in to the realities of the types of clinical roles that exist within each discipline and the types of training, interviewing skills, admission competitiveness, etc. that are needed to be successful in a clinical setting and/or within a health professions school. While these programs most likely provide the most accurate and setting-specific guidance for students seeking a health professions career, they have fallen short in a) failing to meaningfully expose students to a wide range of health professions careers and b) failing to reach a broad spectrum of students.

Students in HHS related programs must have geographic accessibility to the graduate school or independent organization offering such programs, or they must happen to be affiliated with a faculty or community member who chooses to apply for funding for such programs. For students unlucky enough to be incidentally separated from these resources, they are essentially left out of these opportunities for exposure. While effective for some students, the Department of Health and Human Services only has limited access to the vast majority of school-aged children, with the primary department having access to these students being the Department of Education.
U.S. Department of Education. Within the U.S. Department of Education, secondary education is housed under the Deputy Secretary of Education while Career and Technical Education and Postsecondary Education are both housed under the Under Secretary (U.S. Department of Education [DOE], 2018). As a result, the divisions that set guidelines for middle and high school education are in a completely separate division from those that set guidelines for career focused and higher education. Thus, in addition to being separated from the practitioners who actually execute health professions practice, separation even within the DOE itself could affect the lack of consistency in the amount and quality of student exposure to career-relevant content related to these professions.

The need to link educational pursuits to career has garnered significant attention recently in the United States with the passage of the Workforce Innovation and Opportunity Act (WIOA) under President Obama in 2014. This program was designed to provide:

cross-system alignment; education and training that is focused on the needs of high-demand industry sectors and occupations . . . and the establishment of Career Pathways systems that make it easier for all Americans to attain the skills and credentials needed for family-supporting jobs and careers. (U.S. Department of Education, Office of Career, Technical, and Adult Education [OCTAE], 2018, p. 1)

The passage of such an act demonstrates that lawmakers are beginning to recognize the need to connect career agencies such as HHS to educational agencies like DOE. These connections are necessary to accurately determine the preparation and exposure needed for students to earn a sustainable and enjoyable living in their informed career of choice.
As with any top-down administrative effort, bridging the divide between educational preparation and career will take time. Currently, much of the secondary education workforce is staffed with teachers who (while dedicated) have not spent significant time in a health professions setting and thus are not equipped to offer concrete guidance on the tangible steps to translate grandiose concepts of a career in medicine to the realities of the various specialties and specific types of training involved. In addition, with the regional tie-in to employers, Career Pathways programs may be more centralized in areas (or schools) that have the most proximity to economic growth and closer relationships with these programs. For example, of the three high schools established to focus on science, technology, engineering, and math in one school district in Southern California, two are attached to already established universities, and one is situated close to one of the most affluent areas of town (Long Beach Unified School District [LBUSD], 2018). While some school choice policies technically allow students from across the district to apply for these schools, economic realities, particularly as it relates to transportation or other responsibilities closer to home, leaves exposure for students in some of the more economically disadvantaged areas solely at the benevolence of select teachers who choose to go above and beyond to provide access to this information for their students (Godwin, Leland, Baxter, & Southworth, 2006).

**Effect of school choice, magnet schools, and geographic accessibility on exposure to health professions career programming.** School choice and magnet programs. For urban areas with more than one high school and for whom “choice” (or at least choice within one hundred miles) exists, conversations on ways to level the playing field for all students have led to findings on both sides of the debate. Following the end of forced desegregation in some school districts,
school choice, including public school choice, has been the focus of much of the recent momentum related to school reform (Beal & Hendry, 2012; Gamoran & An, 2015). As it relates to health professions education, allowing parents the choice of where their child will attend school could provide access to higher quality programming, particularly as it relates to exposure to health professions related content. Indeed, schools with “enhanced option[s],” such as reduced class sizes, an extended school year, tutoring, and other services have been found to have improved math scores for economically disadvantaged students while enrolled in the better resourced school (Gamoran & An, 2015, p. 45). Unfortunately, however, disparities based on race have been found to persist, even with some degree of choice in a student’s enrolled school. In their 2006 study of Charlotte-Mecklenburg Schools, Godwin, Leland, Baxter, and Southworth found that “Anglo students were more likely to receive their first choice of schools and to improve their scores. African American students were less likely to receive their first choice school and their scores declined” (p. 983). Findings such as these tend to support the idea that efforts to improve educational outcomes, and by default, access to academically challenging careers have failed to reach all students.

**Rural schools.** The lack of access to career-focused or, in some cases, highly resourced schools is especially poignant in rural southern communities, where a sizable portion of the African American population in the United States resides. The tendency to omit rural communities, and in particular the minorities in those communities, from mainstream discussions on diversity may be due to the centralization of power and media structures concentrated in urban environments. Those who have not lived in rural communities may rest their opinions of (or concerns for) those environments at the doorstep of Whites who gain the national spotlight
for choosing to be oppressive in these communities (Romney, 2018). This trend to ignore rural areas leads to limited active sympathy or advocacy for people of color living in the very midst of those conditions. In reality, these courageous champions of social justice, living amongst circumstances they are fighting to change, often receive little or no recognition in the national spotlight (Hauslohner & Guskin, 2017). To this day, my native part of the country, for example, is made up of both those who celebrate statues of confederate hate as well as those, such as leaders throughout my family and community, who are true heroes, daring to fight circumstances from within that many only read about in distant history books. Unfortunately, this oversight of rural communities extends to the exposure to programs that address STEM and health related careers (Mader, 2014).

In the 2016 study by Means, Clayton, Conzelmann, Baynes, and Umbach about college aspirations of rural Blacks, the authors expanded upon the notion of differences in educational and economic barriers between rural and non-rural students. Their qualitative study of rural Blacks supported Adelman’s (2002) assertion that “high school graduates from rural areas/small towns . . . are at the greatest disadvantage in terms of opportunity to learn” (p. 57). Given the restricted resources and geographic distance from alternatives in rural communities, the limited web of information provided by counselors, teachers, and peers can lead to limitations that are disproportionately intense (Means, Clayton, Conzelmann, Baynes, & Umbach, 2016). While African American communities have a long legacy of supporting the children in their communities (Berkel et al., 2009), often due to lack of exposure themselves, parents in these circumstances push and encourage their children without providing a road map of what alternatives for success might actually look like (Means et al., 2016).
Graduate health professions schools. Addressing challenges of implementing sustainable diversity programming. Even for those graduate health professions schools that do determine, at least at some level, that a formal diversity and inclusion effort is necessary, the challenges facing programs to implement these initiatives can be tremendous. In their 2009 article, Nkansah, Youmanas, Agness, & Assemi noted that:

Colleges and schools of pharmacy tend to focus on building diversity through recruitment, admissions, and hiring, without giving due diligence to the efforts required to maintain diversity. Admissions and search committees may make organized efforts to seek out highly-qualified students and faculty and staff members from diverse backgrounds, yet allocate fewer resources to support individuals by fostering an organizational culture that embraces and nurtures diversity. (p. 5)

In other words, schools work hard to recruit diverse students to their institution but do not make meaningful efforts to incorporate the students’ culture into the environment in which they were recruited. The environment remains the same and the students are the ones asked to change and “blend” into their new environment.

Challenges of forced assimilation exist at the very core of science-related education and can vary dependent on the culture and makeup of the institution. Young and Ramirez (2017) exposed the phenomenon in STEM education in which an overemphasis on the sterility of science promotes a belief that culture is irrelevant in these environments. This “culture of no culture” (p. 90) harkens back to the mindset underlying the Flexner report and subsequent insensitive treatment of patients mentioned in Chapter 1 (Duffy, 2011). While students and faculty who have previously been exposed to a heterogeneous (versus homogeneous)
environment might more easily adapt to diversity efforts, addressing issues of climate continues
to be an ongoing struggle for organizations (Nkansah et al., 2009). Moreover, historical
reflections on cultural competency in healthcare have focused on deficits within the minority
culture (non-adherence to medication, eating habits, etc.) with little emphasis on the inequity that
is created by the practitioners themselves (Young & Ramirez, 2017). In their survey of faculty at
a private health professions school in the northeast, Young and Ramirez (2017) found that 40%
of faculty did not formally incorporate cultural competency training into the courses they taught.
This could be due to the sentiment by many faculty who felt ill equipped to teach cultural
competency subject matter, despite strong support school-wide for the need for such training in
developing effective practitioners. It is also important to note that the vast majority of the faculty
surveyed did not identify as a person of color, potentially compounding the lack of comfort with
such topics.

**Stereotype threat.** Lack of comfort or familiarity with differing cultures can also
contribute to inaccurate and unfair assumptions about others. Particularly in such an
academically rigorous educational environment that has historically been reserved for an elite
few, health profession students of color often face what Ackerman-Barger, Valderama-Wallace,
Latimore, and Drake (2016) and others characterized as stereotype threat. Through this form of
bias, fellow students and faculty function under the belief that “people of color are not as smart”
and “students of color don’t belong in health professions” (p. 1240). In their study of graduate
health professions students at a large public university, a Black female focus group participant
was quoted as saying “I was reminded that it’s not normal for a student of color to be a medical
student and that I, maybe, don’t belong in medicine” (p. 1240). The pressure of defying this
stereotype and navigating the underlying scrutiny that comes with it can be tremendous. One Black female participant in the study summed it up as follows:

   In addition to learning all the medical terminology and anatomy, students of color have to learn an added on component of how to conduct yourself in this very different culture than you [have been used to] and that component appears to be weighted, a lot more sometimes, than the actual medical terminology and anatomy. (p. 1241)

   **Further analysis of stereotype threat.** Stereotype threat has been shown to have intense effects, particularly on otherwise high achieving students. In 2010, social psychologist Claude Steele reported upon a culmination of his life’s work of research on this topic. In his book, *Whistling Vivaldi* (2010), Steele discussed the effect that the pressure to disprove stereotypes can have on a number of domains, including but not limited to academic performance and physical health. Over the course of several studies, Steele and his research colleagues conducted a number of empirical tests to determine how students responded to pressure to disprove stereotypes versus other test groups for whom no such pressure was applied. Consistently, studies demonstrated that the pressure to disprove stereotypes weakened academic performance. Not only has stereotype threat been shown to affect “strong, motivated Black students,” this pressure physiologically amounts to an additional weight or task that those without such pressure do not endure (p. 49).

   Perhaps particularly relevant to the context of this study, negative “cues and the threat they [cause] can impair performance and even make a person less interested in a career path” (Steele, 2010, p. 145). For the fortunate few who push past this form of imposter syndrome to gain entry to a health professions program, students can find themselves repeating the same cycle upon matriculation through less than inclusive curriculum. As noted by Nkansah et al. (2009)
and Ackerman-Barger (2010), health professions schools have not paid sufficient attention to the efforts needed to sustain diversity, including ensuring that the various aspects of the student experience (curricula, teaching strategies, etc.) are inclusive of the needs and concerns of diverse students. The following section will look deeper into why these various components are important and provide examples of cases where health professions schools are holistically addressing inclusion of all students.

**Moving past recruitment—holistically addressing the diverse student experience.**

Although there is still much work to be done, various efforts are being made to insert depth and meaning into health professions diversity and inclusion efforts. One such effort has been initiated through the University of New Mexico Dream Makers Health Careers Program where students are encouraged to understand the depth and richness they bring to patients, their communities, and to the health professions classroom (Warshaw, 2016). The need to reframe the narrative in one’s own head is especially poignant for Black women. Many Blacks can identify with being told they have to be “twice as good as Whites” just to get half of the respect (Kusimo, 1999, p. 5). For Black women, this is frequently part of the “superwoman schema” that causes them to be self-reliant to a fault, potentially contributing to health issues later in life (Woods-Giscombe, 2010, p.1). More information on the superwoman schema will be addressed in latter sections of this chapter.

Further, some health professions schools have tackled the difficult conversion of weaving cultural awareness into the actual courses that are taught within a program. Using a grant from HHS, Carroll University in Waukesha, Wisconsin integrated cultural competency into the entire first year of their two-year Physician Assistant Master’s program (Beck, Scheel, De Oliveira, &
Hopp, 2014). Known as the didactic year, students participated in four courses specifically focused on cultural awareness training. Researchers found that repeated conversations about the intersection of culture and healthcare, improving communication skills, and self-analysis had a positive impact on the cultural awareness of students. Through use of a survey, students were able to assess their own cultural/ethnic heritage and how this influenced their way of thinking. As referenced earlier regarding bias that is sometimes unintentional, this awareness could be the critical first step in reducing inappropriate clinical actions based on preconceived thoughts or beliefs.

Nkansah et al. (2009) provided several suggestions for ensuring that diversity efforts do not stall at the theoretical stage. First, given most clinicians’ core motivation to improve patient welfare, Nkansah and colleagues suggested linking cultural competency efforts to decreasing healthcare disparities. Second, while an overemphasis on legal requirements dehumanizes diversity efforts as a legal nuisance, a basic knowledge of these laws is important in order to know how to achieve diversity within them. That being said, Ackerman-Barger (2010) emphasized that healthcare providers should be “motivated to become culturally aware because they want to, not because they have to” (p. 3). Furthermore, moving diversity beyond the theoretical stage requires addressing the “true underlying problems” contributing to bias, versus relying upon punitive mandates to spur sustainable change (Ackerman-Barger, 2010, p. 4).

School leadership can also set the tone in emphasizing the importance of diversity efforts and resources can be maximized by partnering with diversity efforts in the university as a whole. Additional suggestions include designating an officer or committee to focus on diversity efforts, linking participation in diversity efforts to performance evaluations, and seeking support from
national affinity groups such as the National Black Pharmaceutical Association or National Medical Association (Nkansah et al., 2009).

Ensuring diversity and inclusion throughout each stage of a student’s experience in a graduate health professions program requires acceptance that the overall organization may have to undergo change. Bridges (2009) distinguished between various stages of organizational change, noting that some things may need to be done immediately, whereas others may take more time. First, he suggested that the organization recognize what behaviors will need to change. In the case of diversity climate, this may be accomplished through focus groups with impartial (outside) facilitators to identify what has been happening in class. This could also be done through surveys (also administered by impartial parties). As a second wave of implementation Bridges (2009) suggested sending team members to organizations that are modeling the desired behavior. For diversity, this could mean sending faculty and/or students to observe class(es) similar to those conducted in the Carroll University study.

As an additional tier of incorporating change, Bridges (2009) suggested that organizations identify which individuals will have to let go of what they’ve traditionally been used to. In the context of health professions education, this could include faculty and/or student affairs professionals whose sense of competence is based on systems designed around dominant cultures. While some who invest in diversity work might frown upon giving voice to those who themselves, are the perpetrators of exclusiveness, Bridges (2009) posited that in order for the entire organization to move forward, all voices should be allowed to be heard. This may mean open forum/safe space discussions about all issues, including those that make those from the previously dominant culture feel uneasy or resistant to change. Not that this resistance should be
allowed to prevent progress but at least this type of open dialogue provides the option for those in previous positions of dominance to listen to clear calls for humanity from oppressed groups. Those clinicians and health professions students who truly subscribe to caring for all in their professional creed will choose to remain engaged, others will eventually and hopefully get off the “organizational ship” once they see the new direction in which it is sailing.

This acknowledgement of the natural tendency for change to be a process, rather than instantaneous perhaps speaks to the reasons why the intervention in Beck, Scheel, De Oliveira, and Hopp (2014) at Carroll University worked. Cultural competence was interwoven through a series of four classes, rather than reduced to content quickly covered in one session or through informal, incidental mechanisms. To substantiate change, Bridges (2009) suggested that leaders are responsible for providing direction and information in several ways, on several occasions. For example, if an organization operates by key pillars that include diversity and inclusion, these pillars should be repeated over and over again, in as many settings as possible.


Theoretical Foundation: Black Feminist Thought (BFT)

This dissertation rested on the issue that the voices of Black women, particularly in higher education and in the context of graduate health professions education, have not been heard. Before taking action on how to change this from a programmatic and curricular standpoint, it is important to provide specific insight on how Black women’s voices have been silenced in various spaces, both in the midst of other women and in interactions with Black men. The theory that most directly tackles this issue was penned by author Patricia Hill Collins (1991) and is known as Black feminist thought.
**Definition: Black feminist thought.** Black feminist thought recognizes the right of Black women to uniquely define and express their own voice. In her seminal 1991 book *Black Feminist Thought*, Patricia Hill Collins spoke of the tendency for groups or individuals to feel that they can speak for Black women, that actual insistence upon reserving space for Black women to speak for themselves is an unnecessary inconvenience. For the purposes of this dissertation, Black feminist thought is not used as a basis to attack or downgrade other sexes or races, but instead to amplify struggles that the world chooses to keep silent. When defining what uniquely carves out the epistemology that is Black feminist thought, Collins delineated between each section of the phrase—“Black” and “feminist” when describing historical oppression, ironically found within movements of other oppressed groups.

**Black feminist thought and the civil rights movement.** When describing the emergence of Black feminist thought within the civil rights movement, Collins (1991) addressed institutions at the core of the foundation of the civil rights movement, namely the Black church and the Black family. Echoing back to leaders such as Martin Luther King, Jr., and Malcolm X, much of the fuel and numbers contributing to the civil rights movement were based in religious organizations at the heart of the Black community. It was in these sacred spaces that Blacks, particularly in the 1960s, could gather and freely express their thought and outrage regarding conditions they experienced the remainder of the week. The need for unity (and the appearance of unity) in these spaces, and in the civil rights movement was so strong that most within it agreed that any utterance of trouble within would give the oppressor the necessary fuel he needed to defeat them. Thus, any trouble, especially as it related to relationships between Black men and Black women was kept silent.
This regard for Black women to “be seen, not heard” in the presence of Black men continues even today. Grant (1982) referred to women as the “backbone of the church” but pointed out that this really meant “location rather than function” (p. 87). Black women, although pivotal behind the scenes in Black churches are often expected to stay in the background and remain there. “These same institutions [are] locations where Black women learn to subordinate [their] interests as women to the allegedly greater good of the larger African-American community” (Collins, 1991, p. 86).

Within the Black family, in some cases the silencing was even more severe. Black women experience the duality of being assaulted in public spaces for their race and in private spaces by their husbands and fathers for speaking out of turn related to their gender. Hidden partly because of the deep love and concern that Black women have for Black men, these “behind closed doors” encounters are often not exposed to the outside world. When referencing the work of Jo-Ellen Ashbury (1987), Collins (1991) highlighted how the juxtaposition of the economic realities of Black families, and in particular public disrespect shown to Black men, can lead to the redirection of anger onto Black women. “Black men who wish to become ‘master’ and who are blocked from doing so can become dangerous to those closest to them” (Collins, 1991, p. 186). Moreover, [the] “conspiracy of silence about Black men’s physical and emotional abuse of Black women is part of a larger system of legitimized, routinized violence. Because of its every-day nature, some women do not perceive of themselves or those around them as victims” (Collins, 1991, p. 187).

Black feminist thought speaks truth to power in regard to the internal silence that pervaded an extremely outward facing movement. One way in which the oppressor oppresses
marginalized groups is to make them feel as though they have to be perfect, and that any flaw substantiates his oppression against them. Other groups, on the other hand, are allowed to be human, to experience ups and downs that are inherent in any truthful reflection on human life. Because of this, silencing, and in some cases abuse, within the Black community have often never been talked about (Collins, 1991).

**Black feminist thought and the feminist movement.** Dating back to the Seneca Falls Convention of 1848, the feminist movement has long championed equal rights for women compared to those of men. These rights extend to areas of employment and more recently to environments free of harassment, with the “Me Too Movement.” While important, there was a simultaneous counter-narrative taking place within the feminist movement as it relates to differences in interpretation of the movement between Black women and those of other races and in reference to silencing of Black women within the movement. Some have maintained that, for the most part, much of the feminist movement was centered on the needs of White women, rather than being inclusive of women of color (Taylor, 1998).

Much of the differences in interpretation of the movement were due to economic conditions facing Black families that were different than those facing White families. For Black women, the feminist movement was never about the right to work. Due to economic necessity, (and employment discrimination against Black men) Black women have always had to work (Collins, 1991). Moreover, the choice to be exclusively a wife and a mother, due to economic realities, even for those who are married or otherwise in a committed relationship, has consistently evaded the options available for many Black women (Collins, 1991). The inconsistencies in definition of the feminist movement extended to actions taken (similar to those
within the civil rights movement) to hide the efforts of Black women. During the 1921 National Women’s Party Convention, Black delegates complained over being disenfranchised due to Alice Paul’s concern that people would not support a march that included Negro women (Taylor, 1998). It must be stated, however, that these sentiments do not extend to all women, as evidenced by movements such as “Me Too” which have seen thousands of women, from all races, stand together in opposition of sexist oppression.

The unique identifier of Black feminist thought as it relates to the feminist movement has to do with the choice by some women to validate sexist, patriarchal, or chauvinist oppression by turning a blind eye to the struggles of other women. In her 1984 work, Audre Lorde addressed the issue of women who “face the pitfall of being seduced into joining the oppressor under the pretense of sharing power . . . there is a wider range of pretended choices and rewards for identifying with patriarchal power and its tool” (pp. 117-118). This sometimes blatant choice to side with the oppressor can be seen in the recent vote of politicians such as Susan Collins who supported U.S. Supreme Court nominee Brent Kavanaugh, even in the face of repeated accusations of his assault on a number of (in this case) White women.

Relevance of the historical oppression of Black women to graduate education in the health professions. Understanding the layers of oppression that Black women experience is critically relevant to providing support for Black female students. Part of the power of these distinctions being included in Black feminist thought is that it helps to illuminate the complexity of circumstances with which Black female students enter the classroom. Untold stories of abuse and oppression, for example, could partially explain parallel incidences of unreported depression in the Black community. Participants in a study of health, relationships, and emotions of Black
women reported “complex personal trauma histories filled with multiple forms of violent experiences” which “acknowledged the large, long-lasting impact of violence on their lives, self-image, choices, and behaviors” (Nicolaidis et al., 2010, p. 1471). Additionally, those who experience childhood emotional abuse may suffer from feelings of hopelessness as an adult and thus find it difficult to confide in or seek help, even when they most need it (Lamis, Wilson, Shahane & Kaslow, 2014).

Perhaps due to the “strong black woman” and related syndromes, the support needs of Black women continue to go largely unrecognized on college campuses (Glenn, 2018). The effect of the differing financial pressures that Black women face as compared to those from the dominant group also cannot be overstated. As Frances Beale (1970) stated in her pivotal piece Double Jeopardy, “Black women were never afforded . . . such phony luxuries” as having a financial landing place. Beale contended that the exclusive choice (or responsibility) of wife and mother is a “bourgeois white model” (p. 113). Moreover, at the time of Beale’s article, Black women were the lowest paid of all workers, behind both Black men and White women. Given this, and with the tremendous financial and opportunity costs of completing graduate health professions education, the unequal “stakes” and “risk” of Black women as compared to Whites must be considered when evaluating the multi-layered pressures these students bring to the table.

