1-19-2023

Understanding the Experiences of Latino Medical Students in a Learning Medical Environment

Leslie García
Portland State University

Recommended Citation

García, Leslie, "Understanding the Experiences of Latino Medical Students in a Learning Medical Environment" (2023). *Dissertations and Theses.* Paper 6259.
https://doi.org/10.15760/etd.8118

Understanding the Experiences of Latino Medical Students in a Learning Medical Environment

by

Leslie García

A dissertation submitted in partial fulfillment of the
requirements for the degree of

Doctor of Education
in
Educational Leadership: Postsecondary Education

Dissertation Committee:
Esperanza De La Vega, Chair
Michael J. Smith
José E. Coll
Rachael Synder Bhansari

Portland State University
2022

Abstract

Very little is known about the experiences and perceptions of underrepresented minority medical (URiMs) students in U.S. allopathic medical schools. (Najibi, et al., 2019; Weiss et al., 2021). The limited literature posits URiMs experience more adverse experiences in the learning environment and have different learning outcomes in comparison to their White peer counterparts (Orom, et al., 2013). Latino medical students represent 7.1% of all entering medical students across all U.S. medical schools (AAMC, 2021) across all U.S. medical schools while they represent the largest ethnic minority in the United States (Bureau, U.C. 2020.) within parity lack representation among the physician workforce. There is a dearth of knowledge of what factors contribute to the success of Latino medical students progressing in medical school, as well as not knowing what factors serve as barriers in their learning environment (Soto et al., 2022). Using a case study approach, in-depth phenomenologically multi-case interviews (Seidman, 2006) was used to investigate the *cuentos* and counterstories (Delgado, 1989; Solórzano, 2007; Yosso, 1995) of Latino medical students to learn of the facilitators and barriers they experience during their academic journey at the Pacific University Northwest Medical University (PNWMU). The theoretical framework of Critical Race Theory (CRT) was applied as a centered conceptual framework (Ladson-Billings & Tate 1995) and extension of Latino Critical Race Theory (LatCrit) (Solórzano & Yosso (2001) was also applied to this dissertation study. Findings revealed two main themes serving as barriers and one main theme identified as a facilitator that assisted the navigation of eight Latino medical students during the medical education. Findings of this study provide new

insights of the Latino medical student journey in a learning medical environment. Recommendations include the development and implementation of creating an inclusive and familial learning environment and the creation of cultural specific resources to mitigate and eliminate barriers that are unique to address the learning and social needs of Latino medical students.

Dedication

I want to thank my beloved Latino medical students who willingly participated in this study and placed their trust in me. I will always admire your strength, inspiration, and desire for social justice in medicine as students and who are now serving as leading physicians and scientists eradicating health disparities and improving access to care. *Fuertes abrazos a los estudiantes de este estudio que ahora ya son doctores que nunca se dejaron vencer. Fe y Esperanza! Y por nuestros padres, familia, y nuestra cultura que no nos deja atrás*. I am indebted to the eight participants who chose to share their lived experiences *através de compartir sus cuentos y testimonios* and make this research possible. I could not have told your individual and collective stories (*cuentos)* in your own words without your engagement. *Muchísimas gracias por compartir íntimos momentos por el bien de otros.* Not only did you help me with my own accomplishment, but you are also helping those who are coming after you to learn how to prepare, facilitate, and redirect their own learning journey in medicine. Also, to acknowledge that racism and microaggressions are present in the lives of Latino medical students and deserve the proper recognition that it deserves in the development of anti-racism planning in medicine. Being proactive and intentional are two key points to support a welcoming, inclusive, and responsive climate to mitigate structural and social racism in medical education.

Acknowledgements

Primeramente doy Gracias a Dios y La Virgen María por sus bendiciones. To my parents, *Ambrosio* and *Adela García*, for their sacrifices and the support they have provided me and my siblings during our lifetime. They always encouraged and supported my educational and personal goals. Their hard work ethic and resilience showed me the path to academic success. I also want to thank my husband, Frank and my beloved daughters Briana and Isabella who encouraged and cheered me on through the years of this doctoral program. I also want to thank the rest of my family and friends who supported me in this journey too. I am very grateful to my friend Mariana por su apoyo, amistad y ayuda. I am also grateful to my committee chair, Dr. Esperanza De La Vega who guided and supported me through the years, *poco a poco* she would say take one step at a time in this long journey. An amazing individual who gives so much of herself to her students and makes a difference in the lives of so many. I would like to acknowledge my dissertation committee members who are talented educators and leaders, Dr. José E. Coll, Dr. Rachael Synder Bhansari and Dr. Michael J. Smith, who started this journey with me from the beginning of my doctoral program. I also want to recognize Dr. Carlos Maldonado † who founded the Chicano Latino Studies Program at Eastern Washington University, who gave me the opportunity to solidify my identity as a Mexican American and first-generation college student. Lastly, I want to thank Dr. Gilberto García who told me to dream big at my undergraduate college graduation and said *tú también puedes ser una doctora* - you too can become a doctorate graduate. Those words stayed immovable with me for many years and till now. *Y después de tantos años, si se pudo! Gracias.*

Table of Contents

Abstract i
Dedication iii
Acknowledgements iv
List of Tables vi
List of Figures vii
Chapter I: Introduction 1
Mi Cuento - My Story & Why This Research Is Important 12
Chapter II. Literature Review 25
Chapter III. Research Methodology 58
Conceptual Framework: Critical Race Theory (CRT) 71
Latino/a Critical Race Theory (LatCrit) 72
Chapter IV. Findings 80
Theme 1: Alone and Lonely (Barrier) 92
Theme 2: Racism (Barrier) 108
Types of Microaggressions as told by Participants Through Cuentos & Counterstories 116
Internalized Racism & Introduction to Sub -Themes 135
Theme 3: Familismo (Facilitator) 148
Chapter V: Discussion 162
Recommendations 190
Relevance of this Study 194
Areas for Future Research 196
References 200
Appendix A: Participant Consent 225
Appendix B: Participant Recruitment Email 227
Appendix C: Interview Questions 228

List of Tables

Table 1: Participants Demographic Data 66

List of Figures

Figure 1: Participants Profile 67

Figure 2: Critical Race Theory (CRT) 75

Figure 3: Overview of The Findings 92

Figure 4: Types of Microaggressions as Told by Participants Through Cuentos & Counterstories 117

Figure 5: Navigating Two Cultural Worlds 181

Chapter I: Introduction

In this chapter, I introduce the topic of underrepresented minority in medicine (URiM) who are individuals from racial and ethnic groups who underrepresented in the medical profession relative to their numbers in the general population and the choice as a topic for investigating the "lived lives" and journeys of Latino medical students. Using the term umbrella definition for underrepresented minorities in medicine (URiM), includes the following groups: Black/African American, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander and Hispanic/Latinos who are racial and ethnic groups considered to be underrepresented in the U.S. medical allopathic profession (AAMC, 2004). For this dissertation study, Latino medical students who are underrepresented in medicine (URiM) will be the focus of this dissertation study. Latino refers to all genders and identities who derive from origins from Latin America is an appropriate and correct term to use. The term Latinos will be used to reference the participants of this study. In this chapter, I provide a statement of the problem, the background, and the significance of the study. Finally, this chapter will conclude with an overview of the methods used to approach the dissertation study to answer the set research questions. A brief overview of the methods adopted definitions of key terms, and a chapter summary will follow.

Statement of the Problem

The topic selected for this dissertation serves to help understand the experiences and observations of underrepresented minority medical (URiM) students in medical school to learn of barriers and of their social and academic success. The evidence posits

that URiM medical students have different experiences and report less positive experiences during their training in medical school (Bullock & Houston, 1987); (Hung et al., 2007). Latinos, African Americans, Native Americans and other underrepresented minority groups report receiving less favorable academic evaluations from their attending during clinical rotations and less support (Lee et al., 2009; Orom et al., 2013). Furthermore, URiM medical students complete their medical degrees at dissimilar rates in comparison to their peers (Caulfield et al., 2014; Andriole & Jeffe, 2012; Dawson et al., 1994) and also have lower performance rates on the United States Medical Licensing Examination (USMLE) board medical examinations. Huff and Fang (1999) report URiM medical students experience higher rates of academic leave, higher dismissals from medical programs, and higher rates of delayed graduation in comparison to non-URiM medical students. URiM's also lack support for mentorship and have different coaching needs (Najibi, et al., 2019; Weiss et al., 2021). Latinos and other URiM learners experience social isolation, heightened visibility, and racism (Bullock et al., 2020 & Orom et al., 2013). Based on the empirical findings, one can conclude there is a need to better understand the factors that impede the academic and the factors that support success in medical school. While there are limited studies that help to explain the experiences of URiM medical students, the research mainly has focused on their barriers and does not address their successes nor do we know their individual journeys since they are placed into one combined group as underrepresented minorities while not allowing us to learn of their uniqueness in medical school. Scholars cite the urgency to diversify the medical profession with racial and ethnic physicians to better serve the needs of the growing diverse population in the U.S. (Nivet, 2015; Smedley et al., 2004; Sullivan,

2004). Yet, we don't know much about the journeys of URiM's. Each group is unique and must be examined to better understand what barriers they face and what successful strategies they employ. Therefore, this dissertation study seeks to learn of the lived experiences of their own voices in the form of *cuentos* and counterstories (stories and counterstories) to learn how to intentionally support URiM Latino medical students given the small number they represent in U.S allopathic medical schools. Therefore, understanding and documenting the lived experiences and observations of URiM Latino medical students is critical to their trajectory in academic medicine. Learning of the barriers and successes of URiM Latino medical students can contribute to amplifying the current number low of URiM active physicians, where evidence posits URiM physicians are more likely to serve racial and ethnic communities and practice in underserved areas in comparison to non URiM physicians (Xierali & Nivet,2018) and are more likely to increase access, provide culturally competent care, increase communication, and contribute to decreasing health disparities among underserved racial and ethnic populations (Saha et al.,1999; Betancourt & Maina, 2004; Cooper-Patric et al., 1999). Thus, learning of the lived experiences of Latino medical students will contribute to the literature presenting the factors that facilitate and factors that impede the social, emotional, and academic success of Latino medical students.

Latino medical physicians are underrepresented in comparison to the U.S. Latino population (Dall & West, 2016). Diversifying the medical profession is key to decreasing health disparities and increasing access to historically underserved populations (Cohen & Terrell, 2002). A review of the literature for URiM minority medical students for this topic is important and imperative to meet the healthcare needs of the U.S. population.

Nonetheless, the diversification within the physician workforce is slow and an additional six thousand Latino physicians need to matriculate into medical school and graduate from medical school every annual admission cycle to have parity with the population they represent (Dall & West, 2016). Therefore, giving voice to learn of the participant's *cuentos* and counterstories student experiences to learn of the facilitators and barriers faced by Latino medical students during their medical journey; thereby, holding Latino medical students as "holders and creators of knowledge" (Delgado, 2002, p.106).

Significance of the Study

Researchers (Clarke, 2005) posits the need for more qualitative research to help gain insight. Increased knowledge of the URiM medical student specifically, as it relates to Latino medical students' experiences, allows researchers, practitioners, and administrators at academic medical institutions to gain further knowledge and utilize this information to identify facilitators for reducing and eliminating barriers. Findings may inform factors that facilitate the social, emotional, and academic success for Latino medical students to increase satisfaction, sense of belonging, well-being, academic performance and success.

Background

The topic selected for this dissertation is an issue of learning of the journey of Latino medical students as they pursue medical education training. According to the American Association of Medical Colleges 2021 Matriculation Report, Latino medical students account for only 7.1% of all entering matriculants across all U.S. medical schools which is a low number in the medical profession relative to their numbers in the

general population. Furthermore, Latino physicians are grossly underrepresented too representing 7% of all active physicians and as a group continue to experience a decline trend in representation for the last 30 past years (Sánchez, Poll-Hunter, & Acosta 2015). The Latino physician shortage is further compounded by the growing Latino population representing 1 in every 5 Americans, accounting for 62.6 million of the U.S. population with an increase of 24% within the last decade (Krogstad, Passel & Bustamante, 2022). Latinos account for more than 62.6 million of the population and accounted for 19% of the nation's population in 2021 (Krogstad, Passel & Bustamante, 2022). This has created a greater demand for more Latino physicians to meet the healthcare needs of the growing U.S. Latino Population (Sánchez Nevarez, & Bautista, 2015). Given the importance of Latino physicians and not knowing much about their plight or how to support them during their medical training journey is a topic of importance. This dissertation study sought to understand the journey of eight Latino medical students at one site to provide insight to their lived lives, observations and overall journey. In theory, many medical schools have been known to develop recruitment enrollment plans to increase diversity representation among a student body; however, many medical schools not invested in learning how to support the URiM's after they matriculate into medical school (Toretsky et al, 2018). One investment to better learn of those who matriculate in medical school is by conducting a climate survey to support the identification of perceptions and observations of URiM students to address organizational culture and instill positive change. In 2014, the Pacific Northwest Medical University (PNWMU pseudonym) conducted a quantitative climate study at the location where this study took place and will be further discussed in the next section to follow. The PNWMU is located in an urban

setting and historically has been a predominantly White institution (PWI). This medical school has been in existence for more than 100 years and has an aspiration to diversify representation in its medical student body. Much investment in diversifying the medical schools has been invested upon entry, yet there is limited evidenced based retention strategies that have been part of the diversity efforts. There is not much of an explanation why the differences among different completion rates for URiM medical students compared to non-URiM Students (Dyrbye et al., (2007). Unquestionably, it appears URiM medical students have different experiences and outcomes compared to their White peers as learned as demonstrated by the limited literature in Chapter II, which clearly lacks our understanding of the URiM medical student experience and specifically for this study seeking to learn of the lived lives and journey of Latino medical students. The dearth of knowledge cannot point us to evidence-based practices or recommendations on how to support Latino medical students or what to address within the learning environment is problematic in order to support and graduate Latino medical students.

Purpose of the Study

The topic selected for this case study was to explore the observations and experiences of racism and to learn and describe the barriers and facilitators of eight Latino medical students who were in their second and third year in medical school at the Pacific Northwest Medical University (PNWMU). With a focus to learn how medical students experience and navigate the journey.

Research Questions

The questions that guided this study and served as the protocol for the in-depth, phenomenologically in-depth interviewing (Seidman, 2006) included the following:

1. What factors impede the experience of Latino medical students?

This research question seeks to identify and explore those personal characteristics of a student that causes them to withdraw, be less satisfied, and observe differential treatment (observations, experiences, and actions of self, peers, faculty, and others due to race/ethnicity.

2. What are the factors that facilitate a positive experience for Latino medical students?

This research question explores the institutional environment that may impact socialization, access, academics, persistence, and other factors that contribute to success.

3. Interview Three: Reflection on the Meaning: Participants were asked to reflect on the meaning of their experience and make sense of their experiences. Participants were asked about the factors that influence the participants' present lives as URiM Latino medical students.

Definitions of Terms

The following terms and definitions are referenced in this research study and are listed in alphabetical order to provide a common language and perspective to this dissertation study.

Allopathic Medicine is another term for conventional, or modern Western medicine. It is an evidence-based system where doctors and other healthcare professionals treat symptoms using conventional medications (Samson, 2021).

American Association of Medical Colleges (AAMC) represents 171 U.S. and Canadian medical schools along with more than 400 teaching hospitals and health systems. Medical schools are supported by the AAMC for accreditation purposes**.**

Attendings are physicians who attend to patients in a hospital **(**Collings English Dictionary) and also provide mentorship and learning to residents and medical students.

***Cuentos* & Counterstories** also known as stories (*cuentos* in Spanish) and counterstories provide context for an understanding of the voices and experiences of those victimized by racism (Delgado, 1989; Solórzano & Yosso, 2002) and the opportunity to name their own reality (Delgado & Stefanic, 1993).

Critical Race Theory (CRT) an analytical framework that stems from the field of critical legal studies and can be applied to understand the inequities in higher education by allowing for students of color to tell their narratives involving marginalized experiences (Solórzano & Yosso, 2001).

Familismo is a Latino cultural value which shows commitment and care for their family members as well as those whom they consider a part of their family. The practice of familism (*familismo* in Spanish*)* is a central Latino cultural value that involves the

display of loyalty to family and seeking the support of one's family's advice (*consejos*) within the hierarchy of parents and elders. Providing support and assistance and being a whole unit of a family is essential and part of Latino family values (Azpeitia & Bacio, 2022).

Latinos individuals of Spanish or Latino ancestry. Latinos includes any individual who identifies as Hispanic or Latino regardless of ancestry. Latinos are an ethnicity and may belong to more than one race. Latinos account for more than 62.6 million of the population and accounted for 19% of the nation's population in 2021 (Krogstad, Passel & Bustamante, 2022). The term Latino is used in this study. The term Latino references to all genders and is a neutral term.

Latino Critical Race Theory (LatCrit) is a subset of Critical Race Theory (CRT) and can be used to articulate the experiences of Latinos, through a more focused examination of the unique forms through the lens of a social-cultural context (Yosso, 2005).

Microaggressions are described as intentional or non-intentional actions, behaviors, and environmental indignities that come across as hostile, derogatory and or negative racial insults toward people of color. Microaggressions are classified into three different types of forms which include microassault, microinsult, and microinvalidation (Sue, Capodilupo et al., 2007).

Medical School is an educational institution that provides teachings in medicine, and awards a professional education known as a doctor of medicine degree. All medical schools share the goal of preparing students in the art and science of medicine. The learning journey of a medical student can be divided into four areas (a) lecture and small

group discussions (b) academic examinations and tests (c) clinical experiences, and (d) social life that include student activities, and community outreach (Martin, 2021).

Physician/s are medical professionals that diagnose and care for people who are ill or have been injured. Take medical histories, perform physical examinations, conduct diagnostic tests, recommend, and provide treatment. The terms physician, doctor, medical doctor, attending, health care, and provider will be interchanged in this study. They together are licensed to diagnose, provide treatment and may serve as instructors, faculty members, coaches for medical students (Whitlock, 2022).

Racism is defined as a complex ideology composed of beliefs in racial superiority and inferiority enacted through individual behaviors and institutional and society policies and practices (Jones, 2000).

Levels of Racism is a theoretic framework for understanding racism on three levels: institutionalized, personally mediated, and internalized (Jones, 2000).

Resident & House Officer is an interchangeable term for a new graduate from medical school, have a medical license, and train under the supervision of an attending, meaning the supervising physician. A resident can provide personal instruction, training, supervision, and evaluation of medical students. The duration of a medical resident/house officer in training can range from three years to seven years, depending upon the program specialty of the area in medicine (Whitlock, 2022).

Ser Servicial - A term in Spanish that translates to be of service - to be helpful and is a term valued in Latino Culture (Definicion DE).

Underrepresented Minorities in Medicine is a term umbrella for underrepresented minorities in medicine (URiM), includes the following groups:

Black/African American, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander and Hispanic/Latinos are racial and ethnic groups considered to be underrepresented in the U.S. medical allopathic profession. This term was founded by the American Association of Medical Colleges (AAMC, 2004).

Sense of Belonging is the psychological feeling of belonging and feeling connected while minimizing cultural stress (Chun et al., 2016)

STEP 1: U.S. Medical Licensing Examination are exams designed to test the knowledge learned during the basic science years of medical school. These examinations assess knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills that are important to provide safe and effective patient care. (United States Medical Licensing Examination, 2015).

Mi Cuento - My Story & Why This Research Is Important

Prior to presenting the research design, I will introduce the three sources of inspiration for this dissertation which also provided guidance for this study.

The dissertation study of the topic was selected due to my personal and professional experience as a Latina administrator in medical education. I have been professionally committed to supporting diversity and inclusion at a predominately White medical institution for the past 30 years and serving URiM medical students. Reflecting upon the interactions and conversations with URiM medical students over the years, I asked myself what is different and perhaps common among the lived experiences of URiM medical students. I vividly recall certain incidents and conversations, both positive and negative in nature. If only the four walls of my office could speak of the stories of URiM medical students within the confines of a safe space shared with me, perhaps I could help to improve the understanding of the plight that URiM medical students experience and their journeys. There are many more stories that have not been told and deserve to be told to help understand to advance qualitative inquiry, to better learn of the experiences of all URiM Latino medical students. Next, I introduce two *cuentos* and counterstories that stood out over the years to serve as a primer. The actual stories of the study participants will be shared in Chapter III.

***Cuentos* & Counterstories** as introduced in the terminology section are stories (*cuentos* in Spanish) and counterstories to provide context for an understanding of the voices and experiences of those victimized by racism (Delgado, 1989; Solórzano & Yosso, 2002) and allow the opportunity for individuals to name their own reality (Delgado & Stefancic, 1993). *Cuentos* and Counterstories provide that space under the theoretical framework of Critical Race Theory (CRT). The first cuento (story) is told by one, a third-year medical student who was not part of this study but provided inspiration to the researcher to use *cuentos* and counterstories for this dissertation study that took place at a predominantly White university at the Pacific Northwest Medical University (PNWMU).

I'll begin with a story that took place years ago, involving a Black Afro Latino who was a second-year medical student at the time. One day after his lecture, he came into my office and said "I need to talk to you." I responded by asking what is the matter? As he sat on the chair across from my desk, he started to tear up. I gave him a moment of space and reassured him all would be okay and offered him my hand. He composed himself and explained to me that earlier that afternoon, his classroom instructor pointed in his direction and more specifically, to his to black coat that lay next to his seat. The instructor described the color of human waste as he made reference to the color black, as he described a case study of a patient during class. He believed his instructor was racially targeting him during lecture in front of all his peers. He told me he sat in silence for the rest of the class and didn't react to the disparaging remarks and pointing of the finger made by his instructor directed towards him. Meanwhile, he noted that his classmates who witnessed this incident during the group lecture said and did nothing. He said "No one said a word during class." He stated that after class he was approached by White

colleagues and other URiM medical students wanting to know if he was okay. Others felt and experienced this racial motivated incident but said and did nothing from his perspective.

After hearing of this incident, I immediately called the director of Affirmative Action and asked for an investigation of this alleged incident which perhaps was or was not an intentional microaggression against this URiM medical student. Microaggressions are described by Sue et al., (2007) as intentional or unintentional actions, behaviors, and environmental embarrassments that come across as hostile, derogatory, or negative racial insults toward people of color. I don't recall the outcome of this incident but I do remember the emotional pain the student displayed as he recounted that he felt he was being harmed by racist acts from his instructor in front of all to observe. The student in this case shared his counterstory of the way he felt racism manifested in his lecture classroom and that went unnoticed perhaps by many who didn't even notice nor how it impacted others personally. Counterstories are the lived experiences to attempt to unearth the racial struggle and can validate the experience and elevate and magnify ones truths.

The second story is of a third year Latina medical student who shared with me her concern regarding the particularly low ratings she received on her clinical rotation. Clinical rotations are part of medical training where students evaluate, provide diagnoses, and provide a treatment plan to patients in the hospital or clinic as well as provide verbal reporting to the attending doctor. The student told me of a *cuento* (her story) that she felt she was being thorough with her patient visits and report-backs to the attending doctor supervising her clinical rotations but noted she was receiving lower marks. I probed to

ask for further details about her practices and methods of communication. She further noted she was confused and did not understand how her White female peer, whom she noted was aggressive, vocal, and disrespectful to the attending doctor, received positive feedback on her performance. I wondered if there was possibly miscommunication or misunderstanding of expectations from her supervisor based on cultural differences and/or protocol. I asked the Latina medical student what she thought about her White peer's behavior. In her opinion, she thought her colleague was disrespectful in her tone and interactions with the attending. I asked myself, was this the forward-thinking and expression of communication expected of a medical student? I asked the student in other words, are all medical students expected to challenge, diagnose, offer other treatment plans and to explain confidently? It was clear from my perspective that perhaps there was a cultural or gender difference or misunderstanding in the communication that was occurring between this Latina medical student and her White male supervising doctor. As a first-generation, Latina female, I presumed she was socialized to respect her elders and believed that challenging authority figures was considered disrespectful. I encouraged her to try a new strategy. "Be vocal, offer advice, actively participate, question the diagnosis, and offer an alternative treatment plan, if required." She agreed with my rationale and agreed to take a different approach and present herself with a new perspective and approach, the next time, or henceforth in the future rotations. Two month later, we talked again, and she happily reported that she was doing well and had received positive feedback on her clinical reviews. Her attending supervisor noted in her evaluation, "Articulate and well prepared in reporting patient diagnosis and treatment plan of patients." My impression was that perhaps her attending doctor might have perceived her

as timid, not knowledgeable, and not engaged initially at the beginning of the rotation. One of the barriers, I perceived, was that she was acting upon her cultural experience as a first-generation Latina—she didn't know what was expected from her as a medical student during a rotation nor did she have a faculty mentor guiding her on expectations and norms. She was not aware that she was expected to provide opinions to her attending or for that matter, to her elder, or to a supervisor (authority figure) who owned the title of medical doctor. This situation taught us both that perhaps URiM medical students need to persist beyond their cultural upbringing and learn how to adjust, navigate, and adopt to the cultural framework provided in the medical education system. The student graduated from medical school and is now a physician at a hospital and we continue to keep in touch. Although her problem was successfully resolved, I found myself affixed in identifying what these two students had in common. They were both URiM Latino medical students facing either social challenges or academic adjustments due to a systematic cultural framework that perhaps was far different from their own cultural upbringing and practices. How did personal and structural racism play out in these two different incidents? How did medical school foster differences in treatment and support? How can we fill that gap of knowledge to ensure URiM Latino students are welcomed, supported, treated with respect, and mentored? Therefore, as the researcher of this dissertation study, I wondered how I could better support Latino students and other underrepresented minority students during their medical training.

As an administrator in medical education, I have developed and nurtured an understanding of the learning educational environment that led me to focus my dissertation study on Latino medical student's experience and through scholarly work, to

increase my knowledge of the challenges and opportunities of the perceived and experienced barriers and successes of Latino medical students. Moreover, by examining the social and academic components of the lived experiences of Latino medical students in a predominately White medical school, to expand the knowledge gained thru this dissertation study can create awareness and understanding and have a significant role in creating cultural responsive systems of institutional support for the next generation of URiM Latino physicians. The *cuentos* and counterstories, is a pre-introduction to the Theoretical Framework of Critical Race Theory & Latino Critical Race Theory (LatCrit) that will guide this dissertation study to be discussed in Chapters II.

Three Sources of Inspiration

Three sources of inspiration support this dissertation study. The first inspiration arose from my foundational understanding of the overall condition of underrepresented minority medical students (URiM) in medical school as described in Chapter Two's literature review.

The second source of inspiration emerges from my 30 years of experience working in academic medicine as a student affairs practitioner and from observing the journey of multiple Latino medical students at the Pacific NW Medical University (PNWMU). The years spent as an administrator sharpened my consciousness of social injustice and awareness of the students' needs who seek support and advice. As a student affairs practitioner, my role has been uniquely situated to students having access to students and offering services and resources in support. I believe students sought me out because my own ethnic identity and understanding of their cultural ways allowed a safe place, as well my ability to create genuine and trusting relationships. My role at PNWMU

allowed me to help mediate the students' needs by navigating the hierarchical system and finding resources and providing mentorship and guidance they could use to navigate the system. Finally, I provided *consejos* (advice) to the Latino medical students and other students from all backgrounds who needed encouraging words and wisdom to help them persevere in medical school. While I conducted this study, I recognized that my experiences as a first-generation college student and my cultural, ethnic, and linguistic background influenced me to undertake this research study. I was able to break away from being an administrator vs. a doctoral student conducting a this dissertation study.

The third source of inspiration came from the PNWMU's diversity climate survey that I as the researcher facilitated years prior. The climate survey provided findings and further confirmed the need for this dissertation study. It utilized a survey instrument design that yielded both qualitative and quantitative data with the goal to gather data on PNWMU to establish a baseline to inform short-and long-term diversity best practices and strategies. The qualitative component of the instrument consisted of a space where participants could provide open-ended commentaries based on their experiences and observations as students. In addition, two focus groups were conducted with the various stakeholders at PNWMU, including underrepresented minority medical students in medicine who took part in this climate study which was conducted by a third party years prior to the exploration of this dissertation study.

Next is a high overview with some outcomes of the PNWMU Climate Study.

The PNWMU Climate Study Described

As a researcher, I co-directed, developed, and launched a climate study as part of my administrative role within PNWMU. An independent consultant, known as Culture Inc. (pseudonym) was contracted to execute an institutional web-based survey (5-point Likert scale) and conducted a set number of focus group interviews for a complete data analysis. The quantitative and qualitative research approach was conducted to strengthen and gain a deeper understanding (Creswell & Clark, 2007). While all faculty and staff were included in the climate study, the study took a deeper look exclusively to learn of the findings related to racial and ethnic minority students in one academic health center known as the PNWMU. This focused lens included learning of URiM medical students which also included Latino students. Surveys were electronically distributed to PNWMU students. The survey had agree/disagree questions eliciting opinions from participants about the nature of interactions with faculty, classmates, administrative staff, and leadership. In addition, two qualitative focus groups were conducted that drew on students' perspectives about their experiences at PNWMU. Results drew a 38% response rate from student respondents of a diverse group of students that included White/European-Americans, Asian, Other, more than one race, Black/African American, Native American, and Latinos who took part in the PNWMU study. Next, the PNW findings are discussed.

PNWMU Climate Survey Findings

Descriptive statistical and inferential statistical analysis represented student respondents that included White and URiM students and revealed six statistically significant factors that yielded the following findings:

1. Socioeconomic status [SES] differential: Students who were from lower [SES] groups reported less faculty support for diversity.
2. Student interest groups [SIGs] who voluntarily join affinity student interest groups: Students involved in student interest groups [SIGs] reported less faculty support for diversity and perceived that the PNWMU provided less institutional support for diversity in comparison to their peers who responded in the survey.
3. Reflection on medical school support: Medical students reported less institutional support for diversity and felt that there was less support for individual students in the areas of diversity, equity, and inclusion in comparison to other schools.
4. URiM students' promotion of diversity was at a higher rate than their peers. (URiM's) were most likely to support the promotion of diversity and inclusion within the PNWMU.
5. Perhaps, the most significant PNWMU climate survey finding was related to specific to two items which stated the following: (a) Overall, I am comfortable with the climate of inclusion in my program and (b) I have personally witnessed or experienced discrimination at university campus based on some diversity-related characteristic in the past twelve months.

The findings noted URiMs reported to have the highest level of disagreement with the statement of, "I'm comfortable with the climate of inclusion" at the PNWMU. While admittedly imprecise, the question about "witnessing or experiencing discrimination" revealed that race, ethnicity, and gender impacted the way in which this comment was supported or not supported among the student participants. URiMs reported more activity in either observing or experiencing some form of discrimination and this was alarming to

consider at an institution that sought to increase diversity among the student body. It is also important to note that this question (#5) was problematic and posed a non-distinction between whether the student experience discrimination or witnessed discrimination. There was also insufficient information within the climate survey about the whereabouts of the individual who experienced or witnessed discrimination (i.e., classroom, clinical rounds, etc.) and by whom (peers, faculty, etc.). Although, it was hard to determine it was an important finding to address within this climate survey assessment. The findings of the initial PNWMU survey pointed to a need to better understand and learn more about the experiences of discrimination as reported by URiM's which contributed to the need to investigate further in this dissertation study. The PNWMU climate study also held qualitative focus groups where a group of racial and ethnic students participated in two separate sessions that were designed to explore the students' perspectives of the experience of URiM students. Unfortunately, the Culture Inc. consultants did not collect or reveal the make-up of the groups and due to this data collection error on their part, the data could not be analyzed to understand the URiM perspective. However, the missing data served to inspire the present study of this dissertation study to develop a deeper understanding of the specific nature of URiM experiences at the PNWMU with a specific focus on Latino Medical students to better understand how they experienced the climate to learn of racism and to learn of their journey at the PNMWU. After conversation and guidance with my initial doctoral committee, I selected to learn about the lived lives and journey of Latino medical students as a group based on number of available participants for this study. My interest was to learn of the barriers Latino medical students face and the facilitators that support their success is important to this study.

In summary, desire to focus this qualitative study on URiM Latino medical students emerged from three primary sources of inspiration that included my own observations as an administrator; extensive review of empirical data and the scholarly literature; and the PNWMU climate study findings as discussed that indicated URiM students have a qualitatively different experience compared to their White peers. Next, the study design for this dissertation study is presented.

Study Design

A qualitative case study methodology approach was utilized for an in-depth understanding of URiM Latino medical students' experiences in a set location and time, which was in an urban setting referred to as the Pacific Northwest Medical University (PNWMU). Data was collected through participants partaking in in-depth phenomenologically multi-case interviews (Seidman, 2006) were conducted to investigate and document the lived experiences of the participants and enable them to their own realities (Delgado & Stefancic, 1993) via a collection of *cuentos* and counterstories (Delgado, 1989; Solórzano, 2007; Yosso, 1995) and learn of the facilitators and barriers Latino medical students experience during their journey. The theoretical framework of Critical Race Theory (CRT) was used as a central conceptual framework (Ladson-Billings & Tate, 1995) with the extension of Latino Critical Race Theory (LatCrit) (Solórzano & Yosso, 2001) to explain the phenomenon of URiM Latino medical students. The dual framework helped unpack the racism and discrimination that Latino medical students experienced and provided an understanding of the barriers and facilitators impacting URiM Latino medical students. The use of CRT assisted to gain knowledge of and present the qualitative findings of the lived experiences of Latino

medical students to attempt to disrupt the deficit of limited knowledge by bringing forward enriched qualitative knowledge. To conduct a new inquiry (this dissertation study) a qualitative research method was utilized to understand the inner experiences of URiM Latino Medical students at the PNWMU.

Corbin and Strause (2008) explain that qualitative research is often used to determine the meaning of participant's make of their experiences to amplify the quantitative findings, such as the PNWMU climate study. While there are many qualitative approaches available, this study used a qualitative case study design and analysis. A qualitative case study design was utilized to understand Latino medical students' experiences. This case study explored the lived experiences at the PNMWU. Creswell (2007) states that case study research "involves the study of an issue explored through one or more cases within a bounded system" (p. 73). According to Yin (2009) a "case study is used in many situations to contribute to the knowledge of the individual, group, organizational, social, political, and related phenomena (p. 4). In this study of the bounded system, the cases of eight URiM Latino medical students who served as participants shared the nature of their experiences as part of their medical training. All participants attended the PNWMU during the same period and were either third or fourth year in study. Because there is very limited knowledge about the experiences and observations of URiM Latino medical students, this study considered individual study participants as separate cases within the bounded "site" of the PNWMU.

Summary

In this chapter, I provided a statement of the problem, the significance of the study, background of the problem, purpose of the study, research questions, and

introduced the terms and definitions relevant to the study. I also introduced the definition for underrepresented minority (URiM) students and explained this choice as a topic for investigating the journeys of Latino medical students who are underrepresented in medicine per the Association of Medical Colleges (AAMC). For this dissertation study, I use the term Latino. In the Spanish language, it is an appropriate and correct term to use the term “Latino” that is inclusive to all genders and identities. Finally, this chapter concludes with the study design approach that guided this dissertation study. Next, the literature review is presented in Chapter II.

Chapter II. Literature Review

As established in the previous chapter, I introduced the topic and definition of underrepresented minority (URiM) students, provided the background, and explained this choice as a topic for investigating the journeys of Latino medical students. The topic of case study was introduced to explore the observations and experiences of racism and to learn of the barriers and facilitators of eight Latino medical students as they navigate medical school. This chapter reviews the literature related to URIM's in medicine is limited and a noticeable gap exists of Latino medical students and their experiences. Existing research places Latinos with other underrepresented racial and ethnic groups in other words grouping them together which makes it difficult to understand the unique journeys of each group itself. The literature review in this chapter begins with defining the term underrepresented in medicine and follows to address key areas that align with the research design of this dissertation study as follows: (a) a limited pipeline to medical degree programs (b) academic performance of URiM medical students (c) the social learning environment of URiM medical students (d) racism and mistreatment (e) alienation & invisibility (f) coping with stress, and (g) mentorship which are disparities in outcomes. The chapter also outlines the theoretical framework that guided this dissertation study intersecting with the lived lives of eight Latino medical students. Chapter II closes with the methodological approach to address the research problem and summarizes the literature review. Finally, chapter II concludes with a summary.