**Multiple Perspectives within the Black Female Experience**

Just as it is important to encourage Black women to uniquely articulate their own voice, it is also important to acknowledge and explore multiple perspectives within the Black female experience. The next section will explore the work of two authors who, while they did not coin the term “Black feminist thought,” nonetheless articulated specific revelations relative to the
Black female experience. The work of these two authors, bell hooks (1981) and Kimberle Crenshaw (1989), will be further explored through manifestations of their work, namely Black feminism and intersectionality.

**Black Feminism**

In 1981, Gloria Watkins, known by her pen name as bell hooks, published *Ain’t I a Woman*, a book echoing the title of Sojourner Truth’s speech from the Women’s Rights Convention of 1851. Similar to the sentiments reflected upon earlier from Collins (1991), hooks (1981) criticized the relative omission of Black women’s voices from the feminist movement. As an added analysis, however, hooks pointed out the resulting lack of acknowledgement (even on the part of Black women) of the sexist elements of their oppressive existence. Highlighting this point, she maintained:

> Our silence was not merely a reaction against white women liberationists or a gesture of solidarity with Black male patriarchs. It was the silence of the oppressed—that profound silence engendered by resignation and acceptance of one’s lot. . . . We did not see ‘womanhood’ as an important aspect of our identity. Racist, sexist socialization had conditioned us to devalue our femaleness and to regard race as the only relevant label of identification. In other words, we were asked to deny a part of ourselves—and we did. (p. 1)

In articulating Black women’s right to be fully included in the feminist movement, hooks pointed out that many efforts, ranging from women’s studies classes, books, and other publications that were said to reflect the female experience, in reality primarily reflected the
experience of the dominant race of females. When articulating the need for all men, including
Black men, to champion feminism, preferably inclusive feminism, hooks (1981) noted:

Our struggle against racial imperialism should have taught us that wherever there exists a
master/slave relationship, an oppressed/oppressor relationship, violence, mutiny, and
hatred will [prevail]. There can be no freedom for Black men as long as they advocate
subjugation of Black women. There can be no freedom for patriarchal men of all races as
long as they advocate subjugation of women. (p. 117)

While the importance of uplifting the rights of women is important, for women of color,
feminism only describes one aspect of their lived experience and of the oppression, unfortunately
associated with this identity. Crenshaw (1989) examined the intersecting aspects of concern to
women of color, and the limiting effect of refusal to view these women through the various
identities through which they exist.

**Intersectionality**

In 1989, attorney Kimberle Crenshaw published “Demarginalizing the Intersection of
Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and
Antiracist Politics.” In this work, she explained that Black women do not exist in the “single-axis
framework” upon which American society seems to insist (p. 139). To promote one’s experience
as either defined by race or by gender is to essentially erase the existence of women of color
(Crenshaw, 1991). Since many of the civil rights and related laws are typically based on one or
the other (race or gender), these laws and other protections do not address the full “manner in
which Black women are subordinated” (Crenshaw, 1989, p. 140). Moreover, the experiences of
Black women cannot be adequately addressed by “simply including Black women within an
already established analytical structure” (p. 140). This lack of acknowledgement of the intersecting forms of oppression that Black women (and other minorities with multiple identities) face is so pervasive that case law has failed to support dual claims of both sex and race discrimination endured by these individuals.

Not only did Crenshaw (1989) coin the term “intersectionality,” she echoed much of what has been reflected upon by hooks (1981) in Black women’s perceived acceptance of their singular right to focus on racist oppression alone. She shared the details of a personal experience during her first year of law school when she and two Black male students attempted to attend an exclusive alumni meeting at their prestigious primarily White institution. Upon receiving initial resistance attempting to enter through the front door of the meeting, their “training as Black people” taught them to expect that their race would be the basis of their exclusion (Crenshaw, 1989, p. 161). In this particular case, however, it was she and she alone who was asked to enter the establishment through the back door (because she was a woman) while her two Black male colleagues were allowed to walk right through the front entrance. Deciding not to make a scene in a situation where she and her colleagues would ultimately be the first Blacks ever to enter the meeting, she obliged and entered through the back door. Upon reflection, however, she later realized how this demonstrated “the ambivalence among Black women about the degree of political and social capital that ought to be expended toward challenging gender barriers, particularly when the challenges might conflict with the antiracism agenda” (p. 161).

In addition to amplifying Black female voices, these and other reflections are important in encompassing the multi-dimensional spectrum of the Black female experience. They also provide a fitting precursor to the examination of the next level of theories relative to the aims of
this study. Namely, the next section will explore theories that provide tools to take action to change, and preferably improve, the Black female student experience.

**Theories Informing Programmatic and Curricular Change**

Now that the importance of illuminating the voices of Black women has been established, we must transition to addressing specific facets of educational practice that can be better informed by understanding the access, perseverance, and reflections on these women’s experiences. In order to address these factors, I examined two theories (social cognitive career theory and Ford’s (2018) female achievement model for excellence) which serve as tools for scholars interested in providing a roadmap for future students and for the educators dedicated to supporting their success (Lent et al., 1994; Ford, Harris, et al., 2018).

**SCCT—Social Cognitive Career Theory**

As the first theory contributing to the branches of this work, social cognitive career theory (SCCT) is based upon the examination of three dimensions affecting the careers that individuals ultimately pursue in life: interest, choice, and performance. As will be further expanded upon in the following sections, interest assesses factors that initially plant the seed for a career pursuit, choice examines the various circumstances that lead one to take substantive efforts to pursue a particular career and performance determines, in many cases, whether or not an individual is able to achieve significant enough milestones to support the belief that long-term pursuit of a particular career is feasible. To further understand each dimension, we begin with an analysis of each below.

**Interest.** How do students develop interest in a career in the first place? Is an initial spark enough to cement a dedicated interest in a career or does legitimate interest in a career come
from repeated exposure to that career over several years of an adolescent’s life? Lent et al. (1994) posited that career interest is developed through “repeated activity engagement, modeling and feedback from important others” (p. 89). If this is the case, how do students of color who often lack proximal health professionals in their life gain access to these careers?

As noted by Wang (2013), few studies have been conducted to ascertain how students first become interested in STEM disciplines and, moreover, what factors influence their entrance into such fields. Zebrak, Le, Bradley, & Wang (2013) found that having adult role models who specifically nurtured an interest in science was needed in order for students to have meaningful interest in the field. Consequently, many pipeline programs, while well intended, cater to those who already desire or have expressed interest in STEM without proactively seeking out those who may not have had similar factors available to influence their interest. This model of expecting students to have an awareness of what they don’t know to even ask about causes a repetitive cycle of historically oppressed groups being underrepresented in health-related fields. Comprehensively, these variables underscore the need for intentional, early, and consistent career exposure interventions as critical to impacting the career trajectory of underrepresented groups (Caroll et al., 2017).

In 2018, Fernandez-Repollet, Locatis, De Jesus-Monge, Maisiak, and Liu published a study assessing the effect of internship and follow-up mentoring programs on students’ familiarity with health professions careers. While some of the students came to the internship with a basic knowledge of various health professions, the summer internship and subsequent mentoring over a nine-month period helped to solidify students’ knowledge of such careers. Instead of having only tangential knowledge of the health professions, student surveys conducted
both after the internship and after the follow-up mentoring programs indicated students had a more “substantial knowledge of varied health careers” as a result of the internship/mentoring intervention (Fernandez-Repollet, Locatis, De Jesus-Monge, Maisiak, & Liu, 2018, p. 3). In addition, essays written after the experience indicated a deeper understanding of the challenges and expectations of health professions careers such as “varied or long hours, teamwork, and the need for communication skills” (p. 3).

As noted previously, one or minimal instances of exposure to a health profession are usually not enough to serve as a meaningful catalyst to identifying career interest. In their study of 93 university/community college students and seven high school students, Collins and Carr (2018) found that the majority of the students surveyed did not wish to pursue occupational or physical therapy as a career, even after having a patient encounter with an occupational or physical therapist. This may be due to these encounters occurring later in their development and/or to the encounter being brief, and not as a repeated influence in their lives. Alternatively, Collins and Carr (2018) found that nursing remained a popular career identified by students from underrepresented groups. The popularity of nursing may be due to the significant corporate financial resources invested to market the nursing profession. In 2002, the Johnson and Johnson Corporation partnered with nursing organizations to launch a $20 million dollar campaign to address the shortage of nursing services in hospital and long-term care settings (Medscape, 2002). While the success of this campaign is to be applauded, an unintended consequence is that for students whose exposure to health professions careers is limited to what is available in popularized media, nursing is often the only health profession they have reasonable familiarity with and thus, the only one that they put significant effort into pursuing. As a result, many
students of color find themselves competing for the few coveted spots in registered nursing programs, which have seen significant degrees of impaction since the launch of the Johnson and Johnson campaign (Donelan, 2005).

Without intentional interventions or repeated exposure to alternative influences, students begin to “crystalize” their likes and interests solely based off of what they happen to see around them (Lent, et al., 1994, p. 89). Once these interests have been developed, it becomes very difficult to change to another career path, particularly when changing to a different path means financial investment of money or time that many students of color do not have the luxury to give. When faced with the uncertainty of pursuing a path that they are not familiar with, students of color may fall back on careers that seem more within reach such as business or teaching or that appear to provide a clearer path to money or autonomy that has been otherwise lacking in their communities (Collins & Carr, 2018; Lent et al., 1994). “It may take very compelling experiences to provoke a fundamental reappraisal of career self-efficacy . . . and hence, a change in basic interest patterns” (Lent et al., 1994, p. 89). While these changes may occur, it is usually only after financial or life situations force the issue, such as in the case of a layoff, change in family circumstances, or accident that prohibits an individual from continuing in their former line of work.

Choice. Lent et al. (1994) defined career choice as the actions one takes to bring their interests into reality. That being said, the authors delineated between “choice intentions” (the major or career that a student intends to pursue) and choice “behaviors” (the actions a student actually takes when given the ability to choose a major, choose shadowing experiences, etc.) (Lent et al., 1994, p. 94). A student may have a number of intentions (for example to major in
architecture), but due to contextual situations (struggling in an introductory physics class, concern over job security in the architecture field, etc.) that student may actually choose to major in something completely different (such as accounting) due to a stronger sense of self-efficacy (confidence in ability to successfully complete the material) or a need to securely identify a field that will provide economic self-sufficiency as soon as possible. While researchers explained that “choices do not represent static acts . . . [and] once implemented, choices [can] be modified,” the ability to substantially change one’s major midstream, and thus, potentially stay in college longer than four years is, in itself, an act of privilege (Lent et al., 1994, p. 94). Due to time limitations caused by scholarship restraints, working one’s way through school, and the alternative of a potentially threatening environment at home, the ability to bob and weave through college is a chance that students from disadvantaged backgrounds do not have the privilege to take.

While studies specific to Blacks, and in particular to Black women have been limited, those that do exist suggest that cultural traditions may partially explain historic trends in vocational choice (Weathers, Thompson, Robert & Rodriguez, 1994). In their 2012 study of 124 African American students, Walker and Tracey (2012) found that African American students placed a higher value on occupations that were realistic, contributed to social welfare, were entrepreneurial, or traditional. This may be due to a familiarity with these occupations based on others within the African American community occupying such professions, either by choice or by those being the only professions historically available to them (Terrell, Terrell, & Miller, 1993). “African Americans might perceive more social and enterprising related occupations as more [important] because they have strong cultural and communal commitments to members of their community and [thus] might choose occupations that are beneficial to the community”
This could be due to direct knowledge or experience with racial discrimination fueling a need to help others in their community succeed (Walker & Tracey, 2012).

The tendency to choose career paths assumed to provide opportunity for the African American community is laudable but also demonstrates a lack of knowledge of the types of careers that exist within science-related professions. For example, several roles within health professions education revolve around championing social causes, such as health professions admissions roles as well as those in diversity. Particularly in medical schools, these roles tend to be held by those who possess both the clinical training (MD license, etc.) and the socioeconomic empathy to reach out to and advocate for those who have been traditionally marginalized.

Moreover, while a need to give back to the community has been found by some as driving career choice, other studies have found the desire to balance career and family and a need for self-fulfillment as equally important for Black women (Weathers et al., 1994). As noted in Chapter 1, this supports the sentiment of Patricia Hill Collins (1991) that Black women can share aspects of racial identity while simultaneously offering a diverse interpretation on how to achieve happiness, fulfillment, and purpose within this identity.

**Performance.** Lent et al. (1994) maintained that performance included both accomplishments and persistence. Within this, several issues affect the extent to which these factors are maximized, such as self-confidence, high performance goals, and the ability to master sets of skills leading to an overall goal (Lent et al., 1994). Lent and colleagues postulated that students with high self-confidence will have the wherewithal to set incremental goals to help accomplish their mission. They asserted that those with high goals have a greater chance at
higher level achievement than those who set low goals in the first place. Moreover, with complex, time-intensive goals, a series of building blocks must be established and accomplished in order to reach the final goal. In the case of STEM, Lent et al. (1994) provided the example that “students [must] possess effective study, mathematical reasoning, and computational skills” in order to ensure success in college level math (pp. 99-100). One can ascertain then, how those who miss any of these building blocks along the way could experience layers of being behind in critical skills needed to advance to a health professions career.

In addition to setting general performance goals, Lent et al. (1994) expanded upon the power of seeing others who are similar to oneself succeed (or fail and recover) in a certain activity. Educators can intervene in these circumstances by providing role models who are realistic, approachable, and transparent in the challenges they have experienced (Lin-Siegler, Ahn, Chen, Fang, & Luna-Lucero, 2016). In their study of female college students in introductory psychology and chemistry courses, Herrmann, Adelman, Bodford, Graudejus, and Kwan (2016) found that even inexpensive interventions (such as a letter from a graduate student who experienced similar struggles) made a difference in the performance of students. This letter, written by a female who normalized feelings of poor performance and not belonging, assured the students that their time and energy spent in school would pay off.

In addition to providing role models, addressing the root of the problem in an academic area may assist in persevering through a particular road bump, rather than allowing a setback to pervade overall assessment of one’s ability. Herrmann et al. (2016) identified two types of interventions that may help isolate and address root causes of an academic problem. These interventions, including attribution and belonging, can be defined as paradigm shifts to help
students think critically or in some cases reframe what they are experiencing. Researchers posited that attribution interventions or those that “attribute poor performance to unstable factors (i.e. study strategy)” produced better outcomes than interventions focused on ability or other stable factors (p. 260). Likewise, belonging interventions are also preferred in that they “normalize feelings of not belonging and emphasize that [these] feelings are temporary” (Herrmann, Adelman, Bodford, Graudejus, & Kwan, 2016, p. 260). Challenging health science related courses may seem intimidating at first but the promising possibility of adjusting to the material can ultimately create a sense of belonging for students.

F2AME—The Ford Female Achievement Model for Excellence

Beyond general performance in STEM related fields, additional pressures or feelings of isolation may impair the success of women. Being a woman in the midst of a male-centered environment has led some to refer to these environments as “chilly” or “unwelcoming” (Young & Ramirez, 2017, p. 90; Herrmann et al., 2016, p. 259). As noted in Hall and Sandler’s (1982) landmark piece, “women’s educational experiences may differ considerably from those of men, even when they attend the same institutions [and] share the same classrooms” (pp. 3-4). Behaviors such as ignoring female students or pervasive acceptance of sexist remarks, may leave some female students questioning whether persevering amidst such circumstances is worth it. Ultimately, the atmosphere of the institution can either promote or impede the comprehensive development of women, particularly if they are perceived “primarily as sexual beings” rather than for the intellectual characteristics they bring to the table (Hall & Sandler, 1982, p.4).

Even for the most talented or gifted women, microaggressions still find their way into their everyday experiences. Actions such as being forthcoming about aspirational goals may be
judged differently when spoken by a man versus by a woman. It may be seen as normal for men to have high aspirations but women have been judged as “unfeminine” or “too ambitious” to proclaim the same goals (Hall & Sandler, 1982, p. 6). Unfortunately, women may internalize this negative narrative causing them to limit their growth or be unwilling to explore unconventional paths not clearly evident in their immediate surroundings. This problem becomes exponentially larger for Black women and girls. Ford, Harris, Byrd, and Walters (2018) revealed that “females are often treated as a homogeneous group—gender is rarely disaggregated by race, which misrepresents how females who are Black experience schooling” (p. 258). Due to this homogeneous grouping, insufficient time has been spent in the literature examining how to support the performance of Black girls who run the risk of experiencing this isolation in two respects, by both race and gender.

To begin to break this cycle, scholar Donna Ford created the F²AME—the Ford Female Achievement Model for Excellence (Ford, Harris, et al., 2018). This model encourages the nurturing of Black females by increasing their awareness of four dimensions of their development: 1) psychological, 2) socio-emotional, 3) academic, and 4) cultural. The F²AME model builds upon the criteria outlined for Black males by Whiting (2009) and will be further expanded upon in the sections below.

**F²AME—Psychological dimension.** Ford asserts that supporting the psychological dimension of Black females means tapping into their resilience, self-efficacy, intrinsic motivation, goal orientation, racial and gender pride (Ford, Harris, et al., 2018). Other scholars corroborate these elements. In their *Culturally Responsive Equity-Based Bill of Rights*, authors Ford, Dicksen, Davis, Scott, and Grantham (2018) asserted that gifted students of color have a
right to “counselors who understand and promote racial identity development,” . . . “who understand the unique challenges of being a gifted student of color,” and “who understand the relationship between racial identity and achievement” (p. 5). These aspects address the importance of racial pride as a psychological need for Black females to be successful. By expanding upon Whiting’s (2009) model for Black boys, Ford illuminated features that are also be needed to support Black girls including self-efficacy (belief in one’s self and abilities); goal orientation (staying focused and prioritizing education), and intrinsic motivation (having a strong internal locus of control and ability to put aside aspects of social life when needed to achieve one’s goals).

**F2AME—Academic dimension.** The key components of Ford, Harris, et al. (2018)’s academic dimension of success range from work ethic, identity, and independence to a flexible and adaptive learning style. Academic self-confidence, another key element in this area, encourages students not to be ashamed of their abilities. Whiting (2009) concurred with these assertions. He wrote that gifted students of color “do not see any reason to negate, deny, or minimize their academic abilities” (p. 56). Perhaps this is because they feel prepared having spent “time doing schoolwork, studying, and pushing themselves” (Whiting, 2009, p. 56).

**F2AME—Socio-emotional dimension.** The socio-emotional dimension of Ford’s model posits a willingness to make sacrifices, a sense of independence, and a sense of self-sufficiency. While not directly stated in the F2AME model, Ford, Harris, et al.’s (2018) Bill of Rights also stated that gifted students have “the right to be taught how to self-advocate” (p.5). This insistence on equitable and culturally responsive classrooms is echoed in Ford, Harris, et al.’s
(2018) Blacked Out Whited Out article which called for a critical analysis of all courses “to ensure gender, ethnic, and racial parity” (p. 264).

F²AME—Cultural dimension. The cultural dimension of Ford’s model addressed not only the cultural pride of Black women themselves but also the necessity of an open and active interest in learning about the cultures of others. For Black women to be successful they must also be bicultural, in some respects bilingual, and display and demand cultural competence in themselves and in others. Ford, Dickson, et al. (2018) advocated that this level of competence extends to all facets of education stating that the “norms, traditions, and culture of communities of color” must be respected when planning and executing school and community events (p. 6).

Even if the reality of race-gender oppression did not exist, it still would take an exceptional degree of dedication and skill to successfully ascend to and complete a graduate health professions program. In the midst of the ongoing fight for social justice, for Black women, the instantaneous eradication of the double-jeopardy of their oppression, unfortunately is not on the immediate horizon. Given this, the F²AME model uniquely supports Black women through challenges unique to their experience and helps them find strength in the greatness that is already within them.

Facilitating Freedom of Reflection for Black Women

In the preface to the second edition of Black Feminist Thought, Collins (2000) acknowledged the following about the power of reflection for Black women:

When an individual Black woman’s consciousness concerning how she understands her everyday life undergoes change, she can become empowered. Such consciousness may stimulate her to embark on a path of personal freedom, even if it exists initially primarily
in her own mind. If she is lucky enough to meet others who are undergoing similar journeys, she and they can change the world around them. (p. xi)

In addition to increasing knowledge about the experiences of Black women, part of the goal of this study was to provide a sense of support and affirmation for those who graciously gave of their time to participate in the study. Therefore, in addition to a historical reflection on their journey to and through a health professions program, this study also provided space for the women to reflect upon the habits, patterns, and challenges with which they navigated, often times while simultaneously projecting a sense of accomplishment (and in some cases an appearance of perfection) to the outside world. Few areas speak so thoroughly to the pressure Black women feel as does a phenomenon referred to as the superwoman schema.

Superwoman Schema

Just as a paucity of literature exists on Black women’s experiences in health professions education, a similar lack of published academic efforts have been devoted to the study of the negative side effects of the intersecting influences many Black women find themselves living through. Referred to as the “superwoman schema,” this phenomenon describes the reality created by “the sociopolitical context of African American women’s lives, specifically the climate of racism, race-and gender-based oppression, disenfranchisement, and limited resources--during and after legalized slavery in the United States-- [that has] forced African American women to take on the roles of mother, nurturer, and breadwinner out of economic and social necessity” (Woods-Giscombe, 2010, p. 2). This simultaneous asset and fragility allows Black women to be a source of strength catapulting the Black race, or (at a minimum) her own academic and
professional efforts forward. However, this inability to be anything but be strong also can lead to isolation and other stress-related conditions (Woods-Giscombe, 2010).

In her focus groups with 48 African American women in a city in the southeastern United States, Woods-Giscombe (2010) identified five themes underlying these women’s feelings of having to function as a superwoman: obligation to suppress emotions, obligation to manifest strength, resistance to being vulnerable or dependent, obligation to help others, and determination to succeed despite limited resources. The next section explains the factors identified in Woods-Giscombe’s study in more detail.

**Obligation to suppress emotions.** Especially in professional environments (like graduate education in the health professions), Black women feel there is an expectation to be super performers and that even if they wanted to express what they were going through, there were so few around them who could understand or identify with their lens and its attributable feelings therein.

**Obligation to manifest strength.** Perhaps because of the struggles of African American women before them or because [in some cases] entire families were depending on them, the women felt obligated to project strength even in the face of internal fears. Some of the women in Woods-Giscombe’s (2010) study remarked that projecting strength was so core to the experience of being a Black woman that they didn’t know how to do anything different.

**Resistance to being vulnerable or dependent.** This resulted from a defense-mechanism used to avoid being hurt and, at times, due to a general mistrust in the motives of other people. Other women reported that they had been so used to doing things by themselves for so long that it was difficult for them to ask for help.
Obligation to help others. The Black women in Woods-Giscombe’s (2010) study felt a unanimous responsibility to help take care of others in the community. The community could mean direct relatives or others in their church or community-based life. In particular, “single women in the 25–45 years age group believed that because they didn’t have spouses and families, others expected them to have more time, and they uncomfortably found themselves delegated to more roles and responsibilities” (Woods-Giscombe, 2010, p. 9). On a positive note, some in this same group found that taking care of others gave them a “sense of purpose, . . . [helped them] feel valued,” and created a sense of normalcy in their life (Woods-Giscombe, 2010, p. 9).

Determination to succeed despite limited resources. Excerpts from Woods-Giscombe’s (2010) focus group with these women best describe this theme:

Participants discussed that they routinely worked late, neglected taking breaks, sacrificed sleep, and put their health in danger to reach their goals. There was a sense of having to work harder than others to reach their goals . . . .One expressed that the only way to be successful is to work hard constantly. . . . Some women were the first in their family to attain certain educational and professional achievements and, as a result, expressed that they could not rely on their family members to provide the extra boost of resources that other, more privileged, individuals might have. Some made statements such as, “My family expects me to do more than I have time to do,” and expressed that these expectations were burdensome. (Woods-Giscombe, 2010, p. 8-9)

Each of these themes was taken into consideration in the context of the focus groups described in Appendix D of this work. The final themes, lack of financial resources and
differences based on social class, also contributed to the content of interviews and will be examined further in the final section of chapter two, in its relation to the restrictions they place on choices for Black girls in their choice of career.

**Additional Factors Influencing Black Girls’ Pursuit of Healthcare as a Career Choice**

**Economic Factors**

In his 2013 book *Race Frameworks*, Zeus Leonardo addressed the cross section of capitalism and race. Capitalism as a concept, also includes access to capital as well as the degree to which students are able to satisfy their basic needs (food, clothing shelter, etc.) An examination of one’s ability to enter the health professions is incomplete without taking into account the empowering influence of financial capital. When it comes to the significant investment one undertakes to pursue a health profession, scarcely enough emphasis is put on the “risk” involved in forgoing fulfillment of basic needs (working to provide for oneself or one’s family, etc.) in order to take the time (full-time) to pursue pharmacy, medicine, or many of the other health professions tracks. Particularly for those with economically disadvantaged circumstances, any risky decision brings with it the stark reality of lacking a financial buffer where failure could mean potential homelessness or having to return to a life that is counterproductive, abusive, negative, or worse. Omitting the effect of the dominant culture’s control of wealth and property on the degree of freedom its members feel to make educational and career decisions is naive at best. Any efforts to expose students of color to opportunities in the sciences and health professions should be accompanied (at least in part) by the funds to pursue these opportunities. Equipping someone with relevant knowledge but leaving them in a
desert of financial oppression is continuing the setup of unfair layers of struggle as
students/professionals progress through what is supposed to reflect a humanitarian career.

Thomas Shapiro further addressed this in his 2017 book *Toxic Inequality*. He asserted
that the lack of exposure to health professions careers is further complicated by a lack of access
to capital experienced by many African American families. Lack of access to financial capital
affects self-confidence and risk taking, both of which are required to pursue graduate level health
professions education (Shapiro, 2017).

Social Class

Any examination of individuals who have successfully risen to the ranks of preparing to enter a career such as medicine, pharmacy, and dentistry would be incomplete without examining the existence of social class within the Black community. When speculating about the source behind findings from the interviews conducted as part of this dissertation, it is true that at least some of the women in the sample had parents or close family members who were also employed in a field sometimes associated with the upper class (such as a doctor, lawyer, scientist, etc.). Membership in this circle of influencers brings with it a share of discourse and expectations that others within the Black community may not have access to.

Referred to by some as the Black upper-middle class, few scholarly works have been written about this sometimes hidden sector of society. Bound together by member-only organizations such as Jack and Jill of America, Inc. and traditions such as debutante balls and cotillions, women in this group, often comprised of doctors, lawyers, or those married into such professions, have historically gathered together due to exclusion from similar White “members only circles.” For example, Jack and Jill of America, Inc. was founded as a means of “furthering
an inherent and natural desire . . . to bestow upon our children all the opportunities possible for a
normal and graceful approach to a beautiful adulthood” (Jack and Jill of America, Inc. [JAJA
Inc.], 2018). The existence of such organizations has been seen by some as creating division
within the Black community and by others as a valuable tool for exposing the children of its
members to a broader scope of opportunities and for maintaining a sense of African American
culture while living within White communities (Edwards, 2001; JAJA Inc., 2018; Wells, 2016.).
Regardless of where one falls in the Black class debate, the existence of such social circles adds
to the complexity of the fabric of the Black community and to the diversity of experiences of the
women studied in this dissertation (Gatewood, 1988).

As I conclude Chapter 2 and transition into Chapter 3, each of the historical, theoretical,
and practical considerations found in the literature impact the way I approached the research
design and methodology of this work. In addition, the protocols referenced in Chapter 3 and the
interview guides referenced in the Appendices are linked to the underlying research question
guiding the structure of this dissertation. More specifically, Chapter 3 outlines the steps that were
taken to gather the data that will be reported on in Chapter 4 and later analyzed in Chapter 5.
CHAPTER 3

RESEARCH DESIGN AND METHOD

Introduction

Chapter 3 outlines the research design of this project. Specifically, this chapter defines why I chose this particular research question, including its philosophical approach. Next, the chapter explores the meaning of qualitative research, and why this approach is best suited to answer my specific research question. The subsequent section focuses on the design of the study—how participants were selected and recruited as well as what types of interactions were undertaken in order to gather information. Following this, the setting is described and data collection techniques are discussed. Finally, the chapter concludes with how the data was analyzed and further information on both the limitations of the study and on my positionality as the researcher.

Research Question

The primary research question for this study was as follows:

What are the experiences of Black women who gain entry to or complete graduate education in the health professions?

This research question took a phenomenological approach. Merriam (2009) noted that “the task of a phenomenologist . . . is to depict the essence or basic structure of experience” (p. 25). Not only did this research question seek to identify what the experiences of these women were but also to listen to how these experiences had affected them. Given that this study focused on individuals from a group that is doubly marginalized, these effects were often multi-layered and in some cases unseen to the outside world. From a structural perspective, this question
sought to critically examine how these women successfully gained access to health professions education and persevered through each of its challenges. Moreover, it aimed to uncover lessons that can be learned from the coping mechanisms they developed and the “greater purpose” that their strength has served.

Rationale for Qualitative Approach

Bogdan, Biklen, and Jha (2016) argued that “qualitative methods assume that everyone has a story to tell” (p. xiii). Given that this study focused on the experiences of Black women, a group who have historically been silenced by both men and by other women, it seemed fitting then, to focus on a modality that had as its premise vocalizing the concerns of a disenfranchised group. The goal of research of a qualitative nature is to move beyond the surface, to “investigate topics in all their complexity” (Bogdan, Biklen, & Jha, 2016, p. 2). Several issues were found to be central to the lived experiences of the women in this study, noting that not one factor fully explains why their lives have unfolded in the manner that they have.

Because this study focused on understanding and transforming experiences in a setting that was both educational and health-related in context, qualitative methods were perhaps especially appropriate given that “education, health, [and related professions] . . . are considered applied social sciences” ultimately geared towards improving the condition of people’s everyday lives (Merriam, 2009, p. 1). Moreover, particularly for those who are not privy to the inner workings and lingo of a health professions environment, “qualitative research demands that the world be examined with the assumption that nothing is trivial” (Bogdan et al., 2016, p. 8). In my experience in health professions education, there is a plethora of terminology that is “taken for granted . . . oblivious to the details of our environment and the assumptions under which we
operate” (Bogdan et al., 2016, p. 8). By unveiling the sometimes unknown world of the health professions, the rich details revealed through a qualitative method provided access to a landscape often out of reach to marginalized groups in our society.

**Research Design**

**Sampling Methodology**

Participants selected for the study were chosen utilizing purposeful sampling. Generally, purposeful sampling aims to go deep, rather than broad. Participants in purposeful samples are typically selected because the complexity and power of their stories are infused with information from which we can learn a great deal (Patton, 2002). The goal of this study was to explore the journeys of eight women who were selected based on the following criteria:

- Be between the ages of 18 and 64 years old,
- Identify as a Black or African American woman (see discussion of Black/African American identity in Chapter 1), and
- Have successfully gained entry to or completed a graduate health professions program in the United States.

As has been defined earlier, a graduate health professions program is one for which a masters or doctoral degree is currently the minimum requirement for entry into the field. Example professions include physician, nurse practitioner, pharmacist, physical therapist, physician assistant, and so on.

In choosing to engage individuals who had successfully gained entry to a graduate health professions program, it was important to acknowledge the competitive nature of entry into health professions programs, and that gaining entry in and of itself could have been interpreted as a
form of privilege. Numerous structures, such as discouraging admission officers and college counselors or standardized tests unfairly structured in relation to minority groups, might have contributed to numerous students not gaining entry into their school or profession of choice. The purpose of this study however, was to hear the testimony of those who did make it, in the hopes that one day “making it” in the context of health professions education will no longer be a rare phenomenon. True, were exceptional qualities about each of these women that propelled them to the status they had obtained; however, there were also support systems, transferable information, and other resources that intervened in order to make this success a reality. This study identified these co-existing elements of resilience and support in order to provide a roadmap, or at a minimum, a source of inspiration and solidarity for others going forward.

**Participant Recruitment and Selection**

Prospective participants were initially contacted through email. The email contained the purpose of the study, description of what would be expected of them of as a participant, and potential benefits of participating in the study. The email also provided a PDF informed consent form and a link to a separate questionnaire requesting general demographic information. Those agreeing to participate in the study were asked to return the form via scanned or electronically signed PDF. Ultimately eight women signed and returned the informed consent form and agreed to participate in the study. The names of the participants are reflected as pseudonyms to protect their confidentiality.

**Methodology**

This study was conducted in four sections. The first section collected background information about the participants, the second and third sections addressed a period of time in the
participants’ lives and the final section allowed for reflection on what engaging in the study meant to them and to me, as the researcher. In addition to serving a specific purpose, each section was conducted utilizing a custom interface methodology. A brief outline of the methods that were taken to execute this study can be found below, followed by expanded information on each of the study’s major sections.

1) **Background Information**—An initial email was sent to potential participants describing the study and requesting that they complete a brief demographic questionnaire.
   a) Based on returning the demographic questionnaire, participants were selected for the study and emailed the informed consent form.

2) **Journey to admission**—After the signed informed consent form was obtained, the first significant information gathering segment (the one-on-one interviews) was performed. This segment examined the participants’ journey to admission to their graduate health professions program.

3) **Experiences within a health professions program**—This segment allowed for cross-reflection between participants and thus was conducted via focus group.

4) **Reflections on participation in the study**—The final segment included two parts:
   a) A reflective questionnaire for each participant—these are summarized in Chapter 4 and
   b) Field notes that served as reflections from me, as the researcher, chronicling my reactions while conducting the study—these are summarized in Chapter 5.
All interview questions, focus group questions, and questionnaires were reviewed by multiple audiences to test for clarity.

**Section 1—Background Information.** As noted in both Chapters 1 and 2 of this work, differences in resources, geographic location, social class, etc., had the potential to meaningfully contribute to the lived experiences of the women in this study. For this reason, it was important to collect general demographic information from the participants as the first form of interaction in the study. Characteristics such as whether the participant had a health professional in her family, location of upbringing, situational location of secondary schooling (rural, urban, etc.) as well as other factors were gathered within this section.

**Interface methodology—Questionnaire.** Ponto (2015) pointed out several factors that should be considered when designing questionnaires as part of research. Given that questionnaires administered in qualitative studies are either open ended in nature or are administered for the brief collection of background information, considerations such as the order in which questions are presented, appealing graphic design, and ensuring items are clearly arranged can contribute to participants’ successful understanding of the questions that are asked (Dillman, Smyth, & Christian, 2014). Each of these factors was considered in the brief background questionnaire that participants were asked to complete for consideration of involvement in the study. A list of questions that were featured can be found in Appendix B.

**Section 2—Journey to admission to a graduate health professions program.** Structurally, this segment of the study examined what career influences participants had in their lives and at what point they encountered these influences. Some students have health professions practitioners in their families which make considerations regarding this career a natural part of
their vocabulary. Others are exposed through summer preparatory programs or by a teacher or counselor who encouraged their interest or ability in math or science. During this segment, participants also had the opportunity to reflect on academic challenges they overcame and what they did to overcome those challenges.

From the cognitive perspective, this section provided for open reflection on the background influences impacting these women, not directly related to career pursuits. To what degree did life challenges based on their race or gender impact their ability to freely and fervently pursue their goal of entry into a health professions program? Were there any negative environmental influences that they had to overcome in order to stay focused on their goal? Did any personal or familial challenges provide the motivation to pursue the profession they chose? A list of questions used to guide the discussion can be found in Appendix C.

**Interface methodology—semi-structured interviews.** The interface methodology used in this section was semi-structured interviews. Each participant who agreed to the study was asked to participate in a semi-structured phone interview arranged at a mutually convenient time. Semi-structured interviews are those in which the research begins with a general outline of the questions to be asked with the flow or order of each individual conversation unfolding organically. This flexibility increases comfort and rapport between the interviewee and interviewer, enabling the areas of concern most important to each individual to be emphasized. Contrary to strictly structured interviews which require rigid adherence to “predetermined questions,” semi-structured interviews encourage respondents to articulate their own definitions of a phenomenon, using this as a building block for developing an understanding of the meaning that unfolds thereafter (Merriam, 2009, p. 90). The one-on-one interviews lasted one to one and a
half hours each. A list of questions that was used as a guide for the semi-structured interviews can be found in Appendix C. Additional follow-up questions were also included and are labeled as exploration questions (Siedman, 2006).

Section 3—Current experiences in a health professions program or as a graduate of a health professions program. The second segment of the study examined the experiences that the students encountered while enrolled in the program. What were the sources of support that they obtained either within or outside of the formal program that contributed to their success? Did they feel they had “voice” within their health professions program and was their presence and perspective valued?

For participants who had graduated (or were nearing graduation) from their health professions program, this segment allowed for self-reflection on the students’ choice. Did the profession end up being what they thought it would be? Were they able to address issues such as inequity in care, particularly for women of color? What had they learned from their journey that they felt was important to share with future prospective students? What new challenges were they facing? Did they characterize any challenges as having been due to their status as a female or as a person of African descent?

Interface methodology—focus group. For this section of the study, participants were asked to participate in a virtual focus group. As part of the invitation email for the study, participants were provided information on the benefits and anticipated time requirements of each method. Ultimately, two focus groups were held (one with four participants and one with three participants). In total seven women participated in the focus groups.

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Focus groups. Focus groups, or group interviews, as they are sometimes called, are a way of gathering information that allows participants to learn from each other’s experiences and share ideas with one another (Bogdan et al., 2014). Patton (2002) explained that focus groups provide the opportunity for individuals to “consider their own views in the context of the views of others” (p. 386). In an effort to provide a time that might work for many, participants were offered the choice of multiple focus group session days/times. Other factors, such as stressing the need for confidentiality, building rapport between participants, and encouraging differing points of view were fundamental to the environment of the focus group (Bogdan et al., 2014). Towards this end, each of the participants was asked to sign a confidentiality form in order to participate in the focus group. Focus groups were conducted using GoToMeeting® online conferencing software by LogMeIn Inc. A list of questions that were used as a guide for the focus group can be found in Appendix D.

Section 4—Reflections on participation in the study. The final section contained two components: a reflective questionnaire and the author’s self-reflection field notes. Each participant who agreed to the study was asked to complete an online reflective questionnaire (See Appendix E). This section aimed to provide space for the women to describe whether participating in the study impacted the way they thought about their experiences. Did they feel a sense of pride (or exhaustion) after reflecting on their accomplishments? Has participating in the study provided a clearer picture of their professional or personal purpose going forward? For those who participated in the focus groups, did they gain inspiration or other helpful information from interacting with the other women? Ultimately, six of the participants were able to submit the reflective questionnaire.
For the author’s self-reflection field notes, I chronicled my observations and reactions to hearing the stories of study participants. Specifically, at the conclusion of each interview or focus group, a reflection was recorded providing timely insight on each interaction. This also allowed me to identify and articulate specific revelations in the information provided as well as potential parallels to my own experiences as an African American woman.

**Interface methodology—open ended questionnaires and field notes.** Participant reflections through open-ended questionnaires. In alignment with the sentiments expressed in Dennis (2014), providing space for individuals to reflect on their experiences in the study helped to mitigate issues with “research participants [feeling] taken for granted” (p. 395). Beyond the “ethical [commitment] to . . . take participants’ experiences into account ” as a fellow Black woman, it was important to me that, within the context of the study (Dennis, 2014, p. 397), I provided an initial sense of closure and opportunity to reflect on emotions and memories participating in the study has invoked for participants. While participants were not asked to keep a journal throughout the study, capturing their post-participation reflections was accomplished through a brief open-ended questionnaire administered through a Google Form ©2020. By utilizing a series of short open-ended questions, this facilitated focus of inquiry and respected the time of the participants by asking for brief responses to succinct questions.

**Author’s reflections through field notes.** Merriam (2009) noted that field notes allow for the author to capture her “feelings, reactions, hunches, initial interpretations, speculations, and working hypotheses” (p. 131). Given that this study was multi-layered in design, it was important for me as the author to jot down or briefly record my initial reactions and thoughts at the conclusion of each interview and focus group. Not only was this important in immediately
capturing important features of the interaction, this also served as an important tool for growth for me personally as I progressed through the study.

**Setting**

As mentioned in the previous section, there were four phases to this study. The first phase (background information questionnaire) was administered online by way of a Google Form ©2020. The second, (one-on-one semi-structured interviews) was conducted via GoToMeeting®. The GoToMeeting® interface allowed for individuals to call into the service using a phone number and code assigned to that session, from which calls were recorded and transcribed. In order for the transcription services to be applicable, one must subscribe to the GoToMeeting® Pro version of the software and enable transcription on under admin settings-user settings-gotomeeting settings.

The third phase (focus groups) was also conducted through GoToMeeting® since multiple users were able to call into an individual session. This interface tool was used since the participants in this study involved women from across the United States, both currently in graduate school and alumnae. In addition to the informed consent form, each participant in the focus group signed a confidentiality form as well. The transcriptions from the interviews and focus groups were reviewed as soon as possible following the actual activities in order to note initial themes and fine-tune interviewing skills in preparation for the next session. As mentioned earlier, multiple focus group session opportunities were provided. The reflective questionnaires during the fourth phase were administered using a Google Form ©2020 and the author’s self-reflection field notes were written in tandem during the course of the study.
Data Collection

Once IRB approval was obtained, the first two phases of the study (background information questionnaire and semi-structured interviews) were conducted during the months of May and June 2019. The focus groups took place during July 2019, with the reflective questionnaire being sent out following the focus groups. The interview and focus group transcriptions were reviewed immediately following the sessions and all data was ready and available to analyze by mid-August 2019.

Analysis Plan

Data was analyzed both incrementally as well at the conclusion of the data gathering portion of this dissertation. Preliminary thoughts from the background information questionnaire were moderately used to adjust the questions guiding the semi-structured interviews and focus groups. Since gotomeeting.com transcribes audio recordings within minutes, the transcription for each interview and focus group was reviewed as soon as possible after activity to note key themes as well as clarify any questions from the transcription. Each transcription was uploaded immediately into a Google Docs ©2020 file in order to a) securely store the data and b) allow for immediate notes/thoughts to be recorded using electronic comments in the margins of each document. For the questionnaire data used in the participant reflections, results were reviewed as soon as possible after each completed response is submitted and saved in a separate Google Docs ©2020 file in a timely manner. Similarly, the author’s field notes were recorded both during and immediately following each interview or focus group.
Data Organization and Coding

Data was organized around the key themes of the foundation of this dissertation as well as around the three theoretical lens utilized within this dissertation. While gotomeeting.com was an incredibly helpful tool, as the author, it was necessary for me to go back through (in detail) to review each of the transcripts, and in some cases “re-listen” to the audio recording to clarify areas that might have been initially difficult for the GoToMeeting system to transcribe. This extra step, however, made things much clearer later in the process when it came to coding and identifying themes, because it helped to refresh my memory on what was said, issues that were echoed by multiple participants, etc. The women in the study, each had a variety of experiences, however, using the study’s theoretical lens to guide the work provided a basis to investigate parallels and the extent to which these theories held true.

As with all qualitative design, there was flexibility in the analysis to identify emerging themes that were not addressed in the theoretical lenses. Close analysis of the transcripts and “re-listening” to the audio helped to illuminate themes, such as the importance of study abroad, that initially were not expected but emerged nonetheless. The foundation of this dissertation rests in Black feminist thought. Black feminist thought insists that Black women have the right to speak for themselves, to encapsulate experiences in a unique way, and to embrace diversity of thought within the sisterhood of Black women. Questions of self-reflection that directly spoke to the race-gender status of these women were included in both the “journey to the program” and “experiences within the program” stages of data collection. Connecting threads addressing how these women’s intersectionality affected the way their experiences unfolded were identified.
While Black feminist thought marks the foundation of these women’s existence and underlies every experience they might have therein, two additional theoretical lenses mark the branches (and therefore the remaining structure) upon which data for this dissertation was organized. Social cognitive career theory, or SCCT, created a backdrop for identifying key linkages central to participants first becoming interested in a health profession, determinants that drove them to make the decision to choose the appropriate major or take the appropriate classes, and action steps that helped them persevere through difficult math and science courses. Since part of the goal of this work was to provide tools for K-16 and graduate health professions curriculum designers, deans, student affairs, and diversity officers, data analysis also incorporated Ford’s female achievement model for excellence (F²AME). F²AME calls out characteristics that must be developed in order for Black females to amplify the excellence that is within them. These characteristics ranged from resilience, to cultural pride, to work ethic, self-sufficiency and much more (Ford, Harris, et al. 2018). In addition to capturing key quotes, content for each area was coded according to “the frequency and variety of messages [and] the number of times a certain phrase or speech pattern is used” (Merriam, 2009, p. 205).

**Limitations**

As mentioned in Chapter 1, as with any study, this study would not be without a set of limitations. Issues ranging from small sample size to variance between health professions restricted findings from the study from being applied carte blanche to all future health professions educational settings. Given the diverse sense of identity amongst Blacks living in the United States, the initial questionnaire sent out via email at the beginning of the study helped to
provide context to participant responses by gathering demographic data such as age, economic circumstances, parental background, and geographic location.