Underrepresented Minorities in Medicine (URiM)

Using the paradigm of "underrepresented minorities in medicine" (URiM) include the following groups: Black/African American, American Indian/Alaskan Native, Native

Hawaiian/Pacific Islander and Hispanic/Latinos are racial and ethnic groups who are considered to be underrepresented in the medical profession due to the number the low number they represent, and which are not representative in parity with their respective cultural and ethnic groups according to the American Association of Medical Colleges (AAMC 2004). Furthermore, the number of matriculated Latino medical students remains significantly low in representation in comparison to the growing U.S. Latino population. Matriculants are defined as students who apply and are accepted to medical school. The substantial racial and ethnic gap and underrepresentation of URiM's have been persistent in the medical profession throughout the past decades due to segregation and racism (Byrd & Clayton, 2001). Lack of representation in the medical schools deters from not knowing much about URiM matriculants who represent a small number of medical students and who could potentially impact the healthcare system as future physicians (AAMC, 2019). Historically and in practice, medical schools have placed more emphasis and efforts in recruiting efforts of URiM students (Nickens & Ready, 1994) yet, we know very little about retention and barriers that prevent URiM's from progressing in their academic journey posits Nguyen et al., (2022). Climate studies have found that URiM medical students have different experiences and report less positive experiences during their training in medical school (Bullock & Houston, 1987; Hung et al., 2007). Therefore, this dissertation study seeks to better understand the journey and climate of the Latino experience since very little is known about the experiences of URiM students in U.S. medical schools, specifically as it relates to Latino medical students. URiM students who succeed in matriculating are disproportionately more likely to be dismissed, withdraw from medical school, and are less likely to complete a degree or not pass

required tests in comparison to White and Asian colleagues (Andriole & Jeffe, 2010; Nguyen et al., 2022). The limited studies on climate that seek to understand the URiM medical student experiences are thin in the literature but are growing in interest to understand the journey of URiM's in academic medicine in light of anti-racism efforts in medicine. Studies often place all racial and ethnic minority groups into one large group with the assumption they are all similar in background, learning, level of acculturation and experience which may limit knowledge of the individual racial and ethnic groups. Orom et al., 2013, identified 28 studies that placed URiM student's experiences as less supportive, less positive learning environments, and students were more likely to experience racism. They found that the climate environment needs to be addressed but at times was difficult to learn the uniqueness, differences, and communalities of the different groups that make up underrepresented students in medicine. Per the initial review of this literature review, most studies were quantitative studies and less qualitative studies were found based on the experiences of URiM students. Therefore, this dissertation study used qualitative case study to hear and learn through the *cuentos* and counterstories from the "voices" of Latino medical students to learn of their experiences and learn of the barriers and facilitators they experienced along their journey as third and fourth year Latino medical students.

Historical Context of Underrepresented Minorities in Medicine (URiMs)

In present time, the medical profession is not racially or ethnically diverse and predominantly encompasses White male physicians who currently represent 56.2% of all allopathic active medical doctors (AAMC, 2018). In fact, White men throughout U.S. history have dominated the medical profession and racial ethnic minorities and White

females too have been intentionally excluded for centuries in the past (Bullock & Houston, 1987). Historians tell us that Black/African American and other racial minorities were purposefully kept out, discouraged, and provided barriers to seek a profession. Until the 20th century, through the legislation of civil rights and court decisions the medical profession begin to open the doors to racial and ethnic minorities to be able to access institutions of higher education and the opportunity to apply to medical schools across the U.S. (Petersdorf et al., 1990). During 1964, the racial make-up accounted for 2.2% Black/African Americans during this period of time across 83 allopathic medical schools per the AAMC. Although, prior to the civil rights era there were Black medical schools founded during the 1860's, however many barriers prevented doctors from practicing medicine even after receipt of a medical degree. Black doctors did not have hospital rights and were not seen as equals by White physicians (Steinecke & Terrell, 2010). Black doctors were also unable to join the professional medical associations either and were discriminated against because of their race (Bullock & Houston, 1987). Other URiM groups apart from Black/African Americans are not mentioned in the literature until the early 1970's, making it difficult to learn more about Latinos and other racial and ethnic groups in medicine from a historical standpoint (Nickens & Ready, 1994).

During the early 1900's, there were other barriers that prevented URiMs to pursue medicine from being unable to apply and matriculate into medical school. The Flexner Report of 1910 was the major step back which was a job commissioned by the Carnegie Foundation with a goal on reporting on North American clinical and research entities in both the U.S.A. and Canada titled "A Report to the Carnegie Foundation for the

Advancement of Teaching 1910 which as a result placed new standards of American medical education that said to be was subjective and encroach elitist measures (Stahnisch & Verhoef, 2012). The Flexner Report set standardization for U.S. medical education and forced the closure of many medical schools who did not meet the set standards for admission, graduation, or the correct protocols for teaching and research in medical schools (Sullivan & Mittman, 2010). The Flexner Report of 1910 changed the trajectory of Black/African American medical trainees who were not allowed to attend White medical schools across the United States while also developed criteria for medical schools intended for Black medical students (Steinecke & Terrell, 2010). Abraham Flexner, who led this effort of standardization in medicine has been associated to bring rigor in academic medicine but also had biased beliefs that Black/African American students were substandard compared to White students (Sullivan & Mittman, 2010). Flexner also ordered the closures of all Black medical schools with the exception of the Howard University of Medicine and Meharry Medical College, which were the only two Black medical schools that he felt were up to par in his assessment (Harley, 2006). In addition to the closure of medical schools that trained Black doctors, Black/African Americans were not admitted to existing medical schools for the next 50 years, which contributed to the underrepresentation of minorities in medicine (Sullivan & Mittman, 2010). While the goal of the report was to increase the quality of teaching and reduce the number of medical schools, this action caused black physicians to decrease in representation and increased White physicians over time (Savitt et al., 1992). The history of Latinos in medicine is not well documented or known causing a sense of not belonging in medicine. “The history of Hispanics in medicine can be even murkier to unravel, as

few statistics on the participation of Latinos in formal medical establishments exist," according to the historical context as published by the office of Diversity and Inclusion, Heersink School of Medicine at the University of Alabama at Birmingham website (n.d). There is also little recognition of other racial and ethnic groups in medicine as learned in this literature search.

However, there is evidence medical education in the 20th and 21st centuries kept URiMs from pursuing medicine (Byrd & Clayton, 2001). History also posits that White practicing physicians and scientists perpetuated racial inferiority stereotypes in medicine and were routinely taught in U.S. medical schools from the 18th, 19th, and first half of the 20th centuries by using unethical experiments among racial minority groups were a practice (Nuriddin et al., 2020). Medical science played a key role in bringing forward racialized ideas, myths, and differences of treatment of people of color (Kenny, 2015). Race and Racism has been at the center in the history of medicine from the inception of the medical profession. Fast forward to the Civil Rights Era. At the 1968 Association of American Medical College Annual Conference (AAMC, 1968), the membership planned and set goals to diversify the medical profession after civil rights legislation had passed there years earlier. To increase representation among physicians, the AAMC established the Office of Minority Affairs and determined that Black, Hispanic, and Native Americans were underrepresented in medicine (Petersdorf et al., 1990). The AAMC defined the term underrepresented in medicine for racial and ethnic groups and set a goal to increase by 12% representation of these groups in medical schools. (Nickens & Ready, 1994), but they fell short of their goal by 3 percent (Nickens & Ready, 1994). The U.S. Supreme Court in 1978 ruled that race could only be used as a "plus factor" while

banning race quotas in the Regents of the University of California v. Bakke, which ruled against the UC Davis School of Medicine. During this time, Affirmative Action rested on the notion that race could be used in the admissions process to support compelling interests by tailoring the use of race in admissions. By 1968, the enrollment among racial and ethnic medical students increased to 10% in six years and shortly a lawsuit followed known as the Bakke Case claiming reverse racial discrimination (Nickens & Ready, 1999). Years later, revisiting Affirmative Action, in 2003, the U.S. Supreme Court ruled in the case of Grutter V Bollinger, that race could be used in admissions to support the recruitment for student diversity (Grutter vs. Bollinger, 2003). The law stated that no additional points could be added based on a student's racial and ethnic background in the admissions process. The AAMC followed pursuit with guardrails navigating the laws for admission and adopted other sound legal strategies beyond the use of Affirmative Action to diversify the student body in medical schools. In 2007, the AAMC created the "Holistic Review" The holistic review process provided guidance on both legal and educational policy contexts to conduct race-conscious admissions. The holistic review allows candidates to be evaluated based on their abilities, capabilities, and talents beyond grade point average and an examination score to increase the quality and diversity of prospective candidates. This legal approach also provides admission-related tools and resources to help medical schools create, implement, and sustain diversity (AAMC). The AAMC has also developed outreach initiatives to engage and increase the applicant pool among URiM prospective students. This major initiative was known as Project 3000 by 2000 which launched across multiple medical schools (Nickens & Ready, 1994). The

goal of this initiative was to increase the number of URiM medical students in U.S. allopathic medical schools by the year 2000.

Achieving this enrollment goal would mean approximate population parity for URiM medical students would have been reached for racial/ethnic groups that had historically been denied educational opportunities in medicine (Nickens & Ready, 1999). Project 3000 by 2000 was a good attempt but unfortunately did not its goal to increase representation. The AAMC developed multiple outreach initiatives and programs to increase access to other opportunities via summer enrichment programs, diversity career fairs, tours, and other activities focused on increasing interest in medicine (Nivet, 2015). The struggle continues to diversify the applicant pool but again there has been no real focus on URiM medical students once they enter medical school to understand the matriculation journey for URiM (Nwokolo et al., 2021). Scholars report that URiM physicians are critical to the professions and have a positive impact on public health (Nivet, 2010). Lack of representation of URiMs prevents the delivery of adequate care and does not advance the national health care agenda. Both require the inclusion of a diverse workforce (Cohen & Terrell, 2002).

Current Makeup of URiM in Medicine

The substantial disparity between the race and ethnicity of the U.S. population in comparison to the representation among URiM physicians is staggering (Sullivan, 2004). The United States is becoming increasingly diverse in terms of race and ethnicity (U.S. Census, 2021). The Institute of Medicine, the Commonwealth Fund, The Sullivan Commission, the American Association Medical Colleges and other entities confer there is a need to increase racial diversity in the medical profession (Sullivan, 2004; Nivet

2015; Cooper et al., 2004). A closer look at the racial composition of the U.S. population represents the following racial and ethnic percentages: Black/African American represent (13.6%), American Indian/Alaskan Native at (1.3%), Asians (6.1%), Native Hawaiian/Pacific Islander (.0.3%), Hispanic/Latinos represent (18.9 %), two or more races (2.9%), and non-White (non-Latinos) represents and White alone represents 59.3% (U.S. Census Quick Facts, 2021). By contrast, URiM medical doctors account for a total of 11.2% of all allopathic physicians. This data reveals there is a significant gap and underrepresentation of URiM medical doctors currently in the profession. The composition of U.S. URiM medical doctors becomes more difficult to conceal the dearth of physicians accounting for Black/African American AAMC, a report titled *All Active Physicians* (AMMC, 2018) notes URiM make up 5.0% of all physicians as follows: American Indian/Alaskan Native account for 0.3%, Native Hawaiian/Pacific Islander at 0.1%, and Hispanic/Latinos make up 5.8% of URiM doctors representing allopathic URiM doctors. Again, to reemphasize, URiM medical doctors account for a total of 11.2% of all active URiM physicians. Among other active physicians, 56.2% identified as White, 17.1% identified as Asian, and 13.7% are listed as race unknown. Although, URiM physicians represent a very small number of physicians the evidence demonstrates URiMs impact favorably societal, patient care, and health outcomes as discussed in the following section.

Evidence of Importance of Underrepresented Minorities in Medicine (URiM)

What is the evidence of the benefits of increasing racial and ethnic diversity among URiM medical doctors? What is the racial and ethnic significance and how does this relate to both improving access to healthcare and societal needs? There is strong

evidence within the literature that supports the claims that racial and ethnic diversification of the medical profession can benefit the U.S. healthcare system (Nivet, 2015), improve access to patient care (Cooper-Patrick et al., 1999); decrease health disparities (Brach & Fraserirector, 2000); (Cooper & Power, 2004) improve race-concordant visits for improved patient satisfaction (Cooper-Patrick et al., 1999); increase communication between patients and doctors of same race and/or ethnicity (Betancourt & Maina, 2004); while increasing trust between patients and physicians of the same race or ethnic background (Swell, 2015). Whereas Saha et al., (2000) posit minority patients are more likely to choose someone of their own racial and ethnic background when provided a choice. Furthermore, while many factors can contribute to increasing access to care and by reducing health care disparities, increasing the number of URiM providers can significantly assist the increase of access to healthcare to communities of color (Smedley & Mittman, 2011).

Increasing Access to Patient Care

URiM medical providers are identified as being able to provide culturally competent care by increasing the quality of treatment and decrease of health disparities (Hobgood et al., 2006; Betancourt et al., 2003). Being culturally competent in health care is the skill of being culturally and linguistically competent to provide effective cross-cultural situations according to the Cultural Competence Education Resource Book (AAMC, 2005). Being culturally competent is noted to minimize patient bias, prejudice and stereotyping by medical physicians (Smedley et al., 2003). Ochoa (2003) posits cultural competence moves beyond cultural sensitivity and moves towards providing an informed diagnosis and treatment plan for diverse patient populations. In addition to

improving care among URiM patients, studies reveal URiM medical physicians are more likely to practice in historically underserved communities and more likely to serve larger numbers of racial and ethnic patients in comparison to their White counterparts. Researchers (Xu et al., 1997; Cantor et al., 1996; Moy & Bartman, 1995) found URiM physicians are more likely to treat patients of low socioeconomic status, uninsured, and patients covered by Medicaid.

Shortage in the Physician Workforce

"Because physicians training can take up to a decade, a physician shortage in 2025 is a problem that should have been addressed in 2015" according to the AAMC Report titled *Physician Supply and Demand Through 2025*: *Key Finding*s (Markit, 2017). The physician shortage and projected growth in patient diversity create an urgency to graduate every medical student who matriculates to medical school. In addition to diversifying the medical profession, there is also an urgency to attract more URiM students into medicine. Increasing access and opportunities into the educational pipeline to medical school is a key component for increasing the number of physicians. Several states across the U.S. have invested in medical school expansion by building new medical schools to increase medical graduates to serve their local practices (Whitcomb, 2009). Now more than ever, allopathic medical schools are more concerned about the nation's projected physician shortage, with the diversity growth and change in demographics (AAMC, 2015). A multi-pronged approach is required to support the social and academic success of URiM medical students leading to medical degree attainment to respond to the health care needs of patients (Buerhaus, 1999 & The Sullivan Commission, 2010). The evidence posits that by not having a racially and ethnically diverse healthcare workforce,

our society fails to support the needs of an increasingly diverse patient population and respond to the transformation of healthcare. Ensuring that all medical students, as well as URiM Latino medical students, persist and graduate from medical school could be considered a fundamental solution to the shortage of physicians.

Educational Benefits of Diversity in Medicine

Exposure to racial and ethnic diversity in medical school contributes importantly to cultural competence knowledge and skills. A diverse student body contributes to the learning environment. "A racially and ethnically diverse student body has far-ranging and significant benefits for all students" (Gurin, 1999). It can broaden perspectives regarding racial, ethnic, and culture and has been associated with greater cognitive learning outcomes among students (Chang, 1999). In medical education specifically, research reveals the more diverse the student body composition reveals the more cultural competency skills are developed (Hobgood et al., 2006). Furthermore, attending a more diverse medical school helps students develop a stronger outlook for equitable access to health care (Saha, 2008). Villalpando (1996) found that interacting with students of color during and after college has positive effects on White students increasing their sense of social responsibility and participation in community service activities. In sum, increasing the number of URiM medical students is not only a benefit to patients but also helps enrich the student learning experience of medical colleagues (Gurin, 1999; Chang, 2004; Hobgood et al., 2006). The trajectory and lived experiences of URiM medical students who matriculate into medical school is critical in understanding to ensure they are successful socially and academically given the “social capital” URiM doctors bring to the medical profession by increasing access, equity, cultural competence and decreasing

health disparities in healthcare (Brach & Fraserirector, 2000; Cooper & Power, 2004; Cooper-Patrick et al., 1999; Betancourt & Maina, 2004). In sum, URiM doctors are important for the delivery of competent patient care and therefore being able to graduate every URiM medical student is important.

Next, I will review the literature relevant to the problem to substantiate the importance of an inclusive climate for URiM medical students seeking a degree in medicine. In this review, the literature will be organized in two sections as follows: (a) limited pipeline to M.D. program (b) academic performance of URiM medical students (c) the social learning environment of URiM medical students (d) racism and mistreatment, (e) alienation & invisibility (f) coping with stress, and (g) lack of mentorship. Chapter II will close with the methodological approach to address the research problem and summarize the literature review. Finally, chapter II will conclude with a summary.

Limited Pipeline to M.D. Program

Scholars acknowledge more institutional efforts must be put in place to build the URiM student pipeline to increase matriculation into medical school (Nivet, 2015). Although some progress has been made to improve the pipeline of URiM prospective students (Nickens et al.,1994) note a need to build capacity and improvement for diversity and inclusion and should be a priority for U.S. medical schools and teaching hospitals (Nivet, 2015). Despite attempts to grow the representation of under-represented minorities in medicine in health professional enrichment pathway programs, progress is minimal and slow increased diversity representation in medicine (Writing, 2018). The low number of URiM students applying and matriculating to the medical profession

continues to have low representation among applicants to medical school and among underrepresented minorities (AAMC, 2021). To eliminate health disparities, improve patient-to-health-provider concordance, and to increase access to care, there is a need to increase interest, academic preparation, application, and graduation of URiMs, which includes increasing Latinos representation in medicine. For decades, URiM medical students have not increased in number, however, small gains have been made during years 2019 to 2021 on an annual basis among URiM's applicants and matriculants according to the American Medical Association Diversity Entering Medical Class Report (AAMC, 2021). New data shows small progress in representation is slowly increasing among underrepresented minority students. First-year Latino/Hispanic students, increased by 7.1%, to 2,869. Representing 12.7% of matriculants, up from 12.0% in 2020. Black, African American students made up 11.3% of matriculants (first-year students) in 2021, up from 9.5% last year. American Indian and Alaska Native first-year students declined by 8.5%, to 227, making up only 1.0% of matriculants, which is the least representative group. The number of URiM students who matriculated into medical school accounted for a total of 7.3% of all first entering medical (AAMC, 2021). Although there is progress in the representation of URiM matriculants it is not enough to make an impact to change the trajectory of the number of URiM providers immediately as they only represent 9.2 % of all U.S. allopathic medical doctors per the AAMC. Although there is minor progress, the lack of representation of URiMs in medicine does not allow adequate care to advance the national health care agenda and requires the inclusion of a diverse workforce (Cohen & Terrell, 2002). In recognizing the need to diversify the physician workforce, the Liaison Committee on Medical Education (LCME, 2014) which accredits all allopathic

medical education programs set new accreditation policies for diversity standards. The standards call for building an environment that is supportive of diversity and inclusion (LCME, 2014). These policy attempts serve to continue to grow the representation of racial diversity composition plus also set standards for cultural competency within the curriculum to enrich the medical knowledge of medical students per the LCME.

Academic Performance

As discussed in chapter one, the URiM medical trend for applicants and matriculants has been historically low in numbers and continues to be morbidly low for URiM medical students. URiM medical students also demonstrate high attrition and higher incidents of "no-pass" rates on the United States Medical Licensing Examination (USMLE) board exams. This example is critical to continue medical training prior to receiving a medical degree. The literature review indicates URiM medical students perform at lower levels in academic performance, but with the academic and social support they can be successful (Segal et al., 1999).

The next section will describe the academic performance and social struggles of URiM medical students, specifically as it relates to URiM medical students in their educational learning environment. When the public considers the medical profession, the perception is that medical students are the best and brightest. Solórzano et al., (2000) noted that even academically talented students enrolled in elite schools can be affected by the overall academic climate, which impacts their learning experiences.

Academic Struggles Environment

In reviewing the literature on the academic environment there is a theme among URiM medical students who encounter academic barriers. Lee et.al, (2009) found

demographic differences among Black/African Americans and Native Americans/Alaska Natives who reported receiving more negative comments than White students regarding their communication skills during clinical clerkships. However, male immigrants reported receiving the most negative comments among URiM medical students. The study was a cross-sectional self-report survey examining the significance of associations among students' demographics, communication styles, and clinical clerkship feedback. Survey participants included 2,395 students from 105 participating medical schools. The study included 1,620 medical students (1,357 White, 115 Black/African American, 116 Latino and 32 Native American/Alaska Native). Dawson et al., (1994) in a quantitative study found similar evidence of academic failure at USMLE by URiM medical students at higher rates. Black/African American students scored 100-120 points lower and 37 Latino students scored 60 points lower than White students. The pass rate for NBME Part 1 was 88% for White students, 84% for Asian students, 49% for Black/African American students, and 66% for Hispanics/Latino students respectively. This study was a two-year (1986-1988) longitudinal cross-sectional analysis of records from the National Board of Medical Educators (NBME) and the Association of American Medical Colleges (AAMC) which included 10,403 medical students; analyses included 9,433 students (8,517 White, 548 Black/African American and 368 Latino) who took the NBME Part I for the first time in 1988 and who was two years away from graduation. Similarly, Andriole and Jeffe (2012) found that URiM medical students had lower passing rates for USMLE. URiM medical students had lower odds than their White peers of passing USMLE Step 2 Clinical Knowledge. The study was a national cohort quantitative study of U.S. medical school students who initially failed Step 1 of the USMLE. Furthermore, the study was an

eight-year longitudinal analysis of records for students' matriculation from 1993-2001. The study included 6,594 students (2,444 White, 952 Asian/Pacific Islander and 3,198 URiM medical students) at U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME). Kasuya et al., (2003) found lower performance rates in USMLE among Asian and Pacific Islander populations of medical students. The study was a four-year longitudinal analysis of student records from the University of Hawaii School of Medicine graduating classes of 1996–2000. The study involved 258 students (40 Hawaiian/Pacific Islander and 218 other medical students). The study found Hawaiian/Pacific Islanders performed at lower rates than other groups on the USMLE Step 1 but not Step 2. This was the only study that focused on the outcomes of Hawaiian and Pacific Islanders students found in the literature. In examining the literature for attrition and withdrawal from medical school, Huff and Fang (1999) found that 18% of URiM medical students experienced academic withdrawal, leave of absence, dismissal, or delay of graduation, compared with 3% of non-URiM medical students. Huff and Fang (1999) focused on students who were most at risk of encountering academic difficulty. The study was a longitudinal study that examined and reviewed graduation records. The study included 13,118 which represented 81% of the entering class of 1992 from 126 M.D. degree granting U.S. medical schools. Andriole & Jeffe (2010) found that 42.8 % of URiM medical students didn't pass the USMLE Step 1 and/or Step 2 on the first attempt compared to their peers who passed at rates of 38.9% of their White peers. URiM medical students were also found to have increased odds of withdrawing or being dismissed due to both academic and nonacademic reasons compared with White students. This five-year quantitative study was a longitudinal analysis of the AAMC Student

Record System and Matriculating Student Questionnaire data. The study involved 84,018 students (55,514 White and 12,505 URiM medical students) matriculating between 1994-1999 to medical schools accredited by the LCME who failed the USMLE Step 1 and/or Step 2 in medical school. Segal et al., (1999) studied the University of Michigan Medical School's Academic Support Program to recommend intervention and accommodations (i.e., tutors, referrals to medical and/or psychiatric services). Their study found that when academic resources and support are provided to URiM medical students, they demonstrate higher academic success. The study included 28 medical students (4 non-URiM and 24 URiM medical students). Segal et al., (1999) found that 26 (93%) of the 28 medical students had either graduated or were continuing to persist and none were placed on academic probation again. The study was a four-year longitudinal intervention from 1994-1998 aimed to identify at-risk for academic failure due to repeated failure in coursework, USMLE Step 1 or 2 or facing academic probation. Another study that responded to the needs of URiM medical students to help them pass the USMLE included a quantitative approach. Lieberman et al., (2008) found improvement in USMLE Step 1 scores: greatest among URiM medical students (+ 11.9 points), in particular Black/African American students (+ 14.3 points) and a decrease in USMLE Step 1 failure (12.9% to 4.2%) for URiM medical students. In this study, the curriculum was switched from traditional to integrated curriculum that incorporated system- and problem-based learning, exam preparation, and remediation for at-risk students. The study included 255 medical students (74 non-URiM and 181 URiM medical students) and was a longitudinal intervention from 1995-1997 and 2003-2005. In the last study reviewing academic performance, Lieberman et al., (2010) conducted a quantitative study on the effects of

comprehensive educational reforms on academic success in a diverse student body. The study was a longitudinal intervention from 1995-1997 and 2003-2005. This study was designed to switch from traditional to integrated curriculum that incorporated system and problem-based learning, exam preparation, and remediation for at-risk students. The study included 1,114 students (771 non-URiM and 329 URiM medical students). Lieberman et al., (2010) found an improvement in Step 1 scores greatest among URiM medical students (14.6 points), in particular Black/African American medical students (20.8 points) and a decrease in Step 1 failure (16.6% to 3.9%) for URiM medical students. This section concludes the status of academic performances and test taking of URiM medical students. The next section will explore a comprehensive literature review on the learning environment and social aspects of URiM medical students.

Racism in Medical School

Building upon the knowledge of Orom et al., (2013), the review of 28 studies published between the years 1980 to 2012 in the U.S. found URiM medical students were subjected to discrimination and racial harassment and were more likely to believe race had a negative impact on their medical school experiences. Presented studies within their literature search found that URiM medical students experienced a less supportive social climate and less positive learning environment, which propels this research study to learn more specifics about the journeys of URiM Latino medical students. Orom et al., (2013) cited URiM students reported less supportive learning environments and observed their race had a negative impact on their academic medical journey compared to non-URiM students. Furthermore, academic performance on standardized tests and the progress of

URiM medical students was less timely and displayed higher attrition rates for URiM medical students.

This is further supported by the following evidence of other scholars when analyzing the social and academic environment of URiM medical students. Kassebaum & Cutler (1998) found higher level of incidences of racial harassment for Black/African Americans (9.4% for men, 6.8% for women) and Latinos (9.6% for men, 8% for women), followed by Asians and Pacific Islanders (7.4% for men, 6.8% for women). The incidence of racial harassment experienced by students was consistent across public and private schools and regions of the country, but with higher reporting rates amongst Black/African Americans, Asians and Pacific Islanders, and Latinos. This study examined the AAMC's Medical School Graduation Questionnaire (GQ). A total of 747 instances of abuse were reported by 502 GQ respondents claiming racial harassment, 72.7% citing one incident, 16.9% two incidents, and 10.3% three or more incidents. When all the incidents of reported racial harassment are considered, the major abusers, in descending order, were the clinical faculty in the hospital (27.3%), fellow students (21.7%), and residents (19.9%). The survey asked participants to disclose abuses and behaviors directed towards other students they may have witnessed. Participants were asked whether they reported the 41 incidents and to whom. The quantitative survey of Kassebaum and Cutler (1998) included 10,686 graduates (9,087 White, 783 Black/African American, 741 Latino, and 75 American Indian/Alaska Native medical students) from 125 medical schools. This survey is provided to all graduating medical students from 125 medical schools to evaluate their medical training experience. The survey presented individual and institutional questions to understand the medical

student's experience better. Questions explored types of abuse and the frequency of behaviors directed at students directly. In addition, the participants identified the role (i.e., nurse, doctor, resident, peers, etc.).

Another term that is used by medical schools is "mistreatment." Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, sexual orientation, humiliation, psychological or physical punishment, and the use of grading and other forms of assessment in a punitive manner. The occurrences of mistreatment can either be intentional or unintentional between teacher and learner per the AAMC Mistreatment Definition (2018). This subject area currently is being further explored by the AAMC to understand the learning education environment and better understand the experiences of medical students. Dhaliwal et al., (2013) described URiM medical students as encountering racism during their medical training. Survey participants reported having witnessed students and residents exhibiting offensive behaviors toward people of color. Hung et al., (2007) reported similar findings related to encounters of racism as reported by URiM medical students. This cross-sectional report included 216 students (162 White and 15 URiM medical students) and found that 46.7% of URiM medical students perceived racism compared to 19.8% of non URiM medical students. Findings noted that higher levels of incidents of racism occurred in the clinical setting versus the classroom and/or social gatherings. The study found no significant differences between non-URiM and URiM medical students' beliefs that students are accepted and respected by their peers, faculty, and administration. Thus, their findings noted the evidence of racism as well as stating that URiM medical students believed the university was working towards supporting diversity. This study illustrates

race/ethnicity inconsistency in the characteristics in which responses were categorized as: Asian (Chinese, Filipino, Indian, Japanese, Korean, Middle Eastern, Pakistani, Persian, South Asian, Southeast Asian), Black (African American or African), Latino (Central American, Cuban, Mexican American, Puerto Rican, other Latin American, Hispanic), American Indian, White (Caucasian), or other. Students checking multiple boxes were considered non-White. Hung et al., (2007) further categorized Black, Latino, and American Indian students as URiM's.

Bullock and Houston (1987) explored whether racism is perceived or experienced and hypothesized that there were at least two possible causes for the perception of racism: (a) that the perception of racism is the result of unhealthy paranoid attitudes or (b) that the perception of racism is a part of a good and necessary reality testing (p. 602). Further, Bullock and Houston posit whether at some point racism and discrimination become a stressful focal issue compounding the more general problems of adapting to a White medical school environment. Bullock and Houston (1987) conducted a study with thirty-one Black/African American medical students attending five predominately White medical schools (PWMS) conducted in a one-to-two-hour qualitative interview. The study included a series of questions about demographic characteristics, and student perceptions of racism in high school, college, and medical school (specifically the medical school admission process, the preclinical years, and the clinical years). Bullock and Houston (1987) broke down the interview as follows: (a) perceptions of racism during high school and college, (b) perceptions of racism during the medical school-the admission process, the preclinical, and the clinical years, (c) responses to racism; (d) variations like the experience as they relate to student characteristics, and (e) successful

coping styles described by those students recognized as doing well academically or recognized as leaders by other students. Seven students, six of whom had attended Black undergraduate colleges reported experiencing no racism. Twenty students who attended integrated colleges reported they experienced racism, which was described by 11 of the subjects as being subtle and which included not receiving adequate premedical counseling and being discouraged from pursuing a medical career by high school counselors. Racism in high school was experienced by approximately one-half of the participants in the study. Interestingly, one of the findings showed Black/African American medical students attending White undergraduate colleges were more likely to encounter racism than those who attended historically Black colleges and universities, which, coincidentally, graduate 38% – more than 1/3 – of all Black/African American medical students. Emerging themes from the study of Bullock and Houston (1987) are noted as follows: Black students were treated as though they were intellectually less able than White students. Nine Black students reported they were "invisible." The study is reminiscent of the book titled “Invisible Man" authored by Ralph Ellison (1952) which is based on the life of a young Black man as he moves through American intolerance and cultural blindness. Searching for context in which to know himself, he exists in a very peculiar state. "I am an invisible man," he notes in his prologue. "When they approach me, they see only my surroundings, themselves, or figments of their imagination indeed, everything and anything except me.” Of the eight participants interviewed, all but two of them related examples of discriminatory behavior on the part of their classmates or instructors in the preclinical years.

The second theme that emerged from participants points to the subjectivity of faculty members when providing clinical evaluations with lower feedback to URiM medical students. One student stated that nine of seventeen students felt their negative clinical evaluations had been clearly subjective. Interestingly, students were able to provide examples of discriminatory behavior on the part of their classmates or instructors in the preclinical years. All 18 students who had performed clinical rotations also reported at least one example of negative or discriminatory attitudes toward Black patients by White staff. The incidents ranged from Black/African American patients frequently being called by their first names, compared with White patients who were addressed by a title such as Mr. Mrs. Ms., etc. Students interpreted this behavior as a reflection of the instructor's beliefs of Black intellectual and social inferiority. Hill et al., (2020) found mistreatment is common among URiM and among other diverse groups that bear a burden of mistreatment in medical school. The study analyzed data from 2016 to 2017 via the Association of American Medical Colleges Graduation Questionnaire that has as many of 140 allopathic US medical school participants. Results from a total of 257,504 student surveys were analyzed representing graduating medical students at a return rate of 72.1%. The sample included 16 521 White (60.1%), 5641 Asian (20.5%), 2433 underrepresented minority (URiM) (8.8%), and 2376 multiracial respondents (8.6%); and 25 763 heterosexual (93.7%) and 1463 lesbian, gay, or bisexual (LGB) respondents (5.3%), and other multiracial students. In comparing White students to URiM, Multiracial students and Asian students reported a higher level of mistreatment in medical school. They reported offensive remarks or names, receiving lower evaluations or grades because of their race, and a higher prevalence of experiencing two or more

types of mistreatments compared to White students. The findings of this study add to the literature that URiM students experience adverse treatment and are exposed to a culture of racism and fail to offer an inclusive learning environment while impacting their learning abilities and clinical evaluations. Fnais et. al. (2014) conducted a systematic review and meta-analysis to examine harassment and discrimination among residents/house officers' experiences and found 51 studies in the literature that found harassment and discrimination has not declined over a period. Although this meta-analysis focused on residents, it is similar in findings to the learning experiences of Latino medical students.

Alienation & Invisibility

Bullock and Houston (1987) reported several participants feeling alienated, causing them not to not participate in classroom discussions and attempting to learn exclusively from reading materials. One participant reported feeling "uncomfortable" in the classroom because of how she was treated. "I felt I was just there to get by and not excel. I was depressed at times and decided not to go to class. I'd stay home and read notes." The participant was able to get through because of peer support from other Black students and the minority office. This participant noted it was an important learning experience. Student ideas should be included improve the quality of the medical school experience by creating an atmosphere that is receptive and supportive of minority students. All the students found the presence of other Black students and faculty and formal minority programs supportive. Most of the students felt that the presence of even more Black instructors and doctors, in general, would improve the experience and that students would benefit from a more positive attitude about their capabilities on the part of

the school in particular. Frierson (1987) agrees Black/African American medical students experience higher levels of satisfaction and academic success at medical schools that employ more URiM faculty members. Frierson (1987) advises medical institutions to be aware of this finding to address the alienation that might be felt among URiM medical students. Alienation is described as feeling isolated or emotional response and action to an unwelcoming and non-inclusive learning environment (Loo & Rolison, 1986). Franklin (2006, p. 118) refers to the "Invisibility Syndrome" experience of a person of color who feels they are "in a racialized or depersonalized context in which who they are as a genuine person, including their talents and unique abilities, is overshadowed by stereotyped attitudes and prejudice that others hold about them." URiM medical students reported loneliness, and isolation, and described how they developed strategies to establish social networks to support their mental and physical well-being. Peer support was identified as a key component to promote emotional support and motivation toward their academic journey. Dyrbye et al., (2006) inquired into the extent to which the pressures of racist experiences play a harmful role in the scholastic performance of URiM medical students. Their study data suggests that the role it plays varies from student to student, based on both intellectual capacity and dynamic-experiential factors. There are some students for whom the pressure of racism, added to the other pressures of medical school, is decisive in determining poor academic performance. What can be said with assurance is that feelings of alienation do not help. Experiences of prejudice and discrimination are an additional stress for Black medical student as noted by Dyrbye et al., (2006).

Coping with Stress in Medical School

Stress in the lives of URiM medical students was found to be present as reported in multiple stress studies. Dyrbye et al., (2006) states medical school is stressful and approximately 25% of medical students experience depression while approximately 50% of medical students (Dahlin & Runeson, 2007) note medical students display symptoms of burnout. Strayhorn and Frierson (1989) conducted a quantitative study assessing the correlations between Black/African American and White students' perceptions of the medical school learning environment, academic performances, and their well-being. Black/African American medical students reported greater stress due to their minority status. Pyskoty et al., (1990) found Black/African Americans and Hispanics/Latino students entered medical school with higher levels of social support than Whites students; however Black/African Americans and Latinos reported to have less emotional support after year two of their medical training. Furthermore, Hispanic/ Latino students reported to have a higher level of alcohol consumption than Black/African Americans and White students. The study concluded that more formal support and networks to support minority students are required. Epstein and Krasner (2013) agree that student resilience is dependent on the individual, community, and institutional factors to assist in increasing persistence in medical school by developing a social support system (Hsu et al., 2011). Satterfield & Becerra (2010) further confirm peer group interaction and peer support facilitates coping strategies that can lead to resilience and persistence among medical students. There is a need to further understand the experiences of URiM medical students beyond the reported incidences of discrimination, racism, and biases, which occur in medical school (Reitzes & Elkhanialy, 1976; Bullock & Houston, 1987; Hawkins, 1998; Kassebaum & Cutler, 1998; Hung et al., 2007; Orom et al., 2013). The adverse climate

for URiM medical students has been documented in medical schools as not being welcoming, impacting their experience (Orom et al., 2013). Overall, there is a dearth of literature on how URiM medical students cope and persist in the learning medical environment when they encounter racism, discrimination, biases, and/or other demeaning actions directed toward them. What actions do they take? Do they say something? Or do they withdraw? Who is discriminating against them? And where is this taking place? This leads the researcher to question how URiM Latino students respond to the day-to-day racial microaggressions, and discriminatory behavior directed toward them.

Mentorship & Lack of Mentorship

Kosoko-Lasaki et al., (2006) posits that mentors can advance underrepresented minorities in medicine. The classic mentor assists with career development by guiding a mentee through the clinical, educational, social, and political networks. Kram (1983) describes that mentors can enhance the perspectives of mentees to help demonstrate independence, and competence, and inform when appropriate. Tekian et al., (2001) found URiM medical students who had a mentor were at a lower risk of delaying their academic progress in medical school. In the study, students were placed into two groups: ‘‘no delay’’ (nd), indicating no failure in their courses or USMLE Step 1 and Step 2, or ‘‘delay/withdrawn’’ (dw). Tekian et al., (2001) randomly selected twenty students from each group to conduct in-person interviews addressing curriculum, advisor efficacy, mentoring, and personal history. Students were asked about individuals they considered to be mentors and they listed physicians, teachers, advisors, medical students, families, and clergy as mentors. Seven nd’s had physician mentors; two had no mentor. Three dw’s had physician mentors, five had other mentors, and five had no mentors. All physician

mentors were preceptors, and their primary role was ‘‘to advise.’’ The teacher mentors were admired for their ‘‘time management, commitment or exemplary lifestyles, and clergy mentors contributed ‘‘personal perspective’’ or ‘‘learning strategies for personal problem solving.’’ Seven students with physician mentors experienced less academic difficulty. Perceptions of their advisors’ efficacy were associated with the students’ being either (no delay) nd or (delay/withdrawn) dw. Dyrbye et al., (2007) further support the importance of mentors for URiM medical student success. They found student success was dependent on faculty mentorship during the clinical learning environment. Additionally, they found success is dependent on students having an open dialogue with their mentor and feeling supported. However, there must be two-way communication.

Mentors can serve an important role to provide support for URiM medical students to achieve social and academic success. (Hsu et al., 2011). Having supportive relationships and encouragement contributes to resilience and persistence (Rutter, 1993; Werner, 1989). URiM faculty felt the need to serve as role models and mentors (Price et al., 2009). Being a medical professional was the goal of the medical students in this study; however, URiM medical students did not receive mentorship or support to pursue careers in academic medicine. Sanchez et al., (2013) studied the racial and ethnic minority medical students' perceptions and interest in careers in academic medicine. URiM medical students reported a desire to become faculty members in medical academia, however; they did not receive encouragement or information on the career path. In addition, they reported a desire to have been mentored. Dickins et al., (2013) identified the importance of URiM medical students having access to diverse faculty to be able to decrease stereotype threat and feel less burdened. Okwa (2002) states

mentoring must become an active practice for the survival and success of graduate minority students.

In summary, these studies conclude that the environment in medical school can negatively impact the journey of URiM students to feel invisible, alone, and stressed when they lack support and guidance. Having an intentional collaborative learning environment can make a difference by receiving academic support, mentorship, and other guiding resources to support URiM students to increase their sense of belonging and learning. (Tekian et al., 2001). Student resilience and persistence were found to assist with coping, when peer and faculty intergroup interactions were facilitated creating a more welcoming learning environment (Rutter, 1993; Werner, 1989). Racism was found to disrupt student belonging, impacting the overall learning experience of underrepresented minorities in medicine (Orom et al., 2013; Dhaliwal et al., 2013).

Methodological Literature

Clark, (2005) noted the need for additional qualitative research to help gain insight from the student perspective on their transition points in medical school as it would serve as valuable information. Increased research and analysis of the URiM medical student experience allow researchers, practitioners, and administrators at medical institutions to expand their depth and breadth of knowledge and utilize this information to identify facilitators. Findings will also inform the removal and reduction of barriers in support of Latino students to increase satisfaction and academic performance. This study aims to use a qualitative research approach that draws from case study and in-depth phenomenological methodology.

Case study is an appropriate method to capture Latino student voices to analyze the participant's life and history. Gibau (2015) advocates for use of student voices in research endeavors. Examining the experiences of Latino medical students in intervention programs could serve to support students' observations and experiences. The methodological approach to this study was phenomenological by design (Patton, 1990; Creswell, 2009), which will allow participants to share their phenomenological experiences through in-depth interviews to obtain detailed experiences (Guignon, 2006). Because URiM medical students are underrepresented in medicine, they offer a unique perspective derived from their lives as underrepresented minority students in medicine to gain insight into the phenomena of their journey into and through medical school. Phenomenological principles note that scientific investigation is valued information when obtained through rich interpretations allowing the understanding of the experience (Moustakas, 1994). Using CRT and LatCrit coupled with phenomenological methods provided the researcher the opportunity to bring "to the fore the experiences and perceptions of individuals from their perspectives, and therefore, (can be effective) at challenging structural or normative assumptions" (Lester, 1999, p. 1). In addition, a multi-case study (Yin, 2002) approach will be applied to interview URiM medical students at one predominantly White medical school in the Pacific Northwest and will be discussed in Chapter III.

Summary

The strong evidence presented in this literature review reveals the medical school learning environment is perceived as less welcoming and inclusive, as documented by scholars' qualitative and quantitative studies (Reitzes & Elkhanialy, 1976; Bullock &

Houston 1987; Hawkins, 1998; Mangus & Miller, 1998; Kassebaum & Cutler, 1998; Hung et al., 2007; Dhaliwal et al., 2013; Orom et al., 2013; Dickins et.al., 2013; Okwa, 2002), and reveal racism is found in medical schools. These studies provide evidence of the less satisfying experiences and perceptions of URiM medical students and whether an unwelcoming environment contributes to or limits academic and social success. This contributed to the feeling of alienation and invisibility, which resulted from racial harassment, mistreatment, and racial stress (Sue et al., 2007; Kassebaum & Cutler, 1998; Strayhorn, 1980). Studies found that URiM medical students encounter academic challenges in their third and fourth years of study in medical board examinations; however, when a medical school responded by providing academic and social support, URiM medical students succeeded. Perhaps, if medical schools respond more proactively and intentionally in implementing policies and practices to support medical URiM students, every medical student will have an improved experience in their learning journey. There is a need for medical schools to conduct environmental scans by conducting a campus climate survey. A diversity climate survey can provide medical students the opportunity to inform the institution of how students perceive and experience the institution's environment (Hurtado, 2008). While Affirmative Action offices can track the number of harassment incidents and reports on a campus, perhaps it is more beneficial to develop a system to monitor for the campus climate. A climate survey tool using both qualitative and quantitative methods may inform policy and practice for a more inclusive and welcoming environment for URiM medical students and all (Williams et al., 2005). In chapter III, I will discuss the research methods proposed to explore the experiences of URiM Latino medical students. Questions will seek to understand URiM

Latino medical students' experiences in the medical school learning environment and the campus climate.

Chapter III. Research Methodology

This chapter will provide information about the methods used for this qualitative case study dissertation. The research problem will be revisited and relevant findings from a university climate survey at PNWMU that helped inspire the present study will provide a backdrop to the desire to embark in this dissertation study. This chapter will explain the study's qualitative approach, methodology, and the methods used in data collection, participant selection, the researcher's role, and the analysis process. The research questions and study that guided this dissertation study will be presented, which will lead to the findings in Chapter IV, where a group of Latino medical students give voice to their experiences at a Pacific Northwest Medical University where they describe both the barriers and the facilitators which led them in their journey as medical students.

Research Approach and Methodology

To reiterate, URiM students including Latinos are not represented well in U.S. medical schools or the profession of physicians. The limited literature posits URiMs experience more adverse experiences in the learning environment and have different learning outcomes in comparison to their White peer counterparts (Orom et al., 2013). There is a dearth of knowledge of the individual and collective experiences of their journey in medical school and what factors contribute to the success of progressing in medical school, as well as learning what factors serve as barriers in their learning environment. (Soto et al., 2022). The conceptual framework used in this study is Critical Race Theory (CRT) and proposes that "racism is endemic in U.S. society, deeply ingrained within the legal, institutions, and social constructs" throughout our social institutions (Tate, 1997, p. 234). Given that the URiM medical students are situated in an

institution of professional-level training, CRT theory applies because of the historical nature of racism found in medical schools in the United States (Nuriddin et al., 2020). The lens of Latino Critical Race Theory provides specificity of cultural and linguistic assets, traditions, and other factors of intersectionality shared among Latinos. This study employed a qualitative research approach to capture the participants "*cuentos*" known as "counterstories" a method of telling stories by individuals who in general experiences are not often told or shared (Delgado, 1989; Solórzano, 2007). Critical Race Theory (CRT) counterstories allowed this study to learn of the barriers, successes, and strategies of persistence encountered in lectures, small group discussions, clinical rotations, or in academic and social interactions with peers, faculty, and patients. Qualitative research design and methods were the most appropriate approach and are described as an effort to understand the nature of the setting and experiences of others in context (Merriam, 1998). Next, described is the interview process and protocol that guided this dissertation study

Instrument: Three-Part Interview Process

The goal was to reconstruct the experiences within the topic of this study. Individual semi-structured interviews using open-ended questions were conducted with participants collecting data through three sessions of phenomenological in-depth multiple interviewing (Seidman, 2006) on the topic of race and racism in their experiences at the PNWMU. As the researcher, I sought to explore richer data to identify the barriers and facilitators of URiM Latino medical students. This interview approach was guided by three research questions noted below. The participants' responses to these questions added to our understanding of the experiences of URiM Latino medical students at the PNWMU campus. Ultimately, by listening and documenting the lived *cuentos* and

counterstories of Latino medical students to voice their narratives. CRT scholars employ counterstories to illuminate the experiences of individuals who come from minority ethnic groups as a valuable source of knowledge (Ladson-Billings & Tate, 1995). Learning about their individual and collective knowledge aided in identifying barriers and learning of the facilitators in the journey of Latino medical students. The purpose for this dissertation study was to gain better understanding of the lived experiences and learn of the facilitators and barriers in an academic medical learning center and by challenging the dominant narrative of URiMs.

Research Questions

Through qualitative inquiry, the researcher used the below questions that drove this study. The use of the three-interview structure was incorporated to enhance and accomplish validity. Seidman's (2006) in-depth phenomenological multi-case interviewing structure was followed as outlined below:

1. Interview One: Focused Life History: This first interview placed each participant's experiences in context by asking them in detail about their experiences as a URiM Latino medical student.
2. Interview Two: Focused on their Concrete Participant Experience: Participants were asked for details about elicit details of their experiences rather than their opinions.
3. Interview Three: Reflection on the Meaning: Participants were asked to reflect on the meaning of their experience and make sense of their experiences. Participants were asked about the factors that influence the participants' present lives as URiM Latino medical students.

The interview process provided open-ended questions to build upon the

participant's responses by using semi-structured interview protocol. The goal of the interviews were used to reconstruct detailed accounts of the participant's experiences to document and present their "*cuentos*" "counterstories" (Delgado, 1989; Solórzano, 2007) and learn of their medical learning journey. Suárez-Ortega (2013) states participants become co-directors of the study when they share their stories. Seidman (2006) maintains that the three-interview process helps establish validity in the interview process. The interview protocol allows to make sense of the participants' experience with the phenomena, to produce an accurate recording of their experiences. This allowed for consistency with multiple participants and created trustworthiness of the data collected. At the end of interviews, participants were asked to submit questions, offer closing thoughts, or pause for reflection or clarification questions (Seidman, 2006). The design of this qualitative integrated the use of methodological reflexivity and contextual reflexivity to build a strong and bias-free design and protocol. Methodological reflexivity is a tool for researchers to use in decision making form the initial inception of the study through analysis and discussion of the findings (Varpio & Meyer, 2017). As the researcher, I also kept memos and wrote reflective notes (Saldaňa, 2016) and, I used contextual reflexivity to incorporate the cultural and historical context of the problem (Walsh, 2003). In summary, a set process and protocol used in this study were aligned with established theoretical frameworks, ethnical interaction with participants, transparency of reflexivity within the researcher and held rigorous adherence to established protocols.

Data Collection

The main methods used in this qualitative study using in-depth phenomenologically multiple interviews (Seidman, 2006) to explore the lived

experiences to learn of the "*cuentos* and counterstories" of third- and fourth-year Latino medical students at PNWMU. In addition, follow up related questions were asked through the interview, as well based on the related small conversations (Diccio-Bloom & Crabree, 2006). During the intake of the case study, the researcher conducted three individual interviews for each participant to gather qualitative data applying the principles and techniques of the Seidman three part in-depth-phenomenological interviewing structure (2006). The open-ended questions asked participants to think back on their experiences to be able answer the adopted questions for this study. The researcher also used probes, follow-up, and unscripted questions within the roam of the response from the participants (Seidman, 2006) and collected pertinent information. Data collection of multiple sources (or cases) validates the findings as the participants' words and phrases spoken were aligned and clustered together as similar. This pattern of agreement between multiple sources increases the reliability of case study research and increases the opportunity for triangulation (Yin, 2009). This dissertation study interviewed eight Latino medical students to learn of their lived lives by being interviewed during three different opportunities "a major strength of case study" (Yin, 2009, p. 114). Next, informed consent is discussed. This study was reviewed and approved by the institutional review board (IRB). The researcher of this study obtained informed consent from the participants before engaging in observations or interviews with the participants of this study. The researcher protected and continues to protect the rights, well-being, confidentiality, and identities of eligible self-selected participants. All participants were over the age of 18 years of age at the time of study and made the decision of their own free will to participate in the study to share their "lived

experiences" and share their "*cuentos*" at the PNWMU. The informed consent form described the purpose of the study, questions, process, and methods associated with the study noting the potential risks and benefits of participating in the study. See Appendix A: Participant Consent. The informed consent form also gave participants information on their rights if they wished to withdraw from participating at any point in the study. The participants also gave consent to be audio-recorded for data analysis. The researcher retained the signed informed consent forms noted to the participants for three years after the study was completed. The informed consent form also specified to the participants that they had the right to withdraw from participating in the study at any time and all unnecessary risks to a research participant must be eliminated. The researcher has retained the informed consent on file for three years after completion of the study. The researcher took responsibility to ensure their information was safe, and accurate, before, during, and after the study. Next, IRB Procedures are explained.

IRB Procedures

After the dissertation committee provided approval of this study, an application for approval to conduct the study was obtained from the Portland State University Institutional Review Board (IRB). This board monitors research relevant to the U.S. Federal Government Department of Health and Human Services (2009) regulation 45 CFR § 46.10, a law that institutions must observe to determine if the study would cause minimal risk to participants. The law requires that a determination be made prior to commencing data collection to ensure that the probability and magnitude of harm or discomfort should not be greater than that encountered in daily life or during the performance of routine physical or psychological examinations or tests. The proposed

study had multiple-case study of qualitative data and involved human subjects. The IRB approval was dated 12-2-2016. The researcher of this study successfully completed the training course in “Protecting Human Research Participants' ' by the National Institute of Health (NIH) Office of Extramural Research. Certificate Number 2832747 is on file and received approval for this study. Confidentiality of the participants or others identified during the interviews process were kept undisclosed to all and pseudonyms were used. Next, access to the site and participants is discussed.

Access to the Site

As an administrator where the study was conducted, this researcher was well known to the campus and participants of this study. In this role, the researcher had access to adequate physical space to host the interviews in safe, quiet, and convenient locations per the choice of the participants. The researcher gave credibility to this dissertation study because of her position at the PNWMU. Interviews were hosted in a safe, quiet space with no traffic of individuals. Once IRB approval was granted, the researcher began participant recruitment via email to eligible participants. The researcher was flexible and met at the requested times, dates, and locations as per the participant’s schedule. Interviews were held on the weekends when participants didn’t have class or a clinical rotation. As the researcher, I was transparent my position as a doctoral student for this study.

Sampling Procedures

As an administrator at the PNWMU, I had access to a wide variety of students. As the researcher, I followed all set protocols and requirements. In order to select participants for this study, I utilized two sampling techniques namely, purposeful (typical

case) and convenience sampling (Marshall & Rossman, 2011). Purposeful sampling led me to select URiM Latino medical students who were available for the focus of this study; the students represented the “typical case” or the type of students that fit the embedded cases within the single site case study (Marshall & Rossman, 2011; Yin, 2009). Since the study took place at the PNWMU and since students were available to me through the auspices of my work convenience sampling it made sense to use this form within the study (Marshall & Rossman, 2011). Next participant recruitment is discussed, and steps taken to recruit participants.

Participant Recruitment

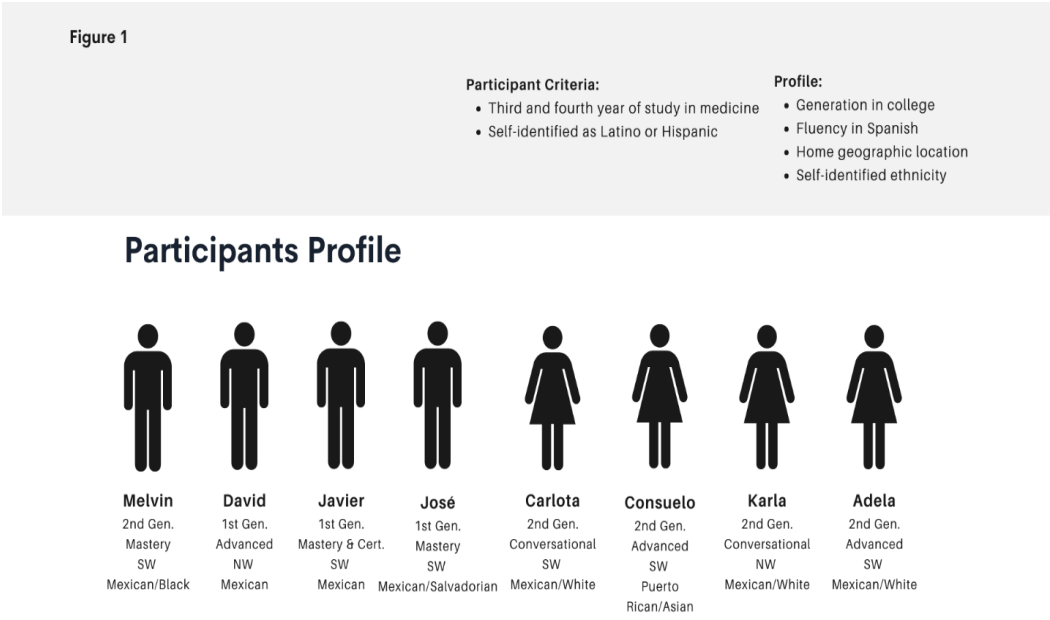
For this qualitative case study, eligible URiM Latino Medical students who met the criteria of being enrolled in the PNWMU and who self-identified as being Latino when reporting their race and ethnicity during the enrollment protocol at the PNWMU. An email invitation went out to all eligible participants who identified as being Latino and Hispanic and were in their third year and fourth year of training per the listing of the registrar's office. The researcher emailed all eligible students individually to confirm their interest in participating in the study. See Appendix B: Participant Recruitment Email. Participant solicitation also covered the purpose of the study, informed consent, answered questions, if any prior to launching the interviews and obtaining signatures for the consent form. The participants of this study consisted of eight Latino medical students who were enrolled at the Pacific Northwest Medical University (PNWMU) and self-reported information was captured per the participants.

Table 1. Participant's Demographic Data

P1	Carlotta	SW	Mexican-White	Second Generation	Conversational Spanish
P2	Consuelo	SW	Puerto Rican & Asian	Second Generation	Advanced
P3	Karla	NW	Mexican & White	Second Generation	Conversational Spanish
P4	Adela	SW	Mexican & White	Second Generation	Advanced
P5	José	SW	Mexican & Salvadorian	First Generation	Mastery
P6	Javier	SW	Mexican	First Generation	Mastery & Certified
P7	David	NW	Mexican	First Generation	Advanced
P8	Melvin	SW	Mexican & Black	Second Generation	Mastery

The table above represents the participants who took part in this dissertation study. Starting from left to right includes the following: the participant assigned number, pseudonym name, origin of location where they grew up either in the Southwest (SW) or the Pacific Northwest (NW), self-reported racial and ethnic identification, generation of college status of participant and the level of fluency spoken in the Spanish language . See

Figure 1: Participant Profile for image plus participant criteria as per the study requirements.



Interview Procedures

For this qualitative case study, as the researcher, I interviewed eight URiM Latino students who were in their third and fourth year of study at medical school who met the set criteria per the set protocol. The interviews were conducted face to face with participants which included four males and four females. By applying the principles and techniques of the Seidman three-part interview process (2006), the research questions were open-ended questions and asked participants to think back on their experiences (See Appendix C: Interview Questions). The researcher used probes, follow-ups, within the roam per the set questions (Seidman, 2006) to be able to get pertinent information from the participant. As the researcher, I provided the availability of safe space and time for each participant. All interviews were conducted in a neutral location where the

participants could not be visible to campus community members. Participants self-selected the dates, times, location, and interviewers. Researchers took from 1.5 hours to 2.0 hours to conduct the individual interviews. The interviews were audio recorded with consent of all participants and later, transcribed for ease of analysis. Participants were given pseudonyms to keep names confidential and adhered to their protection of anonymity. The study drew a total of eight Latino medical students and all participants participated from beginning to end of the interviews. There was no withdrawal of participants from the interviews process. The interviews took place within a two to three weeks span to allow flexibility for the participant's schedule and to provide them a time to reflect for the following interview that followed. Participants shared information regarding their ethnic identity, spoken language, cultural identity, environment, family, and other background information as part of an introduction and to feel comfortable in sharing prior to the set questions. Since this study focused on URiM Latino medical students, questions about racism, discrimination and personal experiences in medicine were specifically included in the interview protocol. Participants were asked about their experiences and observations that took place in lecture sessions, small groups, conducting clinical rotations, and at student social events. The curriculum is delivered by faculty members who represent medical doctors and scientists and are predominantly White in racial background. URiM faculty represent 6.8% percent of all instructors in academic medicine across the U.S. Allopathic schools (Robles, et al., 2021). The learning journey encompasses academic examinations, tests, clinical experiences, and enrichment that includes student activities. As part of the training, medical students are placed in clinical training rotations in regional hospitals and clinics as a training ground for medical

students and residents. They also work in teams and “round" in a team of doctors, residents, and medical students to discuss and present individual patient cases. During clinical training, medical students are expected to have the first interaction with a patient, make a diagnosis, and recommend a treatment to either the attending or the resident, or both. As it pertains to social, student activities, and community outreach, medical students can engage in social and professional interaction by participating in student interest groups which are local chapters of distinguished national medical student organizations by affinity and specialization of areas in medicine. The student interest groups are led by medical students, its membership and allies who support the mission of the designated affinity group support a mission and vision dependent on the group. In this setting, student interest groups of interest are the Latino Medical Student Association (LMSA) and the Student National Medical Association (SNMA). Interview questions surrounded their learning environment and affiliations were also part of the interview process. In summary, the semi-structured interviews kept the researcher focused on a set protocol, which allowed for consistency and trustworthiness of the data to be collected. Each interview was transcribed for thematic analysis.

Thematic Analysis

The analysis began by following Saldaňa’s (2013) coding process, included a six step process the researcher followed: (a) identified relevant works from the extant literature to analyze and synthesize as presented in Chapter II. Prior findings from the PNMWU survey also served to form coding decisions (b) storage and organization of the findings followed the following process. After the interviews were conducted with participants, the recordings were transcribed by a third party and sent back to the

researcher in a safe and confidential online service. Upon receipt of written transcription, the researcher downloaded, formatted, and printed all the transcripts and placed them in three-ring binders. The researcher listened and re-listened to allow for a deeper understanding of the interviews and made notes of corrections if needed (Maxwell, 2013). (c) Emerged in the data, and next was a focus on reading and re-reading the data, of each interview per participant. The transcripts were read four times very carefully line by line for the researcher to understand the broader picture of the individual stories *"cuentos* and counterstories" shared with the researcher began with open coding. The researcher started a code book with some predetermined set of codes formatted in an excel file and assigned first codes after the second review of the study. (d) After reviewing for significant language and patterns in the data, the researcher used axial coding to identify themes in the participant' interview transcripts. The final step in Saldaňa's (2013) coding process was a review of the data culmination into categories, sub-themes, and themes. Narratives related to upbringing and family background information were collected from participants during interview one to learn of their lived lives prior to arriving at the PNW. A narrative was written for each participant and will be presented in Chapter IV. By listening to as well as reading the transcripts of the participants describing their lived experiences and their perceptions while at PNWMU, this study aimed to document more deeply their individual journeys as well as their collective encounters with the institution. Next, the theoretical framework which guided this dissertation is presented.

Conceptual Framework: Critical Race Theory (CRT)

The application of the theoretical framework of Critical Race Theory (CRT) has deep roots in the field of critical legal studies and draws from and extends a broad literature base of critical theory in law, sociology, history, ethnic studies, and women's studies and can be effectively "used to understand the inequities in higher education to reform and research" (Hilarado, p. 53, 2015). Critical Race Theory (CRT) can be described as an analytical framework to understand the inequities in higher education and to assess inequities in education (Decuir & Dixson, 2004; Ladson-Billings & Tate, 1995). Scholars have applied CRT as a framework to help examine and review educational research and practice (Ladson-Billings, 2005). Thus, in this dissertation study applied Critical Race Theory (CRT) was used to better understand the experiences of Latino medical students by placing their "voices" as the center of the discussion to explain their experiences, perceptions, and observations (Solórzano & Villalpando, 1998). Critical Race Theory (CRT) is appropriate for this qualitative study giving a lens to view the "lived experiences" of URiM Latino medical students. "CRT is a framework that can be used to theorize, examine, and challenge the ways race and racism implicitly and explicitly impact social structures, practices, and discourse (Yosso, 2005 p.69)." Finally, Critical Race Theory (CRT) lends a lens to examine and analyze the relationship amongst race, racism, and power (Delgado & Stefancic, 2001). Solórzano (1998) outlines the five tenants for CRT which include: (a) the centrality and intersectionality of race and racism. In higher education, race and racism are embedded in the structures, practices, and policies that guide the daily practices of universities (Delgado & Stefancic, 2001). (b) the challenge to dominant ideology. The belief the legal system is color blind, and that

meritocracy can be fully actualized. (c) the commitment to social justice to eliminate oppression. Delgado, (2002); Matsuda et al., (1993) posit a collective may strengthen and advance the overall goals of Critical Race Theory and (d) the centrality of experiential knowledge where CRT recognizes oppressed racial and ethnic groups are legitimate sources of learning through one's lived experiences known as *cuentos* and counterstories as legitimate, particularly oral traditions (Delgado, 2002; Yosso, 2005).

Latino/a Critical Race Theory (LatCrit)

A theoretical branch extending from CRT is Latino/a Critical Race Theory (LatCrit) which emphasizes the "intersectionality of experience with oppression and the need to extend the conversation beyond a White and Black paradigm. LatCrit enables a better articulation of the experiences of Latinas specifically, through a more focused examination (Solórzano & Delgado Bernal, 2001). LatCrit scholars aim to place the experience of Latinos' experiences and exposures to challenge and to uncover the invisibility of Latinos (Valdes, 1996). Latino Critical Race Theory (LatCrit) seeks to deepen the knowledge and findings by centralizing and validating the intersecting dimensions that unite Latinos through ethnic identity, culture, language, immigration status and other elements that unite Latinos and by presenting findings by a way of storytelling (Yosso, 2005).

Together, CRT and LatCrit provide an important framework for centering students' identities and counter narratives with the foundation to advance social justice and inform culturally relevant educational experiences. Thus, CRT, as a framework and LatCrit as the subset, allows insight to listen and document the student's "voices in their own words" to understand the self-journey of eight Latino medical students that cannot be

captured in surveys or in a group conversation but rather allowing an opportunity to listen to each individual story and empower them to voice their realities contradicting stereotypes of Latinos. For these reasons, it was important to gain knowledge of the participant's self-identity, race and ethnic identity, family, and other related cultural and linguistic backgrounds to help inform this study, in-depth about the participant's lived experiences in a real-life context (Crowe et al., 2011).

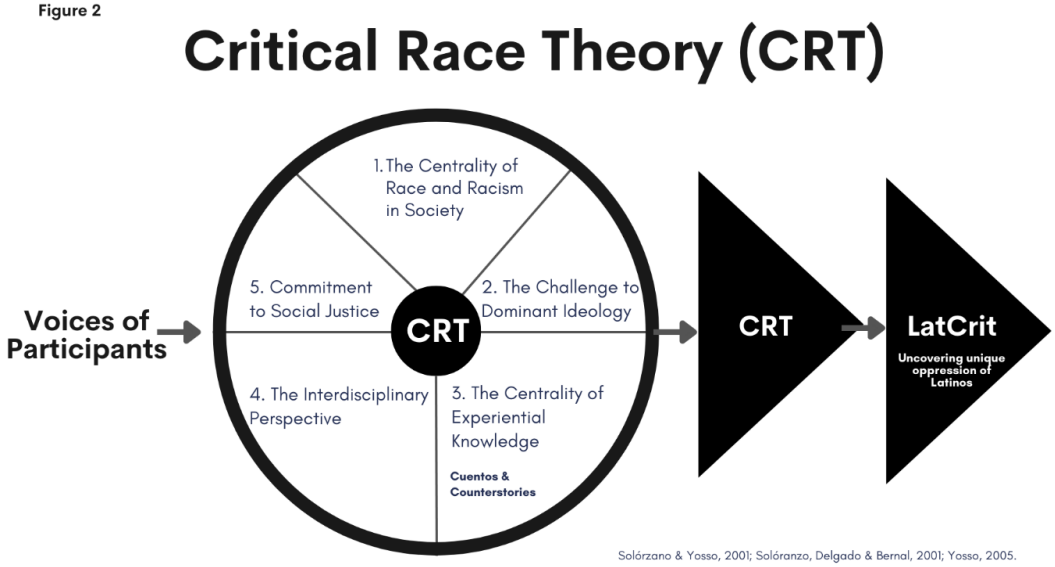
This dissertation study speaks to race, ethnicity, and racism which can be complex in understanding. We begin with the definition of race which places groups into a category based on shared physical characteristics such as phenotype which allows different levels of access and resources (Williams, 1997), while the definition of ethnicity places representation of groups of people together who share a linguistic, cultural origin, religion, and other traits of a shared culture (Chaturvedi, 2001). Thus, racism can be described as a systematic societal classification based on viewpoint or treatment of superiority by treating others differently or not allowing equal distribution of resources, opportunities, and relationships in the daily lives of individuals who do not represent the dominant group (Williams & Mohammed, 2013). Furthermore, Jones (2000) posits that racism can function on three different levels which include: Institutionalized Racism, Personal Mediated Racism, and Internalized Racism. Jones (2000) further expands that racism exists in countless ways and is found in the climate, structures, policies, and within human interactions between different races. "Without acknowledging racism, one cannot address, resolve, mitigate, and end racial indifferences." pg.1214. Williams & Mohammad, (2013) have documented racism can have psychological impacts, such as imposter syndrome and internalized racism that can impact health and the well-being of

individuals.

In summary, CRT and LatCrit is an appropriate framework to better understand the experiences of Latino medical students by placing their “voices" as the center of the discussion to explain their experiences, perceptions, and observations (Solórzano & Villalpando, 1998). Critical Race Theory (CRT) allows for this qualitative study to give a lens to view the “lived experiences" of Latino medical students. The literature is limited in understanding the experiences of URiM initially was reviewed by the researcher in earlier years and then again reviewed recently. Within the last two years, scholarship has gained focus on wanting to learn about the lived lives of underrepresented minorities. The representation of URiM remains low, while there remains a need to learn of the facilitators and barriers that URiM students face in academic medicine. It is critical to learn how to support and remove discrimination and stereotypes from the learning environment in medical school, while providing resources and tools for navigation and success. Next discussed is the data analysis process used for CRT and LatCrit.

Data analysis using the framework of Critical Race Theory (CRT) and the subset of LatCrit was applied to understand the *cuentos* and counterstories of URiM Latino medical students to inform this study (**See below Figure 2: Critical Race Theory (CRT)**.

Figure 2



Steps were taken to analyze and categorize within the frameworks. The researcher took the following steps:

(a) I applied the overlay of Critical Race (CRT) Theory and Latino Critical Race Theory (LatCrit) to learn if unconscious or subtle forms of racism took place.

(b) I listened to their voices via "*cuentos*" known as "counterstories" to learn of barriers, successes, and strategies employed by the participants during their self-told *cuentos and* counterstories stories.

(c) I reviewed the recordings twice and read transcripts up to four times to analyze the details for more complete and accurate results (Saldaña, 2013).

(d) I documented racism, and microaggression encounters that included negative, hostile, or derogatory verbal, behavioral or environmental indignities whether intentional or intentional and noted where the incidents took place in lectures, small group discussions, clinical rotations, or in social interactions with peers, faculty, administrators, and patients.

(e) Under the Three Levels of Racism as defined by Jones (2000) I identified the type of racism experienced by the participants and placed accordingly under: Institutionalized Racism, Internalized Mediated Racism, and Personally Mediated Racism to be further explained in Chapter V.

(f) Based upon the cuento or counterstory, then I analyzed and categorized the type of microaggressions (Microinsult, Microassault, or Microinvalidation) as defined in the article titled Microaggressions in Everyday Life: (Wing Sue et al., 2007).

Researcher Role

As the researcher, who conducted this study, I serve as an administrator at the site location of PNMWU where the study was conducted. I have thirty years of experience working in academic medicine and was known to the known to the participants before and after the study was conducted. While I acknowledge that I held a position in power in administration, I also shared a common cultural and linguistic socio-cultural context of the participants. As a Mexican -American woman who has experienced discrimination in professional, and life situations, I recognized my biases, and put them aside through the practice of reflex methodology (Delve & Limpaecher, 2022). Through the practice of reflexivity, self-examination, and following the set protocols and process the researcher gained knowledge to analyze and report accurate findings (Blair, 2016). In addition, I served as a diversity practitioner, the researcher is knowledgeable about the study of implicit bias. Through multiple training sessions, I understand this subject matter and how to identify and mitigate conscious and unconscious bias through the practice of reflexivity. My stance as a researcher from the beginning to end was to remain open

minded and neutral when either hearing, observing, writing, or analyzing (Ho & Limpaecher, 2022). This was critically important as I had personal knowledge of some the individuals, situations, and events that participants described in their interviews.