**Trustworthiness**

Beyond the general requirements of conducting an effective study that aligns with requirements of solid design, due to my own positioning as an African American woman, it was of utmost importance to me to conduct this study in an ethical way that honored, spoke to the power of, and provided renewal and encouragement to participants. Firestone (1987) explained that qualitative studies should be conducted and reported in a way that provides sufficient detail to demonstrate that the writer’s conclusion “makes sense” (p. 19). As evidenced in the research conducted on interface technology, it was my intent is to conduct interviews and focus groups in a way that allowed for the appropriate level of detail to be derived from each interaction.

Triangulation was accomplished by utilizing multiple methods for data collection in order to create a holistic picture of Black women’s experiences in health professions’ education. Triangulation references various efforts (in this case, research methods) coming together to form a point, or solid conclusion (Merriam, 2009). Utilizing data from several different interactions and sources also contributes to the credibility of the results. By including data from one-on-one semi-structured interviews, focus groups, and post-reflection questionnaires, the study provided an in-depth view of both the state of and possible enhancements to the experiences of Black women in graduate health professions education.

As will be seen in Chapter 4, direct quotes from the participants from the one-on-one interviews, focus groups, and reflective questionnaires were utilized to support the explanation of the findings in the study. Utilizing words directly spoken by the participants also demonstrated
confirmability of the results. Furthermore, these direct quotes supported transferability of the study and provided a personalized glimpse into the women’s lives, potentially mirroring others who have encountered similar scenarios.

Finally, trustworthiness of the data was achieved through great concern shown when interacting with participants during the course of the study. In their article *Sister-to-Sister Talk*, family therapists Few, Stephens, and Rouse-Arnett (2003) pinpointed special considerations that should be taken when conducting qualitative studies with Black women. Given the historical mistreatment of Black women, the authors acknowledged participants who might have been hesitant to trust those who had not earned “insider status,” regardless of whether the interviewer was also a Black woman (Few, Stephens, & Rouse-Arnett, 2003, p. 207). Accordingly, the authors offered the following guidance on conducting studies that both earned the trust of Black female participants and served to honor to the goals of the study:

- Consider the context (geographic location, family background, social class, etc.) of the person you are speaking to and be considerate of this in your dialogue with each person.

- As noted by Bogdan et al. (2016), “some respondents need a chance to warm up to you” (p. 100). Thus, Few et al. (2003) suggested taking time to earn trust such as by learning the respondent’s interests. In this process Few and colleagues advised that the researcher might find that she shares similar interests as well.

- Identify questions that might need to be phrased a different way in order to uncover “unarticulated meanings” that may be less easy to share (p. 211).

- End the interview with a positive, thought-invoking question.
• Understand that the emotional experience of recalling information does not end for
the participant when the interview or focus group is over. (Few et al., 2003)

In addition to having all study instruments reviewed by multiple audiences, I adopted the above
guidelines in the conduct of my study.

**Positionality and Transition to Chapter 4**

In the case of qualitative research, the researcher serves as one of the primary instruments
or tools of the methodology (Merriam, 2009). Thus, it was important that I took time to expand
further on my own positionality as, with any person, this affected how I approached this work,
viewed the world, and interpreted data. As alluded to briefly in Chapter 1, I was raised in the
rural southern United States by a family who held a strong belief in education as well as an
established sense of pride in our culture as African Americans. My mother, aunts, and uncle all
attended segregated schools, with the exception of the last three years of my mother’s secondary
education which was in an integrated school. While many associate the end of US slavery with
the war of 1865, similar to how modern day states adopt federal rules at the speed of their own
choosing, access to formal secondary education for Blacks in my mother’s rural county in
northwestern Tennessee began much later than federally decreed. As noted in an excerpt from
the high school reunion yearbook from her county “in 1925 secondary education began for
Blacks in Crockett County, Tennessee. The houseworkers, sharecroppers, and handymen were
for the first time being given the opportunity to acquire a formal education” (Wade, n.d.).

Starting in 1925, there were three principals of this segregated school, each serving anywhere
from 10-20 years with my grandfather serving as the last principal before integration with a
Looking back, the effect of being raised by those who lived the experience that many only read about in history books was tremendous. Moreover, by the time I came along, my family was still living in this same part of the country and, given, its history, not as much had changed as one might think. While my family (and my mother’s family) was blessed to be one of the few Black families at the time with a masters educated patriarch and matriarch, my mother (and her siblings) were still amongst those who picked cotton for the “man” down the road and whose humanity was referred to as “hands” (for the labor their hands provided) when being spoken about by Whites in the other part of town. In fact, one of the reasons the school was allowed to open in this small county was that administrators agreed to close the school during peak cotton-picking time so that the youth could return to the fields to harvest the crop.

Given this, a few things stood out in my upbringing, that directly relate to the context of my dissertation and of my life’s work. First, as an African American, it was a given that you had to be twice as good. It was such an assumption that there was no need to even speak of it, it was simply a requirement, just as it was a requirement to put on one’s shoes to go outside or to put one foot in front of the other in order to walk. Perhaps this came from the very recent history of people not even being allowed to be educated (or to buy groceries, go to the doctor, or any number of things) in the same room as Whites. Second, there was a great deal of emphasis on proving oneself academically, within the small scope that we had access to. For my siblings and I, the primary goal was to escape the rural (and in many respects prejudiced) environment in which we lived, and college seemed to be the only way to do that. Thus, simply getting to college (and finding scholarships to pay for it) was seen as such an astounding accomplishment, little thought was given to luxuries such as happiness with the major you choose once you got
there. Third, solidarity with disadvantaged groups was a must. In hindsight, this was likely due to existence in such small numbers in our predominantly White integrated high school and being raised by a culture of African Americans who had to be completely self-reliant on one another, because of being so often shut out from other environments.

As I have gotten older and have lived and worked over the course of four different states, I have also become much more aware of the vastness of opportunity and perspective that I was not necessarily privy to, given the limiting effects of certain aspects of my native environment. So much time was spent advocating for rights for African Americans that rights as a woman (and oppression based on gender) was seen as an afterthought, as if it took away from the larger struggle for equity based on race. The right to vocational happiness, and to thrive in careers beyond what we or our forefathers knew was also an out of reach luxury, given that the struggle for basic survival as a person of color was so intense. Moreover, the incredible richness that comes from diversity beyond Black and White, from perspectives not rooted in the same types of pain, and from those who look different than me, but who share my advocacy for social justice, has been an incredible gift that I have been fortunate to receive in the more recent years of my life.

**Scholarly Worldview**

It is with this context in mind and with the health professions niche that I have been fortunate to gain in my professional career, that I translate my personal background into a worldview as a researcher (Creswell, 2014). As a scholar, my worldview reflects a combination of two schools of thought: social constructivist and transformative. The combination of social (concerned about individuals’ lived experiences) and constructivist (a belief that individuals have
the right to articulate what their lives mean to them) makes up the first portion of my perspective and underlies my assertion that is due time for the voices of Black women, particularly in health professions education, to be heard. This worldview most closely aligned with qualitative research in that social constructivist researchers specifically wish to honor and explore the full complexity of a participant’s experience (Creswell, 2014).

My second scholarly worldview—transformative—has roots in my upbringing surrounded by heroes who bravely challenged overt prejudice in the southern United States. This worldview underscored the reason why I had enrolled in a program focused on social justice for my doctoral degree. Revealing truths through research, and expressing these truths through writing, functions as a form of advocacy, as a way to create space where reports of injustice are not withheld but put in plain sight.

In Chapter 4, I will report on the results of this work. This chapter will provide data that serves to answer the research question articulated above. It will also serve as the basis for the discussion and conclusion to this work situated in Chapter 5.
CHAPTER 4
RESULTS

Chapter 4 provides a summary of the results of this work. As alluded to earlier, this study was divided into two distinct sections representing different periods in the life of a graduate health professions student: a) the journey to admission and b) experiences after matriculation. After participating in discussions about these periods, the women also had the opportunity to reflect comprehensively over their entire experience before and during their programs, as well as what meaning they derived from participating in the study. Accordingly, the results articulated in Chapter 4 are divided into parts that align with the sections in which the participants engaged. Part one (journey to admission) is comprised of a deep dive into the influences and influencers that had an early impact on the women; analysis of the key paradigms that were important to their success; and information on the spaces the women had to navigate in order to ascend to the status of an admitted graduate health professions student. Part two (experiences after matriculation) examines the importance of creating space; feelings of affirmation and challenging encounters; and amplify discussions about voice or lack thereof in their graduate experiences. Part three illustrates the reflections of the women who participated. Summative reflections from the author are also included and articulated in Chapter 5.

As a review, participants for this study were selected based on the author’s professional network of having worked for over 13 years in graduate health professions and related areas of higher education. To participate in the study, individuals must have identified as a Black or African American woman, be between the ages of 18 and 64 years old and have successfully completed or gained entry to a graduate program in the United States. Eight women were
ultimately selected for the study which included one on one interviews (primarily addressing the journey to admission), focus groups (primarily addressing experiences after matriculation) and a reflective questionnaire facilitating a comprehensive look at their experiences with their programs and as a participant of the study. The author-maintained field notes throughout the entirety of the study, including items that resonated with her own identity as a Black woman, higher education practitioner, and as a graduate student.

The women selected for the study represented a variety of graduate health professions programs and socioeconomic backgrounds. The richness of their responses illustrates the great diversity within the female gender and within the Black race. A brief description of each participant can be found below, as indicated by a background questionnaire completed at the beginning of the study as well as from elaborating comments provided in the one on one interviews. Additional background and contextual information on each participant can also be found throughout Chapter 4 as this informs the differences and similarities in how they experienced their journeys:

- **Blackberry** was a Doctor of Pharmacy (PharmD) student who attended school in California. She moved to the United States when she was twelve where she spent the remainder of her youth in a medium sized urban city in California. Blackberry’s family was of Nigerian heritage.

- **Cathy** was a graduate of master’s degree and PhD in nursing programs. She was a first generation in college student who did not have any health professionals as major influences in her early life. Cathy was raised in Washington D.C. where she earned
her undergraduate degree in nursing. Cathy’s graduate nursing education was completed in the Midwestern United States.

- **CW** was a DPM (Podiatry) student who attended school in Florida. She was raised by a master’s educated single mother in Massachusetts in a medium sized urban city. Her father holds a doctorate degree but was not a part of CW’s life as a child.

- **Denise** was a PharmD student from a suburban area of California. Denise’s mother was a nurse who worked for a local hospital situated within a large healthcare organization. Denise’s family was also of Nigerian heritage.

- **Grace** was an MD student and a graduate of a Master’s in Public Health program. Grace’s parents were both raised and obtained their bachelor’s degrees in the southern portion of the United States prior to moving to California for her father’s NBA career. Grace’s parents divorced leaving her mother to manage three children as a single parent. Grace’s father passed away suddenly in 2012.

- **Jade** was a graduate of a Physician Assistant (PA) Master of Science program. Although Jade’s parents did have some college education, she was part of the first generation in her family to receive a bachelor’s degree. Jade characterized her socioeconomic upbringing as “low middle class” and was raised in a large urban city in California.

- **Journey** was enrolled in an allopathic medicine (MD) program and was a graduate of a master’s in Public Health program. She grew up in an upper middle-class family with master’s educated parents in a large urban city in California.
• **Sylvia** had a master’s degree and PhD in Nursing. Her father did not graduate from high school; her mother held a doctorate degree. Sylvia grew up in poverty in a rural area of coastal northern California.

**Part One: Experiences Leading up to Admission to a Graduate Health Professions (HP) Program**

**Influences and Influencers**

Throughout the study, the interplay between personal and vocational influences was prominent. While personal (cultural, situational, etc.) factors influenced the core of who these women were, their ascension to a graduate health professions program would likely not have been possible without the coexisting vocational influences present in their lives as well.

**Personal influences.** In some respects, it takes a remarkable person to persevere through the many challenges of gaining entry to and working one’s way through a graduate health professions program. The following section reveals the people and circumstances that helped to shape the participants into the persevering and boundary-breaking individuals they are today.

**Women.** At least five out of eight (63%) of the participants strongly felt that women played a key role in shaping their identity and sense of self. Two (CW and Grace) were raised by mothers they identified as single parents and their strength, character, and belief in them as daughters were key to them forming key paradigms discussed in the subsequent section below. For Cathy, it was her grandmother who, despite Cathy attending what she later learned was an under resourced school, provided a model of strength and accomplishments often unrecognized for Black women of that time. Denise and Sylvia’s comments reflected learning a great deal from their mothers scholastically, from Sylvia’s mother’s strong writing/editing mentorship to
Denise’s mother’s words of caution that “you’re a Black woman and . . . you need to excel in what we believe in . . . because if you don't do it, no one else is.”

**Perspective changing “out of the box” experiences.** Certain experiences are taken for granted as normal activities in child- and young adulthood, however, for marginalized communities struggling to fulfill basic needs, these experiences are in some ways huge risks but ones that must be undertaken to break the generational curses of poverty, abuse, and other inherited oppressions prevalent in the Black community (Zande, 2017). Both CW and Cathy had experiences abroad that significantly affected their decision to pursue a health profession at the graduate level. CW spent ages three through six in Nigeria living in a rural village with her grandparents. Even at that young age she recalls going around with the village doctor who had gone to medical school in London but came back to the village every few weeks to care for people in the community. During this time, she recalls witnessing people in the village with numerous health problems but no health insurance. In particular, CW, a Podiatry student at the time of the study, recalls seeing a woman with a club foot, who due to lack of access to care and inability to wear shoes, struggled with a condition that only got worse.

Similarly, Cathy, having just finished her undergraduate studies in nursing, was approached by the Academic Dean of the nursing department to fill a last-minute slot to go to Thailand to do research on breast cancer. Through this initial encounter with research, she inquired about how she could continue doing similar work as a nurse. She recalls speaking with the Dean and stating “so if I go to graduate school I can do what I was doing in Thailand but I can do it with people who look like me and I can study [things] that affect my community?”
Hearing her Dean respond in the affirmative, this experience sparked Cathy’s decision to pursue a clinical masters in Geriatric Nursing and ultimately also a PhD in nursing.

In some circumstances, these experiences were not intentional and frankly not pleasant but divine wisdom perhaps allowed them to occur as a necessary component compelling the women’s future life direction. In Jade’s case, a personal medical experience at the tender grade of six was the initial spark compelling her to pursue a medically related career. This spark continued on throughout college, although she credits another chance encounter with a woman who was the instructor for a Medical College Admission Test preparation course with providing the inspiration for her finding her specific professional path, leading to her earning the Physician Assistant designation she has today.

*Choice of a specialty.* Choice of specialty is something that likely does not get enough attention at preparatory school level when “medical” careers are lumped in as one monolithic idea. In reality, the choice of a specialty, or even broader, the decision on which health profession to pursue is almost as significant of a decision to pursue a health career at all. A day in the life of a dermatologist in an affluent area can be drastically different than the daily experience of a physician assistant working in the critical care unit of an urban hospital. These differences can be the driving force behind students having the motivation to persevere through a difficult semester or reminding a weary professional of why they must continue to do the work, despite practicing in challenging circumstances. This choice of specialty, in the case of many of the participants, occurred due to intentional or specific efforts to step out of the comfort zone of their typical surroundings. After initially thinking she would focus on practicing medicine abroad, Journey made the decision to pursue a Master’s in Public Health between her third and
fourth years of medical school. This combined with a perspective-changing rotation in a local urban clinic completely changed the direction of her studies and specialty choice. In her interview, Journey noted:

I went to Kenya and I was like, oh I'm going to do all this work abroad and then I got into a clinic at Kaiser . . . and I just noticed there were so many things that were negatively affecting my patient interactions that didn't have s*** to do with what was going on abroad. There were just a lot of things on this side domestically that need to be addressed and all of it was guided by local equation. All of it from how much time I can put in the room with the patient, what I can prescribe for them, what language I speak in the room, what their insurance had to say . . . all of it is dictated by legislation. So that's what drove me [to] the health policy route and [a] health policy track.

**Culture.** The history of slavery in the United States has had an unprecedented impact on the differences between Blacks whose ancestors were brought to this country as slaves versus those who came here of their own free will. The influence of (in particular) Nigerian culture on stressing pursuit of STEM related careers was a prominent feature for at least two of the women participating in the study. This influence was not, however, as clearly evident for those who were descendants of the oppressive and identity-robbing phenomenon of US slavery. For those whose parents most immediately identified with Nigerian culture, becoming a doctor (or potentially also a lawyer) was, as Blackberry noted, “not something you [could or could not do] it was something you were expected to do.” For this reason, both Blackberry and Denise both knew from an early age that they were going to pursue something in science, the question was to determine what [within science] they would decide to pursue.
**Need for stability.** Both of the participants who represented the nursing profession indicated one factor leading to their choice of nursing as a career was a need for a stable career. For Sylvia, this importance of this factor was significant, commenting that “[having] experienced homelessness and . . . food insecurity, housing insecurity, all of those things growing up, I was pretty darn clear that whatever I did needed to have a steady reliable source of income.” For Cathy, after an initial interest in being a flight attendant, nursing was seen as a reliable fall back plan, one that has propelled her to the graduate level of the profession and to a career as a researcher and clinician. A summary of the primary personal influences for the participants can be found below in Table 1.

Table 1  
**Personal Influences**

<table>
<thead>
<tr>
<th>Influence</th>
<th>Blackberry</th>
<th>Cathy</th>
<th>CW</th>
<th>Denise</th>
<th>Jade</th>
<th>Journey</th>
<th>Sylvia</th>
<th>Grace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Perspective Altering Experiences</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>+</td>
<td>X</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Culture</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for Stability</td>
<td>X</td>
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<td></td>
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</tr>
</tbody>
</table>

*Note:* +While medicine had been instilled at an early age as a career option for Journey and Grace, key experiences while in their graduate programs in public health influenced their choice of specialty within the field of medicine.

**Vocational influences.** Some would say that vocational influences are equally as important as personal ones on the ascension of a student to a health professions program. When determining how to spread these influences to other students, it was important to note the
primary influences as well as the reinforcing influences that flamed the fire of interest sparked by the primary source.

**STEM focused or STEM resourced schools.** One of the most consistent vocational factors influencing the women’s career choice and ascension to a graduate health professions program was attendance at a STEM focused or significantly STEM resourced elementary, middle, or high school. Ultimately four of the eight participants described their schools as being focused on these areas. CW intentionally sought out a private elementary school with an accelerated science and math program and a vocational high school that provided hands-on science related experiences. Jade attended a magnet high school in Los Angeles Unified School District situated next to a historically significant hospital known for years of serving the Black community. Journey and Grace attended what Journey described as a “well-funded, well-endowed” high school where they had access to hands-on highly engaged anatomy, physiology, and related classes.

**Influence of individual teachers.** Individual teachers can partially replace the lack of STEM focus in a particular school or further reinforce services that are already available. Blackberry did not feel that her high school was particularly STEM focused but an extraordinary science teacher found a way to establish a HOSA club on campus. HOSA, formerly known as Health Occupations Students of America now known as Future Health Professionals, is a longstanding national organization that provides meaningful engagement for aspiring health professions students. Blackberry was selected to serve as President of the club her senior year in high school, further solidifying the foundation in science provided by her familial community. Although Grace ultimately had access to a significantly STEM resourced middle and high
school, she credits an elementary school science teacher with going out of his way to demonstrate ways to make science fun even at a young age.

**Proximity to a health professional in one’s life.** Nearly equally as consistent of an influence of the preparatory school the participants’ attended was the presence of a practicing health professional in close proximity to the women’s lives. Denise spent time during her childhood accompanying her mom, a nurse, to work. Journey’s aunt was a doctor and she and Grace went to school with kids whose parents were physicians so “it wasn’t outside the realm of possibility.” Blackberry’s father worked at a hospital and Sylvia’s close friend’s mother was a healthcare provider at the local clinic. When reflecting on the importance of the proximity of the relationship with the local healthcare provider Sylvia commented “I just was really able to relate to her on a particular level . . . I've admired her all throughout her life, you know, so yeah, it was interactions over time and in multiple capacities.”

**Intentional shadowing experiences.** Perhaps due to having proximal adults who could facilitate such opportunities, three of the women had specific shadowing experiences that contributed to the accessibility of a health profession as a career choice. After graduating from college, Blackberry’s father was able to set up a shadowing experience for her with the pharmacy director at the hospital where he worked. In addition to the close relationship with the clinician at the local clinic, Sylvia was able to shadow a midwife in the community. This real-life engaging scenario provided her with the confidence that she could “keep [her] head in an emergency situation.” After assisting the midwife with the high risk delivery of a friend’s child, Sylvia reflected upon how the midwife was “so calm and mellow and knew what to do when everything was happening [and] going on.” When Denise accompanied her mother to work at a local
hospital, she had the opportunity to talk with a pharmacist there. “Just being with her and talking
to her . . . I liked her energy and I liked how she talked to patients. . . seeing the reward she felt
from it made [me] pursue [pharmacy even] more,” Denise said.

**Choice of undergraduate institution.** It is important to note that one of the women,
Cathy, did not attend a STEM based or resourced preparatory school, nor did she have a health
professional in close proximity during her childhood. For Cathy, attending a Historically Black
College/University (HBCU) in Washington, D.C., where success of Blacks was a matter of
normalcy allowed her to gain a sense of proximity to nursing not available in previous realms of
her life. “It wasn’t until I got to College,” Cathy said, “that I kept meeting people who were like,
oh, my mom was a nurse.” Attending a school where Black success was an abnormality or where
student support and guidance were not prioritized might have resulted in Cathy getting lost in the
maze. While she didn’t have the benefit of always knowing what she wanted to do with her
career, these encounters, coupled with an unwavering resilience likely created the optimal
intersection of atmosphere and character that fueled Cathy’s ability to succeed.

**Association with undergraduate pre-health societies.** While membership in an
undergraduate pre-health club or society did not provide the original spark for any of the women
to pursue a health profession, association with these organizations created an atmosphere of
supportive and affirming peers and guest speakers who translated interest into the action needed
to successfully apply and be admitted to their graduate health professions program. In total, five
out of eight of the women participated in a pre-health society as an undergraduate. CW and
Journey were involved in the pre-med fraternity Phi Delta Epsilon; Sylvia was president of the
nursing class and a member of the undergraduate nursing honors society Sigma Theta Tau; and
both Denise and Grace were heavily involved in campus activities including the pre-pharmacy society and student health advisory board respectively.