I acknowledged that I was a Latina researcher and provided upfront transparency of my administrative role and position to the participants of this study. As a researcher, I had no set expectations and was prepared to learn, analyze, and interpret while putting my prior experiences and biases aside (Walsh, 2003). I practiced collaborative reflexivity by sharing the initial findings with my dissertation advisor and selected research colleagues and used analytic memos to capture moments of "future directions, unanswered questions, frustrations with the analysis, insightful connections…" (Saldaña, 2016, p. 45). Lastly, as a seasoned administrator, my position has allowed me to learn and serve diverse people from all backgrounds, especially individuals considered to be underrepresented in medicine. The ability to engage with diverse individuals required a level of cultural competency (Milner, 2007). Cultural competence is critical to ensure: (a) effective communication and interaction between researcher and study participants; (b) adequate conduct analysis and interpretation of results as they relate to the participants; and (c) properly engage in the study design and implementation within the research process (Milner, 2007).

In summary, the goal of this study from the researcher's end was to learn of the barriers and facilitators in medical school and to learn of the experiences of Latino Medical students who are underrepresented in medicine by conducting in-depth phenomenology multi-case interviews (Seidman, 2006) through the framework lens of Critical Race Theory (CRT) and Latino Critical Race Theory (LatCrit), to advance the

initial findings of the PNMWU survey through this qualitative dissertation study.

Delimitations and Limitations

This study had the following limitations: The first limitation of the Pacific Northwest Medical University (PNWMU) climate study is that the qualitative findings may not be generalizable to the perspective of the majority of URiM medical students. In summary, there are limitations based on the survey data from the PNWMU, which this dissertation study provided insight of Latino medical students by conducting qualitative interviews to further increase knowledge about URiM medical students, specifically as it relates to Latino medical students at the PNWMU. This study was short-term in nature during a specific time of period. This study did not address long-term impacts of understanding the experiences of URiM medical students and did not measure quantitatively, but rather provided a more in-depth perspective of the experiences during their experience at PNWMU, as third year and fourth year medical students.

Anticipated Ethical Issues

All information was kept private by the researcher. No disclosure of information was or will be shared protecting the identities of the participants of this study. The researcher kept all student information confidential following FERPA, Code of Conduct, and other institutional, state, and federal regulations pertaining to protection of student information. The findings of this dissertation case study using the theoretical lens of Critical Race Theory (CRT) and (LatCrit) is presented as a partial requirement for the fulfillment of doctoral degree in post-secondary leadership education without any preconceived biases from the researcher who conducted this study.

In summary, this chapter details the qualitative design, research design, overview of the data sample strategy, methods of data collection, positionality, theoretical framework, research assumptions, and ethical considerations and confidentiality were discussed.

Chapter IV. Findings

In this chapter, presented are the findings from the case study that served to explore the “lived experiences" of eight Latino medical students who are underrepresented in medicine (URiM), and enrolled at the Pacific Northwest Medical University (PNWMU), a predominantly White institution (PWI). The overall goal of the research questions served to document the observations and experiences of Latino medical students’ journey’s learning of the barriers and facilitators by exploring the institutional environment that may impact access, academic, socialization and other factors that increase or decrease persistence of the participants of this study. This research study involved multi-interviews collecting rich information on the lived experiences of four Latina medical students and four Latino medical student participants.

The “voices” are brought forward to learn of the journeys of eight Latino medical students collected through interviews by documenting their individual *cuentos* and counterstories (Delgado, 1989; Solórzano, 2007), as it relates to the institutional climate, culture, and lived experiences, while undergoing a rigorous medical training program at the PNWMU. The findings of this qualitative study documented three themes that were identified as either a barrier or a facilitator in the participants' lives. The first two themes were “Alone and Lonely” and “Racism” which were both barriers to the detriment of the participants. Racism was the largest theme in this study, illustrating how interwoven and complex this overarching concept impacts the lives of the participants. The third and final theme that the findings point to is a facilitator for the participants in this study was *familismo*. *Familismo* is a Latino cultural value which shows commitment and care for their family members, as well as those whom they consider a part of their family. It also

places the needs of others before those of oneself; providing or seeking advice; and focused on building relationships (Azpeitia and Bacicio, 2022).

This section discusses research findings within the context of two themes identified as barriers and the one theme identified as a facilitator that participants embraced to persist throughout their journey in medical school. Presented are detailed statements and quotes that illustrate the participant's responses, and which best represent the theme applicable in response to the guiding research questions. All participants were assigned pseudonyms to protect their identity and the use of direct quotations are exact and original words as told by the participants as recounted during interviews. The theoretical frameworks of Critical Race Theory and the subset of Latino Critical Race Theory (LatCrit) were applied to interpret the phenomena under research investigation. This chapter will begin with introducing the participant profiles of the participants' backgrounds prior to arriving at the PNW and is followed with the findings which were analyzed and present the themes of this dissertation study.

Participant Case Profiles

Next, participant profiles are introduced to learn about their lived lives prior to arriving at Pacific Northwest Medical University (PNWMU). The profiles of each participant are described in detail bringing them to life by honoring their *cuentos* and counterstories to provide a better understanding of who they are as Latinos who represent a diverse group of individuals and who are all unique, different, and referred to as being an ethnic group known as Latinos or Hispanic. As noted, prior, each participant was given a pseudonym, and for the purpose of this study are referred to as Carlota, Adela, Consuelo, Karla, David, José, Javier, and Melvin. All eight participants met the criteria as

follows: (a) each enrolled at the Pacific Northwest Medical University (PNMU) (b) were medical students at the time of study (c) were registered under the race and ethnicity category as being Hispanic/Latino (d) and provided consent to participate in the study (e) and agreed to share their *cuentos and* counterstories which are appropriate in Critical Race Theory (CRT), to allow participants to unearth and validate their "voices" and experiences. Each participant described their ethnic identity, upbringing, family, and social and academic journey prior to matriculating to PNWMU. Next, it is important to introduce them to help bring them to life and be able to tell of their individual journeys and share of their backgrounds. During the first interview participants as part of their introductions were asked to reconstruct their early experiences, where and how they grew up, family composition, culture, languages they spoke, experience in STEM, and any significant sharing of understanding points regarding their educational preparation before arriving at PNWMU. A brief profile of each of the eight participants follows:

Carlota

Carlota identifies herself as Latina and notes she is half Mexican (father) and (mother) White. Carlota is a second-generation college student who grew up in a middle-class household and grew up in a southwest small conservative town. Carlota comes from an extended Mexican family and has a close relationship with her father and spent her childhood being cared for by her paternal grandparents since both her parents worked. Carlota's father identifies as Mexican -American, served in the military, and attended college with the support of his service. Her mother is of European descent, a loving mother, and took classes at community college. Carlota describes having a close relationship with her father and is someone to whom she can speak when it comes to

racial and ethnic identity. Carlota understands Spanish more than she speaks and continues to work on her Spanish medical vocabulary to increase fluency and understanding. Her paternal grandfather, as she referred to him as her "*abuelito*," was a war veteran of the United States and championed Carlota to consider medicine and introduced her to his personal physician, who was an Asian female physician who was a cancer specialist. Carlota attended a state undergraduate school in the Pacific Northwest and grew up with medical insurance. Carlota was supported by White female mentors during high school and by two Asian female doctors. At PNWMU, Carlota was frequently questioned about her Latino ethnic surname which according to others did not match her light-skinned phenotype. She constantly experienced White peers display actions or behaviors of bias and racism since she noted she could pass as "White". She was an active member of the Latino Medical Student Association (LMSA) and noted she identified and belonged with Latinos and other students of color.

David

David identifies as Mexican -American and is a first-generation college student who grew up in the Pacific Northwest. He was raised by a single mother who completed a certified nursing program in Mexico. In the U.S. his mother worked multiple jobs and was also a teacher who taught migrant students. At the age of seven, David recalls wanting to be a doctor due to health issues impacting his family which many times did not allow them to have access to care. David recalls having some insurance coverage at times and lapsing due to his mother's change of employment status. Although David attended a private four-year institution in the Pacific Northwest, he lacked a clear path to medicine at the undergraduate level. He noted his academic undergraduate advisor

discouraged him from pursuing medicine and he stopped advising altogether. David and his mother sought support from PNWMU (pseudonym) diversity office for guidance and participating in enrichment programs to guide him in his quest for medicine. David is fluent in both Spanish and English and notes living in a non-diverse racial and ethnic environment has prepared him for the direct experiences of racism at PNWMU. David is an active member of LMSA and had early interactions with the LMSA mentorship program prior to matriculation to PNWMU.

José

José identifies as a Mexican and Salvadorian and grew up in the Southwest part of the United States. José describes himself as being fluent in both English and Spanish and has a strong cultural identity and connection to his Mexican roots. He comes from a large extended family made up of parents, grandparents, uncles, aunts, cousins, family friends and grew up in a predominately Mexican neighborhood. While growing up, José's parents held multiple jobs and yet none of them provided medical insurance. José notes his family did not have access to a doctor and his interest in medicine became clear when he learned of his mother's health condition. On multiple occasions, he and his family would seek alternative forms of medicine to alleviate pain and suffering. He also describes mistrust of health providers and how they sought treatment by crossing to Mexico when home remedies had been exhausted. José explains he became interested in medicine at age of seven and both his parents supported his quest in preparation for his journey in medicine. José was placed in honor math and science courses as early as in elementary school and received support from Latino outreach programs. José is a first-generation college student, graduated from an Ivy League school, and had never visited

the Pacific Northwest prior to matriculation at PNWMU. José is a LMSA leader, member, mentor, and advocate for social change.

Javier

Javier refers to himself as "a real Mexican" who grew up in the Southwest near Mexico's border. Both of his parents are of Mexican descent. His immediate family consists of both of his parents, siblings, grandparents, aunts, uncles, cousins, and other community members even as both parents worked multiple jobs and could not acquire insurance benefits. As a family, they worked tirelessly and always made room for others in their homes including aiding individuals who were undocumented. Javier grew up on both sides of the border and spent extended time with his grandparents, aunts, uncles, cousins, and other community members in Mexico. As a young boy, Javier became interested in medicine when he learned his mother suffered from a chronic disease. Javier is proficient in both English and Spanish and excels in Spanish medical terminology. He enrolled in advanced math and science courses throughout his educational journey and participated in enrichment programs sponsored by the Latino science chapters. Javier is a first-generation college student and a graduate of an Ivy League school. He had not visited the Pacific Northwest prior to applying and matriculating as a student at PNWMU. Javier is a leader and active member of Latino Medical Student Association (LMSA) and has been active with LMSA as early as an undergraduate in college.

Melvin

Melvin grew up in a small rural town in the Southern West Coast and comes from a biracial family and identifies as Blaxican Black-Mexican. His mother is of Mexican

descent and his father is Black/African American. Melvin is bilingual, bicultural and is proficient in both English and Spanish. As a child, Melvin grew up with his maternal grandparents and would travel to Mexico for three months during the summer. Melvin is a second-generation college student and the eldest sibling in his family. Melvin was raised in a middle-class family, with a loving mother and father who held federal jobs and were afforded health insurance. He described himself as a shy, avid reader, and one who kept to himself and excelled in school. After high school graduation, Melvin joined the military and participated in a post-baccalaureate science program prior to applying and matriculating into medical school at the PNWMU. He became interested in medicine while serving as a medic in the military. Melvin is interested in addressing health disparities and increasing access to communities who have been historically underserved. Melvin was mentored by Asian physicians whom he shadowed. Because of his dark phenotype complexion, he noted many times his peers, instructors, and patients would not think of him being Latino. Melvin is a member of the Latino Medical Student Association (LMSA) and a leader of the Student National Association (SNMA) which are two affinity groups that work closely together in medical schools.

Consuelo

Consuelo identifies as Latina and is of both Puerto Rican and Asian descent and is a second-generation college student and attended an ivy league as an undergraduate student. She grew up in the Southwest and came to the Pacific Northwest for the first time to pursue her medical training program at PNWMU. Her parents divorced and Consuelo grew up with two sets of parents. Consuelo has a Latino stepfather and a Latina stepmother and shares a special bond with her biological Puerto Rican father. Consuelo

had access to health care via her father's health insurance while growing up. Consuelo is fluent in English, Spanish, and Tagalog. She was supported by multiple enrichment programs which sealed her interest in medicine and exposed her to clinics and the health disparities impacting the Latino Community. Consuelo has an interest in serving the Latino community as a future physician. She notes many times she is not recognized by others as being Latina because of her phenotype and facial features despite having a Spanish surname. Consuelo serves as a member and leader of the LMSA; she also works closely with SNMA in supporting outreach and social justice.

Adela

Adela is a second-generation college student and both her parents have a college degree. Adela describes herself as Mexican and White. She grew up in Southwest California and moved to the Pacific Northwest as a teen. Her *abuelita* – grandmother of Mexican descent lived with her father and passed down recipes, culture, language, and traditions to the family. Adela is close to her father who works in a nonprofit assisting the underserved and is influenced by his strong work ethic, good heart, and cultural identity. Her father was an emergency medical technician prior to leading the nonprofit and provided health care coverage. Adela became interested in a career in medicine as a sophomore in college. Her Latino college advisor encouraged her to participate in a medical enrichment program titled *Chicanos for Latinos in Medicine* due to her strong knowledge in the sciences. Shortly after, she changed her major from history to biology and became a pre-medical student. Adela has a long history of serving as an advocate for social justice, equity, and addressing health disparities among communities of color and supporting equity in Latino matters. She attends rallies and supports DACA students and

immigrant families seeking change in policy and practice and is a leader of social change at PNWMU. Her father's cultural identity, values, and actions to aid others have influenced her to become the person she is today. Adela also explains she is often questioned about her Spanish first and last surname given her olive-toned phenotype and feels stereotyped. Adela is a member and leader of the LMSA and a leader of her peers.

Karla

Karla hails from a biracial family and grew up in the Pacific Northwest. Karla identifies as Mexican & White. Her father is of Mexican and Indigenous descent and her mother is European ancestry. Karla is a second-generation college student and graduated from a public university. Karla grew up with both parents and is very close to her paternal grandparents who are of Mexican indigenous origins and considers herself to be semi-fluent in Spanish. Karla notes she understands more spoken Spanish than she speaks but is taking a medical Spanish course to help her increase fluency at PNWMU. Karla notes her interest in medicine began when she first won a state-wide high school program competition and later developed a relationship with the PNWMU. Karla notes her father supports underserved communities in the Pacific Northwest and is influenced by his role modeling. She describes her mother in helping with her journey into medicine and grew up with health insurance. Karla is often questioned about her Spanish name and explains she is often questioned by individuals want to know her racial and ethnic identity. Karla is a member and leader of the LMSA. She also serves in a leadership role at PNWMU.

Summary of Participants

All participants graduated from an undergraduate college or university from the states of California, Oregon, and Washington and four of the eight attended private Ivy

League schools. All participants applied to the PNWMU and were academically prepared as undergraduates in the sciences. All eight participants went through a competitive admission process and were considered for need and merit scholarship packets alike all accepted students. Four of the eight participants of this study had visited or lived prior in the Pacific Northwest and four knew little to nothing about the PNWMU nor were familiar where the PNMWU was located. Three of the participants noted they learned of the medical training program from their undergraduate mentor. Others selected PNWMU because it is located on the West Coast and wanted to stay close to their families. All eight participants noted they participated in enrichment programs that gave them access to research, clinical experience, and an opportunity for mentorship prior to matriculating to PNWMU. Seven of the participants affirmed undergraduate Latino faculty and staff played a significant role in the guidance and support of the participants during elementary, secondary, and post-secondary education, in addition to the support from their parents. Seven of the participants noted enrichment programs supported and motivated them to gain a better understanding of the pathway and resources available toward a career in medicine. It is important to also highlight the efforts of Latino organizations and other diversity enrichment programs supporting the pathway of underrepresented minority medical students to pursue careers in medicine. All eight participants agreed that pathway programs are important and helpful and needed to increase early exposure in medicine, as a strategy to increase the representation among medical physicians.

Two Latino male participants noted there was a lack of available information about medical school and were blocked by White male undergraduate advisors who

encouraged them to seek other interests. Seven participants noted they gained support from peers who shared information and navigation strategies to support their path towards medicine. Asian peers and Asian physicians also played a critical role in four of the participants' journeys in preparation for medical school. Seven of the participants noted they had never had a mentor who was a Latino physician and six had not met a Latino provider before entering medical school. Five students noted their interest in medicine was in part because of their own journey of not having access to health care and/or having a family members who developed an illness. Lastly, all eight participants of this study spoke of having the strong desire and commitment to provide care to the Latino Community as part of their service.

They all agreed having ethnic representation in medicine is important to address health disparities and eliminate gaps of delivery of culturally specific care. Participants of this study described themselves as trailblazers, first in their families to become medical doctors and substantiated the importance of their cultural, linguistic, and social capital they brought to the practice of medicine. All participants spoke a level of Spanish proficiency, had strong cultural and ethnic identities, and held close to their cultural roots, culture, and tradition. All, identified as being bilingual and bicultural, representing their cultural capital and identities.

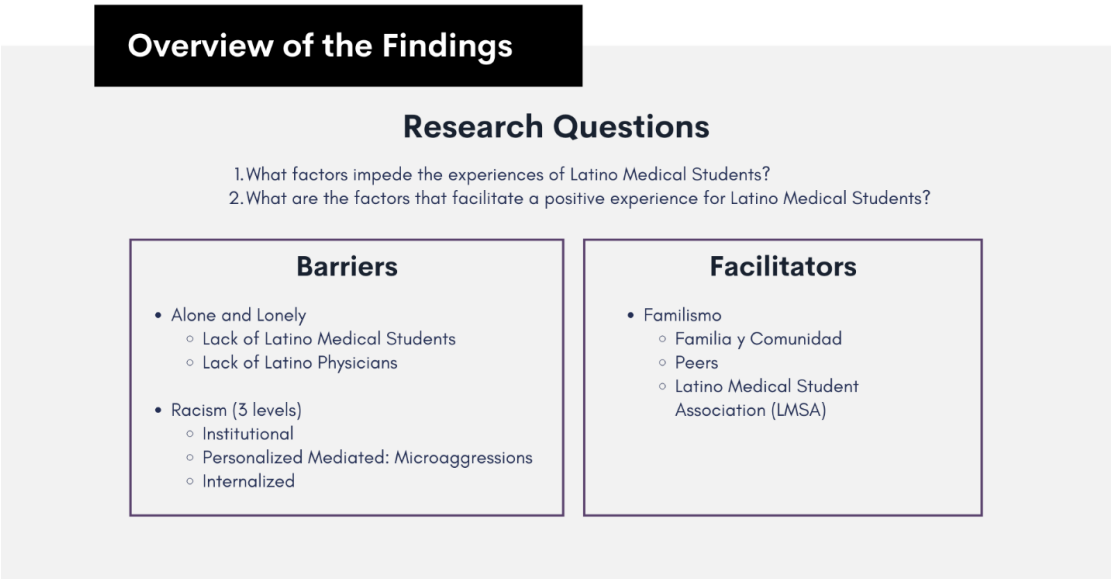
The next sections will look at the participants' "lived lives' and present the findings and themes of the participants' observations and experiences in the classroom, clinical spaces located at hospitals and clinics, and in social settings at the PNWMU. Their individual journey is also explored in social and professional settings as conveyed from eight individual perspectives of each participant of this study.

Introduction to Themes

The findings of this qualitative study analyzed and documented three themes that emerged from the interviews that were identified as barriers or a facilitator in the participants' lives. The first theme to be explored in this section rises out of the participants' voices and words. The theme of "alone and lonely" comes from "in vivo" codes in the interview data that Saldaña (2013) describes as "alive." He describes that: "in vivo' s root meaning is "in that which is alive, and as a code refers to a word or short phrase from the actual language found in the qualitative data record" (p.31). The second theme that became the main finding in this study was the identification of racism and how it infiltrated into the encounters that the participants had individually, and as a collective group. Racism showed up in the transcripts through *cuentos* and counterstories by learning of the lack of mentors, lack of resources, and incidents of microaggressions that were experienced by the participants in lectures, clinical rotations, and in social settings. The outcome of racism created an internalization dynamic among the participants that led to the subthemes of lack of belonging, imposter syndrome, cultural and linguistic taxation, and impacted their mental well-being. The final theme that the findings point to a facilitator that helped the participants navigate as described in this study. The third theme is *familismo* (Azpeitia & Bacicio, 2022), which encompasses the cultural relationships the participants held with their parents, family members, mentors, peers, and others that they identified within the organization of the Latino Medical Student Association (LMSA) at PNWMU. Familismo involves commitment, loyalty, and support among family, extended family, seeking advice and helping oneself.

Multiple codes were listed under each of the three themes, and it became important to note that all the themes are interconnected and that the *cuentos and* counterstories of the eight participants revealed the overlapping nature of their feelings, their observations, and experiences with racism, and how their cultural heritage and collective *comunidad* (community) through their journey of persistence in medical education to become physicians. **See below Figure: 3 Overview of the Findings,** which displays barriers and facilitators as revealed by the analysis.

Figure 3



Theme 1: Alone and Lonely (Barrier)

Alone and Lonely was the first theme to emerge from the analyzed data revealing that the institutional climate was isolating. From the participants' shared *cuentos and* counterstories they discussed how they saw themselves and felt, using the words alone and lonely. Alone refers to being in a physical space where you perceive no one looks

like you (cultural/phenotype), nor represents your cultural traditions, customs, language, and values as an ethnic group. They are alone in representation, and they experience the feeling of not having a "voice." Lonely is described as the feeling of being lonely, sequestered, not being understood, or supported by faculty, residents, or administration. All eight participants shared they were not able to see others like themselves, feeling homesick, missing family and community. A fundamental assumption as described in this study is that Latino medical students represent a small number of underrepresented minorities in U.S. medical schools and at the PNWMU.

Being alone and lonely presented itself from the very beginning of their medical school experience upon the first week of arrival. We begin with the most significant event in a medical students' experience which is the White Coat Ceremony. This event serves as a formal introduction into medicine attended by family where medical students take an oath to uphold the humanitarian goals of the profession in steps to becoming a physician. The medical students are provided a short white coat symbolizing their transition into medicine and are expected to wear it during their clinical rotations that take place at the hospital, clinics, and at rural medical clinics where students conduct individual clinical rotations with attendings and residents, who are licensed physicians. Attendings have supervising roles of medical students and residents and house officers.

All eight participants found themselves alone and lonely, as they experienced themselves being among a sea of White peers, where they could not see themselves reflected among the entering class at the ceremony or within the first week of orientation, as first-year medical school students. Participants describe the feeling of being alone, invisible, and voiceless**.** Some participants also described feeling different due to their

ethnic identity, socio-economic status, and generational differences in medicine compared to their peers, whom they perceived to come from families where their parents are physicians and nurses. The first *cuento* is shared by José who was the only participant as a fourth-year student, he described:

> It felt scary at first for me, because the question that popped into my mind was where are my people? Oh my gosh zero. I didn't see anyone. Out of about 140 students, I was the only Latino there.

Javier, a third-year student expressed a similar recollection of the White Coat Ceremony, one year later:

> I wasn't sure how the experience was going to be at this school. I had never been exposed to these many Caucasians, as I had at that moment. There was a feeling of being culturally alone, disconnected, and uncomfortable but acknowledging this is a reality in medicine, there is little to no diversity ethnic representation of physicians who are Latinos or represent other underrepresented minority groups in medicine (URiM).

Javier continued to explain his thinking in the following way:

> I did feel a little uncomfortable, but what kind of ran through my mind was knowing that the rest of the medical field in general was primarily Caucasian, and I would eventually have to deal. Not just deal but also be comfortable in that environment.

Like Javier, José reflected on his reality of being alone among his class peers and wrestled with the uncertainty. He explained:

> I felt disconnected…I didn't feel like I was going to be able to have somebody in my class who would share the same cultural values and talk about a lot of the things that affect us as Latinos in general and the hardships that we have encountered to get to this point.

Furthermore, Javier expressed his regret for not inviting his family to the ceremony, describing feeling alone without his family due to their family's finances. To alleviate the feeling of being alone and lonely during the White Coat Ceremony he sought the companionship of David (another participant in this study), who identifies as Mexican American and who was in Javier's entering medical class. He shared his thoughts about this in the following:

> I saw many White families. I felt like I wished my family would have been here, but I was with David and his family. Oh man. This would have been great to just hang out but at the same time, I didn't want to have them take out of work and have them fly up here to spend money for just two hours. It seemed more of an inconvenience. I am sad.

Consuelo said she felt alone and lonely which added to a journey of isolation. She perceived her White peers to have social capital in the form of being a second-generation family of physicians who lived locally. Similarly, Melvin agreed and described being alone: "I think when I'm feeling frustrated going to a mostly White school and I can't find my non-White colleagues to share our struggle. Like that sucks. Yeah." Adela further noted that lack of representation of the Latino voice was minimized by the majority of the voices by her White peers when they selected topics for a course selected by the students:

> We think about things differently. And as Latinos we are more aware of different issues affecting our community that our peers may not be aware of. We didn't end up doing the immigration session. We voted and ranked them and debated them. At the end the topic of immigration was not selected. The group decided on the topics. So, it was like, two against a hundred and thirty or so.

Adela's *cuento* as she described the voting process highlights the lack of Latinos in her class of medical students. Participants explained how they were unable to gain support for events of social justice, because they represented a small number of racial and ethnic students. They felt their voices were silenced because they lacked numbers in representation.

Another important gathering for medical students is the first-year orientation which takes over a week where students are provided an overview of campus, curriculum, structure, academic expectations, commitment to professionalism, and learning of student services. The year is 2020, and the death of George Floyd ignites outrage and protests. During the first year's orientation, a small number of students discussed putting together a White Coats for Black Lives Matter affinity group at the PNWMU. Four participants were Latino supporters and felt lonely in their support for social justice in support of Black students and believed they were being targeted due to their engagement.

Adela spoke about her impressions of orientation and how she felt alone after commentaries were made about how a supporting a rally may be considered unprofessional conduct and said:

> I was really kind of floored, when we had our orientation day, our first day, and we got talked to about professionalism and the... White Coats for Black Lives movement was brought up. I feel we were recruited and then told to be quiet. So, I think when you combine that undertone with students being told you can't do these extra things that feed your soul, disproportionately they're like the student interest groups that are diversity based are doing extra work. I think it's just an environment that doesn't make sense to recruit a bunch of people if you're going to put them in a place where their ambitions and their desires are kind of tampered.

Melvin echoed the sentiment that because they represented a small group of URiM students he believed they were being silenced and felt targeted and alone. “I felt disregarded after they recruited me.”

Adding to this idea, Consuelo further expanded how she and others of her colleagues felt they were alone in their plight for social justice. “It felt very lonely and many of our peers didn't talk about what was going on in the real world with White Coats for Black Lives.” She explained, “It was really important to me to participate in social advocacy.”

Carlota was disappointed to learn there was little interest. Furthermore, she immediately became aware that many of her peers were not interested in dismantling racism in healthcare and supporting communities that are marginalized. “Not everybody

views medicine as a social justice tool or comes from a historical underrepresented background where they can see there is need."

Furthermore, because Latinos represent a small number in the medical classes their voices may go unnoticed or diminished in general and in this situation, it was related to a voting process that took place in discussing the curriculum, as described per a class discussion that took place to try to determine the subjects to be discussed within the curriculum. Adela explained her experience.

> We think about things differently. We're more aware of different issues affecting our community that our peers may not be aware of. We didn't end up doing the immigration session. Yeah, we all voted and ranked the topics. We could only pick six topics. It was a smaller group that was deciding for us. So, it was like, it was two against a hundred and thirty. No undocumented content for us to discuss.

José further noted he was happy that Black Lives Matter was being brought to the table for discussion. "I was really glad that the movement happened, because I felt like it was just adding momentum to our issues as minoritized groups."

Despite being happy that the movement occurred, the participants felt the PNWMU was asking them to leave behind their culture, values, and their support for social justice and for topics that were part of issues connected to health disparities and inequities.

David, who grew up in the Pacific Northwest said he was used to being the only one and sounded resigned as an underrepresented minority student at the PNWMU David said "I grew up in the Pacific Northwest and used to being the only one."

Consuelo was the opposite of David who came from a diverse community and had a difficult time in her transition to the Pacific Northwest. Consuelo was not used to being among only one or two within a population of all-White students.

Similarly, Melvin agreed that lack of racial and ethnic representation among his peers was a lonely journey feeling isolated and alone. He stated "I can't find my non-White colleagues to just share our struggle together. Like, yeah, this suck. Yeah. I'm feeling frustrated."

Javier went on to say that for him coming to the PNWMU was eye opening and was having a difficult time because of not being around others who didn't look like him. He had always been surrounded by racial and ethnic peers throughout his studies in the Southwest. He explains, "Well, I think one of the other major struggles was, on top of trying to get used to or adjust to being in a new place, I had never been around so many White peers".

The low number of students represented in medical school keeps them from not being able to see themselves. The participants spoke about feeling isolated and alone, as well as recognizing that they represented a small number among their White peers. Their *cuentos and* counterstories exemplified the isolation experienced by the Latino medical students in this study.

The low numbers of Latinos at the White Coat Ceremony, orientation, and in the classroom extended into the clinical wards where there was a scarcity of Latino residents and attending doctors as recounted by the participants. All participants discussed their lack of social and professional interactions with Latino physicians both residents and

attendings. They described their lack of interactions with Latino providers on the PNMWU campus and with associated hospitals and clinics.

Carlota was hoping that finally she would meet more than one Latina physician during her medical training and was disappointed.

> I didn't see many Latino providers when we rounded on the wards. Nor did I see I didn't see other Latino residents nor Latino physicians. It was disappointing and I could not find others. Physicians in general were nice, but I didn't feel welcomed to be like tell me about you. I want to know your journey.

José, Javier, Consuelo, and Karla all commented on the lack of Latino residents and attendings when they rounded on the wards.

Karla said "I could not visualize myself. No role models."

José was upset in his sharing of feeling alone by not having the opportunity to be mentored by a Latino/a physician but found comfort in being supported by another member of an underrepresented minority in medicine who was a resident. He felt he could not ask questions of White attendings or residents for feeling unsafe from prejudgment. However, José felt more at ease asking other providers who were not White and said,

> I didn't see a single Latino physician and I only remember an African American resident who I felt more comfortable approaching him than a White resident. I don't know why, but I just feel like I can connect with them better. If I have a question that I perhaps one may think it's stupid, would rather ask him. He looks friendly. I would just go in and he would welcome me and say 'oh welcome, welcome. What is your question? I have this question I don't understand. That is a

> great question and we would start to work together.' I don't know but I feel that perhaps, now that I think about it a little retrospectively, it could be the fact we are both minorities in medicine.

Karla similarly recounted her disappointment like José of not having a Latino physician she could look up to as a role model. She further noted there was no intentionality of being placed with a Latino resident or attending. She found some comfort in one of the few female African American physicians, who she felt she could support as a student too but perhaps not identify with the Latino experience.

> There are No Latino Physicians. There is No Latino Faculty to look up too. I could not visualize myself. When you don't see Latino or other diverse physicians. I only recall seeing one Latino provider during my rotation and was by chance. Dr. Johnson was the only racial minority doctor I remember, and she was African American.

David lamented "I don't think I've had a Latino resident. I can't think of a Latino physician. How sad!" Javier had similar feelings about the importance of having a Latino physician as a role model. He described that "It has always helped seeing other Latino doctors, having them talk to us about their experiences has always been inspiring as an undergraduate."

Only one participant of this study confirmed she met and recruited a short-term mentor who she met at a clinic during a rotation. Carlota was so excited and invited her to meet fellow Latino medical students.

Javier mentioned he had met one Latino physician and invited him to the Latino Medical Student Association (LMSA) meeting. "He is a cardiothoracic surgeon, went to

Davis for medical school, was active in LMSA, and was active in a clinic primarily for Latino communities."

Both Carlota and Javier noted it could be of benefit to all Latino medical students in LMSA to meet Latina/o physicians who could mentor them to navigate social and cultural aspects of medicine. Carlota was ecstatic in sharing of her meeting this Latina physician during her rounds as she recounted her experience:

> I didn't see many Latino providers when we rounded on the wards. I did meet one on a clinical rotation. She does not work for PNWMU. A Latina (Venezuelan). She came and talked to us for a bit. So that other Latino medical students could meet her too. She just emailed me saying 'let me know if there is anything I can do to help. I really want to be part of this community.' I was drawn to her immediately, she reminded me of my grandma or my family. I immediately felt very, very comfortable around her. We were together for two weeks. I feel like I was able to know her as a person, as well as a physician compared to others. I can learn from the journeys of others, so I can make my own.

The *cuentos and* counterstories shared by all eight participants of not being able to see or meet other Latino physicians were seen as a barrier to visualize themselves as potential future physicians. They also spoke about the benefit that mentorship from Latino/a physicians could assist them to navigate the cultural and linguistic aspects that are unique to Latinos in medicine but was missing. Also, the need for representation and role modeling as identified by the students is key to supporting their growth and navigation. The commonality of being alone and lonely speaks to the recognition of a deficit in experiences and a lack of access to Latino residents and physicians, as well as the

resources needed to affirm the participants are able persist in their journey's in obtaining a medical degree but that it is a lonely journey. The participants desired to see those who look like them in medicine and contributed to their sense of not belonging at the PNWMU.

A sub-theme that emerged through the interviews was "lack of self - belonging," which is often revealed in students' departure from higher education. All things considered, the greater the individual student's "sense of belonging" to the university, the greater the commitment and satisfaction and increased likelihood they will be retained to progress in degree completion. Part of the barrier of not seeing themselves among the physicians contributed to the participants' questions if they belong in medicine.

Adela said she had the impression that they were being "weeded out", while three other participants felt they were being observed by the administration in how they presented themselves at the PNWMU. Adela remembers hearing an administrator say that "it was their job to figure out the students dangerous to patients and make them not be here anymore." Adela interpreted this comment as a warning for those who did not do well academically. The system is set up to remediate and if not able to succeed students' journeys could be altered by removal from the medical school. She goes on to explain how this made her feel "When you use these types of words it's hard to feel like we're all welcome."

Javier also sensed being watched or judged. He said "I felt very uncomfortable being here. For some reason, I felt like the eyes were always on me. So dealing with all of that simultaneously made it harder."

Jaime echoed Adela and Javier's sentiments as he described his perceptions.

> I felt very isolated. I think as the only Latino student in the classroom, I was reminded of how much I think as a community, we struggle to get our graduates through college and to medical school and then to feel as if I don't belong.

Consuelo and David spoke about "not fitting in" and this contributed to their sense of not belonging. Consuelo describes that "They were nice, but I didn't feel welcomed." She goes on to explain that she desired for them to ask her "tell me about you. I want to know your journey as well. Nothing…" It appears that Consuelo was looking to make a connection or to form a relationship or bond. This aspect of longing points to her cultural value of *familismo,* which is described in the third theme of this dissertation.

While David, who was from the Pacific Northwest, said he was acclimated to being in a predominantly White environment he still desired to belong stating "I just want to fit in." Consuelo was a strong social advocate and had a strong sense that her colleagues "live in this bubble and I really hate that…And then, yeah, it just made me feel like I don't belong here. What do people care about here?"

In this sub-theme of a Lack of Sense of Belonging, the participants shared how they felt, what they heard, and their adjustment to being only one or few Latinos in the class of medical students. This is a stark contrast to their cultural ways in their home and community. The participants transitioned into an institutional environment that was predominantly White in representation which mainly focused on the science and practice of medicine and not so much on establishing and nurturing relationships. This was a contrast from a nurturing home and community environment where the participants were embraced, welcomed, but most importantly had deep relationships that cared, accepted,

and welcomed them. Missing were relationships as perhaps, the participants were used to being in STEM diversity pathway programs as undergraduates that provided a family structure space with diverse mentors, instructors, and surrounded by racial and ethnic peers. The PNWMU and its surroundings perhaps did not offer the environment and relationships that they were accustomed to prior to admission. This transition was a barrier that all the participants crossed over.

Another barrier that was discussed during their interviews was how the Latino medical students were physically and socially far from family, culture, and their respective communities. Latino families far the most are close-knit and include immediate and extended family members. Azpeitia and Bacio, (2022) explain the practice of *familismo* is a central Latino cultural value that involves the display of loyalty to family and seeking the support of one's family's advice (*consejos*) within the hierarchy of parents and elders. Providing support and assistance and being a whole unit of a family is essential and part of Latino family values. It is important to note, only two of the eight participants grew up in the Pacific Northwest and six participants were from the Southwest. The adjustment for many participants immediately realized it was difficult because of their new reality as they were far away from their families and communities which was different in comparison to the Pacific Northwest and at PNWMU. The two participants who grew up in the Pacific Northwest noted the lack of diversity representation was not new to them and could go home more easily to visit their families but were limited in the time given their schedules. However, six of the participants spoke about financial barriers, work schedules, school schedules, and the distance that kept families from not being able to travel to visit in person and proved to be difficult in

maintaining personal interactions with their parents and other family members. For all eight families and participants, this created distance in their relationships that was emotionally, socially, and culturally isolating for all. Most of the students spoke of being far away from their parents which added additional isolation and loneliness in their experiences at PNWMU.

The medical school journey proved to be difficult to practice within the familial system to support the participants as a collective. Part of their cultural practices involved spiritual traditions which some participants were unable to regularly practice. Their busy class and training schedules prevented some participants from attending services which they lamented.

Consuelo was one of the most impacted students in the study who spoke at length about her slow adjustment in being far away from her family and living in a non-racial diverse setting as she explained,

> I was not familiar with the Pacific Northwest. And the first four months were very hard for me and the adjustment. I am still struggling today. I felt very depressed and didn't want to hang out with people. I didn't want to participate. Anytime I had a small break that I could afford in time and money I would leave. Most classmates would say... Oh, I'm going to go have dinner with my parents. And my parents made me food, or like, I'm going to go sleep at home. I'm like, well, I'm alone!

Consuelo further expanded how she was homesick and missed her family and at the beginning of her first year of medical school would try to escape PNWMU. “I would

go visit my family, as often as I could. My parents felt sad because they felt they could not be there for me. They don't understand medical school, so that was hard on all of us."

Carlota also experienced missing her family and like Consuelo, she said "I miss my family and try to go visit when I can. They also come from time to time to check on me." Javier shared similar sentiments as his peers. He explained,

> The first four months were very hard for me. My parents don't understand how competitive medical school could be… I miss my father. After medical school, I feel it's time for me to go back home, be with my parents, take care of them, and be more immersed in the community.

Javier spoke about his affection and bond with his grandmother *(abuelita*) and how he missed her. Adela also described having a close relationship with her father and notes she does not see him often. She went on to say, "I also miss my *abuelita* who helps keep me grounded."

In the context of this study, the term family encompasses more than just a father, mother, and siblings, "family" is at the root of *Familismo (Familism)*. *Familismo* in Spanish refers to the collective family unity which was something each participant discussed as a means that was often a barrier to making them whole since they missed their family and resorted to many phone calls and from time to time in person visits. For all participants, collectivism is shared and valued among their respective families. There was no difference in the role family played in the lives of the participants even when families represented different generations whether they were first, second, and third generation in the United States. Latino participants practiced *familismo* which was present in their cultural identity, heritage, closeness to family and how they presented

themselves at the PNWMU. The first theme from the transcript in vivo codes of "Alone and Lonely" captured a wide range of feelings and experiences that the participants spoke about. These *cuentos and* counterstories revealed the impact of experiences they had at PNWMU, which unveiled a sense of feeling alone but also experienced a racist and discriminatory institutional culture that collided with the participants' world.

Theme 2: Racism (Barrier)

Racism was the second theme to reflect the central finding of this study. Racism showed up in the transcripts through *cuentos and* counterstories of the lack of mentors, lack of resources, and incidents of microaggressions that were experienced by the participants in lectures, clinical rotations, and in social settings. The outcome of racism created an internalization dynamic among the participants that led to a lack of belonging, imposter syndrome, cultural and linguistic taxation, and which impacted their mental wellbeing.

Institutional Racism.

Institutional racism is defined as having differential access to goods, services, and opportunities by race (Jones 2000). When asked about the academic or social support received from a designated coach (faculty to provide support) and assigned sib (an appointed upper classmate) all eight participants responded they either didn't have a coach or sib, and if they did, they felt their relationship was not genuine or meaningful.

Karla explained, "My assigned coach and sib were not helpful. I met twice with my White female physician. No intentional relationships. My sib did not connect with me regularly. It was robotic and was a checklist - was not genuine". Melvin agreed with Karla, in the following: "I didn't receive support. I think it is just their lack of experience

with minority students. I definitely don't think this is something they could get from just watching modules." Javier shared similar experiences with the coach and sib, by saying "I never had much interaction with either of them."

David further expanded about the lack of support by sharing of his cuento.

> I haven't met with my coach for the past year. They are supposed to provide emotional guidance, insight, and what to expect in the coming months and year. Especially for board exams or shelf exams. I should clarify, they provide career n trajectory advice. There's nobody who offers emotional support. But yet I had neither. I have never met with my sib.

José had a similar experience as David and commented the following,

> I never had interactions with my assigned coach and peer mentor. I think one of the major struggles was trying to adjust and get used to medical school. I was trying to adjust to being in a new place. And I don't have that support structure that I wished I would have had in medical school.

A coach is a faculty member who is assigned to support medical students as advisors and sibs are peers who are assigned to support their peers. The four participants spoke about not having support from their coach and peer mentor while the other participants agreed that their student learning at PNWMU was not supportive of racial, ethnic, and minority students. They all described how the lack of relationship with their coaches and sibs was inadequate.

Melvin confirmed the experience of his peers and believed that the coaches should be there to help medical students through tough times. He spoke about the

importance of having a relationship “You should connect,” and then went on to explain that “My coach was not helpful to me. My sib I don’t remember who that was.”

Like Melvin, Adela noted she didn’t have the guidance or relationship to support her in medical school,

> I didn’t have a coach that I recall. I only recall my undergraduate Latino faculty member who supported me and told me to dream ‘Be a doctor.’ No one here asks me about my dreams or guides me here.

The connection and support that the participants spoke about came to surface during an event called “Step 1,” which was an examination given at the second year of medical school and medical students must pass before moving on to the next part of their medical journey.

Adela reflected on how previous academic preparation contributed to passing or not. She said,

> I think some of us were fortunate. I came with a science background and so did Rosa, we were very solid and ready for this. But the curriculum doesn't necessarily work for every single student. And I think they know that certain proportion of students are not doing well, and it's really hard to see that and then to have nothing be done.

Javier similarly noted that the lack of support from a coach or sib and felt it was a contributing factor in how he did in the Step 1 examination,

> I never had much interaction with either of them in regards. I felt like I knew I was struggling, but in hindsight, I don’t think I exactly know if I was. When I didn’t pass Step 1, I met with my coach, and she recommended I reach out to the

> diversity office because they probably had scholarships for Latinos to take a prep class. I think that was the first time I felt like she was more comfortable bringing up that I was Latino. This was only after I updated my Facebook profile that I was Latino.

Failing Step 1- Lack of Mentors (coaches and sibs) Participants spoke about their experience with Step 1 which is a one-day examination and is divided into 60-minute blocks and is an eight-hour testing session. There are an estimated 280 questions during this exam and assesses important concepts of the basic sciences in medicine with a special emphasis on principles and mechanisms related to health, disease, and modes of therapy. This examination is required during second year of medical school and students must pass this test to continue into their third year of study. Six of the eight did not pass on the first attempt of this required test. Participants told their *cuentos and* counterstories of their experiences with this required test.

We start with Javier, who did not pass Step 1 on this first attempt, he spoke about the barriers they faced with retaking the examination. José spoke about his past experiences with standardized tests. José recounts his *cuento* as follows:

> I have a horrible history with taking standardized tests, I'm not very fast. I learned I had a disability as I reached my threshold in medicine. Once I had more time on the test I was able to pass with no problems. I didn't know I had a disability nor did I know I could get tested or an accommodation. By the end of my third year in medical school I discovered this problem and resolved with a solution. Once the accommodation allowed me more time – I aced them all. It was pacing and timing. It's a psychological issue of calming down

> when you're trying to take a test that is requiring you to answer questions quickly. It's trying to learn how to calm down, take deep breaths, be mindful and be present in the moment, not question yourself and move on. I self-sought the support from a therapist because my stress level was high after I didn't pass Step 1. The diversity office and the office that supports students with disabilities helped me with resources.

Karla also said she did not pass the first time either and was upset. She sought assistance to find herself empty-handed with no resources. "After I didn't pass the test, I went seeking help from PNWMU. They were not approachable; they were not genuine and were robotic. My experience was that they were not open to diversity."

David, similar to Karla, had the same concerns that they were at a disadvantage of not having tutoring "No post-tests, no follow up, no guidance, and no response. I just gave up on receiving any help from those who are supposed to be helping us."

Karla explained that tutoring was only available for students who are not passing within the coursework. Because she was not failing any of her courses, she could not access tutoring services at the PNMU.

> Yeah. I think the support around board examinations is really challenging. I think the tutoring services that are available within school are available to a select amount of people who have demonstrated difficulty during their coursework, but for those who have not demonstrated a difficulty with their coursework, they don't get access to the tutoring services despite maybe at one point needing them. And so that was my case with the board examinations. I did well during my coursework, and then I struggled with my first set of boards. And I think that ... I

> know I couldn't access the tutoring services that I needed. So, I ended up hiring a tutor myself, yeah, to help me with my boards. And yeah, I had a lovely tutor, no problem passing the boards after that." Okay. And then in terms of hiring the tutor, is this something that you did on your own? "My family had to help me. I went 50/50 with my family.

Karla went on to describe how she felt she was at a disadvantage for not coming from a family of physicians and not knowing some of the terminology.

> There were certain terms that I couldn't pronounce. And then when I'm on the wards and I say it wrong; it makes you look really bad and then it looks like you don't know what you're doing compared to someone who, people who scribed for a while or whose parents are both doctors or something like they've just heard the terminology a lot. So, I just feel like it's a different kind of advantage that does not allow me to do well.

These examples of the participants not having support or access to resources can reveal Institutional Racism, which Jones (2000) describes as "having differential access to goods, services and opportunities by race." In this case, PNWMU did not have a structural support system for medical students who did not pass the Step 1 exam for unknown reasons. Out of all the participants, José floundered on his own until he navigated his way into being assessed for a disability. Through his own persistence, he was able to obtain accommodations.

Historically, institutional racism did not allow underrepresented minorities (URiM) enter medical school, which contributed to the lack of Latino medical physicians in the participants' lifetime. The field of medicine is vast and underrepresented Latino

medical students need the benefit of guidance and preparation before matriculation, during the four years of milestones in medical school. As a first-generation college student, David reflected upon his own preparation and shared the following *cuento* that occurred during clinical rounds with his peers:

> So, for instance, I think certain things that are presumed to be fundamental, I remember having to ask questions about the preceptor. We were rounding and the preceptor said, ‘This patient has syncope,’ and I've never heard what a syncope was in my life, so I asked the high medical students, "What is syncope?" And they just looked at me like, "You don't know what syncope is?" Then quietly when we were walking, they were like, "It just means to faint." You know? So, the preceptor wouldn't hear. But that was one example, but there were other examples where I just did not know, I guess, fundamental things. The other two medical students, both White, one female, one male, and then the one in my class, her father is also a physician, so she, I think, they knew things that just were kind of common sense for them, and it just wasn't for me. You know? So, I think that's probably why I think having those experiences kind of maybe built up and led to my preceptor from being disengaged from me. And I think at the time I was embarrassed, but now I'm like, I don't know what that is. Screw you. Yeah, exactly. That's why I'm here, to learn. Right? I'm here to learn.

David’s *cuento* demonstrated the frustration and the emotional toll that his knowledge wasn’t at the level of peers. His recognition that his peers had privileges unavailable to him created an inequitable starting point in medical school.

Carlota and Melvin also commented they failed to pass Step 1 and they too did not receive any resources either and instead connected with other Latino and other students of color who didn't pass either and studied with each other. Step 1 was an important milestone in their medical school journey, and it was a source of discouragement but continued to persist.

Javier had insight into one explanation for their gap of their knowledge that contributed to failing Step 1. He believed it was due to being first generation medical students and not having connections to physicians or parents who are physicians placed them at a disadvantage. He reflects by saying,

> I think professors and administration here assume that you come from the medical field, and they teach you in that way. I don't think they are used to students that didn't come from that background. We then aren't prepared and can't pass. Maybe that is one explanation why I didn't pass.

The lack of resources, whether people, experiences or social capital created a situation where institutional racism showed up. The institution did not take into account the socioeconomic and cultural background of their Latino students, therefore treating the "same" or "equal" - but in reality, this type of treatment is not equitable. Racism occurs on multiple levels and the next section will reveal the participants' experiences with personalized racism.

Personalized Mediated Racism. Racism is the act of prejudice or discrimination directed against an individual or against a group of persons based on their membership racial and ethnic group. In this dissertation study, the participants are represented by the ethnic group of the membership representing Latinos. The analyzed data revealed the

climate at the PNWMU revealed a journey of racist acts and behaviors caused by different groups of individuals displaying different types of racism and microaggressions. Microaggressions have been studied (Sue et al., 2007) identified in the literature, which allowed the researcher to categorize the types of experiences the participants endured, where they took place and identified the perpetrator. All eight Latino participants in this study identified racism as part of their journey and described in detail through numerous *cuentos and* counterstories about how they experienced incidents of microaggressions.

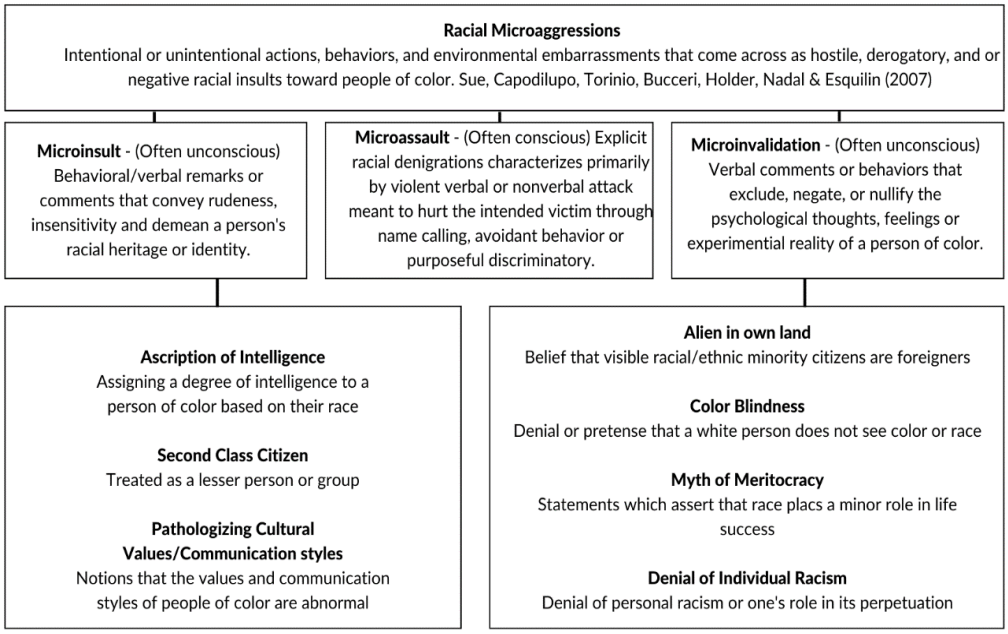
Participants were able to identify the perpetrators, identified where these acts and behaviors occurred and provided details of incidents and conversations that took place whether it was in the classroom, small group discussions, and while rounding at hospitals and clinics. Participants shared their counterstories and distinguished whether they witnessed or experienced bias, discrimination, and microaggressions and the researcher identified the type of microaggression that took place as per the description of *cuentos* and counterstories as told by participants

Types of Microaggressions as told by Participants Through Cuentos & Counterstories

Below see Figure 4: Titled Types of Microaggressions as Told by Participants Through Cuentos and Counterstories which outlines the types of racial microaggressions experienced by participants that were exhibited by peers, instructors, attendings, residents, and patients. *Cuentos* and counterstories are told as follows:

Figure 4

Types of Microaggressions as Told by Participants Through Cuentos & Counterstories



We begin with a cuento-counterstory as told by David in response to how he defined racism in his own words.

> It's a spectrum. For me it's like increments. It's a part of it as well as lack of respect is another part of it, and aggression is another part of it. So, for me personally, racism, it's... how do you say? It's like cultural adversity. There's one thing about growing up and then being on the receiving end of racial slurs. That was an act of aggression. That was racist. That just wasn't right...Then there's other things where it's like growing up and being in a classroom where you weren't provided the amount of support just because the teacher from their viewpoint thought that you have the potential to grow as much as another student. That's also part of racism. Then there's racism that can be very subtle, the body language and intentional and unintentional microaggressions. So, for me, it's like this whole spectrum of very subtle things to very aggressive things, and it's hard

on the mind and hard emotionally, because at some point over time, you're like, when does it stop? You know?

Racism Exhibiting by Peers.

When asked about incidents in the classroom where they witnessed and /or experienced a racist incident, the participants had much to share. Adela recounted an incident that took place with multiple White peers in the classroom while discussing content on a course organized and co-led by students. She assumed her peers thought it was okay for them to talk and felt safe, not knowing she had Mexican roots and said,

> We had a structural competency meeting which is a
>
> curriculum that's led by second year medical students taught to first year medical students, where we talk about different structural systems that affect our patients such as racism, trauma, homelessness, food insecurity, things of that sort. And we went through this terrible process of weaning down the topics that we could talk about because we only had a few sessions. And we came to the topic of immigration and there were a handful of us, mostly Linda and I, who wanted to talk about undocumented status. And a couple of my White classmates said, "Oh well we don't need to talk about that because we're never going to see those patients." It was difficult to figure out what to say because that's just wrong. I guess you can choose not to see or care or ask those questions, but it's just false, you're going to see these patients. Well, I said like, I disagree, and I think we will

> see these patients, but at the same time we were cutting a number of topics and I understand that not everybody wants to do this topic. It's fine, BUT we will be seeing these patients whether you want to or not. And I think it was just more surprising to me when one person said it and then a number of other students were like, "Oh yeah, Oh yeah, because we won't see these patients." And it's like, no, no. Who are you? Why are you here I thought? (Microinsult: second class citizen).

Adela experienced this incident and was shocked that her peers would not take care of undocumented patients. This caused her to question why they were in medical school if not to care for all people in medical need. While it was clear that her peers disagreed with her perspective, she continued to remind them that they would, indeed, have potential patients that are undocumented.

Karla shared another incident where the subject of health disparities was being discussed. She noted that her White peers didn't find the course to be of importance and heard many complaints, grumbling, and questioning why they were studying this topic. Karla said,

> I think it's mostly just when we have specific talks about diversity, or we have this one class that we have to take that's led by other students about social determinants of health and a lot of that revolves around racism and mental health issues, poverty and social injustice. And, I'd say that probably almost all of my White classmates found that to be a complete waste of time and

> really didn't try to participate or learn much from it. They complained all the time during the class. (Microinvalidation)

Carlota also shared in addition that racism and microaggressions from her peers that occurred outside of the lecture hall. She described talking with her White peers who questioned her diversity scholarship,

> During my first year, I was talking to two of my peers, both of whom were White. And we were talking about scholarships and stuff and I was like, "Oh, yeah, I got a scholarship too." Because they also had scholarships and then they, I don't know why they felt this was appropriate to ask, but they were like, "Oh, well, how much is your scholarship?" And I was like, "Okay, whatever." And so, I told them, I was like, "Oh, its full ride tuition." And they were like, "What? Oh, my god." And I felt they were mad and they were like, "Why did you get a full ride scholarship?" And I told them it was like a diversity scholarship in addition to academic success. And they didn't seem very happy about that. They were just kind of, "Wow, well why didn't I get that?" "Why do you get special treatment?" And so, I think in their minds they felt like I was getting special treatment, which it's going back to, it makes me really mad, or I feel I have to defend myself and say I worked really hard for this too. Also, White peers would say racist jokes, I would try to laugh it off, but deep down it is not cool. That hurts. They would make generalizations about Mexicans. It would just make me mad. (Microinsults: Ascription of Intelligence)

Carlota further expands to share about another *cuento* that occurred with other classmates while in a small group who believe Latino students and other minority students receive special treatment because of their race and ethnicity while serving as tokens.

> Yeah. I think it's interesting with our White classmates because a lot of times when the photographers come into the room to take pictures of our curriculum for whatever brochure they have, they will take pictures of the minority students as well, but they take pictures of everybody. But I heard sometimes our classmates say, "Oh, of course they have to take a picture of these people," and it's just to show on the brochures that there is diversity here and I feel like they're kind of trying to be, why are you guys getting special treatment when I don't think that we are. (Microinsult)

Karla also spoke of a similar *cuento* to Carlota where the topic of the brochure came up,

> My White female colleagues one day were going on racist rants and saying "these people are put on the brochure, while also laughing at the pictures on the website collectively of other diverse students. They went on to talk about how racial minorities were given full scholarships and given special treatment. I was hurt and didn't know how to defend myself. They were not open-minded people and were a waste of my time. (Microinsults: Ascription of Intelligence)

José shared an experience where his peer's displayed disbelief that he could be successful.

> My White peers would say "you are actually a Latino?" You made it all the way through like they were surprised." I would get a lot of questions from peers and patients. They would say what kind of last name is that? Where do you come

> from? (Microinsults: Ascription of Intelligence and Microinvalidation: Alien in own land).

The participants shared incidents of microaggressions which reflected personalized racism that occurred on the campus. However, these incidents can be found outside of the classroom. For example, Karla described an interaction with her roommate who had a perception of the Latino Medical Student Association (LMSA) membership that they were all Mexicans. Karla recounted the conversation that took place in her own apartment,

> She is my roommate and in my class. She's done a lot of things that have made me really mad, but I'm part of LMSA and she knows that. And this was within the first year or two when I was really more active within the group. We decided to have a social event, just have some people over to our house to drink margaritas, speak Spanish, and do something fun. And we were eating dinner before everybody came over and she was like not being nice about it, "Oh, yeah, so your Mexican club is coming, right?" And I was like, "Oh, yeah. LMSA." And she's like, "Oh, yeah, whatever." And I was like, "No, not all of us are Mexican. Not everybody who is Latino is Mexican. We have a diversity of people" That made me really, really mad when she said that. And I told that to some of my other peers in LMSA and they were not so happy either. She kind of laughed it off. She was like, "Oh, ha ha, I was just kidding." And I'm like, well, it's not funny. (Microinsult)

Another incident that involved White peers was experienced by Melvin during clinical rounds.

> My peers were talking disparagingly about Mexican patients while rounding in the hospital and I told them I was Mexican. They were in shock because they only viewed me as Black/African American and further invalidated me by saying “You are one of us. We don’t see color” (Microinsults: Second Class Citizen and Microinvalidation: Color Blindness).

Karla further explains that because of her lighter phenotype she probably experienced less racism than her peers who have darker complexions and also acknowledged her privilege. However, she still experienced microaggressions and was profiled as an outsider. She explained that she was continually asked by people ‘where are you from?’ She explains her frustration when in fact the Pacific Northwest her hometown was yet, many assumed she was an outsider and said:

> I'm half Mexican, half White and I know that a lot of people can't pinpoint what my race is and a lot of people, I can't tell you how many times people in my life have asked me, like the awkward question, like what are you? And then I'll tell them and they're like, "Oh, it makes sense now, but I thought you were maybe Asian or Pacific Islander. Yeah, people still ask me, where are you from? What's your ethnicity? I'll tell them. But it's always kind of awkward because when you're asking me where I am from, what do you really mean by that? Do you mean that, "Oh, you look like you're not from this country," or are you literally just like, "Oh, what state are you from?” (Microinvalidation: Alien in Own Land)

José also has many inquiries about his heritage and explains:

> I get it from attendings when we round. I think their questions of where I come

> from are just genuinely wondering where I'm from. And then if I say, I'm from California, they're like, "Oh, okay, great." They keep asking, "Oh, but where are you really from? Or where is your family from?" (Microinvalidation -Alien in Own Land).

David similarly shares a *cuento* he recalls that took place at the hospital,

> My attendings will say, "Hello, my name is" and then they say, "Where are you from?" I think that they should have asked more like, "Oh, are you from the Portland area?" Yeah, because I've heard a lot of physicians ask other people, "Are you from the Portland area?" Whereas with me, it's always, "Where are you from?" "Where are you really from?" "Hello, I'm from here …this urban city and I remain cool…. like it doesn't impact me. BUT it does. (Microinvalidation – Alien in Own Land).

As we can see from the *cuentos and* counterstories, the participants were constantly questioned about their identity, heritage, and had to deal with subtle insults of not belonging or not being smart enough to be in medical school. All these incidents of personalized racism occurred with interactions with their White classmates in and out of the classroom lecture halls, in social settings, and during clinical rotations.

Racism Exhibiting from Instructors, Attendings, and Residents.

Within a medical school setting, there are hierarchies that exist. The different levels of power they hold over a medical student during their instruction, which takes place in the classroom and in clinical rounds. In addition to the sensitivity to the power differential, participants brought their own cultural lens to be respectful of elders and people in positions of authority. Consuelo described the following incident,

> So, when I was on my OB-GYN rotation, my resident was sending me an article via email. And she's like, "Oh, what's your last name? Is it Martinez?" Gonzales? I don't know if that was her getting me confused with one of my classmates who was on OB right before me. "Oh, that sounds Latino, so I'm just going to spew out whatever Hispanic name I can think of." So, I'm not sure if she really meant to do that, but it was kind of, we don't all have the same last name. I don't even look like Carlota. We have very distinctive features and look nothing alike. (Microinvalidation)

While Consuelo's *cuento* describes a microinvalidation that was directed to her personally, David tells about an incident that took place during a lecture which offended many medical students of racial and ethnic diverse backgrounds.

> I was the witness, the professor was giving a presentation on…oh I forget on what subject, but then the presenter thought it was relevant to bring up a picture. I think it was spousal abuse. Like domestic violence, how to report it and things like that. An example he brought up was Middle Eastern... like he showed a picture of a Middle Eastern group of people, like a wife dressed in her garments and the husband, and there was... I mean, it was just them. There were no physical abuse pictures in that image, but that was his example of domestic violence. One of my close friends who also went through the equity program, she's from the Middle East and for her it was just completely offensive and just... you know? racist. It was hurtful for her, myself, and other minority students.

David's example of the professor showing a picture feels very subtle and it could easily have been countered with denial that the act was racist. This act and picture was pathologizing Middle Eastern people as abusers and abnormal, which is a microinsult.

David spoke about his exposure to racism and microaggressions he experienced when he received his clinical evaluation. Medical school is known to have subjective evaluations, letters of recommendations, and judgements. Unfortunately, David received a verbal evaluation from an instructor in front of his White peers. He sadly described his *cuento* in his own words as follows,

> It was more... not benign, but more on the subtle areas of racism. Going back towards that teacher student relationship and kind of... so, for instance, what happened was that my rotations, it's just disheartening to, especially when you're on a rotation with other medical students, and you get personal feedback in front of all the other students and the students each get personal feedback. The preceptor said, "Oh, yeah, David, you're a great guy. That will go far for you. It's like, "Well, okay. Thanks." You know? And the other students were described as "Excellent scholar," or, "Excellent summary and that." You know? It's like the way you can do this physical exam or this presentation, it's tremendously on point. It seemed like this whole experience was just shaped by less effort and less involvement of a preceptor to really engage each student at the level that they were at, and seeing more like, "Oh, you don't know this. You're just going to have to learn it on your own." You know? Kind of giving up on you. That's kind of how it felt. (Microinsult: Ascription of Intelligence)

The preceptor conveyed a message to David that he wasn't smart enough and therefore, only gave him feedback on his personality. While with other medical students, the preceptor gave out positive academic feedback. Melvin, like David, shared a similar counterstory: "I believe I was treated unfairly in my rotation evaluation. I worked harder than my peers and received low marks. How could that be?"

Melvin was in disbelief because he had prior training as a medic and made a decision not to pursue why his evaluation was low. He just moved to the next rotation without asking his preceptor for an explanation about his low rating evaluations. He noted he was fatigued and just wanted to move on. Melvin knew inside himself that he was capable and simply did not accept the microinvalidation about his knowledge or intelligence.

Javier also told a similar cuento about an evaluation he received that did not represent his capabilities. Upon reflection, he felt his peers were very vocal and he was softer spoken and not as assertive in presenting his patient cases, which led to his low marks. He further described how he felt perhaps his cultural upbringing might be contributing to his instructor's biases because of his physical mannerism which he felt represented his Latino culture:

> I grew up more in a humble environment where we don't really talk over people, challenge our elders or speak arrogant, and that's been something I have had to work on since I got into medical school. I kind of got that sense, that's the culture of medicine. You have to be vocal and direct about things in order to stand out, otherwise you're going to get overlooked. (Pathologizing Cultural values & Communication Styles).

Javier understood that he had to adapt to the "culture of medicine" and realized that in order to fit in and excel, he would have to learn how to communicate directly and be more assertive. He was being judged on an expectation that was not a part of his cultural norms.

Consuelo shared a similar story and said "I just finished a rotation where on my evaluation, the attending wrote, 'She is very shy, which can come off as if she's not interested, but that's not the case." …I don't know what to do about it."

Consuelo and Javier were able to hold onto his own cultural ways at the same time they were learning how to navigate between the two worlds: the Latino culture and the culture of medicine. Javier went on to explain that the instructors made assumptions about his "level", thus creating incidents of microinvalidation.

> I guess sometimes that as a Latino medical student, attendings may see me differently. They probably think I'm not at the level of maybe my Caucasian counterpart in regard to being academically prepared or knowledgeable. And I don't know sometimes; I feel like doctors or whoever I'm working with will try to dumb down whatever they're trying to teach me." (Ascription of Intelligence)

The role of instructors, attendings, and residents is to provide instruction to the medical students. However, the reality of the participants' experiences showed that instead of learning, they were being judged and evaluated differently than their peers according to their *cuentos and* counterstories. For example, Melvin tells about an incident where he was judged differently based on his phenotype creating hypervisibility.

> I don't feel welcomed nor fit in this school. I was five minutes late to class and received an email saying it was unprofessional and I was cited. My White

and Asian classmates came in after me and they didn't get the same email. But when you have one Blaxican (Black Mexican) guy, I think honestly they know when I'm not in class or when I'm in the class - I just stand out more.

Melvin explained that from the email he was given an assignment to appease his instructor. This was not a learning assignment but more like an apology letter. The unfortunate thing about this incident was that his White and Asian peers were not required to complete this assignment, and some did not even get an email. Melvin shared another counterstory about what he believes were assumptions and stereotypes placed on him because of his phenotype. He described a disturbing incident that took place in a surgical room with his attending and chief resident. He said,

The surgeons decide on the music and take requests from residents and students too. They played gangster music. I did not grow up listening to this type of music. It was prohibited in my home. My mother would not allow me to even wear baggy pants or wear my shirt hanging outside my pants. I was shocked by them assuming that I would welcome that type of music especially with the use of inappropriate language in the lyrics. I didn't say anything but I was in disbelief. I remained silent and didn't say anything (Assumption of Criminal Status).

In this cuento, we hear that Melvin experienced a microinsult in the surgical room. Whether intentional or not, this incident speaks to stereotyping that connects Black/African American people to rap or gangster music that contains the "N" word. It's not clear whether this was a conscious or conscious act by the surgical team, but if it was, it would be considered a microassault.

All eight participants were sent subtle and direct behaviors, messages, and actions that were considered to be biased, racist, or placed stereotypes against them. This created an environment that was not conducive to the participants' learning or sense of belonging. All eight participants experienced similar types of personalized racism which included microaggressions. Again, these acts of microaggressions occurred in the classroom, evaluation setting, clinical areas, and social settings where no one intervened on the behalf of the eight participants of this study. All acts of bias and microaggressions were directed by either their peers, attendings, or instructors. The final interaction that occurred among the participants was with the patients during clinical rotations. This took place in clinics and hospitals in urban or rural settings.

Racism Exhibited by Patients.

Latino medical students were also exposed to patient acts of racism and microaggressions that ranged from indirect to direct blatant racism. The participants in this study experienced emotional pain as they were exposed to abusive remarks and microaggressions during the process of providing care. Their White attendings, residents, and peers remained silent and did not act to protect, nor interrupt these acts of personalized racism. All the assailants of prejudice, bias, racism and microaggressions were White elder males and females who were being treated at both urban hospitals and rural clinics that were associated with the PNWMU. These experiences also added to the isolation being far away from their families causing participants more racial fatigue due their behaviors, actions, and remarks. Racial fatigue is described as the cumulative psychological and emotional impact of microaggressions. Smith (2008) refers to this as racial battle fatigue, a term he coined which describes the negative racially charged

experiences minoritized people experience in the U.S. Minoritized is a term to describe individuals who are oppressed by the majority and is about power and not about lack of representation (Wingrove-Haugland & McLeod, 2022).

Consuelo recounts a cuento as follows,

> I had a white female patient who was talking about one of her doctors and she couldn't remember her name and she knew she was of Asian descent, so she was, "Oh, maybe it was like Ching, Chang, or Chong. I don't know. They all sound the Same she said." And I kind of just ... I didn't say anything nor did I laugh. And then she was like, "Oh, I'm just kidding. I didn't mean that. I'm not a racist person." And I was like, "Okay." She didn't ask me any questions. I don't know if she was defensive afterwards saying things like, "Oh, I'm just joking." I don't know if she thought maybe I was part Asian or something like that. And maybe that's why she really got like, "Oh, my god." She didn't ask me specifically where I'm from or anything like that but I just felt so conflicted. (Microinvalidation: Denial of Individualism Racism).

Melvin shared that while he was conducting his rural rotation, he was exposed to White patients wearing red hats that read “Make America Great Again.” He noted,

> The providers didn’t say anything. As a Blaxican, I was very uncomfortable and feeling targeted. No one in the clinic said or did anything. I also had a White elder woman who was afraid to be with me in the examination room and made some slided comment about being in a dark room. I didn’t understand what she meant by it but I’m certain she was targeting me because of the color of my skin. My attending said nothing. (Microinvalidation)

The attending demonstrated silent bystander behavior that did not support nor protect Melvin but at that time of the "Trump Era" people experienced anxiety, fear, and uncertainty.

José shared about blatant discrimination that took place during his rotation that involved an incident with a White elderly female. He stood wearing his short white coat and was attentive as they rounded as a team when they entered the patient's room for consultation. During his interview, José became teary eyed, as he described the following painful memory,

> There was a White female patient who said "wait a minute" as she interrupted the attending while in consultation, as he asked her a medical question. She didn't address the attendings' questions. Instead, she turned directly to me and said "Are you Filipino?" I was standing up there asking myself does it really matter whether I am Filipino or not? I was really perplexed by the question and the team was making an expression trying to figure out where did that question come from but they all said nothing. I responded and told her "No, I am Hispanic and I'm from Los Angeles." She continued to ask me more questions. "Oh really how did you get here? What are you doing here? My attending didn't stop her. He said "Well Mrs. So So "So sorry to interject but we really need to discuss this important question" he said to her. My face was just turning a little red and I was like it was really awkward. I think there was that moment of awkwardness and embarrassment. I didn't know what to do or what to say. No one said anything, not even my peers. (Microinsult: Second-Class Citizen & Microinvalidation: Alien in Own Land & Microassault).