It is important to note again, however, that not all students have the flexibility to devote time to extra-curricular activities. Sylvia commented that she had to work to provide for herself and send money back home to family for the majority of her college experience. It was only during her final year of nursing school that she was able to devote 100% of her time to school and student activities. Likewise, Cathy mentioned several times being so “focused on finishing” and the responsibility of working during school. “When I look through my college yearbook and I look at all of these clubs and programs . . . I didn't even know that this stuff was here . . . like it was just about [finishing, going to school and working].” A summary of the primary and secondary vocational influences of the participants can be found below in Table 2.
Table 2  
**Vocational Influences**

<table>
<thead>
<tr>
<th>Influence</th>
<th>Blackberry</th>
<th>Cathy</th>
<th>CW</th>
<th>Denise</th>
<th>Jade</th>
<th>Journey</th>
<th>Sylvia</th>
<th>Grace</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEM focused or STEM resourced school</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Influence of Individual Teachers ++</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>++</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximity of a health professional</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Intentional shadowing experiences</td>
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<td>X</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>Choice of undergraduate institution</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Involvement in undergraduate pre-health societies</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td></td>
<td>++</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
</tbody>
</table>

*Note: ++These influences were not the initial element that sparked an interest in a health profession but rather served as a secondary influence to reinforce the interest initially sparked in some other way.*

**Paradigms Embraced**

Aside from having personal and vocational factors influencing their journey, each of the women adopted key paradigms that were vital to their success. These philosophies and practices were those that they tapped into during their adolescence and later reverted back to as they progressed through their graduate careers.

**Resilience.** One of the most recurring themes for the participants was a hearty sense of resilience. For some, resilience meant the ability to create triumph out of trauma. For others,
resilience grew from pushing past academic pitfalls, through a journey in their own way and in their own time.

*Triumph over trauma.* As members of a doubly marginalized group, the women in the study exhibit extraordinary measures of endurance. All the while, for many of the women, a look behind the curtain reveals experiences that can only be described as trauma in various aspects of their lives. Nevertheless, still they persisted (Wang, 2017). While a piece of every person remains with the trauma they have experienced, the women in the study clearly articulate a resilient spirit that copes with, learns from, and finds purpose in their pain. One participant persevered through a career-ending volleyball injury, her parent’s divorce, and her father’s death. While these experiences challenged her in unforgettable ways, she now exhibits triumph by encouraging awareness of mental illness and a parallel sense of compassion for the patients she serves. Another participant has distinct memories of growing up in poverty, being wrongfully accused of cheating, and being “constantly uptight about how easily [her] life could become unraveled by one catastrophic event” such as a car malfunction preventing her from participating in rotations (a requirement for graduation in many health professions). Even though these factors significantly impacted her, she now fuels triumph in others by teaching about the importance of health equity and working to diversify the profession she loves. Yet another participant coped with “moving around a lot” as a child and having a father incarcerated for having assaulted her when she was sixteen years old. Although there are insufficient words to describe the pain of this experience, the resulting relationship with her grandmother, whom she lived with thereafter, provided a consistent example of both strength and savvy, and paved the way for a passion to understand and care for older adults.
Pushing past academic pitfalls. Given that successful admission to a graduate health professions program is a requirement for participation in the study, it might be surprising to learn that many of the women initially struggled with at least one aspect of math or science, subjects thought to be gatekeepers for entry into these fields. It was these initial struggles, however, that helped to craft their current testimony and the resilience they would need to get through the remainder of their academic careers.

Although she was one year from graduating from medical school at the time of the study, Journey described herself as being “awful” at math for much of her childhood. Later, however, she found solace in academic support networks such as Phi Delta Epsilon that provided peers who helped one another in areas where they might otherwise fall short. After initially struggling with the “black and white” sterility of her science courses in college, Blackberry learned to how to co-mingle her major in biology with a minor in philosophy. “I just needed to find a middle ground to understand it better,” she said. “To be honest social science allows you to understand [life] sciences a lot better. I suppose that's the reason why they are now required as . . . prerequisites to health professional programs. They do allow you to see the balance in life.” CW ended up majoring in biochemistry even though chemistry was a subject she initially struggled with due to a poor foundation in high school. Enrolling in a master’s program prior to Podiatry school helped her learn how to study, mature academically, and decipher how to maintain sustenance socially. When reflecting on the value of this transition, CW remarked:

It takes discipline to . . . want to sit there and study for 12 hours a day or especially when you see . . . other people having fun and you're . . . here at your home studying . . . for
hours on end, but I feel like what I learned [in my master’s program] taught me how to balance school life with . . . having a social life.

**Openness.** Nearly all of the women maintained a remarkable sense of openness to new experiences and to learning. Especially in an environment where openness to information is key to improving patient health and wellbeing, this state of mind might be a needed prerequisite for entry into the field.

Grace and Denise exercised their openness through involvement in a diverse array of student activities. During her undergraduate experience at Princeton, in addition to serving as a member of the varsity volleyball team Grace was involved in the Christian faith-based organization Athletes in Action, the Varsity Student Athlete Advisory Committee, a campus-wide leadership committee representing all student athletes, and served as an Executive Board member of the student volunteer council. Moreover, she chose to major in public and international affairs, a major that went against the norm for a pre-med student. Through immersion in this major, she was required to take classes in several different departments of the university such as higher level Spanish, Religion, Children’s Literature, and American Family in Law in Society. Within this framework, for example she chose to take Introduction to Buddhism, as a way to gain exposure to belief systems outside of Christianity and Judaism (which were more familiar to her growing up). “[It] was exciting . . . to see how just as strongly as I am in my beliefs in this way, there are other people in the world who approach the world differently than I do,” Grace said.

The Children’s Literature and American Family Law in Society courses perhaps undergirded Grace’s decision to take a year away from medical school after her third year to earn
a Master’s in Public Health from Harvard and, ultimately, to select Pediatrics as her chosen area of specialty upon returning to complete her fourth year of medical school. These experiences helped her take a step back and explore “the messages that we as a society are passing on to our children and what are the different morals and lessons and things that we are saying [to them] . . . very early on.” For her, studying the ways families were situated within the legal system was also interesting since it allowed her to “look at . . . how we as a society have shaped and structured ourselves in a way to protect children or to protect some groups but maybe not other groups.” Likewise, although Denise identified as a Black woman, she had a desire to see different perspectives other than her own, and accordingly sought out membership in clubs outside of her identity such as the Vietnamese Club. In addition, Denise was involved in the LBGT club, the Chemistry club and the Pre-Pharmacy society, all of which she credits with creating a supportive network to assist with pharmacy school applications, courses, and other requirements.

For three of the women, openness also meant openness to diversity that extended beyond US walls. CW intentionally selected her Podiatry school because of its openness to diversity. “I felt like it was a school I could thrive in” she commented. “They do a lot . . . abroad help[ing] with different countries [such as] . . . Mexico, Haiti, Dominican Republic, Africa . . . that was one of the main reasons I wanted to [go there]” she said. Similarly, Cathy’s encouragement of study abroad programs can be traced to her paradigm shifting research experience in Thailand. “Just do it,” Cathy remarked. “It doesn’t matter how short [the study abroad experience] is. It’s just such a unique opportunity to get a [broader] worldview. So I definitely am in support of that.” Although Journey ultimately chose to specialize in issues related to US policy during her
MPH, her undergraduate experience at an HBCU was filled with study abroad experiences including an experience in Bocas del Toro Panama and the aforementioned opportunity in the African Republic of Kenya.

**Academic identity.** Part of the process of weathering the academic peaks and valleys of pursuing of a health professions degree is to develop a grounded and self-aware sense of academic identity, a tool that can be used to navigate the challenges inherent in such pursuits. Three of the women identified having to overcome issues with entrance tests required for medical school. The Medical College Admission Test, or MCAT, is a required component for many of the medical schools throughout the United States. After studying diligently but initially still receiving a less than optimal score, Grace had to re-assess her own confidence, bestowing belief in herself as a whole person and as a whole student—beyond just a test score. Two of the other participants opted for a health profession (related to but outside of specifically an MD) that allowed them to pursue their goals without such a significant emphasis on an entrance test score.

Sylvia had to develop an internal confidence with her learning style, despite the negativity of certain professors. She learned the parts of math and science she was really good at and those she had to work harder at or approach in a different way. As a self-driven, self-motivated learner, Denise demonstrated incredible self-awareness in a number of ways including identifying areas in which she needed extra support. “The thing about me is: . . . I’m very honest with myself.” To get assistance with physics, a prerequisite for many pharmacy schools, Denise sought out the tutoring center on campus. “They basically knew me, I basically lived there. It was just something I wanted to understand. There is something about having a problem that I like to solve.”
Both Blackberry and Jade had to return to school after completing their bachelor’s degrees to take prerequisite courses. Actions such as these exemplify a sense of confidence that the extra effort will be worthwhile. In particular, Jade points to the value and academic nurturing she received at a local community college she attended after graduating from a large state university. When speaking about the sense of academic identity she gained at a community college, Jade remarked:

I loved it. It was that small setting I craved at the university . . . [the professors] knew what I was coming back to school for and they validated that and they encouraged that and they knew my name, so it was totally worth it and it lets me think I wish I would just have, you know, come here first. There were tons of teachers of color and so I saw somebody who looks like me which is also encouraging to say, okay, you know I can do this.

Navigating Spaces/Belongingness

**Yearning for connection.** Three of the women in the study notably mentioned growing up in communities where there were very few Blacks. While this reality reflected their surroundings, it did not hamper their intense desire to connect with their African American roots. To do this, however, these three women and their families had to be very intentional about making efforts to ensure that Black culture was not lost simply due to its minimal presence in their immediate circumstances.

Although her parents were graduates of Morehouse and Spelman, Historically Black Colleges in the southern United States, they struggled to find ways to immerse Journey and her brother in Black culture outside of their suburb of Los Angeles. They attended a Black church,
involved Journey in the Black community service organization Jack and Jill and intentionally selected minority serving communities for her to play volleyball. She recalls her mother placing her brother in “Rancho instead of Beverly Hills” for basketball and her in “Baldwin Hills instead of Beverly Hills” for volleyball, for example. Even with all of these efforts, however, Journey’s pride as a person of African descent was not notably shaped until she enrolled in Howard University, an HBCU in Washington D.C. When commenting on what it meant to be immersed in the cultural safety of Howard, Journey remarked:

It wasn't until I got [to Howard that] I was like, oh, I get it now . . . I left [Howard] . . . aware of [my] Blackness, secure in [my] Blackness, proud of [my] Blackness . . . and I think that only happened because I was in this . . . safe haven of Blackness—this like diasporic magical . . . wonderland of Blackness, of all educated Black people . . . educated, driven successful, diverse, Black people. I left with this whole sense of grounding and appreciation.

Similarly, Grace commented on the differences she noticed between the close-knit Black community at church or in her family’s home state of Louisiana as compared to her day to day reality being raised in a suburb of Los Angeles. She credits her mother with making sure that every summer, she and her siblings returned to Louisiana for at least a month, closer to this sense of history. Fully aware of the contrast of her life in Los Angeles and her family’s roots in Louisiana, as an adult she now uses this to fuel her advocacy for patients and for young people. “I’ve had immensely powerful opportunities and privileges that are not afforded to many people who look like me, and great responsibility comes with that,” she said.
Sylvia, who experienced a similar cultural isolation in her predominantly White community in northern California, found refuge in Black culture through reading. As a mixed-race person living as a physical minority in her community, she remarked:

It seemed like there was this tacit agreement between the White people in the community and maybe me (I'm not sure if my dad was having the same experience), but you just didn't talk about race because it ultimately made them uncomfortable. So I kind of felt like I'm having this racialized experience—I’m very interested in my African American roots, but I'm not really able to talk about it or ask questions about it.

While she was able to experience occasional immersion when visiting family on her dad’s side in Oakland, it was getting lost in books by powerful Black women where she found her sense of peace. Losing herself in a world away from her reality, Sylvia commented:

I felt like Maya Angelou [1969] was a mentor because I read I Know Why the Caged Bird Sings when I was a teenager and was like, “Hey, she's a badass, check this out” and Alice Walker and, you know, Toni Morrison. . . . They were really important to me when there was a void in my life of Black women.

Circles of rejection and acceptance. One thing that is sometimes hidden in the Black community is how we do not always accept each other. The assault of “acting White” has been thrown on many members of the Black identity, including the study participants. Thinking back on her experiences growing up, Denise remarked:

I felt really judged by Black people when I was growing up . . . but now I feel like I'm older . . . so . . . I feel more confident with my race . . . it’s hard to explain, I don’t talk about it usually. It’s just like being more comfortable with my race kind of accepting or
realizing that what people say doesn't mean much as long as I know who I am and part of me knowing who I am is, you know, embracing my race.

Sylvia experienced a similar challenge with acceptance during college:

I was invited to a session with the BSU (the Black Student Union) at our school and it was a very, very unpleasant experience. They had essentially invited me to . . . I was not a participant . . . I was like the subject of the meeting and they wanted to know why I as a woman of color was dating White men rather than men of color and [I felt] just like super put on the spot about it and I felt humiliated and you know, like wow all of you guys, none of you know me, none of you have had a conversation with me, but you invited me here to like publicly scorn and by the way, none of you guys have asked me out!

Similar to Denise’s experience of coming to embrace the diverse definitions of Blackness, Sylvia has had a much different experience after graduating from nursing school. She is now a member of NBNA (the National Black Nurses Association) and NAHN (the National Association of Hispanic Nurses) and is finding a much different degree of acceptance and embrace than ever before in her academic and professional career.

Part Two: Experiences During their Graduate Health Professions Program

A look into the situations and circumstances of the women after matriculating into their programs revealed a necessity to create their own space; feelings of affirmation and other challenging encounters; as well as discussions around ensuring voice for a group that fully deserves the right to authentically and unapologetically be heard.
Creating Space

During the focus groups, it became clear that there were factors that affected the degree to which the women had to create new spaces for themselves in their graduate health professions programs. In particular, disposition and composition of the faculty and lack of action on diversity related issues were two notable points of commonality among the focus group participants.

Disposition and composition of the faculty. Diverse mindsets and diverse composition of the faculty played a key role in whether the women felt like they had an outlet within their graduate health professions program. Blackberry attended a program where there were currently no Black faculty or staff. The students had attempted to create a Pan-African student association but due to other pressing issues at the school, pronounced efforts to address diversity had not been the priority. In contrast, CW and Grace had generally positive remarks about the diversity and social activism of their health professions faculty, although this had not always been the case during their undergraduate experiences. Cathy and Journey both credit the small number of Black or LatinX attendees or faculty with doing what they could to recognize the challenge of difference the students might have experienced.

Lack of action. A recurring theme amongst the focus groups was the general passiveness of many of the women’s institutions around taking action to address issues of diversity or concerns of diverse students. When asked whether her institution created a safe space for her to talk about issues that were important to her, Journey responded:

Even if people in high places of Academia claim to care about the plight of the Black students, I rarely see that in actionable way . . . my answer might sound really negative but my answer to your question . . . would be . . . absolutely not because quite frankly we
weren't even supposed to be there . . . I will say that I've often had to kick more doors down to get people to hear me then there'd be some open town hall where they just welcomed that kind of critique.

Although they give full credit to the intentions of the individuals holding these positions, none of the seven women who participated in the focus groups had any meaningful interactions with a Chief Diversity Officer at their institution. Many of the participants had to actually conduct an online search in the midst of the focus group session to determine whether such a position existed at all in their educational space.

**Experiencing Both Ends—Feelings of Affirmation versus Challenging Encounters**

**Feelings of affirmation.** People (including patients) are often surprised when a Black woman wearing a professional or student white coat walks in the room. As role models, the women were aware that young people (including future health professionals) looked up to them and considered that an important responsibility of theirs. This awareness is part of the inspiration the participants had in moving forward to “mentor others,” “leverage [their] degrees for positive change and activism,” and be “a source of inspiration for young children of color.” Specifically regarding this aspect, Grace remarked:

I'm very rare. . . . I see immense amounts of responsibility . . . [to] get more young Black girls to where I am now and . . . to look out for people who share my background and to make sure that . . . our needs and our concerns and our health and our wellness and well-being are on the table when . . . decisions [are being made].
In reference to patient care, the women’s interactions with patients have brought them some of their most profound satisfaction. Grace recalled times when she was participating in medical team rounds:

I would see . . . when we would have Black patients or patients of color they would be kind of be looking at me like “Oh wow I have somebody who looks like me who is here to take care of me.” I could just see that kind of light come up in people and there would be patients who would pull me aside and [say] “I am so proud of you . . . keep going, you’re doing amazing” . . . literally, this is our first conversation and [they’re] in a hospital bed [and] I’m here to take care of [them] but we had that kind of deep emotional human connection through our shared identity and so I . . . really really love that.

**Microaggressions and implicit bias.** At the other end of the spectrum, however, it has been patients, and in some cases fellow students, who have demonstrated some of the most profound microaggressive behaviors and comments. When asked if they had experienced any encounters related to their identity that had been less than optimal during their programs, five of the women responded most certainly in the affirmative.

Blackberry remarked that people tend to be shocked at her intelligence, speaking ability, etc., questioning whether she is actually Black (inferring that intelligence or speaking ability must be associated with some other ethnicity). CW also remarked about the presumptions of classmates who assumed “at first glance” that she would be at the bottom of the class. “It isn’t until they end up figuring it out that all of sudden now people want to be your friend,” she said.

Grace, Denise, and Journey had all experienced microaggressions or manifestations of implicit bias from patients. Grace revealed that these encounters can be very frustrating, in
particular, noting “the frustration that comes with people not seeing . . . me . . . as a Black woman, not being able to . . . see and understand me as . . . a physician. Just because . . . they see . . . a White man in the room . . . it’s [assumed] . . . that's the doctor.” Denise remarked that she had definitely experienced similar encounters with patients:

But it's like we can't really, on our own part, we can’t really do or say anything . . . you just take it, especially in that patient environment . . . it's just kind of, keep on moving, you know . . . They’re very blatant too because they know that you can't do anything either. It’s kind of embarrassing too when it happens, and it’s happening around people who are not of color and so they’re like ‘what's going on right now’ and you don't have the time to explain it, you're just trying to [provide appropriate care for the patient and get away from the situation].

Journey explained that medical school does not train them for the unique nuances they will face as Black healthcare professionals. “There was no extra assistance offered in how to navigate these spaces as a Black woman. . . . I'm going to be a perfectly competent physician, but nobody told me . . . how to be a Black female physician.”

**Other challenging encounters.** While not directly related to race or gender, the women articulated other challenges during their programs, both curricular and non-curricular in nature.

*Curricular.* The women expressed frustration with unexpected expenses, changing instruction modes, lack of training for post-graduate opportunities and feelings of isolation during their programs. Blackberry mentioned unexpected expenses required for studying for boards. CW expressed frustration with a sudden shift from longitudinal courses to a block format (also at the point of studying for boards). Cathy, who ultimately chose to pursue a faculty role
upon graduating with her PhD in Nursing felt that equitable training should have been provided for key components of faculty responsibilities, such as teaching and diverse opportunities for research. Grace felt that socioemotional support near the end of her program could have been improved. As an M.D. student, the first two years of her program were didactic (in-class) and the last two years were out in the field (on rotation). She feels that there should be a check-in point during the last two years with classmates, to help cope with the day to day (sometimes new) clinical and personal challenges they now face.

Non-curricular. We may not fully acknowledge that these are adults with adult responsibilities. Given that the vast majority of health professions programs are full-time, they are generally time prohibitive of simultaneously pursuing full-time work. Nevertheless, Grace and Journey both had part-time jobs at various times during their medical school tenure. Denise worked “two jobs at two different pharmacies” while in pharmacy school, while actively serving in pharmacy student organizations, including in a presidential leadership role. CW and Blackberry both worked for a period of time during their graduate programs to fill in the gaps financially for family members who had lost their jobs or needed other forms of support. Cathy, who shared that she was the first in her family to go to college and certainly the first to pursue a graduate degree, explained that she also had to work to help support her family back home:

Even when things got hard it's like but I'm the only one that's earning enough money to . . . enough is not the right word . . . but I'm the only one who's earning any kind of money to help anybody. So, you know . . . it's hard. It's like but what's going to happen if I stop and how do you balance the two? I can't tell you how, but it happened.

The Power of Voice and the Importance of Meaningful Inclusion
One of the core purposes of this study was to amplify and compassionately listen to the voices of those who so frequently have their voices muted by outside forces. Two key portions of the study explicitly addressed the literal and psychological meaning that amplifying this sense of voice had on the participants. As part of the reflective questionnaire, the women were asked, “How did it feel to be asked your opinion and to be provided the opportunity to articulate your unique perspective?” Consistently, the responses demonstrated the affirming effect of active and engaged listening, as well as creation of a truly safe dialogical space. A full accounting of responses to the reflective questionnaire can be found in the latter part of this chapter. The full responses to this particular question are displayed here:

- It felt liberating and empowering to have a potential positive impact on this subject and the benefit it will have for generations to follow. (Jade)
- It felt good! Validating and affirming to have my experiences heard. (Grace)
- I'm always happy to share my experience, especially to an understanding, safe and supportive audience. I had no problem speaking my mind in this space because I knew my answers wouldn't be misconstrued or taken out of context. I didn't feel the need to tip toe as much as I would in other open interview type settings. (Journey)
- I felt like my opinion was valuable and I appreciated the opportunity to share. (Cathy)
- It felt great. It was an amazing opportunity to touch upon different subjects that I have held within on a day-to-day basis while going to school. (CW)
- It is not the first time my opinion has been asked, but the first time it felt like my opinion mattered. (Blackberry)
Given the value of soliciting voice, the focus group captured a snapshot of the status of whether this voice has been provided in current graduate health professions programs. Many of the women felt that there were formal feedback systems in place for individual courses in their program. To some degree, the amount of individual course feedback was deemed at times excessive with one of the women commenting that these types of tools were only taken seriously if there was a significant issue. What did seem to be lacking, however, was the opportunity for overall programmatic evaluation, particularly for inclusion of issues related to diversity, social determinants of health, and similar topics. When discussing the importance of inclusion of these topics in the curriculum, the women felt strongly that inclusion was needed in a comprehensive, fully intentional way, rather than as an individual course or as an elective side element. In fact, some of the most unifying discussion during the focus groups came around this issue. When speaking about this issue, Jade remarked:

I think they prepared me to just practice medicine . . . to make a diagnosis but not really understand some of the struggles and the plights of my patients. And so after graduation, I went on to pursue my public health degree because that was information that I didn't get in the PA program and that I wasn't prepared for . . . they fulfilled one part of the mission statement, but they completely failed in another part because I felt completely helpless trying to meet the other competing needs of my patients outside of writing them a prescription for a medication that they may or may not have been able to fill because they don't have money for food. . . . All medical programs need to have a better understanding of the patients you are about to serve.
In regard to how to include this content into the curriculum, many of the women were in agreement with what Journey explained “shouldn't be extracurricular . . . shouldn't be supplemental . . . shouldn't even be optional. It should be inherently part of your education as any other basic science course.” That being said, the women felt that a heightened level of attention should be paid to ensuring the course is meaningful and engaging as well as to who is teaching the course. Cathy and Journey both strongly agreed with this issue. By not using discernment in who is teaching the course, Cathy pointed out:

You're just perpetuating the problem that we're trying to address and unpack. I mean that's not acceptable but you need somebody to teach it and you know, you don't find someone who's willing to teach it who has the knowledge or the compassion . . . to actually do a good job of it. You just find someone who can or whatever, whoever signs up, or whatever criteria comes up and it's not the right person and that is the problem.