José's cuento portrays a White elderly woman who targeted him directly with her questions, because of his phenotype. This bordered on microassault behavior. Her question of "why are you here?" came across as a challenge to José because of his racial and ethnic background. The other members of the team remained silent, demonstrating bystander behavior. The attending on the other hand, redirected the patient, but did not address her racist behavior.

Javier told a similar story of a patient of a White woman while in rounds. He described the following:

> She wanted to know if I spoke Mexican? And then she asked why I was in the clinic? She said she thought I was the janitor. I speak English with an accent and believe that is why she asked me. My attending was there and didn't say anything. I was in shock and pretended it didn't hurt me. How could she mistake me? I was wearing my white coat. (Microinsult: Second-Class Citizen & Microinvalidation: Alien in Own Land).

All eight participants encountered personalized racism and microaggressions. David recaps the experiences of all eight participants with his following words: "Microaggressions are hard on the mind and emotionally when it does not stop? One needs skills, resilience, and try to ignore it. Very frustrating."

Karla recounts a cuento that speaks to the overall climate at the PNWMU recalling a conversation where the topic of racism was discussed in an open forum among a group of her peers that reaffirms the journey of Latino medical students is different from that of White medical students.

> And so just the other day I was sitting in a room with people who said ... The

> question was posed to the group of people that we asked ... He kind of asked, "do you know any of your peers who have ever experienced racism? And it was a room full of all White males and two females, myself and a White female, and every single one of them said no, they couldn't think of anyone in our class who had felt racism, which was jaw-dropping to me because I could immediately think of people. People of color who I know that they've experienced that, and so I think you just have some of my classmates ... they aren't looking for it. They don't carry their everyday looking for inequity, but there are people in my class whose days have been clouded by inequity. And I think as being a part of that community, my experience, when I'm looking forward to my education on my rotations and my interactions with my attendings, my advisors and my residents, I feel the weight of inequity when I see one of my peers get hit by it and I don't think it's felt the same by White counterparts.

All eight participants noted they had either witnessed or experienced racism and were able to identify the perpetrators and location of where these incidents took place. None of the participants knew where to report these types of racist incidents whether they were committed by their peers, residents, attendings, and or patients. All felt as if they were left to fend for themselves; they noted that no one stepped in to assist them when the behaviors or words of racism and microaggressions were enacted upon them.

When Carlota was asked if she reported these harmful acts, she reflected by saying,

> No. Honestly, I probably wouldn't ... I don't know who I would report it to…. and I would just talk about it with my friends. I maybe would tell my coach, but again, we are not in contact. I don't really feel there's somebody that I could tell.

These *cuentos and* counterstories are stories that have not been told before. However, the participants were more than willing to share their lives and experiences for this dissertation study. Participants want their *cuentos and* counterstories to be told and be able to expose the barriers of inequities they face as Latinos in medicine in order to bring change for others who come after them.

Internalized Racism & Introduction to Sub -Themes

The impact of having to endure personalized racism and institutional racism funnels into the lives of the Latino medical students and shows up as Internalized Racism. At the most dramatic level, internalized racism shows up in acts of dropping out of school, losing hope, and feeling resigned. According to Jones (2000) she describes internalized racism as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth" (p.1213). Sub-themes that appeared were the impact of racism on the participant's mental health well-being, cultural and linguistic taxation, and experiencing imposter syndrome as a result of their surroundings at the PNWMU.

Mental Health Well - Being.

For the participants, this internalization process impacts their mental health and well-being. For example, Javier explained the following: "I feel down and demoralized when I hear stereotypes being mentioned of my community by my peers and providers. So frustrating and hurtful."

Participants discussed their mental health and spoke how they were reluctant to share with others, however, they had a level of trust with the researcher and wished to tell their

personal stories and lived lives seeking support for others that followed them. Seven of the eight participants noted they either worried about their own mental health and of their colleagues' mental health status. The participants noted that Latinos, in general, do not disclose mental illness as it could be considered to be a sign of weakness for some. Others fear being thought of as being “loco”, in Spanish meaning crazy. Only two participants of the seven sought counseling services. David shared the following:

> I think mental health is a problem, even for me. It’s a hard issue for me to bring up… Medical school is challenging and its life draining, and I know it affects us emotionally and affects us mentally. I just don't know to what extent because I think Latinos are more reserved, and I think we all share that in common in being reserved about our behaviors and our mental health. I was alone and needed mental health services. I was fearful of revealing my mental health status.

Karla, also like David, gave some insight into the participants’ experiences at PNWMU. “Nobody speaks of depression. There is a stigma. Not sure where we go for help? Mental health is not emphasized enough.” She goes on to describe that the schedule of the therapist doesn't match up with the medical students’ schedule.

Carlota agreed with Karla and David that:

Nobody really talks about depression within my class and not really within my group either. And, I think it's because of the stigma with depression and people not feeling comfortable. I didn't feel comfortable talking about my emotions in regard to just feeling so different from everyone. I felt like it was kind of one of those taboo things you don't talk about.

The participants all were experiencing their mental health situations in isolation, but for some, like Consuelo, she attempted to alleviate her depression. “I was depressed and got a cat and just stayed in my home and didn’t seek assistance. I would call my parents and go home as much as I could.”

Melvin also attempted to act proactively but chose a different route than Consuelo. He explained, “I was fearful of revealing to anyone about my mental health needs. Didn’t know where to seek help too. I finally found the space but learned there was no one there that could identify with my background.”

Javier also found an alternative method rather than seeking counseling services. He noted, “Medical school is so stressful and I try to make it not apparent to others. I didn’t seek any professional help. Just prayer and working out.”

José was one of two participants who noted he sought care and felt better after seeking professional support and also with the reassurance of his mother. José openly shared his success as follows:

> I was able to get some help from student health services. I went to them as I was able to strategize, practice mindfulness techniques and be more proactive to help me with my well-being. I think it's multiple things, just again kind of culturally we don't really seek out help. We try to do things on our own. Too, I don't know if it's related, but I'm afraid it'll make me look vulnerable, just weaker, which is something I don't really want to feel when I already feel like that in this setting. Although, those feelings are starting to change and I'm starting to see value.

In these *cuentos and* counterstories about mental health wellbeing, all the students spoke about how they did not want to reveal their struggles because it would make them appear to be weak or vulnerable. This was especially true in a medical school setting, where it is a competitive environment where the strongest excel. In addition, their Latino cultural ways did not promote seeing counselors or therapists. The cultural tradition of *familismo* encourages those who need advice to seek *consejos* from a family member, a godmother, a pastor, or wise elders.

Cultural & Linguistic Taxation.

Part of the internalized racism that the participants experienced revolved around a term I noted to be identified as "cultural & linguistic taxation." Participants were frequently asked by residents and attendings to interpret for the rounding teams. Often, White residents and attendings made assumptions that the participants were fluent in knowing Spanish medical terminology and could effectively communicate with Spanish speaking patients during service (See Table 1. for participant's profile). When asked to translate the participants felt taxed and overwhelmed when being asked repeatedly. Seven of the eight Latino medical students were asked repeatedly to translate instead of the attending or resident calling a certified medical interpreter. These seven participants had a first and last surname in Spanish. Only one participant had an English name and was never asked to translate because he was not associated with being Latino due to his darker phenotype and non-Spanish name. Many assumed Melvin was not Latino but in fact he was multiracial Black/African American and Mexican American. Melvin was fluent in Spanish (both speaking and writing) and was a former medic, and therefore was

probably the most qualified to translate from all participants in this study. He was asked to interpret once when they found out he spoke Spanish.

All participants felt burdened at times but also felt a sense of responsibility to assist patients who needed language support. Some participants felt they had the proficiency to provide Spanish medical interpretation, but other participants felt ill-equipped to handle due to their lack of fluency in Spanish. In addition, some participants felt conflicted because they were not certified medical interpreters and wanted to ensure Spanish speaking patients received equitable information and care. Adela explained how the cultural taxation impacted her by creating an unspoken role of a cultural navigator for Latino patients, with whom she felt a sense of responsibility toward. It was an internalized process and conflicting pulls for the participants as Adela describes in the following,

> I think that if you speak multiple languages, which is true for some Latino students, you get asked to do things because you can speak that language. So, I think I was pulled to translate multiple times during clinical rotations, and sometimes it would be... I mean, I think it's hard because every single time I saw Latino or Spanish speaking patient, I wanted to see them because that is the best, most amazing patient connection I think you could ever have. And those are some of the most meaningful experiences that I had in medicine here. But at the same time, we're learne**rs** and I'm not here to learn how to translate. I'm here to learn medicine. And many times, I would be pulled to translate... So, I think it gets a little frustrating when it's a pattern. They say it's faster to just carry a med student with you that speaks the language. I never

> did any consents. It was a kind of morning check-ins. There were a couple times that I asked to get a translator and they did because sometimes some of them spoke a dialect that I just couldn't quite pick up on.

Adela's cuento shows the push/pull dynamic that being asked to translate created. This internalized process or cultural taxation was experienced by others. For example, David shared that "Because I had a first and last name in Spanish, if we had a Spanish speaker patient, in different rotations they would ask me, do you know how to speak medical Spanish? Kind of –" David could speak Spanish but knew his limitations with Spanish medical terminology. Carlota noted she worried because she was not a certified interpreter and repeatedly was asked by her attendings and residents to translate when there were encounters with Latino patients.

> The attending that I am working with right now does not get interpreters. They got an interpreter for the Russian speaking patient, but not for the Spanish speaking patients. I don't know if these doctors are fluent in Spanish. So, it's hard to tell if what they are saying is completely registering to the patients. It's kind of scary to think what if the patient didn't fully understand. I think this could lead to bad outcomes. My attending asked me, "Do you speak Spanish? I am like, "yes but I am not fluent. I can speak conversational Spanish but not medical Spanish. I had another ask me and he said "Well why don't you go in there and try. You're telling me to go and talk to them about a medical condition that I don't know? I have an app on my phone, I guess I could use that. I was like I didn't want to sound bad so I was like, okay. So, I went in there and it turned out the patient spoke English too. I think he just assumed

> because she had a Spanish sounding last name that she only spoke Spanish. The patient probably felt that it was rude for her to say she spoke English too and just followed along given she had seen him during her initial consultation. Just because my last name is Martinez, doesn't mean that I am fluent in Spanish.

Carlota's *cuento* reveals assumptions that the medical profession makes about patients' identities based on their phenotype and last name. Physicians are stereotyping, which is an aspect of racism and in turn, the participants witness this while being culturally and linguistically taxed by requests to translate.

Adela expressed her frustration when on a hospital rotation she found herself in a situation where she advocated and requested that a Latino Spanish patient be provided a walker and follow-up care with a Spanish-speaking provider at the patient's discharge. The charge nurse and assigned social worker were not helpful in finding a Spanish speaking provider or follow-up instructions in Spanish. Adela exclaimed her outrage as she described the lack of motivation of the nurse and social worker to provide culturally responsive care to her Spanish-speaking patient and his family. She noted she did her best in advocating, translating, speaking in Spanish, and seeking to provide culturally specific follow up care.

> I was trying to get a walker for one of our patients who had a really terrible broken-down walker and we were about to discharge him to a shelter, which was terrible. And she (the social worker) wouldn't pick up my calls. Part of her job is to help find follow-up for patients, especially if they're pretty tenuous or really need close follow-up. And we had a Spanish speaking patient and it was really complicated. I was very upset. And I was trying to find him a walker and

> a Spanish speaking provider because that's the one thing they asked for, and the nurse was like, "Oh, I'll just give them the information and it's fine." And then I was like, "Well, do you have a referral, and do you have it in Spanish?" And she was like, "I don't think so. And I was like, okay. So, she ended up leaving earlier, like at 3:00, and I saw the paper that she handed this man's father, and it was all in English and it was to call the Medicaid line, dah, dah, dah, and I was furious, and I just ended up talking to the family in Spanish and called myself. It was insane, no interpreter on sight either.

Both Carlota and Adela shared similar stories about their discouragement in the health system and how it is failing monolingual Spanish-speaking patients. This speaks to the inequity in the medical system and the lack of resources or providers to meet the needs of the patients. The health care system is not easy to navigate, and it is important to advocate for yourself, but with monolingual Spanish speakers, this task is almost impossible. To receive equitable and culturally responsive care, the information needs to be understood by the patient and the environment needs to allow for questions to be asked. Otherwise, how can patients make medical decisions that will impact their health?

Javier talks about the importance of not only listening closely but also watching for cultural cues in the communication process. He states,

> How do you say this in Spanish? Or when I'm communicating with a patient, for example, what are some of the cues or body language that I should be in tune or aware of? I would explain that as Latinos, we really revere doctors. We are more reticent when receiving feedback or advice, being more complacent. Rather if a doctor says something we would say, "Yes, Doctor. We will obey.

> We will try to follow your recommendations and not question it." Not very curious in that sense, but it's I think more out of a sense of respect.

José adds insight into Javier's comments related to watching for cultural cues. He said,

> I'm not an official interpreter and I wasn't really allowed to serve as an interpreter simply because of policy. I explained to the doctor that I am more in tune to picking up those subtle cultural cues. In explaining this to the doctor he said, "Okay well we're just going to go in there. We're going to talk to this patient and explain to her what's going on with her baby." So she would be there in the room sitting like this, very concerned, and the doctor would come over, talk to her, and he would just explain a load of information. She looked overwhelmed. I don't think the provider really saw the subtlety in her expressions. I told the doctor, "I would like to step back in and ask if they really understand." I explained in Spanish what was really going on with her child. She felt better after that and I went to record the doctor and I told him I was able to explain the information to our patient and connected with her on a cultural level, to bring a sense of relief to her. The doctor thanked me for being able to at least pick up the cultural cue.

José further expanded on how the PNWMU policy was established but not always followed. He explained that "in my internal medicine service, we had a lot of Latino patients. My team would frequently say, "If we may, he can ask questions for us." So cultural and linguistic taxation did not follow policy, but was requested by those who held authority and power. Working in an environment with translators and interpreters,

the participants had insights into how this process played out in reality with the patients. Carlota shared the following *cuento*,

> I was with a resident who didn't speak Spanish and I noticed the translation was incorrect. The interpreter was not telling the patient what the resident was asking accurately. The interpreter asked the wrong questions and the patient responded and I stopped the conversation. I said the interpreter did not ask what you asked. It is an important question. I told the resident to explain again to the interpreter the question but in a different way. The second time the interpreter got it right. After the encounter the resident was thankful but just shrugged it off. Makes me wonder about accuracy in diagnosis?

Carlota's *cuento* reveals a serious question about the medical care this patient was receiving. José spoke about the satisfaction he would get in serving as a translator. He indicated he felt as if he was the cultural bridge between assisting but also noted not using the medical interpreter made the consultation go faster for the attending.

As students, we try to approach the problem simply as a question to not to step on anyone's toes. I would say – Señora so so, I noticed you look somewhat confused. Is there anything you would like for us to clarify? The interpreter then kicks in. My peers are very relieved when we step in to be of support. At times we would follow policy, but the encounters would go much faster if they would allow me to be an interpreter.

José's culturally responsive approach to simply posing questions in a respectful manner is aligned with the cultural value of *respeto y confianza*, meaning respect and trust. For the

Latino patient, this intentional demonstration of care and support is familiar to them. In contrast, the sterile and systemic checklist approach does not create *confianza* (trust).

Javier also provided culturally responsive care when he was able to pick up on the cultural cues of a patient.

> I explained in Spanish what was going on with her child and she was relieved. She felt great after that and said thank God. 'Gracias a Dios. I thought something was very wrong.' I reported back to the doctor and told him I connected with her on a cultural level and helped her bring a sense of relief to the parents... I think that, somewhere where a person who is not a native speaker or Latino won't be able to pick up if they don't understand the culture aspect. It is a very subtle point that you have to be able to distinguish between sicknesses and between not understanding something.

These *cuentos and* counterstories of internalized racism show the conflicting experiences of being taxed by serving as an interpreter and at times, wanting to help and become as José commented a "cultural bridge" for monolingual Spanish speaking patients. By internalizing the expectation that they translate when requested, the participants accept this role of interpreter even though they are not certified, and it is not part of the medical training. Instead of focusing on their learning they are accepting the role of serving. The last type of internalized racism that showed up in the interview data findings is described as the Imposter Syndrome.

Imposter Syndrome.

Another aspect of internalized racism is Imposter Syndrome, which is a psychological occurrence in which an individual doubts their skills, talents, or accomplishments and has a persistent internalized fear of being exposed as a fraud. The term Imposter Syndrome (IP) is coined by psychologists Paule Clance and Suzzane Imes, which they describe to be a belief that one's academic/professional accomplishments are not due to their capability or intellectual ability, but rather luck, or other possible factors. One may consider themselves to be a fraud or fear they will be discovered lacking knowledge or skills (Clance and Imes, 1978) despite external evidence of their competence, individuals may question their abilities when stressed.

Seven of the eight participants expressed doubt about their intellectual abilities and skills and began to question whether they belong at the PNWMU as described by their *cuentos and* counterstories. Consuelo described her reaction to failing the Step 1 examination the first time she took it.

> I was told well, if you don't pass this, maybe you should think about taking time off. Maybe I don't belong here if they don't think I belong here. Yeah. And I really considered dropping out for a while. I only missed this by a few points. He said you should think about taking time off. Which I took really hard because I was like, I'm trying to stay and I feel like you're giving me the opposite advice, which is really disheartening. Maybe I just don't belong here, this really sucks.

Consuelo's voice tone intensifies with emotion, and she tears up as she recounts the conversation with the faculty member.

> But as a student I'm like, this is not what I want to hear. And if I were to take time off, that puts my back, what? A year? What am I supposed to do with my student loans? Where am I supposed to live? This is not good advice, maybe you should know what's going on in my life before saying I should just leave school for a while. You don't know anything about me. You know!

Consuelo's counterstory received advice that could have been detrimental or ended her career in medicine. The advice reinforced the idea that she did not belong by telling her to take a leave of absence. That contributed to her feeling that she doesn't belong in medicine and is a clear example of how internalized racism shows up as the Imposter Syndrome. José was excelling after receiving his educational accommodation and yet he questioned his intellectual ability. He disclosed the following, "My experience overall in medical school has been difficult because I do not believe in myself very much. I think it wasn't until I really snapped out of that little trance that I had been able to become more accomplished and fulfilled."

José is describing the Imposter Syndrome and yet, he was "acing" all of his exams. This demonstrates that the feeling is not reflective of reality. When asked about strategies on how to overcome Imposter Syndrome José said the following,

> I self-directed myself. I can't self-doubt. People are going to rely on me. I have to take the role of being the provider. I spoke to my friends, spouse and therapist. Just every day I would say to myself you're going to say negative comments about yourself. Just say this could happen, but this is what is going to happen. So, try to motivate myself and boy did I see a big difference.

Karla shared about the conditions that contributed to her feelings of inadequacy. She said,

No balance, stressed and questioning myself. I needed help validating a boost in my confidence. It's hard. I questioned myself after not passing Step1 on my first attempt. I needed help but I didn't know where to seek assistance.

Clearly, the internalized racism that the participants endured showed up in multiple ways. The findings spoke about mental health well-being, cultural and linguistic taxation, and imposter syndrome. These all contributed to the barriers the participants identified through their *cuentos and* counterstories which they shared about their journey to become physicians. The next and final theme to be presented is familismo.

Theme 3: Familismo (Facilitator)

The final theme that the findings point to is a facilitator for the participants in this study. The third theme is *familismo (familism)*, which is a Latino cultural value that encompasses family structure, relationships, and strong ties to the community. F*amilismo* conveys a sense of loyalty to family, respect for elders, *ser servicial* (to be of service to others), and to promote and support the Latino family well-being.

Familia y Comunidad.

The participants all spoke of missing their family members while they were at PNWMU, and each dealt with their feelings in different ways. For example, Consuelo decided to alleviate her loneliness by adopting a cat. She also said that she "made Puerto Rican food to feel closer to home". It was evident through the participants' *cuentos and* counterstories that their family played a critical role in their identity and connection to their cultural roots. Carlota spoke about this during her interview and said:

> Being with family, close to parents, aunts, and uncles is important to all of us. I have carried this with me through my life and something I will continue to pursue. I miss my family and try to go visit when I can. They also come from time to time to check on me. My father is college educated but doesn't know how to help me in medical school but he is here for me. I miss them so much.

Carlota's *cuento* revealed how she loved and missed her family and also how her family loved her but was unaware and unable to comprehend the demanding curriculum and expectations in the PNWMU environment. José echoes Carlota's connection to family as well. In particular, José's identity and cultural connections were instrumental in facilitating his persistence. He said,

> I speak to my mother every day. When I speak to her, I am reminded of her tortillas. I like to have a little essence of home with me. It brings back memories when I was a kid, of when my mother made me feel grounded and made me feel stable. Coming from a poor family makes it hard being enrolled in a professional program to receive guidance from my parents. My parents are not able to help me at this point of my journey. I vent sometimes, a little bit of frustration to her and she hears me out.

Like Carlota, José felt the love and support of his mother but also acknowledged that his family was unable to understand or guide him through his studies. However, his family and cultural connection sustained him. José further explained how he uses his faith in absence to fill the void since family is far away. He said,

> I wear this blessed cross that my mother gave me with the idea that it helps protect me and guides me through difficult times. I carry this because it gives me

> a sense of security being far from my family. It gives me a sense of comfort and stability when I am rounding while taking care of patients. I speak to God every day. I used to go to church very regularly last year, but now what stops me is the schedule. My mother prays for me. My mother tells me no matter the hardship, have faith in God. My mother says, we are Latino, ask God for help and he will get you through this difficult time.
>
> For José, his spiritual and religious beliefs were an important part of his journey. Religious traditions are often seen as part of the Latino cultural and identity as being a whole person.

Javier agrees with José and Carlota about how his family couldn't help supporting him academically, but his parents' encouragement was instrumental in his perseverance. His father serves as his role model as he describes in the interview,

> The first four months were very hard for me. My parents don't understand how competitive medical school could be. I try to protect them from it all. I miss my father. He inspires, motivates me, and is my role model, despite only acquiring a sixth-grade education. I see my father in person maybe once a quarter because of financial costs, work schedules, and my school schedule. My parents tell me they will pray for me. After medical school, I feel it's time for me to go back home, be with my parents, take care of them, and be more immersed in the community. Because that's what got me on track in this journey.
>
> Like José, Javier's cultural connection to his family and faith are inseparable. He knows his parents pray for him and in turn, he also practices his faith when going through loneliness or a tough time.

> I have a cross my grandma blessed, and I have it with me. It just kind of keeps me sane. Kind of like an outlet. It gives me someone to cry to. Javier's cuento resonated strongly with the theme of *familismo*. His commitment to return home when he becomes a physician is a clear example of caring for and loyalty to his family and community.

Adela, also talked about how her family kept her grounded while in medical school. She said,

> My father is the most inspirational person in my life... He is dedicated to the community and only visits me from time to time given our schedules. He is my role model and holds the legacy of our family. I also miss my *abuelita* (grandmother) who helps keep me grounded.

Melvin speaks of his mother and father as the guides which are part of *familismo* illustrating the need for social and emotional support. "My mother has been my rock and kept me straight since I was a kid. We would spend summers with my grandparents in Mexico. I was taught that family always came first."

Each of the participants brought their family's *consejos* (advice) and inner strength and resilience that comes from the support and love, as well as the roots of their cultural traditions. These assets contributed as facilitators for all of the participants at PNWMU.

David is supported by his mother and is one of two participants who sees his mother more often because he is from the Pacific Northwest but also found it hard for him to stay connected due to his academic schedule.

> My mother is my inspiration and demonstrates hard work, discipline, and instilled in us family values. There was never a moment in my life where she did not prioritize education but the most importantly is our family. I am lucky I can see my mother unlike my peers who miss their families who are far away. I am Catholic. I use my mother and religion as fortitude and keep both beside me.

David further reflects on his journey in medical school and like the other participants, he notes the importance of his family and culture,

> The medical school journey has made me reevaluate and reprioritize what is important in life. I think it's difficult for everybody but think especially for those of us who are family oriented and hold our culture. For me it's a hard balance between discerning what is professional, such cultural assimilation, and what is retaining values of my identity, and retaining what makes me a person, which include how to talk, how to dress, how to act, and how I seek family.

Participants acknowledged that their families were their foundation and were always there for them regardless, even if they didn't understand the academic journey they were facing. Through familial emotional support, culture, and tradition all participants were able to navigate PNWMU. The role of mothers and fathers became clear in each of the lives of each participant where the family's dream revolved around their son and daughter's chosen profession in becoming the first physician in all eight families. Frequently, participants indicated their parents supported them throughout their lives with cultural wealth (Yosso, 2005) to build upon their strengths and assets of being raised with *familismo* in their family. The strength of each participant came from their families' cultural beliefs and values and also through the persistence of each participant who

aspired to become a physician. Three participants spoke about how they were also seeking guidance and support similar to the type of relationships they had with their families. David, José and Karla spoke about how they felt when they received reassurance, validation, and confirmation from their attendings, instructors, and administrators which spoke to the relationships and validation they were seeking.

> Last week one of the doctors who I've worked with for the past year emailed me saying, 'You did a tremendous job this past year. If you need a letter of rec, I'll be more than willing to write you a good one,' and things like that are good, moments that affirm what you're doing and affirm that you're not just wasting time… I forwarded it to my mom. So, it was reassuring to get that type of support.

José, shared that having support from attendings was key to his ability to thrive. There was one pathologist who was always affirming my hard work…that just goes a long way. I think that is the reason why I continue to do this journey in medical school." Finally, Karla shares the story of when she failed to pass Step 1 and how the student affairs administrator came to her aid which made her feel that someone cared about her as a person for the first time after two years as a medical student at the PNWMU. Kala felt after that incident this administrator was the sole person who cared for her success and felt she had established a connection. Karla said the following,

> He just took the time to just understand and help me. I remember sitting in his office. He then called a person into the room, was responsible for schedules and logistics and was advocating for me, "This is what Karla needs. How do we make this happen?" And in front of me he would be navigating what this would look like, so that I felt included in the process, when some of the other people ... It was

very much, "We are so sorry that this happened. This is what's going to happen. You need to pass by this date. You have as much time to study.

From these *cuentos and* counterstories we can see that the family and supporting attendings are the cornerstone that allowed the participants to continue in their journey. This was clearly a facilitator that assisted them along the way. Another facilitator that the participants spoke about was the Latino Medical Student Association (LMSA).

Latino Medical Student Association (LMSA).

During the interviews of the eight Latino medical students, all individually discussed the importance of supporting one another by building a sense of community through the Latino Medical Student Association (LMSA). The Latino Medical Student Association is a 501 © (3) a non-profit organization founded to represent, support, educate, and unify US Latino medical students (LMSA.com). The LMSA is composed of five regions spanning throughout the US: Northeast, Southwest & West region. The PNWMU is represented as part of the West region encompassing the Pacific Northwest and the Southwest of the United States. Each medical school has the ability to establish a chapter to belong to the national organization. Furthermore, the LMSA also serves as a voice and vehicle to promote recruitment and retention of Latino medical students while also serving as advocates and in service projects to promote Latino health care issues.

Building a shared sense of community helped counteract being alone and combated the feeling of loneliness and lack of self-belonging - they sought out the friendship and support of the membership of the Latino Medical Student Association (LMSA). The LMSA welcomes all medical students who identify as Latino/Hispanic or those individuals who seek to serve as an ally and are interested in the mission of LMSA

are welcomed to join the group. All eight participants discussed the importance of bonding and supporting each other which they immediately connected when they found each other in their current class or within the classes ahead of them or behind them. Karla explained the LMSA provides a sense of community and familial connection within the group.

> I feel we're all very in tune with ourselves, and how we identify ourselves, I feel like that makes us comfortable talking about our issues with each other. It's just really easy to talk to them because they're all really compassionate and empathetic. We can all kind of understand a little bit better. The LMSA, I think we are a very tight knit group. I really appreciate that. They feel like family. I feel like the four of us in LMSA and other classes have four of them, they just feel like my brothers and sisters. I feel like we really look out for each other. Every time I see one of them, I'm like we really look out for each other, I'm like, and I missed you so much. I don't have any family here. So I feel they are kind of like a little mini-family. We also leaned on the Student National Medical Association (SNMA) that is a historical Black student medical association. We were both really small groups and did a lot of things together. I think that was really helpful too.

In using the word "family" to describe her feelings and relationships with the other students, this extends the reach of *familismo* as she experiences an extension of family. She wasn't the only one who felt like this. Melvin reflected on the lack of representation and how LMSA helped.

> I think the expectation was that LMSA and SNMA would be working very closely together because we were both so small and had very similar goals. I was technically on the leadership board. The LMSA represented a familia (family) at the PNWMU and provided an enclave of safe space and support.

Javier also found LMSA provided a place of support and noted "I think it was probably one of the major things that kind of kept me on the medical journey. I was aware of the LMSA, probably a sophomore in college". For all the participants, LMSA was a family which as a collective and united group gave the participants a source of guidance, encouragement, mentorship, and safety within the group. When many felt discouraged, uncomfortable, unsafe and questioned their existence at the PNWMU, the LMSA was their family away from home. The local, regional, and nationwide networks of the LMSA provided an environment of bonding and gave a familial connection within the LMSA as *el colectivo (*the collective). Participants spoke to the importance of having peer mentors and support from the LMSA.

José explained the LMSA members supported his learning, "Academically, they took time to explain things to me, giving me the background on how I should approach, how I should go about studying for it…quizzing each other. Adela continues to explain the unity of LMSA. It's not just support, but just the solidarity I have with my fellow classmates, especially my close ones, seeing the struggles they go through and seeing them persist as well. They're a year closer to finishing than I am."

Javier reaffirms the importance the LMSA membership holds to help facilitate his success along his journey.

> My peers have been a positive force. They've only been an encouraging, positive force. We help each other. We're students. We recognize that we're really at the bottom of a hierarchy and we want to succeed. We want to be who we are, so we share notes, we share ideas. I teach them certain things. They teach me certain things. We have conversations. If there's something really that I don't understand they say, Oh I read about that. Here let me tell you about it.

Carlota further noted that the group is united and close "I know that we have a comradery among each other and so that when something goes sour ... Or we can turn through each other pretty quickly." Participants appreciated the safe space, support, and strong connection Latino Medical Student Association (LMSA) provides to their community. LMSA also provides a space where students are able to see others who look like them or share the same cultural traditions, values, a second language or come from a similar background. David describes his experience with LMSA,

> The LMSA regional meeting was very empowering. I was very surprised at the amount of work, motivation, and intelligence that each school brought. It was eye opening. It provided some sense of national or statewide community. Also met fellow students in other institutions working towards similar goals. They hit issues on how the environment feels on their campus to national issues including the dynamics between nurses and providers. Our close partner that we most frequently communicate with is the West Coast University. It is a bit of a challenge… I have been involved with the LMSA and think it is a very, very valuable program. It's another thing that played a big part of my undergrad, when I participated in the mentor mentee program when I was a junior in

> undergraduate, and being paired up with a Latin mentor, who I ran into recently. He is now and M.D. Ph.D. student. I think he is very valuable and being able to relate to the experiences and find solidarity in that aspect.

From David's cuento, we can see that the organization was instrumental in providing a mentor in his undergraduate education. The Latino Medical Student Association (LMSA) brought the group of participants together across different medical classes and provided opportunities to network and interact with people they might not have otherwise met. It is clear, the LMSA brings students together who are interested in the health and well-being of the Latino community, while providing social and professional support to Latino/Hispanic medical students. Non-Latinos are also welcomed to partake in LMSA by serving in community service involvement to address health disparities. The LMSA works collaboratively with the Student National Medical Association (SNMA) at the PNWMU. Consuelo also identified the LMSA to serve as a connecting force to bring different Latinos of the different medical classes together. She spoke about mentoring other students, in order to pass along knowledge that she learned along the way. She wanted to share them with, especially the younger ones, especially because they're about to start wards or they have just started wards, just to be like. "Just so you know, this is what it's like." In addition, LMSA created opportunities for community service. Consuelo reflected on this aspect of their activities,

> I'm like, I don't know when I'd have time to do volunteer work, because in my mind I wouldn't even put LMSA and volunteer work because it's just something I like to do almost, because you're giving back in a different way. To your own community versus out in the community sometimes. You do things out in the

> community but I'd say most of my work is like mentoring other medical students or putting on events for other medical students and stuff like that or bringing light to issues in the community.

Serving the community was not only a part of the LMSA mission, it also resonated deeply with the participants. *Ser servicial* (to be of service) is a strong Latino cultural value, which several of the participants spoke about. For example, José talked,

> I think what helps me thrive through all this time is my ultimate goal. I want to be a great provider to my community. I want to be a great example for future providers. Sometimes I think in the midst of going through a lot of medical information, feeling bogged down and very tired, I have to just simply remind myself of what my goal is…I want to make a positive influence, I think, about my maternal grandmother who died of cancer, and what I can do for future cancer patients and their families. That is what keeps me going.

LMSA provided support and facilitated the advancement of the participants in multiple ways. Adela shared the following,

> The biggest resource I use now are my connections. If I want to learn more about a residency program at a school, all I have to do is reach out to a few people and I can be in contact with students, residents, and even faculty at that school. LMSA is a large network of people with similar goals including mentorship. I loved LMSA to collaborate and attend LMSA summits. LMSA inspired her to be a doctor. LMSA Latino Faculty members supported me and told me to dream be a doctor if that is what you want.

> There is an empowering feeling to being supported, and to have resources and people to call upon during medical school. Karla said Peers help me learn what to expect and what to prepare for rotations and not get blindsided by the residents or attendings. Finding people to help facilitate their journey was what helped the participants persevere. Carlota described the LMSA community, with whom she culturally identified, in medical school.
>
> I have friends in medical school who are majority from minority groups and LMSA. I feel like we are very in turn with ourselves and how we identify with ourselves. I feel like that makes us comfortable talking about our issues with each other. It is just really easy to talk with them because they are all compassionate and empathetic. We can all understand.

Through the cultivation of support networks, the participants appeared to recreate the supportive elements of their "family" within their new environment of LMSA. The strength derived from the support and encouragement within the cultivated networks facilitated the academic and social development of the participants. To understand this theme of *familismo,* we look to Yosso (2005) who describes familial capital as a component of the Cultural Wealth Model.

> Familial capital refers to the cultural pieces of knowledge nurtured among familia that carries a sense of community, history, memory, and cultural intuition… this form of cultural wealth engages a commitment to well-being and expands the concept of family to include a broader understanding of kinship. From these kinship ties, we learn the importance of maintaining a healthy connection to our community and its resources (pg. 79).

In conclusion, the theme of *familismo* (familism) was the hidden gift with much meaning that the participants brought with them to the PNWMU in pursuit of their dream of becoming a physician. This dissertation study found that Latino medical students deeply value *familismo* (Arditti, 2006) which supports the findings between family and community (Calzada et al., 2012) which they benefit from family support and *consejos*, as a strong collectivistic cultural group value. In summary, the findings found that the participants navigated two different worlds and the journey of Latino medical students is unique in comparison to being placed as a group categorized as URiM medical students in medicine. The next chapter will take a step back to review the reasons for this dissertation study and the theoretical framework that was used to guide the analysis.

Chapter V: Discussion

This chapter consists of introducing the purposes of the study, the theoretical frameworks used to analyze the interview data, research questions, and background of what led to this research study. Next, followed with a summary of the findings highlighting the barriers and facilitators that Latino medical students encountered during their journey at the PNWMU. Selected "voices" as presented by the participants are highlighted to be followed by recommendations and final thoughts.

Purpose of Study

The purpose of this qualitative case study was to explore the observations and experiences of eight Latino medical students who were in their second and third years in medical school at the Pacific Northwest Medical University (PNWMU). Participants were interviewed using in-depth phenomenology multi-case interviews (Seidman, 2006) to capture their lived experiences and explain the phenomenon of URiM Latino medical students at one site. The first objective of this study was to provide a safe space for Latino medical students to collect their *cuentos* referred also as counterstories (Delgado, 1989). This allowed participants to name their own reality (Delgado & Stefancic, 1993). The second objective was to provide an understanding of barriers and facilitators impacting Latino students' social and academic success as self-reported experiences in a learning medical environment and to assess the climate in the classroom, clinical setting, and social context of their lives. Finally, the third objective of the study was to document medical students' perceptions and experiences of the premise, scope, and type of racism impacting participants.