Part Three: Participant Reflections

While pieces of the reflective questionnaire have been revealed in other relevant parts of this text, this section will provide a space to holistically discuss the results of the reflective questionnaire from the study while the latter portion of Chapter 5 will address the author’s reflections as a critical data collection tool.

Reflections of the Women Regarding Participation in the Study

As noted in prior areas of this text, one of the core purposes of this study was to center the perspectives and experiences of Black women, a group that is so often glossed over, forgotten, stereotyped, and otherwise not granted the full credibility and action they deserve. The very act of being heard, of being asked one’s opinion and feeling that opinion is listened to in a
truly safe space, is powerful, perhaps beyond measure. This section will expand upon and dive deeper into the participant responses to the reflective questionnaire, examining their feelings about participating in the study, their experience looking back over their journey, and their inspirations and hopes moving forward. In addition to the questions articulated in other parts of this paper, the women were asked additional questions to reflect upon their participation in the study, all of which will be collectively analyzed here.

In the spirit of situating this work in ways that can be transformed into practice, this data will be divided into four components. The first component will briefly summarize the career-related reflective comments of the participants. The second will focus on the value of reflection itself, on looking back over one’s experiences and how those experiences have shaped who one is today. Finally, the third and fourth components will provide specific revelations relative to defining safe spaces and creating a listening culture, for Black women and others from minoritized groups.

**Career-related thoughts.** Regarding their academic and career background, the women were asked whether there were any aspects of their undergraduate or graduate education they would have done differently and whether their current career goals were different than when they first entered their graduate programs. Even though they were enrolled in or had graduated from highly sought after professional programs, some of the women noted the importance of the undergraduate experience and how it should be evaluated critically. When asked if they would have done anything differently, responses were particularly poignant relative to the bachelor’s degree, one stating that she would have chosen a different school, another that she would have spent more time connecting with faculty and students of color, and a third stating that she would
have asked for more help when needed. Most had different career goals than when they first entered their graduate health professions program and all were inspired to move forward as mentors or patient advocates.

**The power of reflection.** Often in the pursuit of highly rigorous academic programs or highly sought-after careers, so much of our effort is spent on “just making it” or on getting to that next step. Likewise, for incredibly resilient students/professionals, such as the women in this study, it may be unusual to acknowledge the accomplishments achieved or reflect on the role model that you now represent to others. To provide a breath of fresh air and acknowledgment to the women in this study, specific questions were discussed to invoke this well-deserved opportunity to self-reflect.

As part of the reflective questionnaire, the women were asked questions that not only allowed them to reflect back but also to inspire forward. In terms of reflection, participants were asked, “What do you think about your journey now looking back?” and “To what extent do you feel you can say you are proud of what you have accomplished?” Each of the respondents understood, now, how the various steps in their journey prepared them for who they are today. Moreover, they understood their positioning relative to others who may follow behind them or on whom they may now be positioned to have a positive effect. Relative to the challenges she experienced, Cathy reflected “I am so incredibly grateful for my journey even though it was challenging and it looked like there were numerous odds stacked against me (in hindsight). I realize now that I have a story to share with others and my voice deserves to be heard.” Relative to having pride in one’s journey, CW remarked, “Even though I forget sometimes, I am very proud of my accomplishments.” Similarly, in acknowledging help along the way, Blackberry
explained “My journey has been shaped by family, friends and professors who have been more than supportive [towards] the goals and dreams that I have.”

Using this reflection and the general experience of participating in the study, the women were asked “What is one thing you are inspired to do moving forward?” and “What is one thing you will do to engage in self-care going forward?” In regard to moving forward, half of the women were focused on mentoring or being an inspiration to others, while the remaining half were focused on ways to impact patients, from policy reform to patient advocacy and global health outreach. In regard to self-care, the majority of the responses recognized the need to prioritize their own health, whether that meant eating healthy, getting enough sleep, exercise, or making sure to take vacations/time off. Other responses reinforced the value of trying new things and of surrounding oneself with supportive family and friends. Towards this end, advice from the participants to other Black women likely summarizes it best. Journey suggests finding your “posse/niche/safe circle” and Grace echoes in saying “Find your tribe! People like you who you feel comfortable with, who support you, and can lift you when you’re feeling low.”

**Defining safe spaces.** Another significant theme that arose in this study was the need to create truly safe spaces for Black women to share thoughts and ideas. Accordingly, as a matter of practice, it is important to define what these “safe spaces” look like, from the lens of the study and from existing literature. In a “Faculty Forum” for the *Journal of Nursing Education*, Lepp and Zorn (2002), provided the example of a “circle” of safe space rooted in the culture of Native Americans and other Indigenous people around the world (p. 383). While the circle is a physical symbol, philosophically it represents a “sense of unity, harmony, connection and fellowship” (p. 383). Above all, these spaces represent those where each person in the conversation is treated
as an equal. Tactically, these spaces are those where each person introduces themselves or provides greetings at the beginning of the discussion and attention is paid such that “all . . . [are affirmed] as individuals with meaningful life worlds. In this way invisibility or students being treated as objects is prevented” (p. 385).

Similarly, as I conducted the focus groups with the women in this study, I made sure to create a space where everyone felt at ease and felt that they could be heard. I encouraged participants to speak up when their experience seemed unique or to chime in when someone else’s experience resonated with their own. Upon the advice of colleagues, I also started the focus group off with an icebreaker for the participants to get to know one another. Each of the participants seemed to recognize the value of the moment and were extremely respectful of one another during the course of the conversation. When asked what they learned from interacting with the other women in the focus group, responses reflected a sense of community and validation from learning that others are having similar experiences. For many, this sense of shared experience and perspective yielded a renewed passion for advocacy. As commented by Jade, “This was a phenomenal experience that yielded affirmation and hope for change!”

**Truly safe spaces.** Over the course of my career, I have been blessed with individuals who are few in number but vital in significance who served as mentors with whom I could share the reality of my work and academic experiences. I have also experienced the breath-taking harm of being retaliated against, bullied, or otherwise figuratively suffocated for speaking my truth in these same types of settings. The process of hearing the stories of the women in this study illuminated the importance of truly making spaces safe, not only for Black students but also for Black faculty and staff.
Safe spaces for Black students. One of the most affirming but also troubling moments in the study was hearing the responses of the women when asked to name an environment where they felt like they could let down their guard and be their authentic selves. Excerpts from the discussion surrounding this question can be found below:

CW: So I made . . . a group of close-knit friends at school where I can authentically be myself. [However] in school, I feel like I'm more . . . quiet . . . I don't really let . . . my personality shine just because a lot of people, unfortunately, think as a Black woman our personalities are over the top.

Journey: My mom calls it being bilingual [when referring to how we conduct ourselves and what we choose to say in different spaces]

Grace: It's to an extent. . . . I think we feel comfortable and . . . we start to kind of go there but then at the same time, we’re like, okay . . . there's just something in us . . . feeling that you kind of have to prove something, . . . that you have to . . . act or be a certain type of way because you're . . . let into this space that wasn't originally made for you. I think [that] . . . kind of pervades all of our daily interactions.

Cathy: As a graduate student, I think I definitely came in trying to be my authentic self and realizing that this culture was not ready for me to be my authentic self. So you know, it was a struggle to maintain that and so now I feel like I'm trying to not wear masks as much.
While much of this particular discussion centered around students feeling at ease in scholastic settings, for me it also resonated with the repercussions I have experienced in my professional career for speaking up or simply speaking truth in various settings.

_Safe spaces for Black faculty and staff._ Much of the discussion from both Blackberry and Cathy rested in either the lack of Black faculty or staff or in the lack of empowerment of Black faculty and staff, and the effect this has on students. No one wants to be hired as a token and moreover, no one wants to be retaliated against for standing up for what is right related to issues of race or for the instances when they dare to advocate for students with whom they have a shared identity. Blackberry noted instances in her program where other students had stated “well, you're not on the same competence level” or “you're nothing but an affirmative action [case].” When asked what the school could do to ensure this never happened to another student, Blackberry replied:

When a Black person brings up issues about being Black . . . it’s difficult to see an occasion where a White person [fully] understands that . . . so if I'm at an institution where I have no Black faculty or staff . . . if they don't see the importance of it . . . because we do have situations where . . . the Dean or someone would come and meet with the students . . . and they’re like ‘oh the faculty talk about it.’ Well when [we begin to discuss real issues related to race] . . . that is going to be such an awkward conversation between [that faculty member and the students]! [So then we think about it] . . . laugh and say ‘that [conversation] ends there.’ So we try to hold ourselves up and we've been doing well [taking care of ourselves; sticking together; finding out how we can help one another as students].
When recalling the importance and struggles of Black faculty during her graduate experience, Cathy remarked:

There were only a few Black faculty . . . when I was in my graduate program and they left during my program, but they were the people to reach out and just say ‘hey haven't seen you in a while, you doing okay,’ but again they were also dealing with their own challenges and there were few of them . . . and then again, they left for better opportunities and honestly, I think part of it was just you know, they just got tired of fighting that fight in that particular institution and it's like I'll fight it somewhere else.

Creating a listening culture. When performing an academic search for published works on “the power of being heard” or “safe spaces” within the scope of higher education, unfortunately, very few results can be located. There are, however, pieces situated in other contexts that help provide a basis for examining the type of culture needed to establish such a setting. In a 2017 article for Restorative Justice, Dr. Martha Brown discussed findings from her dissertation involving a study of Title I middle schools in Oakland, CA. While Dr. Brown’s study was situated in K-12 education, the findings relevant to developing a listening culture resonated with the comments of the participants in the current study about Black women in graduate education in the health professions.

For the schools in Dr. Brown’s (2017) study, there were several key components that had to be established for students and staff to feel that there was indeed a “listening culture” (p. 53). In her study, Dr. Brown identified that there must be attention paid to the “relational ecology” of the school and to the ways in which people in the institution relate to one another (p. 55). In this environment, everyone in the school community has an “equal opportunity” to be heard and to
hear others, especially when a harm has been committed (p. 64). Key themes underscoring a
listening culture are trust and structural processes, such as listening circles, that exist in the
environment to facilitate a truly equal exchange of ideas.

Similarly, when the women in the current study were asked to describe their feelings
about participating in the one on one interviews, words such as “comfortable . . . [at] ease . . .
safe and open” were used. Blackberry summarized her experience with the one on one interviews
in saying the “one-on-one interviews were private and intimate. They allowed me the
opportunity to express myself without my having to feel like someone else would glare or
misunderstand.” In addition, in alignment with the sense of peace that comes from open and safe
reflection, in the words of Cathy, respondents felt the one on one interviews were an opportunity
to bring up things they “hadn't thought about in a long time, or at all.”

When thinking about how to create a safe and welcoming environment for minoritized
students, faculty, and staff, these are important observations to note. As seen from the
questionnaire, the one on one interviews provided an environment of trust, comfort, and the
absence of judgement. The focus groups provided comradery, knowledge of others in similar
situations, and the importance of sources of support. As we begin to move beyond numerical
diversity, maintaining and nurturing safe spaces within a culture of listening will be key to
actionable inclusivity going forward.

In this chapter, I have answered the research question by describing the experiences of a
sample of Black women who gained entry to and/or completed graduate education in the health
professions. This description has included experiences leading up to their admission as well as
experiences while in their graduate health professions program. In addition, this chapter has
provided insight into the perspectives of these women upon looking back over their journey. The
final chapter of this work will summarize major findings, areas of alignment of departure from
theory, recommendations, and opportunities for future research. It will also provide a section for
the author’s reflections and concluding thoughts.
CHAPTER 5
DISCUSSION AND RECOMMENDATIONS

The purpose of this study was to learn from the experiences of a sample of Black women who defied the odds and successfully ascended to a graduate health professions program. Through a series of one on one interviews, focus groups, and a reflective questionnaire I had the privilege of learning from the journeys of these remarkable women. Chapter 5 will close out this study with an analysis of major findings, areas of alignment (or departure) from existing theory, recommendations, as well as opportunities for future research.

Major Findings

Some Mentors Are Inherent/ Others Must be Sought Out

Part of the purpose of this paper was to ascertain what it took for the women in this study to successfully ascend to the ranks of a graduate health professions student. Lent et al. (1994) postulated about the importance of having a mentor in close proximity to one’s life. That being said, given the history of the United States, relying upon who is in close proximity alone cannot be the sole basis upon which students must rest their hope for success. Only one of the women, Denise, had a health professional in her immediate family. While five additional participants had health professionals in close proximity in their communities or in their health professions-focused schools, two of the participants, Blackberry and Cathy, did not. For Blackberry, part of the difference was having a father who took proactive measures to ensure she had access to shadow a pharmacist in the local hospital. For Cathy, it was her own sense of persevering spirit that largely accounted for her willingness to go through whatever doors were open in her path. The lesson to be learned from this is that as adults with influence in children’s lives, it is our
responsibility to insist upon active measures to at least expose students to realities outside of their immediate surroundings. Moreover, even for those, such as Grace and Journey, who grew up in more affluent circumstances, it was actively seeking out mentors (for Grace) as well as immersing oneself in positive images of Blackness (Journey) that empowered them with the tools needed to navigate new spaces with pride, confidence, and a firm sense of their own identity.

**Experiences and Forward-Thinking Reinforcement Matters**

**The importance of “out of the box” experiences.** One of the issues with the structure of American education is that we ask all students to pick a major very early in their lives, before many have had the experiences to responsibly make this decision. Therefore, many college students may (by default) select a major that fits within the logic or “box” of what they currently know. This tendency, however, can have an extremely limiting effect on a student’s ability to push past their situational boundaries and walk into true, generation-changing opportunities. For four of the participants, engaging in activities outside of their pre-existing boxes meant experiences abroad or attending high schools with consistent exposure to health professions-related experiences.

While programs such as study abroad may not get the attention they deserve, for Journey, CW, and Cathy, were it not for early experiences abroad, they might have been locked out of an entire set of possible career specialties and trajectories. For this reason, as members of marginalized groups, we must advocate for ways for our children to have access to these types of experiences as well. Groups such as Girls Going Global, are, for example, realizing the transformational power of these experiences and are doing their part to expose young Black girls
to worlds beyond their own. By organizing trips abroad for girls of color and accompanying mentors, Girls Going Global, and others are taking the first step towards reducing these types of disparities (Girls Going Global, 2019).

Jade and CW did not have a health professional in their proximate circumstances, however, they both attended high schools that provided consistent exposure to health-professions related experiences. Jade attended a high school in urban Los Angeles adjacent to a medical school and hospital known for service to the Black community. It is important to note that this high school was available to Jade due to school choice, not due to circumstances that were financially superior. CW also gained this exposure by attending an elementary school with an accelerated science and math program and a vocational high school that provided hands-on science related experiences.

**The importance of forward-thinking reinforcement.** As we grow and develop the voices that surround us ultimately may have a large impact on how we think about ourselves and what we later become. While not directly related to a health profession, the power of the voices of the women surrounding the participants in this study cannot be overstated. Cathy was influenced by the strength of her grandmother, who as a widow fought to own her own home and gain her financial independence, demonstrating to Cathy that she too could push past any barriers that stood in her way. Similarly, CW was influenced by her mother who raised her in the absence of her father as was Denise whose mother always cautioned her to “excel in what we believe in . . . because if you don't do it, no one else is.” Grace benefited from a mother who was open with her about challenges she faced and Sylvia credits much of her success as a writer to the guidance and keen editing skills of her mother. All of these influences helped the participants to not shy
away from the qualities that made them who they were and to stand proudly and go boldly into what they aspired to become.

**Sense of Security Matters**

With the rising burden of debt among many college students today, we cannot underestimate the critical decision that is made in both attending college and in deciding what to do once there. While it is true that (on average) over the course of one’s lifetime, college graduates have been reported to make more, this must be balanced against the debt/interest that these graduates pay throughout the course of their lifetime as well as the number of people who are employed in something outside of their degree. In alignment with the career pathways component of President Obama’s *Workforce Innovation and Opportunity Act* (2004), we owe it to the next generation to help them think critically not only about getting to college but also about what types of vocations will both bring them joy and facilitate a reasonable ability to take care of themselves and their families. For Sylvia, after experiencing housing insecurity and other income-related challenges, despite having a mother with a doctoral degree, nursing, for example, provided a fit between both of these considerations. Likewise, while Cathy initially had career intentions outside of the health professions, the thought of nursing as a fall back option was always there. Moreover, as she was exposed to different aspects of and opportunities in nursing, she also now works to encourage others to consider nursing as a first option as well.

**Student Diversity Starts with a Diverse and Supported Faculty**

Blackberry expressed significant frustration with the absence of Black faculty and Cathy noted how Black faculty who were once in her program left during her tenure as a student. It has been said that part of the power of having a Black faculty member is to provide mentors and
sources of support to students. However, if the Black faculty who do miraculously make it through the screening process to employment do not feel supported once there, ultimately, it is the students (in addition to the faculty member themselves) who suffer. We must think in active terms about how to better support diverse faculty and staff once hired. Otherwise, it will be the students, recruited under the pretense that they have access to such faculty, who will suffer. The effect of faculty and staff turnover on health professions students, especially when these individuals are members of underrepresented groups, is an area that warrants further research. While studies have examined the challenges of retaining diverse faculty (Price et al., 2005; Stanley, Capers, & Berlin, 2007), minimal research has directly sought the feedback of the students left behind in their absence.

**Bias—Both Inside and Outside of School—Must be Addressed**

When encouraging students to pursue a profession, it is also important to be realistic about some of the challenges they may face while engaging in the practice of that profession. While implicit bias in the classroom is beginning to be a much more studied phenomenon, for the participants in this particular study, implicit bias from patients was found to be much more universal. Patients, in this case, are not only the customer/client; understandably, patients also encountered the women in this study (and other clinicians) when they were at their very worst. For this reason, it becomes very difficult for women and clinicians of color to take action at the point of care to address implicit bias that they exhibit. A 2019 article in the *Journal of Ethics* for the American Medical Association noted that “relatively little has been done to address the problem of patients’ discriminatory behavior towards health care professionals” (Paul-Emile, 2019, p. 517). Especially for “trainees,” these issues are complicated, straddling requirements to
treat all patients versus employment law establishing the right to a workplace free of
discrimination based on sex, race, religion, and ethnicity (Paul-Emile, 2019, p. 514). More
models, including those advocated by Kimani Paul-Emile (2018) and others need to be studied
and ultimately implemented to better assist trainees, supervisors, and clinicians with coping with
patient bias.

**Inclusion Must be Genuine and Meaningful**

A key theme of the discussions around diversity and inclusion for the participants was a
lack of action. More than one participant reflected upon experiences of being asked to pose for
brochures or being tasked with being on every committee because they were one of few, or the
only Black student or professional within reach. Furthermore, while at least two of the
participants had Chief Diversity Officers/Offices assigned specifically to their schools, none of
the participants expressed feelings that this person or office, while well-intentioned, had any
effect on their lives as an individual student. Given that this study involved eight women who, in
some respects, represent the very population that inclusive practices are designed to protect, we
must do better in making our diversity practices, genuine and meaningful. While marketing was
traditionally used as the default tool in telling the story of diversity, if there was no meaning
behind the message, these efforts failed to impact the very people they were originally designed
to protect. The need to ensure substance behind diversity efforts is supported by a growing
number of studies. These studies investigated university tendencies to project “cosmetic
diversity” (Ford & Patterson, 2019, p. 99) or utilize websites featuring ethnic diversity as a form
of “self-presentation” to recruit future students (Boyer, Brunner, Charles, & Coleman, 2006, p.
136).
There is Power in Being Heard

Far too few academic works focus exclusively on the experiences of Black women, where their issues are not pushed to the margins, but instead are the center of topics being discussed. Consistently, the reflective questionnaire responses exhibit that for many of the participants, this was their first encounter with being so clearly and unapologetically heard. As noted by Blackberry, “This was not the first time I have been asked my opinion, but this is the first time I felt like my opinion mattered.” Moreover, the safe space created by the study, ensured that the women felt that their words were not going to be, as Journey remarked, “misconstrued or taken out of context.” Given that so many of the women described this freedom and safety as a being a “first,” this begs the question, what are other ways that we can more frequently provide this well-deserved opportunity to other marginalized students and professionals?

A summary of major findings can be found in Table 3 below:

<table>
<thead>
<tr>
<th>Finding</th>
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<tbody>
<tr>
<td>Finding 1</td>
<td>Some Mentors are Inherent/Others Must be Sought Out</td>
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<tr>
<td>Finding 2</td>
<td>Experiences and Forward-Thinking Reinforcement Matter</td>
</tr>
<tr>
<td>Finding 3</td>
<td>Sense of Security Matters</td>
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<tr>
<td>Finding 4</td>
<td>Student Diversity Starts with a Diverse and Supported Faculty</td>
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<tr>
<td>Finding 5</td>
<td>Bias—Both Inside and Outside of School—Must be Addressed</td>
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<tr>
<td>Finding 6</td>
<td>Inclusion Must be Genuine and Meaningful</td>
</tr>
<tr>
<td>Finding 7</td>
<td>There is Power in Being Heard</td>
</tr>
</tbody>
</table>
Areas of Alignment and Departure from Existing Theory

The next part of this chapter will discuss areas of alignment with the theory used to ground this work. As noted in previous chapters, these three theories included Black feminist thought, social cognitive career theory, and the Ford female achievement model for excellence. While there were areas of alignment with each of these theories there were also areas where the information from the study illuminated new information not specifically articulated by these particular theoretical frames.

Black Feminist Thought

As it relates to Black feminist thought, the writings of Collins (1991), hooks (1981), Crenshaw (1989) and Steele (2010), cause us to take a deeper look behind not only the experiences of the women in the study but also at the assumptions embedded in the socialization surrounding their experiences. This section will begin with an attempt to decode what it meant for the women in the study to stand out front in their academic and professional pursuits. Next, it will discuss the importance of the women finding their way and creating their particular circles of support. Third, it will explore the concept of feminism and its importance relative to the experience of being Black. Finally, this section will conclude with summative thoughts relative to the “situational contingencies” and “concentration of factors” that underscore the Black female experience (Steele, 2010, p. 87, p. 26).