As mentioned in Chapter I, the PNWMU conducted a qualitative and quantitative survey in 2014 and put forward an admittedly imprecise question on the survey which focused on whether students "witnessed or experienced discrimination". This initial question was problematic because it did not separate out whether students of the PNWMU witnessed or experienced racism. The flaw findings of the initial PNWMU survey question pointed me as the researcher to want to learn more about the experiences of URiMs at the PNWMU which inspired the investigation of learning about the journey of Latino medical students through this dissertation study. The literature review as presented in Chapter II Reveals racism exists in academic medicine but what is not clear is who, where, and what types of acts and behaviors of racism take place in the medical school learning environment. Which also led me to want to learn if racism was a barrier in their journey plus to identify facilitators of persistence. As an administrator in academic medicine, there was also an interest in sharpening support for social justice, equity, by bringing forward the "*cuentos"* of Latino medical students to learn of their journey.

Theoretical Framework

The application of the overarching theoretical frameworks for this study used Critical Race Theory (CRT) (Solórzano & Villalpando, 1998) to facilitate a deeper understanding of the lived experiences of the participants. Latino Critical Race Theory (LatCrit), an extension of CRT, enabled the researcher to better articulate a more focused examination of the unique forms of oppression through a socio-cultural context. (Solórzano Delgado & Bernal, 2001). Latino Critical Race Theory (LatCrit) was applied to deepen the knowledge and findings by centralizing and validating the intersecting

dimensions that unite Latinos through ethnic identity, culture, language, and other elements that unite Latinos (Yosso, 2005). The below questions guided the development of this research.

Research Questions

The following questions guided this study and served as the protocol for the in depth phenomenologically multiple interviews (Seidman, 2006) as follows:

1. Interview One: What factors impede the experience of Latino medical students?
2. Interview Two: What are the factors that facilitate a positive experience for Latino medical students?
3. Interview Three: Reflection on the Meaning: Participants were asked to reflect on the meaning of their experience and make sense of their experiences.

Synthesis of the Findings

Findings were collected from four Latino males and four Latina females who were enrolled as either a second or third-year medical students at the PNWMU, and who provided detailed enriched qualitative data of their “lived lives" stemming from *cuentos and* counterstories as recounted by the participants of this study. The findings were analyzed under the tenets of Critical Race Theory and the subset of Latino Critical Race Theory (LatCrit) and resulted in three themes which emerged from the collection of multi-in-depth interviews in which exposed oppression, racism, acts and behaviors against social justice and equity. (See Figure 3 for an Overview of Findings, p.92). Displays the view of the lens used in the analysis of the in-depth multi-interview data analysis and the outcome of the three identified themes which include Alone and Lonely (Barrier), Racism (Barrier), and *Familismo* (Facilitator).

The three themes emerged strong with the support of the rich information collected from the participants. There were multiple codes listed under each of the three themes and it became important to note that all of the themes were interconnected and that the *cuentos and* counterstories of the eight participants revealed the overlapping nature of their feelings, their observations, and experiences with racism and microaggressions, and how their cultural heritage and a strong sense for *comunidad* (community); *el colectivo* (the collective) held strong which was supported by their persistence during their journey at the PNWMU in their quest to become physicians.

Theme 1: Alone & Lonely (Barrier)

The findings of this study indicate that Latino medical students experience multiple barriers in the medical learning environment. The first theme that emerged from the interview data reflected how the participants saw themselves and how they felt while attending PNWMU. This theme came from "In Vivo" codes of "Alone and Lonely." Alone refers to being in a physical space where you perceive no one looks like you (cultural/phenotype), nor represents your cultural traditions, customs, language, and values as an ethnic group. Participants were alone by the lower number of Latino classmates within their entering class but also within the school at the PNWMU. On arrival at the White Coat Ceremony and at Orientation Latino students did not feel represented in numbers and could not visually identify other Latinos which made the participants feel alone. These experiences of being the only one or one of the few were significant and stood out for the participants.

The selected following quote captured the experiences of many upon their arrival to the PNWMU "It felt scary at first for me, because the question that popped into my

mind was where are my people?" "Oh my gosh zero. I didn't see anyone. Out of about 140 students, I was the only Latino there." Participants also felt unrepresented coming from a cultural and linguistic member of a group from the start of their journey as learners. Participants noted because of the lack of representation among Latinos, as an ethnic group, found their voice to be minimized by the majority of their White peers when it came to group discussions. Adela captured the storyline by describing how their small number of representations, as Latino medical students put them at a disadvantage by not allowing their culture and their voices to be heard as she described "We think about things differently. And as Latinos we are more aware of different issues affecting our community that our peers may not be aware of. We didn't end up doing the immigration session. We voted and ranked them and debated them. At the end the topic of immigration was not selected. The group decided on the topics. So, it was like, two against a hundred and thirty or so." In addition, they exclaimed that by not having Latino student representation, they were unable to gain support for events of social justice or health equity issues because they represented a small number of ethnic students. Participants noted they felt their voices were silenced or limited given the nature of their interests for social justice, observing other colleagues who they felt were not as interested in diversity or health equity issues like them. Further findings found the participants were disappointed by not seeing or interacting with Latino physicians. The scarcity of Latino physicians as role models was emphasized by each participant in not being able to see themselves mirrored in the medical profession within the classroom and/or clinical areas. Karla noted "I could not visualize myself. No role models." Participants also spoke about how they noticed the lack of Latino physicians among instructors, residents, and

attendings adding them to feel alone and lonely as an ethnic group. Lonely is described as the feeling of being lonely, sequestered, not being understood or supported by faculty, residents and administration. Not having a presence of U.S. Latino physicians predates as far back to the early 1900's documented in the Flexner Report, when racism and segregation purposely excluded Latinos and other racial and ethnic groups from the medical profession of medicine (Nivet, 2010).

Other barriers found in the findings revealed participants experienced being isolated and disconnected from their family and cultural community, which exasperated them to feel more alone and lonely given the distance, schedules, lack of resources, and lack of family personal connections between the participants and their families. All participants spoke about how their parents and family members did not understand the complexities of the participants attending medical school, but noted they firmly **v**alued their aspirations and career professional education in medicine which was analyzed to be a facilitator. This speaks to the counterstories that Latinos do not value education, which is a stereotype and part of racism, when in fact all eight participants excelled academically and all families of participants held high aspirations for higher education prior and during arriving at the PNWMU. The backgrounds and profiles (See Chapter IV) of the students varied by generation, make up of races and ethnicity, spoken language fluency in Spanish, phenotype and physical appearance etc., but all identified as being Latino medical students and shared common cultural values, upbringings, and traditions. Five of the seven participants were from out of state and were far away from their families, communities, and hometowns. In summary, the alone and lonely theme refers to

the Latino participants feeling alone and lonely during their journey which participants noted impeded their academic and social journey during medical school at the PNWMU.

Theme 2: Racism (Barrier)

The second theme that became the main finding in this study was how Racism infiltrated into the encounters that the participants had individually and as a collective group experienced at the PNWMU which emerged as a major barrier in their journey in medical school. The conceptual framework used Critical Race Theory (CRT) proposes that "racism is endemic in U.S. society, deeply ingrained within the legal, institutions, and social constructs" throughout our social institutions (Tate, 1997, p. 234). Accounting that Latino medical students are situated in an institution of professional-level medical training, CRT theory applies due to the historical nature of racism found in medical schools in the United States (Nuriddin et al., 2020, Nivet, 2010). The theoretical framework of Latino Critical Race Theory, referred to as LatCrit, was applied as a subset to better understand the participant's journey as Latino medical students in its application to the second theme of Racism. In this dissertation study, the definition for racism is defined as the belief that humans possess and exhibit different behaviors and actions corresponding to inherited attributes based on the superiority of one race or another. It is said to show up in the actions, believes, practices or in systems of prejudice, discrimination, and ranking of superiority against others because they are of different race or ethnicity (Cooper, 1986). All participants provided a description of the term racism and used similar language and concept, indicating they were familiar with the term and description. In addition, Jones (2000) posits there are three different levels of racism which include: Institutionalized Racism, Personal Mediated racism, and

Internalized Racism which can permeate in climate, policies, structures, and within human interactions between different races and ethnicities. After thorough analysis, the findings revealed the participants experienced all three levels of racism within the theme of racism emerging throughout. The finding's revealed racism was permeated at different levels and by different interactions within the journey of the participants as Latino medical students. There were multiple barriers that will be described below. We begin with Institutional Racism findings that served as a barrier per "voices."

Institutional Racism: Lack of Mentors. The participants spoke about the lack of support from faculty members and upper-class medical students who were assigned by the PNWMU to serve as advisors and sibs. A coach is a faculty member who is assigned to support medical students as advisors and sibs are peers assigned to support their peers from a lower class. The participants of this study described there was a lack of relationships with their coaches and sibs and found their pairing to be inadequate and meaningless. Some participants did not know when the last contact between them had been made while others did not recall the names of their coaches or sibs. José said "I never had interaction with my assigned coach and peer mentor. I think one of the major struggles was trying to adjust and get used to medical school, I was trying to adjust to being in a new place. And I don't have that support structure that I wished I would have had in medical school." and further supported in agreement by Melvin "My coach was not helpful to me. My sib I don't remember who that was."

Overall, participants felt that they did not have the support of their assigned coach and sib which served as a barrier in their student learning and navigation at the PNWMU. The participants strongly emphasized they did not feel the PNMWU coaches and mentees

were supportive of them as diverse students, attributing lack of support, and mentorship. The lack of guidance served as a barrier to their learning and navigation did not allow them to form important relationships in order for them to be successful as per the participants. Developing personal student-faculty relationships is important to students who are benefiting from individual advice and improve medical school performance (Frei et al., 2010). As told by their *cuentos* and counterstories, findings reveal participants believed their assigned coaches and sibs were either not interested in them as participants nor knew how to communicate with them as Latino medical students. The lack of resources, whether people, experiences, or lack of obtaining social capital from their assigned coaches and sibs created a situation where institutional racism showed up per the *cuentos and* counterstories as observed and told from the participants.

Institutional Racism: Lack of Resources. Participants of the study noted that PNWMU did not help them facilitate their journey impacting their learning journey. They felt they did not have the proper support, resources, guidance, and/or knowledge during their journey in medical school when they failed Step 1 which is a one-day examination with an estimated 280 questions focused on the basic sciences in medicine and a test required during the second year of medical school. The findings of this study revealed the participants, who did not pass Step 1, spoke about the barriers they faced with retaking the examination and were not able to secure resources and support from the PNWMU. Participants who failed Step 1 were told they were not eligible for tutoring. Participants noted they did not know of the set criteria to access tutoring or reference. David's quote captures the experience of the findings of the majority of the participants who did not pass Step 1 and said "No post-tests, no follow up, no guidance, and no response. I just

gave up on receiving any help from those who are supposed to be helping us." Karla explained tutoring was only available for students who are not passing within the coursework. Because she was not failing any of her course work, she and others could not access tutoring services at the PNWMU. For those who could afford a tutor they sought services to help them prepare to retake the exam. Karla was the only one who was able to hire a tutor. Others did not have money to hire a tutor, instead they studied on their own and with others who didn't pass the test as a group.

Findings also reveal some participants felt disadvantaged for not coming from a family of physicians and felt they didn't have a compass to guide them feeling disadvantaged in knowledge, process, and what to expect on the test and along their medical journey. In summary, not having support, guidance, or mentors, are examples of not having access to resources align to the definition under Institutional Racism, which Jones (2000) describes as "having differential access to goods, services and opportunities by race." In this case, PNWMU did not have a structural support system for medical students who did not pass Step 1 exam nor offered bridge monies to help them access alternative resources. The overall findings as per the reported "lived experiences" of the participants noted they felt the PNMWU was not supportive of racial, ethnic, and minority students and did not take into account their social economic status nor other lived cultural experiences to meet their academic and social needs. The next section will focus on personalized mediated racism.

Personalized Mediated Racism. Personalized Mediated Racism is the act of prejudice or discrimination directed against an individual or against a group of persons based on their membership in a particular racial and ethnic group. (Jones, 2000). The

analyzed data revealed the climate at the PNWMU revealed a journey encompassed by racism acts and behaviors caused by different groups of individuals displaying different types of racism and microaggressions. These findings reveal racism was a major barrier in the journey of all eight Latino participants in this study, who experienced daily microaggressions. Personalized mediated racism were daily acts or behaviors that experienced as part of their individual journeys and described in detail through numerous *cuentos and* counterstories whether they experienced or witnessed racism and were able to describe the incidents of microaggressions directed at them ranging from their peers, instructor, attendings, residents, and patients. Participants were also able to identify the perpetrators, identified where these acts and behaviors occurred, provided details of incidents and recounted of conversations that took place and pinpointed to classroom, small group discussions, and occurring in the clinical areas.

Microaggressions & Classifications by Type. Examples of microaggressions will be presented next. The below section will speak about racism as a barrier (See Figure 4 on the Types of Microaggressions on p.117). The definition for microaggressions are described to be intentional or unintentional actions, behaviors, and environmental embarrassments that come across as hostile, derogatory, and negative racial insults toward people of color (Sue et al., 2007). Classifications of microaggressions include: Microinsults, Microassaults, and Microinvalidation and were all identified in this study per the captured *cuentos and* counterstories as told by all participants of this study. Under the Personalized Mediated Racism level findings found that racism and microaggressions were enacted upon Latino medical students by their peers, instructors, attendings, residents and patients. Internalized Racism was also identified as serving as a barrier

which revealed how Cultural and Linguistic Taxation, and Imposter Syndrome came into play given the hostile climate that surrounded them at the PNWMU.

Racism Exhibited from Peers. When asked about incidents in the classroom where participants witnessed and /or experienced a racist incident, the participants provided many examples of incidents which the researcher classified them by type of microaggressions within Chapter IV as part of the analysis. Findings revealed *cuentos and* counterstories revealing stereotypes, name-calling, to not engaging to support diversity and health equity etc., which were examples the participants shared with the researcher. Small group discussions with their peers ranging from scholarship monies to social settings the participants described examples of how they experienced racism, stereotypes, and biases from their own peers during academic and social settings.

Racism Exhibited by Instructors, Attendings, and Residents. Within a medical school setting, there are hierarchies and different levels of power they hold over a medical student during their instruction, which takes place in the classroom and in clinical rounds. In addition to the sensitivity to the power differential, participants brought their own cultural lens to be respectful of elders and people in positions of authority even when they experienced racism and microaggressions. This finding revealed that Latino students many assumed they were not from the area, were raised outside the USA, and were stereotyped at times felt were not treated fairly or equally in their treatment. Participants felt hurt and were exhausted by the constant asking about their origin and heritage, and assuming they were immigrants to the U.S. Some instructors displayed stereotypes in their curriculum delivery as well. Some participants spoke about their exposure to racism and microaggressions when they received their

clinical evaluations from attendees. An example would be the case of David where he told a cuento of his preceptor who conveyed a message to David that he wasn't smart enough and therefore, only gave him feedback on his personality. Javier, like other participants, understood they were being judged on an expectation that was not a part of their cultural norms. In summary, the role of instructors, attendings, and residents in general is to provide instruction to the medical students. However, the reality of the participants' experiences found that instead of learning, they were being judged and treated differently than their White peers according to their counterstories. Next, we learn of the participants' interactions with patients during clinical encounters.

Racism Exhibited by Patients. Latino medical students were exposed to patient acts of racism and microaggressions that ranged from indirect to direct blatant racism. The participants experienced emotional pain as they were exposed to abusive remarks and microaggressions during the process of providing care. Findings revealed all eight participants were sent subtle and direct behaviors, messages, and actions that were considered to be biased, racist, or placed stereotypes on them. This created an environment that was not conducive to the participants' learning or sense of belonging. All eight participants experienced similar types of personalized racism which included microaggressions. The racism they encountered from the patients was the most damaging in comparison to others at PNW from the researcher's perspective in the analysis of the findings. Participants were exhausted by the constant asking about their origin, heritage, and questioning of their existence within the space. Findings found that phenotype played a significant role in who received more acts of microaggressions or racism. Participants who were darker in skin phenotype received more harsh language and were demeaned at

a greater level compared to participants who lighter skin tone. José shared a painful incident:

> There was a White female patient who said “wait a minute” as she interrupted the attending while in consultation, as he asked her a medical question. She didn’t address the attendings' questions. Instead, she turned directly to me and said “Are you Filipino?” I was standing up there asking myself does it really matter whether I am Filipino or not? I was really perplexed by the question and the team was making an expression trying to figure out where did that question come from but they all said nothing. I responded and told her “No, I am Hispanic and I’m from Los Angeles.” She continued to ask me more questions. “Oh really how did you get here? What are you doing here? My attending didn’t stop her. He said “Well Mrs. So So “So sorry to interject but we really need to discuss this important question” he said to her. My face was just turning a little red and I was like it was really awkward. I think there was that moment of awkwardness and embarrassment. I didn’t know what to do or what to say. No one said anything, not even my peers. (Microinsult: Second-Class Citizen & Microinvalidation: Alien in Own Land).

These stories as told by the participants revealed all acts of microaggressions were directed by patients who were White elderly men and women and who lived in both urban and rural areas. In summary, microaggressions of different classifications occurred in both the clinics and hospitals while under the supervision of attendings and residents. Instructors, attendings, and residents remained silent and did not act to protect, nor interrupt these acts of personalized racism when directed at Latino medical students who

were harmed. Latino male participants were more prone to receive microassaults and microinvalidations from the patient populations. Participants described attendees, residents, and peers said or did nothing to interrupt or redirect the patient when they in the room. Next, we discuss the findings for Internalized Racism.

Internalized Racism. Jones (2000) describes internalized racism as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth." (p.1213) The impact of having to endure personalized racism and institutional racism funnels into the lives of the Latino medical students and shows up as Internalized Racism which is identified to be a barrier. At the most dramatic level, internalized racism shows up in medical school of losing hope, feeling down, and feeling resigned. Findings revealed participants spoke about feeling demoralized, saddened, and reluctant to share with others of their mental and emotional state of mind. Medical school is stressful and may impact mental health (Neufeld & Malin, 2021) and adding the encounters of racism adds more stress but participants kept their feelings and status of worry to themselves. Distress of the impacts of distress is an area not well known about minority students in medical school Dyrbye & Eacker, 2007). Seven of the eight participants noted they either worried about their own mental health and of their colleagues' mental health status. The participants noted that Latinos, in general, do not disclose mental illness as it could be considered to be a sign of weakness for some. Others fear being found out about their well-being.

Only one participant sought counseling services and was open about his strategies to address his stress levels. Carlotta, Karla and David and others revealed they kept to

themselves although they could have benefited from therapy but relieving their struggles would make them appear to be weak. Revealing were the role family played in this space as participants reached out to their parents, family and others within the community. Next, cultural and linguistic taxation is exposed as part of internal racism which can be seen as additional stress being placed on Latino medical students.

Cultural and Linguistic Taxation. Part of the internalized racism that the participants experienced revolved around "cultural/linguistic taxation." Participants were frequently asked by residents and attendings to interpret for the rounding teams. Often, assuming participants could effectively communicate with Spanish-speaking patients during service. Findings revealed the participants felt taxed and overwhelmed when being asked repeatedly to translate. Some participants felt they had the proficiency to provide Spanish medical interpretation but other participants felt ill-equipped to handle it due to their lack of fluency in medical Spanish causing them stress. In addition, some participants felt conflicted because they were not certified medical interpreters and wanted to ensure Spanish-speaking patients received equitable information and care. Seven of the eight Latino medical students were asked repeatedly to translate instead of the attending or resident calling a certified medical interpreter. Seven out of the eight participants had a first and last surname in Spanish. Only one participant had an English name and was never asked to translate because he was not associated with being Latino due to his darker phenotype and non-Spanish name. The cultural and linguistic taxation placed additional responsibility impacting their student learning. Cultural and linguistic taxation at times served as an obstacle as learners but participants also found themselves conflicted by having a sense of responsibility to Spanish speaking patients. Participants

explained how they never declined to serve in the role as an interpreter because of the hierarchy and because they were being evaluated by the residents and attendings. Adela, José, and Carlotta and others described how the cultural and linguistic taxation impacted the unspoken role as an interpreter and serving as a cultural navigator for Latino patients, with whom they felt a sense duty to interpret. It was an internalized process and conflicting pulls for the participants, as Adela acknowledged she was a learner and should not be expected to translate. She said, "I'm here to learn medicine. And many times, I would be pulled to translate ... So, I think it gets a little frustrating when it's a pattern." Adela's cuento shows the push & pull dynamic that being asked to translate created. Another finding that because they are bilingual and bicultural there is also an additional responsibility for the participants to provide culturally responsive care by watching for cultural cues in communicating with Spanish speaking patients since their attendings or residents could not provide that skill. Participants noted they were able to navigate and deliver culturally specific care but at times felt a burden was placed on them as learners. Participants also noted many of them were asked to serve as interpreters knowing that certified medical interpreters should have been called but noted using the Latino medical students saved time on their schedules per the attendings and residents. The findings of these *cuentos* and counterstories of internalized racism show the conflicting experiences of being taxed by serving as an interpreter and at times, wanting to assist and also serving as a "cultural bridge" for monolingual Spanish speaking patients. By internalizing the expectation that they translate when requested, the participants accepted the role of interpreter even though they were not certified and were not part of the medical training role. Instead of focusing on their learning, they

unwillingly accepted the role of being “servicial” to their supervisors on the hospital or clinic floor. Serving in this capacity they took on the cultural and linguistic tax that is not asked of medical students in the curriculum and clearly placed additional burden, anxiety, and stress on the participants but also because we're not all fluent in Spanish or knew medical Spanish terminology. Overall, serving as an interpreter was seen as a barrier to their learning but again fed their soul knowing they had a sense of responsibility being bilingual and bicultural. The last type of internalized racism that showed up in the interview data analysis findings is described as the Imposter Syndrome which is described next.

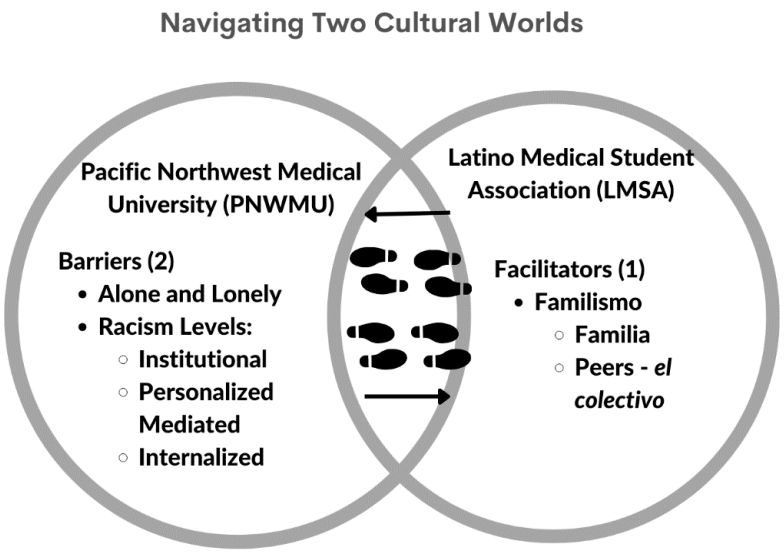
Imposter Syndrome. Imposter Syndrome is described as a psychological occurrence in which an individual doubts their skills, talents, or accomplishments and has a persistent internalized fear of being exposed as a fraud. Despite external evidence of their competence, individuals may question their abilities when stressed. (Clans, 1978) Seven of the eight participants expressed doubt about their intellectual abilities and skills and began to question whether they belong at the PNWMU as described by their *cuentos*. Overwhelmingly, they questioned if they belong based on their academics, exams, and conversations with the PNWMU. Consuelo’s counterstory spoke about advice that she received when she didn’t pass STEP 1 of being told she should take a leave of absence. The advice reinforced the idea that she did not belong by telling her to take a leave of absence. That contributed to her feeling that she didn’t belong in medicine and is a clear example of how internalized racism shows up as the Imposter Syndrome. Karla and José reiterate that feeling like even after they passed their tests, they still feel inadequate. These all contributed to the barriers the participants identified through their *cuentos and*

counterstories which they shared about their journey to become physicians. The next and final theme to be presented is *familismo*.

Theme 3: Familismo (Facilitator)

The final theme that the findings point to is a facilitator for the participants in this study. The third theme is *familismo*, which encompasses the cultural relationships the participants had with their parents, family members, mentors, peers, and others that they identified within the organization of the Latino Medical Student Association (LMSA) at PNWMU. *Familismo*, which is a Latino cultural value that encompasses the family structure, relationships, and strong ties to the community (Azpeitia and Bacio, 2022). The structure of *familismo* conveys a sense of loyalty to family, respect for elders, *ser servicial* (to be of service to others), and to promote and influence the Latino family well-being. Findings of this theme speak to how the promotion of close and inclusive environments created by their families and the Latino Medical Student Medical Association serves a facilitator of success and facilitates their journey in medical school. Findings of the *cuentos* of the participants demonstrate how culture, values, and traditions associated with families to are revealed at the PNWMU. The findings indicate that Latino culture plays a major role in the lives of the participants of this study and indicate that their cultural emphasis on families is an important aspect and complements belonging and inclusion among peers within the LMSA. See below **Figure 5: Navigating Two Cultural Worlds.**

Figure 5



Familia y Comunidad. The participants all spoke of missing their family members while they were at PNWMU, and each dealt with their feelings in different ways. It was evident through the participants' *cuentos* that their family played a critical role in their identity and connection to their cultural roots. Findings revealed how participants were supported by their families and peers of the LMSA which were identified as facilitators. In particular, the participants indicated through their *cuentos* how their cultural connections were instrumental in facilitating their persistence with the support of their parents and community. Participants noted their parents could not help them with content of curriculum but provided encouragement and were instrumental in their perseverance. Frequently, participants indicated their parents supported them throughout their lives as represented in the Cultural Wealth Model (Yosso, 2005). The model is presented from CRT view point that Latinos bring cultural capital as part of their persona, identity, and culture. Building upon their cultural strengths and assets of

being raised in a culture that practices *familismo* consists of valuing family, kinship, and the importance of building and maintaining relationships, as part of Latino Culture. The practice of *familismo* gave strength and resilience came from their families' cultural beliefs and values through the persistence of each participant who aspired to become a physician. Parents served as supporters, advisors, and prayed for them from afar. Parents served as their role models, provided inspiration, reassured them and helped them persist by keeping connection and frequent open communication ties with participants in this study. For all participants, family came first, and they held strong connections with their grandparents too. The role of faith also came into play and gave the participants a sense of security and protection. Religious traditions are often seen as part of the Latino cultural and identity as being a whole person. For many the cultural connection to family and faith were inseparable and prayer was used when they were feeling alone, lonely, stressed, and perplexed during their academic journey. Each of the participants brought their family's *consejos* and inner strength and resilience which come from the support and love, as well as the roots of their cultural traditions and values as described by Yosso's Cultural of Wealth Model, (2005). Their cultural assets contributed as facilitators for all of the participants of this dissertation study. Through familial emotional support, culture, and traditions all participants were able to navigate PNWMU as a collective. Frequently, participants indicated their parent's emotional support gave them strength and being raised with *familismo* in their family was key to their identity. The strength of each participant came from their families' cultural beliefs and values but most importantly through the persistence of each participant who aspired to become a physician. Some participants spoke about once they obtained their medical degrees, they

would return to their hometowns to be close to their family and community. Participants also spoke about how they were seeking guidance and support similar to the type of relationships they had with their families. David, José, and Karla spoke about how they felt when they received reassurance, validation, and confirmation from their attendings, instructors, and administrators which spoke to the relationships and the validation they were seeking to aid persistence. David said:

> Last week one of the doctors who I've worked with for the past year emailed me saying, You did a tremendous job this past year. If you need a letter of rec, I'll be more than willing to write you a good one, and things like that are good, moments that affirm what you're doing and affirm that you're not just wasting time… I forwarded it to my mom. So, it was reassuring to get that type of support.

José, shared that having support from attendings was key to his ability to thrive. "There was one pathologist who was always affirming my hard work…that just goes a long way. I think that is the reason why I continue to do this journey in medical school." Finally, Karla shares the story of when she failed to pass Step 1 and how the student affairs director came to her aid which made her feel that someone cared about her as a person for the first time after two years, as a medical student at the PNWMU. Karla felt after that incident this director was the sole person who cared for her success and felt she had established a connection which she had not had experienced prior. From these *cuentos* (stories) the findings of this study are focused on a family or individuals who were described as the cornerstone that allowed the participants to continue in their journey. When they were able to find that sole instructor, attending, and administrator it gave them hope and reassurance. Developing relationships, receiving guidance, acceptance, and

validation was key and part of what participants sought. Familismo was clearly a facilitator that assisted them along their journey and gave them a sense of belonging at the PNWMU. A sub-theme facilitator that the participants spoke about how the Latino Medical Student Association (LMSA) held community space and made them feel at home. The LMSA was a refuge but also a place they could share and gain skills, information, and build community.

Latino Medical Student Association (LMSA). Findings revealed all eight Latino medical students individually discussed the importance of supporting one another by building a sense of community through the Latino Medical Student Association (LMSA). The Latino Medical Student Association is a 501 © (3) a nonprofit organization founded to represent, support, educate, and unify U.S. Latino medical students (LMSA.com). The LMSA is composed of five regions spanning throughout the US: Northeast, Southwest & West region. The PNWMU is represented as part of the West region encompassing the Pacific Northwest and the Southwest of the United States. Each medical school can establish a chapter to belong to the national organization. Furthermore, the LMSA also serves as a voice and vehicle to promote recruitment and retention of Latino medical students while also serving as advocates and in service projects to promote Latino health care issues. Findings revealed that building a shared sense of community helped counteract being alone and combated the feeling of loneliness and lack of self-belonging. All eight participants discussed the importance of bonding and supporting each other which they immediately connected when they found each other in their current class or within the classes ahead of them or behind them in academic

years. Karla explained the LMSA provides a sense of community and familial connection within the group. She said:

> I feel we're all very in tune with ourselves, and how we identify ourselves, I feel like that makes us comfortable talking about our issues with each other. It's just really easy to talk to them because they're all really compassionate and empathetic. We can all kind of understand a little bit better. The LMSA, I think we are a very tight knit group. I really appreciate that. They feel like family. I feel like the four of us in LMSA and other classes have four of them, they just feel like my brothers and sisters. I feel like we really look out for each other. Every time I see one of them, I'm like we really look out for each other, every time I see one of them, I'm like, I missed you so much. I don't have any family here. So I feel they are kind of like a little mini-family. We also leaned on the Student National Medical Association (SNMA) that is a historical Black student medical association. We were both really small groups and did a lot of things together. I think that was really helpful too.

Melvin, Javier, and others found LMSA to be a safe and familial space at the LMSA. Findings revealed for all the participants, LMSA was a family which united the group gave the participants a source of guidance, encouragement, mentorship, and safety within the group. When many felt discouraged, uncomfortable, unsafe, and questioned their existence at the PNWMU, the LMSA was their family away from home. Through the local, regional, and nationwide networks of the LMSA provides an environment of bonding and gave a familial connection within the LMSA as a collective - *el colectivo*. Students spoke to the importance of having peer mentors and support from the LMSA.

Participants also spoke how they academically supported one another, quizzed, and explained concepts with each other. Adela explains the unity of LMSA, “it’s not just support, but just the solidarity I have with my fellow classmates, especially my close ones, seeing the struggles they go through and seeing them persist as well. They're a year closer to finishing than I am.” Javier reaffirms the importance the LMSA membership holds to help facilitate his success along his journey. Javier shares

> My peers have been a positive force. They've only been an encouraging, positive force. We help each other. We're students. We recognize that we're really at the bottom of a hierarchy and we want to succeed. We want to be who we are, so we share notes, we share ideas. I teach them certain things. They teach me certain things. We have conversations. If there's something really that I don't understand they say, "Oh I read about that. Here let me tell you about it.

Participants appreciated the safe space, support, and strong connection LMSA provides to their community. LMSA also provides a space where students are able to see others who look like them or share the same cultural traditions, values, a second language or come from a similar background and provides a network. It is clear, the LMSA brings students together who are interested in the health and well-being of the Latino community, while providing social and professional support to URiM Latino/Hispanic medical students. In addition, LMSA created opportunities for community service. Serving the community was not only a part of the LMSA mission, it also resonated deeply with the participants. *Ser servicial,* is a strong Latino cultural value, which means to be of service to others to which several of the participants spoke about. Through the cultivation of support networks, the participants appeared to recreate the supportive

elements of their "family" within their new environment of LMSA. The strength derived from the support and encouragement within the cultivated networks facilitated the academic and social development of the participants. To understand this theme of *familismo,* we look to Yosso (2005) who describes familial capital as one component of the Cultural Wealth Model. CRT in this framework introduces cultural assets that recognized as a strength instead as deficits, stereotypes, or biases. Familial capital (familismo) refers to cultural knowledge that bring sense of community, history, and cultural intuition. Familial capital also refers to the nurturing of family (familia) and community and to serve community as part of social responsibility. Yosso, (2005) identifies the Cultural Wealth Model to include other cultural assets in addition to familismo to include the following: (a) aspirational capital which is described as the ability to dream despite encountered barriers (b) linguistic capital includes the intellectual and social skills to communicate with others (c) social capital to communicate and build networks and (d) navigational capital, a skill used to navigate unknown structures. In summary, the Cultural Wealth Model engages a commitment of skills, abilities, knowledge and expands the concept of family to include a broader understanding of kinship while placing a high value on relationships and connections. From these kinship ties, we learn the importance of maintaining a healthy connection to community and its' resources (pg. 79). The concept of *familismo,* a cultural framework that was identified in this study, served as a facilitator in the journey of all eight Latino medical students. While *familismo* has been investigated in post-secondary education by scholars (Marín and Marín 1991; Saenz & Ponjuan 2009; Suárez-Orozco & Suárez-Orozco, 1995) it is important to bring understanding of the role of *familismo* in academic medicine in order

to build cultural responsive systems which is not term nor definition explored in academic medicine per review. Understanding familismo and Yosso's (2005) Cultural Wealth Model can help better understand how to support Latino medical students through inclusion, equity, and enrichment of space and environment. Perez et al., (2017) posits that acknowledging the cultural wealth of assets that Latino students bring to higher education can increase sense of belonging by allowing students to incorporate their skills, knowledge, and abilities while mitigating others to abandon negative ideologies and approaches that are deficit-based perspectives and that might validate stereotypes of Latino students. Incorporating new perspectives on how to validate a sense of belonging in academic medicine is a key strength to aid and enrich the environment, curriculum, activities, mentorship, and identity of Latinos in medicine.