Decoding and redefining what it means to stand out front. Perhaps due to the participants in the study representing a new generation of Black scholars/clinicians, the women in the study articulated ways in which they fought to stand “out front” versus being pushed behind others. This is somewhat of a departure from some of the revelations originally
articulated in Black feminist theory. Historically, Black feminist thought as originally articulated by Collins (1991), largely investigated Black women’s relationship to Black men, to the Black community, and to other women. Questions relating to romantic relationships were not discussed, and consequently there was not a great deal of feedback from the women on their relationships with Black men. Collins’ (1991) discussion of relationships with the Black community primarily centered around Black women being asked to take a back seat, publicly, to Black men in community anchors such as the Black church. As it relates to feeling pushed behind the scenes, publicly, in relation to Black men, none of the women in this study articulated this concern. In fact, five of them were inspired by “fierce” women who gave them the courage to resist taking a back seat to anyone at all. The relationships of the women in the study relative to the Black community centered around being squarely focused on improving health and fighting injustice. Thoughts of taking a back seat to others within this effort did not appear.

While standing out front was a clear characteristic of the participants, this standing did not come without struggle, however. One issue that was not discussed outright but was clear in speaking with the participants was the strength these women had to maintain in pushing through their daily experiences. This strength, however, came at a cost. In her book, hooks (1981) noted:

When feminists acknowledge in one breath that Black women are victimized and in the same breath emphasize their strength, they imply that though Black women are oppressed they manage to circumvent the damaging impact of oppression by being strong . . . that is simply not the case. . . . To be strong in the face of oppression is not the same as overcoming oppression. (p. 6)
Given this, it is reasonable to question whether any of the participants felt “safe” exhibiting vulnerability in their school or clinical environments or whether they were so accustomed to having to be strong that they were no longer able to notice the degree to which they were “fighting” on a daily basis. This tendency to exhibit strength even to the extent of not recognizing it may extend to the ways in which the participants expressed frustration relevant to implicit bias from patients as well. Crenshaw (1989) reflected upon the socialization of Black women to simply endure circumstances that in reality should be unacceptable. hooks (1981) noted that this socialization may lead Black women to “feel that our interests [are] not worth fighting for, to believe that the only option available to us [is] submission to the terms of others. We [do] not challenge, question, or critique; we [react]” (p. 9).

Creating their circles. As it relates to positioning within the Black community, two of the women struggled to find their place amongst other African American peers who saw them as acting White, criticized them for dating outside of their race, or placed unfair judgement on them for, perhaps, not meeting a stereotype even within their own communities. The lesson learned from these experiences is that there is diversity within the Black community. The women learned not to associate singular instances of rejection with all and to realize that there is a place for their purpose. In fact, the participants who initially felt rejected have now created celebrated relationships, as they have grown and been introduced to a more diverse circle of individuals within the Black race who share their sentiments, passions, and career interests.

This need to discover circles where they will find support extends to the women’s relationships with faculty members. Journey, Blackberry, and Cathy all commented on the relative lack of faculty members of color or, in Journey’s case, the comradery with Latinx
faculty, given that they were the only faculty of color within her school. Steele (2010) commented on the power of a critical mass of racial minorities or women in a space as being important for those who fall into these categories to feel comfortable in that particular environment. With that said, however, it is worth examining whether having one Latinx faculty member or one Black faculty member is enough for that individual to feel numerically significant and welcomed in that space. It is perhaps in the best interests of our students that we advocate for multiple faculty who meet these descriptions and who represent the identity of multitudes of students, including Black female students.

**The relative importance of feminism.** The concept of being a woman, and by default, the relationship to other women was not as pronounced in discussions with the participants as the concept of being Black. This is a notable observation. This could be due to disenfranchisement based on one’s race being so pronounced that time to think through and recognize disenfranchisement based on gender is a luxury that Black women have not always had. In *Ain’t I a Woman*, hooks (1981) articulated the phenomenon of Black women not having an awareness of treatment based on gender. This may partially account for treatment based on race being foremost in the awareness of how many of the women articulated their experiences.

Another area where the lines separating the female experience (versus the Black experience) became blurred was in regard to stereotype threat. One of the women remarked that as a Black woman, many of the other students initially underestimated her and that this fueled her desire to prove them wrong. Future studies should investigate then, whether any of the women of other ethnicities in similar circumstances feel this way or whether this is a unique/intersecting experience felt by those who carry the Black female identity.
Situational contingencies and a concentration of factors. Finally, the diversity of perspective and experiences within the participant group is an element that is important to discuss. There is something to be said about the situational differences of the women in the study. Some attended health professions schools in historically liberal cities with faculty they described as activists in their own right. Others attended private health professions schools in the suburbs or those in outlying areas that historically had struggled to match the diversity of thought more frequently associated with their urban neighbors. Steele (2010) found in his studies that “social identities like whiteness and blackness were rooted in situational contingencies” (p. 87). Thus, dependent upon the composition and disposition of fellow classmates and of the perceived support of faculty and staff, the consequences of one’s race could be felt more strongly in one setting versus another.

As efforts to recognize and include Black female voices in health professions education increase, successful outcomes will be based in-part on the extent to which health professions schools are able to address the “concentration of factors” that affect Black students in these settings. These factors, according to Steele (2010) range from “racial marginalization [and] racial segregation of social and academic networks” to “group underrepresentation in important campus roles [and] racial organization of curriculum choices” (p. 26). While the women exhibited diversity of perspective on a number of fronts, there were aspects of their experiences as Black women in highly rigorous fields that united them nonetheless. By earning a seat in a graduate health professions program, each of the participants have demonstrated that they are high achievers, at the vanguard of academic resilience amongst thousands of students vying to make it through the health professions pipeline. For this reason, as students embodying multiple
identities at the height of their profession, the sometimes unacknowledged, self-inflicted pressure can be incredibly intense. As noted in an unpublished study by Mikel Jollet, an undergraduate protégé of Claude Steele, “[W]hat made . . . vanguard Black students susceptible to stereotype pressure was not weaker academic confidence and skills but stronger academic confidence and skills” (Steele, 2010, p. 58). Their strengths led them to tie a portion of their identity to their success in school and as a result “to care about school and how well they did” (p. 58).

In closing out this section, it is helpful to reflect on an aspect of Black feminist thought that clearly echoed the sentiments of the women in this study—the liberating necessity of Black women being able to and encouraged to speak for themselves. Collins (1991) referenced the tendency for groups or individuals to feel that they can speak for Black women, and that actual insistence upon encouraging Black women to speak for themselves is unnecessary. By focusing this entire work on amplifying the voices of a doubly marginalized group, this paper is one step towards bringing these vibrant, intelligent, and deserving voices out of the shadows. The next portion of this chapter will examine participant experiences through social cognitive career theory and Ford’s female achievement model for excellence, tools that form the theoretical branches of our understanding of the study results.

**Social Cognitive Career Theory**

Social cognitive career theory largely addressed the career exposure and career selection portions of the study. Originally posited by Lent et al. (1994), social cognitive career theory, or SCCT, divides career going decisions into three components: interest, choice, and performance. The authors propose that career interest is developed by “repeated activity engagement, modeling and feedback from important others” (p. 89). Career choice is divided by the authors
into career intentions (what students aspire to do) to career behaviors (what students actually do). Finally, performance discusses whether students were able to perform to meet the necessary requirements of the career.

**Career interest.** Regarding career interest, the necessity of repeated exposure and engagement held true for seven out of eight of the women. These seven either attended STEM focused or resourced schools or had health professionals in close proximity to their lives. The career interest aspect of SCCT did not hold true for one participant, Cathy, however. Cathy, in fact, defied the odds, given that she did not have these influences consistently present. For Cathy, an intervening combination of chance encounters intermingled with a supportive, student centered undergraduate experience that illuminated the normality of Black success helped to chart her path forward.

**Career choice.** Six of the women seemed to have relatively defined career intentions early in life, which through their hard work and supportive mentors transitioned into the career behaviors necessary to gain entry to or graduate from a health professions school. For one of the women, much of her career intentions were based on identifying an option that provided financial stability. This foundational need combined with simultaneous access to health professionals likely contributed to her identifying nursing as a profession for which she could direct these intentions. Even in the absence of health professions career role models, another participant was able to academically and personally persevere until liberating and revealing doors opened along the way.

**Career performance.** Lent et al. (1994) posited that student performance is largely dependent upon a having a high degree of self-confidence, setting high performance goals, and
mastering building blocks along the way to one’s goal. To a certain extent, health professions programs, by the nature of how they are structured, tend to align with these tenants. For example, simply gaining entry into medical school is a high-performance goal in and of itself. Furthermore, to reach this goal, one must complete stepping stones of undergraduate courses, standardized tests, essays, applications, and interviews as a prerequisite for entry.

When examined on an individual or personal level, however, for the participants in this study, the source of ability to perform was not as clear cut as Lent et al. (1994) had suggested. Several of the women mentioned experiencing imposter syndrome and doubting whether they had the ability or right to be in the pre- or post- matriculation health professions educational space. While the women tapped into a degree of self confidence in pursuing their end goal (of becoming a doctor, nurse, etc.), many had to actively seek mentors, “near peers,” and other outside influences to boost self-confidence and provide a sense of reassurance along the way. Regarding setting high performance goals, the women had differing experiences at the secondary and postsecondary levels. Some attended poorly resourced high schools or unsupportive undergraduate schools whereas others attended heavily endowed, sufficiently resourced, academically challenging secondary schools. While the type of school one attends does not necessarily correlate directly with the type of goals one sets, those who attended highly supportive schools appeared to have more instances of guidance and direction from teachers, counselors, and other educators than those in schools that were less supportive. In terms of mastering building blocks, some of the women had to overcome “broken” blocks along the way. Both CW and Sylvia mentioned having negative experiences with specific teachers in high school that affected how they initially performed in college. Likewise, the building blocks of
Cathy’s goals were not specifically crystalized until the latter part of college, but instead influences of strength from her grandmother and others helped her walk through doors even if what was on the other side was something that she, nor her family had ever experienced.

**Ford’s Female Achievement Model for Excellence (F²AME)**

The model that perhaps most clearly provides educational tools associated with the results of this study was the Ford female achievement model for excellence, or F²AME. Portions of the four dimensions of F²AME (academic, psychological, socio-emotional, and cultural) were found in the statements, reflections and experiences of each of the participants.

**Academic dimension.** Within the academic dimension, work ethic, field-independence, and flexibility/adaptability were clearly consistent traits. After moving quite a bit during her youth, Cathy developed a knack for figuring things out in various circumstances and being able to adjust to different environments. This skill has manifested into a sense of field-independence and flexibility/adaptability that has served her well over the course of her career. The openness of Grace and Denise to involvement in student activities as well as the adaptability of Journey, Cathy, and CW to immersing themselves in global health issues and experiences demonstrates a flexible and adaptable mindset similar to that outlined in F²AME.

**Psychological dimension.** Within the psychological dimension, resiliency, intrinsic motivation, goal orientation, and racial pride were prominent throughout the participant interactions. At a certain level, the participants’ ability to persist not only through the bachelor’s degree but also through two to five years of post-graduate work exhibits a certain degree of intrinsic motivation in and of itself. This underlying need to be self-motivated is underscored by
Jade’s comments when reflecting about the small number of African American students in her health professions program:

Out of a hundred there were probably five percent African American male or female students and so it was really kind of reminiscent of undergrad where there weren't a lot of us and so, you know, we rallied together to encourage each other but moreover . . . [I had to remember] why I decided . . . to start the journey because it didn't matter what anyone else thought, be it family or friend, I had to be the one to stay up studying and preparing and all of that.

Relative to goal orientation, many of the women clearly exhibited this trait, albeit in their own way. Much of this was exhibited through their determination to make a difference in the next step of their academic or professional careers. Cathy, Jade, and Sylvia were strongly committed to increasing the diversity in their respective professions, serving on Admissions committees for their institutions and bestowing confidence in undergraduate and secondary students. CW, Journey and Grace had specific desires to impact future clinical practice, whether it be working internationally, affecting health policy, or increasing awareness of the importance of mental health. Finally, while traditional notions of feminism were not featured prominently in the comments of the participants, modeling of strong women for five of the participants most likely developed a sense of gender pride or at a minimum a refusal to take a backseat to men in pursuit of their goals.

**Socio-emotional dimension.** In relation to the socio-emotional dimension, two of the women (Sylvia and CW) commented on their experiences making social sacrifices and how this is important for students wishing to pursue a health profession. More specifically, Grace
expanded on how these sacrifices can occur within the context of ups and downs of the medical school admissions process:

I took the MCAT . . . during the Spring of my junior year in undergrad . . . that process was just . . . emotionally and intellectually very draining and exhausting in addition to . . . I was taking . . . four and five classes. I was an athlete so I was training and having games. I was heavily involved in campus activities and on top of that I was studying for this big test that was going to quote unquote determine my future . . . I'm going to finally achieve my dream . . . so I was happily kind of sitting down on Saturday night or Sunday, you know party time when everyone was going out and having fun . . . So I was . . . kind of a weird . . . masochist in a way . . . then I remember getting my score back and it was low—like it was not at all where my goal score was. It was lower than . . . I was getting on the practice test and it was just like the most demoralizing thing in the world and [I] . . . remember just like bawling when I got the score report back.

Despite all of this, Grace, was later admitted to one of the top medical schools in the United States, Sylvia now holds a PhD in nursing, and CW was more than half-way through her Podiatry program at the time of this research. Given these outcomes, one might reflect that a certain degree of social sacrifice is worth it. Furthermore, as another element of the socio-emotional dimension, the requirement of all of the women to independently pass clinical progression requirements demonstrates an extensive amount of self-sufficiency in their personal character.

Cultural dimension. Finally, within F²AME’s cultural dimension, cultural pride and cultural competence were of paramount importance to all of the women. Even those who initially
struggled to find support within the African American community now take pride in significant involvement in culturally relevant health professions groups. The vast majority of the women also support formal longitudinal inclusion of health equity, social determinants of health, and cultural competence content in the health professions curriculum. Moreover, the reference to being “bilingual” and having to navigate the cultural and linguistic landscape of their various clinical and classroom settings was not only referenced in F²AME but also explicitly identified as a requirement during one of the focus groups.

A summary of this study’s key areas of alignment with Ford’s Female Achievement Model for Excellence can be found in Table 4 below:

Table 4
*Key Areas of Alignment with Ford’s Female Achievement Model for Excellence (F²AME)*

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<thead>
<tr>
<th>Dimension</th>
<th>Key Areas of Alignment</th>
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<tr>
<td>Academic</td>
<td>Work Ethic</td>
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<td>Field Independence</td>
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<td>Flexibility/Adaptability</td>
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<td>Psychological</td>
<td>Resilience</td>
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<td>Intrinsic Motivation</td>
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<td>Goal Orientation</td>
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<td>Racial Pride</td>
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<td>Socio-Emotional</td>
<td>Social Sacrifices</td>
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<td></td>
<td>Self-Sufficiency</td>
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<tr>
<td>Cultural</td>
<td>Cultural Pride</td>
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<td></td>
<td>Cultural Competence</td>
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Recommendations

Based on the work conducted in this study, the following section brings together recommendations for various sectors of education as well as for entities outside of education who have impact on the experiences of students and graduates. First, recommendations for educators working in the K-12 context are discussed. Next, recommendations for those engaged in efforts at the undergraduate and graduate levels are examined. Finally, recommendations for practicing clinicians and policy makers are provided.

K-12 Education

For K-12 education, this study encourages a look beyond “college readiness.” Just as graduate education should be concerned with the plight of their students beyond the immediacy of graduation, so must K-12 educators when considering how to advise and educate students. It is a perhaps an injustice to structure twelve years of education primarily around getting to the next level of education. Perhaps we should begin to think more critically and structure tests, A-G requirements, and other mechanisms around demonstrating life skills, technical expertise, and other vocationally relevant abilities to better ensure that our populace is not only educated but also that prosperity extends beyond the 1%. For the health professions, specifically, more conversations need to be held around the diversity of options, other than just “medical careers” or the physicians portrayed on American television. Perhaps K-12 programs targeting “medical pathways” should be re-directed towards the specific specialties (such as doctorally prepared nurses and primary care physicians) that are clearly lacking amongst providers currently available, towards the ways that emerging forms of technology are changing these professions, and towards ways that we can more equitably serve frequently left behind groups (American
Association of Colleges of Nursing [AACN], 2020; American Association of Colleges of
Medicine [AAMC], 2020).

**Undergraduate Education**

Many of the recommendations for K-12 education extend to undergraduate education as well. Given the time limits of most scholarships, at a certain level, some might define undergraduate education as being “too late” to implement the types of deep structural changes that need to be made to truly impact the numbers of underrepresented groups pursuing a health profession. This sort of dooms day sentiment, however, is unfair to those for whom the bachelor’s degree represents their first journey beyond the socioeconomically limiting circumstances of their native surroundings. Thus, we must re-think the composition of “general education” requirements in undergraduate education. So much of the first two years seem to be spent demonstrating basic competencies versus spending time on experiences to determine which competencies might be most important for the goals of that individual student. While these elements of our existence are important, perhaps instead of every College freshman or sophomore being required to take American History, Geography, and College calculus, perhaps these courses should be replaced with required immersion experiences so that students can actively understand why these subjects are important to our humanity, or more directly, what types of careers can be discovered through each of these areas. For example, instead of requiring an American History lecture course that primarily involves taking notes from Power Point, perhaps all students should be required to perform a certain amount of hours of community service studying the impact of how the history of America has left permanent inequities in the lives of various groups of Americans.
Undergraduate education’s responsibility for building the diversity and inclusion framework. As explained in earlier sections, the focus groups in this study examined and critiqued the experiences of the participants during graduate school. Clearly educators in graduate school settings bear a responsibility for proactively addressing the conditions of students entrusted to their care. That said, the intensity of issues in graduate school could be curtailed if they are more effectively addressed at the undergraduate level.

Diversifying undergraduate faculty and staff. There are students who will graduate from masters and doctoral level programs having had only one or perhaps zero Black faculty members in their entire higher education experience. This ongoing phenomenon is truly unacceptable. Increasing the numbers of supported Black and other faculty of color is critical, not only at the graduate level, but at the undergraduate level as well. As demonstrated by many of the participants in this study, mentorship at each stage of progression is important, especially during the bachelor’s degree timeframe, critical to shaping the future of one’s trajectory as a young adult. While increasing faculty diversity in STEM appears most directly related to the experiences of health professions students, faculty diversity in social sciences and other areas can influence the holistic development of future clinicians as well.

Better supporting Black women and other underrepresented students. Study participant Jade reflected on her challenges attending a large state school for her bachelor’s degree and how she looked to community college to fill the gaps she missed at her four-year institution. She also commented on how the experience during her Physician Assistant graduate program was “reminiscent of undergrad where there weren’t a lot of us.” Despite the size of the school, students who make the choice to attend our institutions deserve to be supported and recognized
for their individual needs and contributions. Particularly when students represent such a significant minority, venues in which those with shared identities can gain support should be a minimal expectation of higher education at any level.

**Anti-bias training at the undergraduate level.** Some of the most critical literature reviewed for this work discussed implicit bias in the graduate health professions classroom, with the results of this study illuminating additional pronounced bias from patients as well (Ackerman-Barger et al., 2016; Rainey, 2001; van Ryn et al., 2015). It is safe to say that the bias evident in graduate health professions education did not start there and as such, undergraduate educators also bear a responsibility for impacting the cultural humility of the prospective student pipeline. Just as chemistry, biology, and (in some cases) entrance exams are prerequisites for admission into health professions school, so too then, should requirements for consistent anti-bias training during the bachelor’s degree. Relevant to aspiring health professions students, the implementation of this training could be in collaboration with graduate health professions schools who set the competencies necessary for aspiring health professions students to pursue. As noted by the success of the longitudinal course format explained in Beck et al. (2014) anti-bias courses that are didactic and experiential in nature should be required over multiple years of the undergraduate experience.

**Broadening true access to student programming.** One of the key findings of this study was the importance of engaging in out of the box experiences, particularly in study abroad. A 2015 article published in *The Atlantic* noted that only five percent of study abroad participants are Black (Tensley, 2015). The opportunity to study abroad forces one to step outside of not only their comfort zone but also out of the oppressions and challenges of their particular surroundings.
For people of color living in the United States, this could be particularly helpful in embracing their power to challenge the status quo as well as discovering how their plight aligns with those in other parts of the world. Broadening access to these types of eye-opening experiences should be a major focus of philanthropic efforts at the undergraduate level and to the efforts of academic and career advisors.

**Graduate Health Professions Education**

**Recruitment and admissions professionals.** Recruitment and admissions professionals are advised to be intentional about recruiting at Historically Black Colleges and Universities. It is there that one may find pearls of excellence, like Cathy, who bring with them a richness of experience and understanding critical to serving future patients. Recruiters should not fixate on one aspect of a student’s profile. Several of the women struggled with the MCAT or with a particular subject yet have proven themselves to be incredible leaders in many aspects of their health professions class. Schools should bring more Black women to the forefront in admissions panels and for input on admissions committees. Not only is it important for prospective students to see these role models but the school will benefit from highlighting their often unheard perspectives.

**Student affairs and curriculum professionals.** Student Affairs and Curriculum professionals should prepare to listen and be ready to act on the viewpoints of Black female students. Do not hide these women’s perspectives behind any other group but instead encourage these students to speak up and be heard. Create truly safe spaces for Black female students, staff, and faculty to highlight issues of concern. Utilize the resources and critical mass found in national organizations, such as the Health Professions Chapter of the National Association of
Diversity Officers in Higher Education, to bring Chief Diversity Officers out of the shadows and into acts of meaningful implementation. Regarding curriculum, health equity content must be a required, consistent and pronounced part of the curriculum. This is critical if we truly intend to serve the needs of our socioeconomically different society.

**Practicing Clinicians and Policy Makers**

For practicing clinicians and policymakers, some of the most important information from this study revolves around the importance of giving back, having discussions about how to cope with patient bias, and inclusion of health equity content in the curriculum. The only way we are going to increase the numbers of minorities practicing in these professions is if, those who understand their plight, take the time to be visible and to share their stories with the next generation. While more platforms need to be created, activities are being hosted from the high school, through the community college and on to the baccalaureate level to provide exposure to students who otherwise would not benefit from this expertise. Some organizations are even creating online platforms, such as MentorNet (healthcareers.mentornet.org), to allow practicing professionals to connect with students in an online format, reducing travel cost and time for all involved. For policymakers, in addition to getting involved in the career exposure efforts taking place in the schools and in the community, more discussions need to be held regarding how to cope with bias received from patients. These discussions should be extended to those just entering the clinical environment, including interns and others completing rotational exercises within the clinical setting. Policy makers also have the prerogative to make significant and longitudinal inclusion of health equity content in the curriculum as a mandatory component of meeting accreditation and other structural requirements as well.
Opportunities for Future Research

This study represented one of the first, if not the first multi-disciplinary study of the lived experiences of Black women in health professions education. Thus, it fills a void in published literature on this topic thus far. Based on the issues raised in the study, it identifies further areas worthy of additional research. Since this study overlapped both clinical and educational domains, there are a number of directions in which future research could lead. The following observations and recommendations are generated from the lens of attempting to provide solutions to some of the issues identified in the study.

Investigating Curricular Models Focused on Health Equity and Social Determinants of Health

With the exception of individual course offerings (Avant & Gillespie, 2019; Fischbach & Hunt, 1999), there seems to be a lack of examples in the literature of health professions programs that have substantially integrated health equity content longitudinally into the curriculum. This does not mean, however, that such examples do not exist (Beck et al., 2014). Going forward, hopefully more instances of actively implementing this type of curriculum will be documented in the literature to serve as a roadmap for others.

Documenting Actionable Diversity and Inclusion Efforts

Furthermore, this study, along with the creation of the Health Professions Chapter of the National Association of Diversity Officers in Higher Education, provided evidence of the need for a more visible/impactful role of Diversity Officers on the individual student and faculty level. Perhaps future research could investigate what conditions need to be present for meaningful
inclusion to occur and what models, most relevant to a health professions setting, exist that could be replicated in the future.

**Methods of Coping with Patient Bias**

As evidenced by the participants in this study, further efforts need to be made to bring discussions regarding coping with or addressing patient bias into training within the health professions classroom. Perhaps these discussions could be stimulated by research that documents the degree to which patient bias affects burnout/turnover in the profession. Similar to other facets of student training aimed toward preparing clinicians to cope with (or preferably change) the realities of life after graduation, this frequently under-discussed area is warranting of further research.

**Cultivating New Networks—To Whom Much is Given, Much Is Required**

Many of the women in the study exhibited either an immense desire to give back or a deep passion to change inequitable conditions for future students or patients. Therefore, further research should be conducted to highlight ways that Black women, and in this case, those who are health professionals can gain access to aspiring students. Moreover, this research could investigate the extent to which marginalized individuals feel a duty to give back, in addition to whether there are sufficient mechanisms within the community (relevant to career exposure) for them to do so. Regarding improving the conditions of patients, perhaps more specific research could be conducted relevant to Black female healthcare providers and how their presence impacts the patient experience.
Education/Career Access

In the area of K-12 education, further efforts are needed to document ways by which students who attend under resourced, rural, or non-specialized schools can access career exposure mechanisms similar to those available in more heavily resourced settings. While, notably, a participant in this study, Cathy, was able to overcome this barrier through the bachelor’s degree, there may be other instances of similarly positioned students who gained access to this information while still in high school. For undergraduate educators, a somewhat unexpected finding of this study was the impact of “out of the box” experiences, particularly those abroad. For this reason, there may be parallels to this study with those doing research on increasing minority access to study or service abroad as well.

Increasing Research with Black Women at the Center

In alignment with the analysis of theory articulated earlier in this chapter, one of the most powerful takeaways from this study has been the necessity of amplifying the voices of Black females in higher education settings. As noted from the study, experiences of minority faculty members trickle down to affect the experiences of students as well. For this reason, multiple studies are encouraged that specifically reveal the experiences of Black female faculty, staff and students in a number of higher education settings.

Expanding and renaming traditional notions of feminist theory. There has been a great deal of discussion about the historical underpinnings of the feminist movement, namely that it was primarily a movement that centered White women, with a veil of opportunistic inclusion of women of color. In her 2013 work, Rousseau noted that “no one theory has been able to grapple with the multi-tiered simultaneous and interconnected oppressions that make up
In addition to the work of Collins (1991) and others relative to Black feminist thought, other theories, such as “womanism” or “womanist thought” have emerged to claim the wholeness of the Black female experience and its full consideration in scholarly activity and community activism (Paris, 1993). Similar to how historical womanist theory acknowledges the unrecognized labor of Black women as the backbone of many organizations, the women in this study stepped into roles others could not or would not assume (Paris, 1993). Whether it meant serving on disproportionate numbers of committees or singularly representing perspectives and faces of color, this study speaks to the necessity of promulgation of theory to elevate Black women’s experiences.

Examining how individuals see themselves versus how groups are perceived. In Chapter 1 of this work, I addressed the debate around differences in the term “Black” and the term “African American.” Although the women in this study represented significant geographic and cultural diversity, each of them expressed some degree of having been treated with bias based on societal associations with being Black. Given the history of the United States, these differential “associations” are complex and warrant additional investigation of their own, within multiple contexts, including that of Black womanhood and of existing within a health profession. While worthy of consideration, issues such as colorism (or favoritism based on complexion) or a pronounced preference for a label in how they were described were not featured in the dialogue or focus of this particular study (Burton, Bonilla-Silva, Ray, Buckelew, & Freeman, 2010; Sigelman, Tuch, & Martin, 2005). The women in this study saw themselves as individuals whose unique voices deserved to be heard and who rejected the assumptions that were projected upon them by society. Regardless of background, many were staunch advocates for the health and fair
treatment of those with shared identity and drew inspiration from this in their professional and academic work.

**Examining the effect of the communication medium used on study results.** One thing that is important to note is the significance of the medium used to implement this study. Rather than being in the same room (in-person), the participants interacted with one another via phone, using a call-in number to facilitate group discussion. In hindsight, this medium accomplished two things: 1) it removed the judgement that society imposes upon others based on appearance and 2) it facilitated a greater focus on listening intently and on the dialogue that is created by mutually respectful discussion. Future studies might be warranted, then, utilizing a similar medium to determine the extent to which this type of medium affected the results. These types of studies might be especially relevant given the evolving modalities of interaction and the rise of social media as a mechanism of getting to know another person. Alternatively, future in-person studies may also be needed, within and outside of the context of Black women, so that face-to-face realities and the revelations that come with that can be more fully explored.

**Consideration of Similar Studies with Males or with Other Women of Color**

There were several aspects of this study that were important in highlighting the voices of a marginalized group. These issues ranged from examining the admissions journey and secondary/post-secondary influences of the participants to illuminating their post-matriculation experiences with patient bias and lack of curricular focus on health equity and social determinants of health. These factors not only apply to Black women but could likely be examined in relation to men and to other women of color as well. As noted in earlier chapters, the focus on Black women in this particular study was not an effort to create division in the
struggle for equity, but instead highlight the importance of taking time to examine the unique journey of each group therein. Therefore, future studies are encouraged with additional diverse groups to determine if their experiences mirror those of the women in this study or whether there are notable differences in the experiences of each group therein.

Author’s Reflections

Listening to the stories of the women in this study has been such an incredible journey for me; in fact, it has been therapeutic. I, too, have occupied so many spaces where I was fully aware that I was the “only” or if not the only, was in a space where the truth of my perspective was not always welcome. So many of the women’s experiences parallel my own and it was an honor to listen to them so humbly and honestly articulate their truth. Some of the key observations that stand out from the study are explored in the sections below.

Assumptions and Compassion

The process of conducting this study revealed both unintentional assumptions and the universal importance of compassion. Even though I identify as a Black woman, hold a full-time job, am a full-time graduate student and consider myself as a lifelong social justice advocate, this study provided insight into my own unintentional assumptions and the blessing of continued opportunities to learn. One of the questions on the background questionnaire asked the participants to indicate the highest degree their mother or father earned and listed various options ranging from some college to a doctoral degree. With these choices, the questionnaire unintentionally omitted those whose parents did not earn a high school diploma. Another question asked participants to indicate the state in which they were raised which again did not do justice to the co-existing context of how someone might describe where they grew up. As a
member of a marginalized group, it was important for me as an author and as a researcher to demonstrate the compassion that I seek from others. I was a visitor in the personal chapters of these women’s lives and was fully aware of their tremendous obligations as students and professionals. Thus, approaching each interaction with openness was key to providing a peaceful and safe space to illuminate their voices and ensure that they were heard.

**Phenomenal Woman**

The biggest takeaway for me from this research is how phenomenal the women in the study are and how much it seems that the world does not give them credit for being so. It reminds me of the poem “Phenomenal Woman” from legendary author Maya Angelou and of the popular annual celebration *Black Girls Rock* aired solely on Black Entertainment Television (Angelou, 1994; Bond, Orlando, & Rouzan-Clay, 2006-2019). Not only had these women risen to enormous heights in their academic and professional spaces, their state of mind and positive, forward way of communicating were refreshing and inspiring. Without question, the women were engaged in programs that were rigorous and challenging on a daily basis. However, it was clear that the key to their success rested largely in their refusal to give in to negativity, insistence on surrounding themselves with positive people, and core belief in their responsibility to give back. I will be forever changed by the privilege to have had in-depth conversations with them and am honored to bring their important perspectives to the forefront.

**Concluding Thoughts**

Many of us enter college with the expectation that it will lead to higher and happier earnings. By this I mean doing something we enjoy that also pays well. The stark reality though is that many of us do not ultimately get both ends of this bargain, either we are doing something
we don’t enjoy, doing something that does not pay well (or does not pay off our debt), or both. It is my belief that by providing access to make more informed decisions about what we major in and in what careers we pursue, we can begin to change this (Svrluga, 2019). Moreover, as many learn once they have the privilege of being immersed in environments of healthcare (as I have), educators have a critical part to play in whether we (and our family and friends) are treated equitably and compassionately as patients. As mentioned in Chapter 1, when you are sick, nothing else matters. Thus, even though health professions is indeed a niche area of education, it is one that we should all care very deeply about and make every effort to positively impact for ourselves and for future generations. Finally, it is my hope that as a Black woman myself, this work has done at least a small part in liberating the voices of this wonderful, diverse, vibrant, intelligent identity. May we all live to elevate the stories of those who more often and more profoundly deserve to be heard.
APPENDIX A

Video Clips

Naomi Wadler’s Washington D.C. speech advocating the importance of highlighting the voices of African American girls and women


Congressional Black Caucus Foundation 47th Annual Legislative Conference

“The Impact of the Decline of African Americans in the Medical Profession”

[Congressional Black Caucus Foundation] (CBCF). (2017, September 22). The impact of the decline of African Americans in the medical profession—ALC ‘17. [Video File] Retrieved from https://www.youtube.com/watch?v=uo5zG99zxUs&index=21&list=PLPjG6g5PtGGxIG8K0j2EECW0gRfwT0cJJ&t=0s
APPENDIX B

Background Information Questionnaire

1) Please provide your email address.

2) Do you identify as Black or African American? Yes or No

3) Do you identify as female? Yes or No

4) How would you characterize your socioeconomic status?

5) The highest degree my mother earned was:
   a) Drop-down box listing: high school diploma, some college, Associate’s degree, Bachelor’s degree, Master’s degree, Doctoral degree (SCCT)

6) The highest degree my father earned was:
   a) Drop-down box listing: high school diploma, some college, Associate’s degree, Bachelor’s degree, Master’s degree, Doctoral degree (SCCT)

7) Please indicate the number of individuals in your family who are or were employed in a health profession. (SCCT)

8) The health professionals represented in my family include (check all that apply): (SCCT)
   a) Registered Nurse
   b) Physician
   c) Pharmacist
   d) Licensed Vocational Nurse or Licensed Practical Nurse
   e) Occupational Therapist
   f) Doctor of Veterinary Medicine
   g) Doctor of Dental Surgery
9) Please indicate the state in which you were raised.

10) Please indicate the country in which you were raised.

11) How would you describe the primary environment you grew up in?
    a) rural, b) large urban, c) medium sized urban, d) suburban

12) Please list the state in which you attended (or are currently enrolled) health professions school.

13) Please list the state in which you were enrolled in your bachelor’s degree:

14) What type of health professions program are you enrolled in (or did you graduate from)?
    a) MSN
    b) DNP
    c) MD
    d) DO
    e) PA
    f) DPT
    g) MOT
    h) DOT
    i) DVM
    j) DPM
    k) Other

15) Please indicate the year you entered your graduate health professions program.
16) Please indicate the year you graduated (or anticipate graduating) from your graduate health professions program.

*These questions address the research question in that identifying the demographic background of the participants adds to the analysis of how factors such as geographic location, socioeconomic status, etc. might have contributed to the manner in which the participants accessed the tools, training, and influences needed to ascend to a health professions program.

**Questions that most directly address the theoretical frames in the study are abbreviated as follows:

Black Feminist Thought (BFT)

Social Cognitive Career Theory (SCCT)

Ford’s Female Achievement Model for Excellence (F²AME)
APPENDIX C

One-on-One Interview Guide—Semi-Structured Interviews—Journey to Admission to a Health Professions Program

Section I:

1) I know you filled out some basic demographic information in the background survey, but just to elaborate, how would you describe where you grew up?

**Exploration Question:** You indicated in the survey that you were raised in __________ state, how do you feel this affected who you are now or is there anything in particular you would like to share about growing up in that area?

2) Did you attend a school that focused on STEM or health professions? (SCCT)
   a) **Exploration question:** If not, how did you foster this interest on your own?

3) What was the first person or thing that motivated you to pursue a health profession? (SCCT)

4) Was this your only career path or were you involved in another career before this? (SCCT)

5) How did you generally perform in school? (SCCT)

6) Were there any subjects you particularly enjoyed in school (this could be in high school or in undergrad)? (SCCT)

7) How would you describe your social circles growing up? (SCCT)

8) Was there any one person or thing that encouraged pride in your identity as a person of African descent? (BFT and F²AME)
9) Was there any one person or thing that encouraged pride in your identity as a woman encouraged? (BFT and F^2AME)

10) Were you involved in any special programs related to the health professions? (SCCT)
   a) **Exploration Question:** What was the name of the program?
   b) **Exploration Question:** How did they contact you or how did you find out about it?

11) Tell me about some of your teachers or advisors (from high school or college) who were particularly meaningful to you. (F^2AME)

   **Exploration question:** What were some of the specific things that they did that you felt showed an interest in your education, career, or you as a person? (F^2AME)

12) How do you explain how you ended up in the health professions? (BFT)

13) Were you involved in any particular programs, perhaps not directly related to the practice of law that fostered your sense of self and identity? (BFT and F^2AME)

14) Describe your process of applying to a health professions school. Are there any things in particular that stand out in your head?

15) Were there any particular subjects that you found challenging in high school or during your bachelor’s degree? (SCCT)
   a) **Exploration Question:** How did you overcome these challenges? (BFT)

16) Were the financial requirements of ________ (type of graduate health profession) school a concern for you?
   a) **Exploration Question:** How did you approach or deal with that?
17) Were there any factors in your childhood that serve as motivation for you to choose to work in _______ (type of health profession)?

Section II:

15) Building off of . . .

- You mentioned ________________, what kinds of things did that involve?
- Exploration Question: How do you feel that affected you?

16) Were there any specific life related challenges that, looking back, you feel you had to overcome to achieve your goals? (SCCT and F²AME)

Exploration Question: How did you overcome these challenges?

17) Did any personal or familial challenges provide the motivation for you to pursue the profession you chose? (F²AME)

Section III:

18) Research shows that there are specific dimensions that contribute to the success of students, particularly Black female students. I am going to say 6 words. Of these please tell me the word (or words) that resonates the most with you: (F²AME)

- Resilience
- Self-confidence
- Self-motivation
- Clear goals
- Pride in your race
- Pride in your gender.
19) Same thing, for the next 3 words, please tell me which word (or words) resonates most (if at all): (FAME)
   - Work ethic
   - Openness to other cultures
   - Ability to communicate across cultures

20) Research (social cognitive career theory) suggests that career interest is developed through repeated engagement, modeling, and feedback. When you think about what most influenced you to pursue a health profession, how consistent was this influence in your life? (SCCT)

21) If applicable . . . You mentioned that you participated in a special program that helped to foster your interest in the health professions. What was it that program did well? (SCCT)

22) When did you seriously consider applying to ________ (type of graduate health professions school)? (SCCT)

23) What resources did you tap into to prepare for your health professions application?

24) What resources did you tap into to prepare for the interview?

25) What resources did you tap into to prepare for the standardized test (if applicable)?

26) Did you know anyone else who was or is enrolled in a health professions school? (SCCT)

**Exploration Question:** How did your relationship with that person affect your success?

27) You have worked really hard to get to where you are. Do you have any advice for others applying to ________ (type of graduate health profession) school?

28) Do you have any specific advice for other Black women considering applying for health professions school?
***These questions address the research question by diving deep into the experiences of the women relevant to their journey prior to admission to a graduate health professions program.
APPENDIX D

Focus Group Guide—Experiences within a Health Professions Program

● We have ____ women participating in today’s focus group. Some of you are currently enrolled in your graduate health professions program and some of you have graduated from your programs.

● It has been such a PLEASURE getting to know you and hearing your stories.

● Today’s discussion is SUCH an opportunity to share and to learn from one another. It is an EXCITING time where we can have ______ individuals, from a VARIETY of health professions programs, all of whom identify as Black women, gathered in one space to discuss issues that are important to YOU.

● Thank you for signing the confidentiality form agreeing to the confidential nature of this focus group.

IN TERMS OF GUIDELINES FOR THE DISCUSSION:

● I want this to be a time and a space where:

● EVERYONE feels at ease

● EVERYONE feels that they can be HEARD.

● PLEASE feel free to SPEAK UP when your experience seems UNIQUE or to CHIME IN when someone else’s experience resonates with your own.

● It is absolutely okay to disagree with someone else’s opinion, I just ask that you wait until the other person is finished speaking and then feel more than welcome to present your point of view.

● We have 1 hour and 30 minutes reserved for this session.
Section I: Introductions

1) So, with that said, I’d love to get started with introductions.

   Could everyone please introduce themselves?

Let’s start off with an icebreaker.

2) I’d love for each person to name one thing they do most to relax.

Section II: Classroom and Clinical Experiences within the participants’ graduate health professions program

Now, I’d like to transition to your classroom and clinical experiences in your graduate health professions program.

3) One of the words that resonated with many of you from the interviews was resilience. What are some of the tools, habits, or practices you have engaged in to keep moving forward with your program? (F²AME)

4) Were there any co-existing responsibilities that you had to balance while you were or are in school?

   a) Exploration question: How did or are you doing that?

5) Do you feel that your institution created a safe space for you to talk about issues of importance to you? (BFT)

   a) Exploration question: If so, how consistent was this platform provided? Were these topics that were already present in the curriculum or were they discussed because you highlighted their significance? (BFT)
6) Another thing mentioned frequently in the interviews was the importance of being comfortable with your learning styles. To what extent was or has your program been conducive to your learning style? (F²AME)

a) **Exploration question:** If the program has NOT been particularly conducive to your learning style, what efforts have you taken to translate the curriculum or the experience into a format that works for you?

7) Name an environment where you feel like you can let down your guard and be your authentic self? (BFT)

**Exploration question:** If your school is not that place, please describe why that is the case.

8) As the final question in this section, I want to provide space to openly discuss any experiences closely connected to your identity as a woman, to your identity as a Black person, or to the intersection of those identities that have been less than optimal in your program? This could be an encounter or any issue that we have not touched upon thus far. (BFT)

**Section III: Support and Understanding—Both Inside the Program as well as from Family and Friends**

Now we are going to transition to discuss support and understanding, both within your program as well as from family and friends.

**First, within your program:**

9) To what extent do you feel the faculty and staff in your program understand or understood the intersecting challenges you face as a Black woman? (BFT and F²AME)

10) Was there a Chief Diversity Officer in your program or at your University?
a) If so, to what extent do you feel that person was effective?

**Exploration question:** What were some of the specific strategies that person employed that led you feeling that they were effective or not effective? (BFT)

**So now in regards to family and friends,**

I wanted to discuss both family support and family understanding.

**Support,** I am defining as well wishes, **general** words of encouragement, etc.

**Understanding,** I am defining as **knowing** the context, knowing the degree, the difficulty, or the time demands of your program.

My questions are:

11) How would you describe your family’s support during your program?

12) How would you describe your family’s **understanding of what is required** for your program?

**Exploration question:** For those who stated they have experienced LESS support or understanding, how do you cope or deal with that?

**Section IV—Moving Forward—Within the Program**

Next, let’s discuss the design and function of your program:

13) If you could redesign your program to better fit your needs, what would that look like?

(BFT)

14) Regarding post-graduation plans, do you feel that your program is meeting your expectations relevant to assisting with that?

**Exploration question:** To answer that, if you could please describe what your professional plans are after graduation and then what you would like to see from your program related to help with that transition?
For those who have graduated, if you could share what you did to obtain your first role after graduating from the program and whether your program assisted in securing that role.

Section V—Moving Forward—Future Plans

15) Are any of you working on things that you are excited or passionate about that you would like to share?

16) Relevant to your experiences in your graduate health professions program, could you share any instance, whether it be a faculty member or administrator, a program, or other effort that you feel “got it right” for you or for the issues that are important to you? In other words, something that you feel should or could be replicated? (BFT)

Section VI—Closing Questions

17) Why DO YOU THINK the voices of Black women are important in graduate health professions education? (BFT and F²AME)

18) Are there any closing comments or areas you feel we did not address in the discussion? Especially given the group of phenomenal women we have gathered here today, I want to make sure that we have covered what you feel is important.

****These questions address the research question by examining what the experiences of the participants were as they worked their way through their graduate health professions program.
APPENDIX E

Participant Reflection Questionnaire—Reflections of the Women upon Participating in the Study

1) Please provide your email address.

2) How did it feel to be asked your opinion and to be provided the opportunity to articulate your unique perspective?

3) Describe your feelings about participating in the one-on-one interviews. (BFT)

4) If you participated in the focus groups, describe what you learned from interacting with the other women. (BFT)

5) If there is something about your undergraduate or graduate experiences that you would do differently, please indicate what that would be and why (if there is nothing you would do differently, please indicate "N/A" here).

6) What are your current career goals?

7) Are your career goals the same as when you first entered your graduate health professions program?

8) If your goals are different, why do you feel that those goals changed?

9) What do you think about your journey now looking back?

10) To what extent do you feel you can say you are proud of what you accomplished?

11) To what extent do you recognize how young people (including future health professionals) look up to you?
   a) I do not think young people look up to me.
   b) I am aware that young people look up to me but I do not know why.
c) I am aware that young people look up to me and consider that an important responsibility of mine.

d) Other

12) If you selected “other” in the previous question, please expand upon this response.

13) What are your suggestions for Black women who are just beginning their graduate health professions program? (BFT and F²AME)

14) What is one thing you are inspired to do moving forward?

15) What is one thing you will do to engage in self-care going forward?

16) Please provide any additional feedback on your participation in the study not addressed in the questions above.

****These questions address the research question given that they provide an overall reflection of the women on their experiences in a graduate health professions program and with the study itself.
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