The findings on the importance of family and practices of *familismo*; as revealed by the findings per the *cuentos and* counterstories of the participants is a key finding. The importance of *familia*; and the practice of *familismo* created an environment that was conducive to the participant's needs and can be described as a facilitator strategy. It became clear through the voices of the participants, the LMSA sought to create intentional safe space and to cultivate familial relationships beyond a generic relationship which was important to the participants. The participants brought their own cultural values of *personalismo* and expectations of forming a deeper connection with the PNWMU. *Personalismo* is a practice in Latino Culture that seeks to make personal connections before getting to the task at hand as part of familismo. Therefore, the participants presented themselves, whole, intact, and brought a form of familial identity towards creating family and community in a medical learning setting. To reiterate,

familismo is a strong cultural element that places a higher value on the collective versus to the individual level (Consoli & Lamas, 2013). *Familismo* is also known to be passed down from generation to generation (Marin, 1993) and this certainly the case for all participants of this study. Regardless of generation the participants of this study represented and diversity of backgrounds, *familismo* showed up as a strong cultural value and practice, as explained in each participant's *cuentos* and counterstories. The high reliance on family and emotional support is tied on how *familismo* influences and impacts well-being is also key to understand (Marin & Marin, 1991) Evidence also suggests that *familismo* has been found to lead to positive health outcomes among Latino youth who face discrimination (Gil et al., 2000). Umaña-Taylor & Updegraff, (2007), found that high levels of involvement in Latino culture can serve as a protective factor minimizing the negative effects of discrimination. They posit the greater involvement in Latino Culture decreases negative relation between discrimination and self-esteem while reducing depressive symptoms may serve to protect Latinos. This finding is consistent with broader empirical work highlighting the positive associations between Latino adolescents' orientation toward their ethnic culture and well-being (Gonzales, Knight, Morgan-Lopez, Saenz, & Sirolli, 2002). Finding strategies to support Latino students who face discrimination in light of these *cuentos* and counterstories are key to assist increase a sense of belonging, persistence, and a healthy and safe journey.

Recommendations

The recommendations I want to share with the readers of this dissertation study, are many, but I chose to highlight three areas that are culturally responsive to the identified needs. The first area is the importance of mentorship. The second area is to ensure that we include the voices of Latino medical students to improve our medical schools. And finally, the critical nature of supporting medical school organizations known as student affinity groups to support Latino medical students to navigate between their cultural heritage/identity and within the culture of medical school. A list of other, equally important, recommendations follow these three areas.

Mentorship

A more diverse study body is critical in attracting more Latino medical applicants to address the shortage of physicians but just as important to graduate more Latino medical students to care for a growing diverse population. Similarly, retaining and creating a community of inclusion is key to help Latino students thrive given their underrepresentation in the profession of medicine. Given the small number of Latino medical students they represent it is important to learn how they are feeling, learn of their needs, and seek their opinions to ensure their voices are being heard. A welcoming and engaging relationship that is meaningful should be considered by establishing a diversity mentorship program to pair students up with diverse faculty members or faculty members who want to have meaningful relationships with Latino medical students. Protected time for faculty members and additional resources to support mentorship pairing, support, and evaluation will be required. The mentorship concept program can serve to build relationships to facilitate a community of inclusion in a group concept model similar to

familismo. Establishing intergroup interaction may mitigate or eliminate the feeling alone and lonely. There must also be purposeful interaction within and across the medical school and between the enclave of the LMSA.

Listening to the Voices of Latino Medical Students

To address racism and microaggressions, a climate and culture assessment (qualitative and quantitative) is recommended to learn of the climate and issues to respond with solutions and resources. A comprehensive and sustained assessment can invite all Latino medical students to provide opinions and comments about (a) institutional actions required (b) teaching, learning, evaluation, and grading (c) group learning and curriculum (d) and to understand and improve intergroup interactions. In addition, the creation of an alert system to mitigate microaggressions by establishing an advocate role (similar to an ombudsperson but specifically to support on issues about discrimination and microaggressions) to provide consultation and resources. This position will bring assurance, support, and ability to address clinical rotations specifically to address the acts and behaviors of patients. Finally, require active bystander training to be facilitated at the department and program level for instructors, attendings, staff, students and others.

Support Medical School Organizations/Affinity Group

The LMSA is a replication of family within an enclave as a Latino learning community, where students find a sense of belonging, are validated, and welcomed to a group. Consoli & Lamas, (2013) posit that *familismo* contributes to resilience and can lead to positive learning outcomes and increase self-esteem and well-being. The feeling of not belonging can lead to feeling isolated and even experiencing depression (Haggerty

et al., 2002). Therefore, providing resources and administrative support to the LMSA is a strategy that could benefit the students and the medical school with retention efforts. Formalizing the relationship and finding time, space, and relevant education to address race and culture would also be beneficial. The role of *familismo* in medical school is an area untapped and perhaps unknown in academic medicine. *Familismo* involves dedication, commitment, and loyalty to the immediate family and to those beyond the immediate family. The close-knit family that participants displayed and based on these findings strongly recognize a need for a framework similar to *familismo* be considered in academic medicine to understand and to remove cultural and environmental barriers for Latino medical students.

The following list of recommendations comes from the *cuentos* that participants shared which created barriers in their journey through medical school. The list is also part of the researcher's experience, knowledge, and expertise in working in an administrative position at a medical school. And finally, the recommendations have also been influenced by the literature on increasing the diversity in the medical profession. All three sources contributed to the recommendations for medical schools to consider and implement:

1. Provide training on how to intervene when bias, racism, discrimination, and harm are being directed at Latino medical students.
2. Deliver culturally relevant training to assist Latino students to learn how to combat racism and microaggressions and seek how to protect themselves against harm by engaging directly, learning how to report, and how to seek support.
3. Campaign awareness on how to mitigate and eliminate bias, racism, and microaggressions.

4. Provide training to residents and physicians about how to use certified medical interpreters and how to avoid microaggressions.
5. Train residents and attendings on how to conduct bias-free evaluations - best practices.
6. Review and update policy on patient code of responsibilities and alert patients that racism will not be tolerated at the PNWMU.
7. Learn of the cultural framework of *Familismo* to better understand the needs of Latino medical students by becoming aware of their culture, language, family dynamics, and cultural values to help support their identity and cultural well-being.
8. Strategize to deliberately recruit more Latino/Latina faculty, instructors, staff, and administrative leaders.
9. Build a stronger Latino community, to help serve as role models to increase a sense of belonging.
10. Train department chairs, residency directors, chief residents, staff, and leaders to be trained on cultural competency/culturally humility regarding Latino Culture.
11. Share the findings of this dissertation study to inform administration, instructors, faculty, residents and students about how to best support Latino medical students.
12. Student Affairs personnel to meet and establish stronger relationships with Latinos and other underrepresented minorities in medicine.
13. Engage with Latino medical students to learn about their journey through one-on-one interviews, Qualtrics surveys, and facilitate an open dialogue with student affairs leadership and management.

14. Invest in the membership of Latino medical students and encourage their participation in the Latino Medical Student Association, the Hispanic Medical Association, and other Latino associations to build community virtually and in person to further support their cultural identity and needs.
15. Support the LMSA locally, regionally, and at the national level to ensure Latino medical students have access to information, resources, and professional support.
16. Conduct short and long-term assessments through examinations to learn how to understand how to serve and meet the needs of Latino students.
17. Expand resources to ensure tutoring is available to all students who request assistance regardless of academic status.
18. Seek and assign mentors who can provide cultural-specific mentorship for students and conduct check-ins. Monitor pair assignments to ensure students are supported actively and regularly.
19. Seek to support Latino families and provide information and resources to better support their son or daughter in medical school. Make information available in both English and Spanish.
20. Provide Spanish language courses for residents, attendings, and staff to be able to increase communication with Spanish patient speakers.
21. Provide culturally specific mental health services and reach out to Latino medical students.

Relevance of this Study

This study is unique and provides insight into the lives of eight Latino medical students at a predominantly White medical university (PNWMU). The research findings

provided insight of the Latino medical students navigating their individual journey at the PNWMU. Findings reveal students operated in two different environments which required two different navigational systems, one that sought familial support from their peers and family, and one where they found themselves to be isolated and alone.

The participants of this study retreated back and forth from the Latino Medical Student Association (LMSA) and the Pacific Northwest Medical University (PNWMU) and again to face isolation, be one of few, experience and observe and experience racism on three different levels during their academic journey. Yosso (2005) refers to this as navigational capital referring to where students use their skills to navigate through a racially hostile university campus. Fostering connections and community at the local, regional, and national levels among Latino medical students, residents, and physicians was key for their continued journey in medicine. The LMSA promoted a sense of belonging, a community, and also provided a path to career development across the medical education continuum. The findings of this study confirms the lived experience of Latinos in a learning medical environment is distinctive and dissimilar and that they experience an adverse climate based on their ethnicity, phenotype, spoken languages, and perceived national origin. Furthermore, these findings provide new insight that documents their experience of isolation, racism and microaggressions occur in a learning environment impacting the student's well-being and ability to thrive. The inequities they faced, along with the shared experiences require actions, resources, and leadership to create change in the learning environment. Cultural responsiveness is require in order to create a sense of belonging by providing a more familial environment, while also eliminating acts and behaviors of bias of racism.

In conclusion, this dissertation study set out to explore the journey of eight Latino medical students at the PNWMU to learn of the facilitators that impede the experience of Latino medical students and to also identify what are the factors that facilitate a positive experience for Latino students. The eight participants of that study were a small sample size, but their voices, *cuentos,* and counterstories represent the lived lives at one medical school. Although this is a small sample, the learning of this study is important and significant and offers more information than one knew prior of the journey of Latino medical students. As the researcher of this study, it was an honor to interview the eight Latino medical students who placed their trust in me to be able to tell their lived lives. My goal as an administrator in academic medicine has always been to help others - an article was written about me back in 2001 titled "*Ayudando a otros obtener el éxito*" Helping others attain success featured in *the El Hispanic News*. Fast forward to 2022, my goal and inspiration is to continue to make a difference in the lives of others, help and continue to *ser servicial* - to be of service.

Areas for Future Research

This research study brought forward new information to help identify barriers in the journey of Latinos in medical school, while also capturing new information about factors that facilitate a positive journey. Additional research is warranted to learn how to incorporate the cultural framework of *familismo* and the Cultural Wealth Model (Yosso, 2005) in medical school settings, which may serve to be beneficial and help advance the retention of Latino medical students to persist during their journey in medical school. Every Latino medical student that enters medical school has invested time, energy, money, and has developed aspiration goals as a child or young adult to become a

physician. Yosso (2005) refers to aspirational capital as the ability to maintain hopes and dreams for the future, even in the face of real and perceived barriers. “This resiliency is evidenced in those who allow themselves and their children to dream of possibilities beyond their present circumstances, often without the objective means to attain those goals “(Yosso, 2005 p.77-79). Therefore, future studies to explore the role of the medical students’ cultural and linguistic assets through Yosso’s framework would further expand knowledge on how to support the next generation of Latino medical students. Exploring the participant’s level of acculturation would also be beneficial to better understand Latino medical students’ adjustment in medical schools at Predominate White Institutions (PWI’s). Acculturation is defined as a process of leaning and incorporating values, believes, customs, mannerism and the learning of new environments different from one’s own cultural group. The work of Sabogal et al., (1987), observed the effects of familismo and acculturation were found to be beneficial in a learning environment. The finding of familismo as a facilitator indicates Latino students’ value family/kin as a cultural value in order to establish community and strong relationships. In addition, acknowledging the importance Yosso’s (2005) framework can further elevate Latino medical student’s sense of belonging, well-being, and acknowledging their unique skills, knowledge, and cultural assets contribute to medical profession.

Medical schools can also benefit by learning how to engage with Latino parents of matriculants to learn how to best support their son or daughter while in medical school, which may seem out the norm given medical students are considered adults, however Latino culture does not always consider the age barring parents from being their sons/daughter’s advocates, protectors, or role models. Because many Latino parents and

family members are unfamiliar how to support students in medicine they could benefit from information, resources, and guidance on how to best support Latino students. Expanding knowledge on the role of Latino families play in the lives of Latino medical students is an area which remains untapped.

In summary, as the medical profession seeks to address the growing diverse patient population and increase access and quality of care, there is a need to learn of the lived experiences of Latino medical students, to ensure they progress to become tomorrow's medical physicians. An intentional learning inclusive climate and commitment to fostering student diversity is evident for medical student success (Dickins et al., 2013). The role of racism and microaggressions that impact the experience of Latino medical students must be recognized and addressed by medical schools. It is clear structural and personal racism, bias, and stereotypes contribute and impact the experiences of Latinos in medicine. Fernández et al., (2021), affirm that antiracism efforts in academic medicine must address Latino perspectives, disparities, and the lack of representation of Latinos in medical training which is not widely acknowledged and at the forefront of discussions. Toward that effort, it is imperative for medical school faculty, residents, instructors, leadership, student affairs personnel, and students to acknowledge and eliminate all forms of discrimination and racism displayed toward Latino medical students to increase inclusion, respect and a sense of belonging. The racist experiences encountered from patients need to be addressed by attendees and residents in real time in support of Latino medical studnets. Cultural and linguistic taxation must also be addressed to ensure Latino students are not being asked to serve the role as translator which takes time away from their learning. Additional duties,

expectations, and responsibilities should be addressed with residents and attendings. These contributions can be taxing because they are rarely regarded as scholarly productive or noted in their clinical reviews. Finally, in order to increase a sense of belonging medical schools must also increase Latino representation among students, faculty, attendees, and residents for them not to feel isolated, alone, and unseen. Fernández et al., (2021) have recommend medical accreditation and licensing bodies implement policy and practices to increase outreach, recruitment, and stronger support for Latinos in academic medicine. The creation of cultural responsive action plans must also seek to engage and serve Latinos in academic medicine, as part as the anti-racism agenda in medicine is both required and overdue.

References

Association of American Medical Colleges. (2004) Underrepresented in medicine definition. Retrieved https;//www.aamc.org/initiatives/URiM.Accessed.

American Association of Medical Colleges (n.d). "*Holistic Review in Admissions*". Retrieved from https://www.aamc.org/services/member-capacity-building/holistic-review

American Association of Medical Colleges (AAMC). (2005). Cultural Competence Education Resource Book Retrieved from

American Association of Medical Colleges (AAMC) (2012). Medical School Graduation Questionnaire. Mistreatment definition. Retrieved from https://www.aamc.org/download/54338/data/culturalcomped.pdf

American Association of Medical Colleges (2013-2014) AAMC *Applicants and Matriculants to U.S. Medical Schools by Race and Ethnicity*. Retrieved from https://www.aamc.org/data/facts/applicantmatriculant/85990/byraceandethnicity.AAMC.

American Association of Medical Colleges. (2015) "The Complexities of Physician Supply and Demand: Projections from 2013 to 2025 Retrieved from https://www.aamc.org/download/426242/data/ihsreportdownload.pdf

Association of American Medical Colleges. (2018) All Active Physicians (AMMC). Retrieved https;//www.aamc.org/initiatives/URiM.Accessed

Association of American Medical Colleges. (2019) *Diversity in Medicine: Facts & Figures*. (AAMC) Retrieved https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

Association of American Medical Colleges. (2021) *Medical School Enrollment More in Diverse* in 2021. (AAMC). Retrieved from https://www.aamc.org/news-insights/press-releases/medical-school-enrollment-more-diverse-2021

American Association of Medical Colleges (2021b) AAM Report Reinforces Mounting Physician Shortage June 11, 2021. Retrieved 5.6.2022 https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage

American Association of Medical Colleges (n.d) AAMC Website Retrieved from https://www.aamc.org/

Andriole, D. A. and D. B. Jeffe (2012). "A national cohort study of US medical school students who initially failed Step 1 of the United States Medical Licensing Examination." Academic Medicine 87(4): 529.

Andriole, D. A. and D. B. Jeffe (2010). "Prematriculation variables associated with suboptimal outcomes for the 1994-1999 cohort of US medical school matriculants." JAMA 304(11): 1212-1219.

Arditti, J.A. (2006), Editor's Note. Family Relations, 55: 263-266.

Azpeitia, J., & Bacio, G. A. (2022). "Dedicado a Mi Familia": The Role of Familismo on Academic Outcomes Among Latinx College Students. *Emerging Adulthood*, *10*(4), 923–937. https://doi.org/10.1177/21676968221099259

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*, *118*(4), 293.

Betancourt, J. R., & Maina, A. W. (2004). The Institute of Medicine report" Unequal Treatment": Implications for academic health centers. The Mount Sinai Journal of Medicine, New York, 71(5), 314-321.

Bell, L. A. (2003). "Telling tales: What stories can teach us about racism." Race, Ethnicity and Education 6(1): 3-28.

Bieler, P., Bister, M. D., Hauer, J., Klausner, M., Niewöhner, J., Schmid, C., & von Peter, S. (2021). Distributing reflexivity through co-laborative ethnography. *Journal of Contemporary Ethnography*, *50*(1), 77-98.

Blair, E. (2015). A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurement in the Social Sciences*, *6*(1), 14-29.

Buerhaus, P. I. (1999). Is a Nursing Shortage on the Way? Nursing Management, 30(2), 54-57.

Bullock, S. C., & Houston, E. (1987). Perceptions of racism by Black medical students attending White medical schools. Journal of the National Medical Association, 79(6), 601-608.

Bureau, U. C. (2020). Census Statistics Highlight Local Population Changes and Nation's Racial and Ethnic Diversity. 2021. *Contract No.: CB21-CN*, *55*.

US Census Bureau. (2012). Population Projections. *2012 National Population Projections*. Retrieved from

Bureau U.C. (2012). 2012 National Population Projections Datasets Retrieved August 3, 2021 from https://www.census.gov/data/datasets/2012/demo/popproj/2012-popproj.html

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical care research and review*, *57*(1_suppl), 181-217.

Byrd, W. M., & Clayton, L. A. (2001). Race, medicine, and health care in the United States: a historical survey. *Journal of the National Medical Association*, *93*(3 Suppl), 11S–34S.

Calzada, E. J., Tamis-LeMonda, C. S., & Yoshikawa, H. (2013). Familismo in Mexican and Dominican families from low-income, urban communities. *Journal of Family Issues*, *34*(12), 1696-1724.

Campos, B., Ullman, J. B., Aguilera, A., & Dunkel Schetter, C. (2014). Familism and psychological health: the intervening role of closeness and social support. *Cultural Diversity and Ethnic Minority Psychology*, *20*(2), 191.

Cantor, J. C., Miles, E. L., Baker, L. C., & Barker, D. C. (1996). Physician service to the underserved: implications for affirmative action in medical education. Inquiry, 33(2), 167-180.

Caulfield, M., Redden, G., & Sondheimer, H. (2014). Graduation rates and attrition factors for US medical school students. *AAMC Analysis in Brief*, *14*(5).

Chang, M. J. (1999). Does racial diversity matter?: The educational impact of a racially diverse undergraduate population. *Journal of College Student Development*.

Chun, H., Marin, M. R., Schwartz, J. P., Pham, A., & Castro-Olivo, S. M. (2016). Psychosociocultural structural model of college success among Latina/o students

in Hispanic-serving institutions. *Journal of Diversity in Higher Education*, *9*(4), 385.

Clance, P. R., & Imes, S. A. (1978). The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. *Psychotherapy: Theory, research & practice*, *15*(3), 241.

Clarke, A. E. (2005). Situational analysis: grounded theory after the postmodern turn Sage. *Thousand Oaks, CA*.

Collings English Dictionary Retrieved November 1, 2022 from https://www.collinsdictionary.com/us/

Constantine, M. G. (2007). "Racial microaggressions against African American clients in cross-racial counseling relationships." Journal of Counseling Psychology 54(1): 1.

Creswell, J. W. and V. L. P. Clark (2007). "Designing and conducting mixed methods research." CA: Sage.

Creswell, J. (2009). Research design: Qualitative, quantitative, and mixed methods approaches: SAGE Publications, Incorporated.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Corbin, J. and A. Strauss (2008). "Basics of qualitative research: Techniques and procedures for developing grounded theory, 3e." Washington, DC: Sage

Cohen, J. J., Gabriel, B. A., & Terrell, C. (2002). The case for diversity in the healthcare workforce. *Health Affairs*, *21*(5), 90-102.

Cooper, L. A., & Powe, N. R. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient–provider racial, ethnic, and language concordance* (pp. 7-1). New York: Commonwealth Fund.

Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA*, *282*(6), 583-589.

Coulter (n.d) History of Minorities in Medicine, School of Medicine Alabama Retrieved from https://www.uab.edu/medicine/diversity/initiatives/minorities/history

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, *11*(1), 1-9.d

Dahlin, M. E., & Runeson, B. (2007). Burnout and psychiatric morbidity among medical students entering clinical training: a three year prospective questionnaire and interview-based study. *BMC Medical education*, *7*(1), 1-8.

Dall, T., Chakrabarti, R., Iacobucci, W., Hansari, A., & West, T. (2017). The complexities of physician supply and demand: projections from 2015 to 2030. *Association of American Medical Colleges*.

Darder, A. and R. D. Torres (2004). *After race: Racism after multiculturalism*, NYU Press.

Dawson, B., Iwamoto, C.K., Ross, L.P., Nungester, R., Swanson, D.B., Volle, R.L. (1994). "Performance on the National Board of Medical Examiners Part I examination by men and women of different race and ethnicity." *JAMA* **272**(9): 674-679.

Definicion.for *Servicial* DE Retrieved from https://definicion.de/servicial/

Delve. Ho, L., & Limpaecher, A. (2022b, February 25). The Importance of Reflexivity in Qualitative Research. Essential Guide to Coding Qualitative Data. https://delvetool.com/blog/reflexivity

Delgado Bernal, D. (2002) Critical race theory, Latino critical theory, and critical raced-gendered epistemologies; recognizing students of color as holders and creators of knowledge. *Qualitative Inquiry*, 8, 105-126.

Delgado, R. & Stefancic, J. (1993,). Critical Race Theory: An annotated bibliography. *Virginia Law Review, 79*(2), 461–516.

Delgado, R., & Stefancic, J. (2001). An introduction to critical race theory. *Critical Race Theory: The Cutting Edge*, 1-167.

Delgado, R. (1989). Storytelling for oppositionists and others: A plea for narrative. *Michigan Law Review*, *87*(8), 2411-2441.

Dhaliwal, J. S., Crane, L. A., Valley, M. A., & Lowenstein, S. R. (2013). Student perspectives on the diversity climate at a US medical school: the need for a broader definition of diversity. *BMC Research Notes*, *6*(1), 1-8

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321.

Dickins, K., Levinson, D., Smith, S. G., & Humphrey, H. J. (2013). The Minority Student Voice at One Medical School: Lessons for All? *Academic Medicine, 88*(1), 73-79.

Dictionary, M. W. (2002). Merriam-Webster. *On-line at http://www. mw. com/home. htm*, *8*, 2. http://www.merriam-webster.com/dictionary/experience

Dyrbye, L.N., Thomas, M.R., Power, D.V., Durning, S., Moutier, C. Massie, F.S., Jr, Harper, W., Eacker, A., Syzdlo, D.W., Sloan, J.A., & Shanafelt, T.D.(2010)

Burnout and serious thoughts of dropping out of medical school: a multi-institutional study. Academic medicine: journal of the Association of American Medical Colleges, 85(1), 94-102.

Dyrbye, L. N., Thomas, M. R., Eacker, A., Harper, W., Massie, F. S., Power, D. V., & Shanafelt, T. D. (2007). Race, ethnicity, and medical student well-being in the United States. *Archives of internal medicine*, *167*(19), 2103-2109.

Epstein, R. M. and M. S. Krasner (2013). "Physician resilience: what it means, why it matters, and how to promote it." *Academic Medicine* 88(3): 301-303.

Farber, D. A. & S. Sherry (1993). "Telling stories out of school: An essay on legal narratives." *Stanford Law Review*: 807-855.

Fernández, C. R., Silva, D., Mancias, P., Roldan, E. O., & Sánchez, J. P. (2021). Hispanic identity and its inclusion in the race discrimination discourse in the United States. *Academic Medicine, 96*(6), 788-791.

Fnais, N., Soobiah, C., Chen, M. H., Lillie, E., Perrier, L., Tashkhandi, M., Straus, S. E.,

Franklin, A. J., Boyd-Franklin, N., Kelly, S. (2006). "Racism and invisibility: Race-related stress, emotional abuse and psychological trauma for people of color." *Journal of Emotional Abuse* 6(2-3): 9-30

Frei, E., Stamm, M., & Buddeberg-Fischer, B. (2010). Mentoring programs for medical students-a review of the PubMed literature 2000-2008. *BMC medical education*, *10*(1), 1-14.

Frierson, H. T., Jr. (1987). "Black medical students' perceptions of the academic environment and of faculty and peer interactions." J*ournal of the National Medical Association* 79(7): 737-743.

Gibau, G. S. (2015). "Considering Student Voices: Examining the Experiences of Underrepresented Students in Intervention Programs." *CBE Life Science Education* 14(3).

Gil, A. G., Wagner, E. F., & Vega, W. A. (2000). Acculturation, familism, and alcohol use among Latino adolescent males: Longitudinal relations. *Journal of Community Psychology*, *28*(4), 443-458.

Gordon, J., et al. (2000). "Strategic planning in medical education: enhancing the learning environment for students in clinical settings." *Medical Education* 34(10): 841-850

Gonzales, N. A., Knight, G. P., Morgan-Lopez, A. A., Saenz, D., & Sirolli, A. (2002). Acculturation and the mental health of Latino youths: An integration and critique of the literature.

Guignon, C. (2006). *"History and Historicity." A Companion to Phenomenology and Existentialism:* 545-558.

Gurin, P. (1999). Expert Report." Gratz et al. v. Bollinger, et al." No. 97-75321 (ED Mich.);" Grutter, et al. v. Bollinger, et al." No. 97-75928 (ED Mich.). *Equity & Excellence in Education*, *32*(2), 36-62.

Grumbach, K., & Mendoza, R. (2008). Disparities in human resources: addressing the lack of diversity in the health professions. Health Affairs, 27(2), 413-422.

Grutter v. Bollinger. 539 U.S. 982; 124 S. Ct. 35; 156 L. Ed. 2d 694. Decided on April 1, 2003.

Hagerty, B. M., Williams, R. A., & Oe, H. (2002). Childhood antecedents of adult sense of belonging. *Journal of Clinical Psychology*, *58*(7), 793-801.

Harley E. H. (2006). The forgotten history of defunct black medical schools in the 19th and 20th centuries and the impact of the Flexner Report. *Journal of the National Medical Association*, *98*(9), 1425–1429.

Hawkins, B. (1998). "The dominant images of Black men in America: The representation of OJ Simpson." *African Americans in sport*: 39-52.

Hill, K. A., Samuels, E. A., Gross, C. P., Desai, M. M., Sitkin Zelin, N., Latimore, D., Huot, S. J., Cramer, L. D., Wong, A. H., & Boatright, D. (2020). Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation. *JAMA internal medicine*, *180*(5), 653–665.

Hiraldo, P. (2015). "The role of critical race theory in higher education." *The Vermont Connection* 31(1): 7.

Hobgood, C., Sawning, S., Bowen, J., & Savage, K. (2006). Teaching culturally appropriate care: a review of educational models and methods. *Academic Emergency Medicine*, *13*(12), 1288-1295.

Hooks, B. (2003). Teaching Community: A Pedagogy of Hope. Vol. 36. Novato.

Huff, K. L., & Fang, D. (1999). When are students most at risk of encountering academic difficulty? A study of the 1992 matriculants to US medical schools. *Academic Medicine*, *74*(4), 454-460.

Huschka, M., Novotny, P.J., Sloan, J.A., Shanafelt, T.D., (2007). "Race, ethnicity, and medical student well-being in the United States." *Archives of Internal Medicine* 167(19): 2103-2109.

Hung, R., McClendon, J., Henderson, A., Evans, Y., Colquitt, R., & Saha, S. (2007). Student perspectives on diversity and the cultural climate at a U.S. medical school. *Academic Medicine, 82*(2), 184-192.

Hurtado, S., Griffin, K.A., Arellano, L., Cuellar, M. (2008). "Assessing the value of climate assessments: Progress and future directions." *Journal of Diversity in Higher Education* 1(4): 204.

Hsu, Y.-W., Chou, C., Nguyen-Rodriguez, S.T., McClain, A.D., Belcher, B.R. Spruijt-Metz, D. (2011). "Influences of social support, perceived barriers, and negative meanings of physical activity on physical activity in middle school students." *Journal of Physical Activity and Health* 8(2): 210.

Jones C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American journal of public health, 90*(8), 1212–1215.

Judd, N.K. (2003). "USMLE performances in a predominantly Asian and Pacific Islander population of medical students in a problem-based learning curriculum." *Academic Medicine* 78(5): 483-490.

Kassebaum, D. G. and E. R. Cutler (1998). "On the culture of student abuse in medical school." *Academic Medicine* 73(11): 1149-1158.

Kasuya, R. T., Naguwa, G. S., Guerrero, Anthony P.S., Hishinuma, E.S., Lindberg, M. A., Keltner, D., Gruenfeld, D.H., Anderson, C. (2003). "Power, approach, and inhibition." *Psychological Review* 110(2): 265.

Kenny, S. C. (2015). Power, opportunism, racism: human experiments under American slavery. *Endeavour, 39*(1), 10-20.

Keltner, D. and R. J. Robinson (1996). "Extremism, power, and the imagined basis of social conflict." *Current Directions in Psychological Science:* 101-105.

Kosoko-Lasaki, O., Sonnino, R. E., & Voytko, M. L. (2006). Mentoring for women and underrepresented minority faculty and students: experience at two institutions of higher education. *Journal of the National Medical Association*, *98*(9), 1449–1459.

Kram, K. E. (1983). Phases of the mentor relationship. Academy of Management Journal, 26(4), 608-625.

Krogstad, J. M., & Noe-Bustamante, L. (2020). Key facts about US Latinos for national Hispanic heritage month. Pew Research Center. Retrieved at October 21, 2022 from https://www.pewresearch.org/fact-tank/2022/09/23/key-facts-about-u-s-latinos-for-national-hispanic-heritage-month/

Ladson-Billings, G. (1995). Toward a Theory of Culturally Relevant Pedagogy. American Education Research Journal, 32(3), 465-491.

Ladson -Billings, G., & Tate, W.F. (2016). Toward a Critical Race Theory of Education. Critical Race Theory in Education, 10-31.

Lawrence, K., & Keleher, T. (2004, November). Chronic disparity: Strong and pervasive evidence of racial inequalities. In *Race and Public Policy Conference, Berkeley, CA*. Retrieved from September 15, 2021 from https://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf

Lee, K. B., Vaishnavi, S. N., Lau, S. K., & Andriole, D. A. (2009). Cultural competency in medical education: demographic differences associated with medical student communication styles and clinical clerkship feedback. *Journal of the National Medical Association, 101*(2), 116-126.

Lester, S. (1999). *An Introduction to Phenomenological Research*. Retrieved October 2020 from http://www.psyking.net/HTMLobj-3825/Introduction_to_Phenomenological_Research-Lester.pdf

Liaison Committee on Medical Education. LCME *Diversity Standards*. Retrieved November 15, 202, from https://www.lcme.org/connections/connections_2013-2014/IS-16_2013-2014.htm

Lieberman, S. A., Frye, A.W., Thomas, L., Rabek, J.P., Anderson, G.D. (2008). "Comprehensive changes in the learning environment: subsequent step 1 scores of academically at-risk students." *Academic Medicine* 83(10): S49-S52.

Lin, A., Grant, R., Kubota, R., Motha, S., Sachs, G.T., Vandrick, S., Wong, S. (2004). "Women faculty of color in TESOL: Theorizing our lived experiences." *Tesol Quarterly* 38(3): 487-504

Loo, C. M., & Rolison, G. (1986). Alienation of ethnic minority students at a predominantly White university. *The journal of higher education*, *57*(1), 58-77.

Mamdani, M., Al-Omran, M., & Tricco, A. C. (2014). Harassment and discrimination in medical training: a systematic review and meta-analysis. *Academic medicine: journal of the Association of American Medical Colleges*, *89*(5), 817–827.

Mangus, R. S., Hawkins, C. E., & Miller, M. J. (1998). Prevalence of harassment and discrimination among 1996 medical school graduates: a survey of eight US schools. *Jama*, *280*(9), 851-853.

Marin, G. (1993). Influence of acculturation on familialism and self-identification among Hispanics. *Ethnic identity: Formation and transmission among Hispanics and other minorities*, 181-196.

Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Sage Publications, Inc.

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research*. Sage publications.

Matsuda, M. J. (1997). *Where is your body? And other essays on race, gender, and the law*. Beacon Press.

Markit, I. H. S. (2017). The complexities of physician supply and demand: Projections from 2015 to 2030. *Association of American Medical Colleges*.

Martin, L, *What to know about allopathic medicine.* Retrieved October 13, 2021, from *https://www.medicalnewstoday.com/articles/allopathic-medicine*

Matsuda, M.J., Lawrence, Cr.R. III Delgado, R., & Crenshaw, K.W. (1993). Words that wound: Critical race theory, assaultive speech, and the first amendment. Boulder, CO: Westview Press.

Merriam, S. B. (1998). Qualitative Research and Case Study Applications in Education. Revised and Expanded from" *Case Study Research in Education*.", ERIC.

Moerer-Urdahl, T. and J. Creswell (2004). "Using Transcendental Phenomenology to Explore the “Ripple Effect” in a leadership mentoring program." *International Journal of Qualitative Methods* 3(2): 1-28. Retrieved from https://www.ualberta.ca/~iiqm/backissues/3_2/pdf/moerer.pdf

Morgan Consoli, M. L., & Llamas, J. D. (2013). The relationship between Mexican American cultural values and resilience among Mexican American college students: A mixed methods study. *Journal of counseling psychology*, *60*(4), 617.

Moustakas, C. (1994). *Phenomenological Research Methods*. London: Sage Publications.

Moy, E., & Bartman, B. A. (1995). Physician race and care of minority and medically indigent patients. *JAMA, 273*(19), 1515-1520.

Nachman, R. L., & Marzuk, P. M. (2011). Flexner redux. *Perspectives in biology and medicine, 54*(1), 55–60.

Najibi, S., Carney, P. A., Thayer, E. K., & Deiorio, N. M. (2019). Differences in Coaching Needs Among Underrepresented Minority Medical Students. *Family medicine, 51*(6), 516–522.

Neufeld, A., & Malin, G. (2021). How medical students cope with stress: a cross-sectional look at strategies and their sociodemographic antecedents. *BMC medical education, 21*(1), 299.

Nickens, H. W., & Ready, T. (1999). A strategy to tame the" savage inequalities". *Academic Medicine, 74*(4), 310-311.

Nickens, H. W., Ready, T. P., & Petersdorf, R. G. (1994). Project 3000 by 2000: racial and ethnic diversity in US medical schools. *N Engl J Med, 331*(7), 472-476.

Nguyen, M., Chaudhry, S. I., Desai, M. M., Chen, C., Mason, H. R., McDade, W. A., & Boatright, D. (2022). Association of sociodemographic characteristics with US medical student attrition. *JAMA internal medicine, 182*(9), 917-924.

Nivet, M. A. (2010). Minorities in academic medicine: Review of the literature. *Journal of Vascular Surgery, 51*(4), S53-S58.

Nivet, M. A. (2015). A Diversity 3.0 Update: Are We Moving the Needle Enough? *Academic medicine: journal of the Association of American Medical Colleges*.

Nuriddin, A., Mooney, G., & White, A. (2020). Reckoning with histories of medical racism and violence in the USA. *Lancet (London, England)*, *396*(10256), 949–951.

Nwokolo, V., Longoria, K., Loftis, C., Tapia, B., & Robledo, C. (2021). Examining the Gap Between Medical School Matriculation and Graduation Rates Amongst Self-Identified Minorities. *Journal of the National Medical Association*, *113*(3), 315–323.

Ochoa, K. C., Evans, M. A., & Kaiser, S. A. (2003). Negotiating care: the teaching and practice of cultural competence in medical school: a student perspective. *Med Educ Online [serial online]*.

Okawa, G. Y. (2002). Diving for pearls: Mentoring as cultural and activist practice among academics of color. *College Composition and Communication*, 507-532.

Orom, H., Semalulu, T., & Underwood III, W. (2013). The social and learning environments experienced by underrepresented minority medical students: a narrative review. *Academic Medicine*, *88*(11), 1765-1777.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*, Thousand Oaks, CA: Sage Publishing.

Pérez, D., Ashlee, K. C., Do, V. H., Karikari, S. N., & Sim, C. (2017). Re-conceptualizing student success in higher education: Reflections from graduate student affairs educators using anti-deficit achievement framework. *Journal on Excellence in College Teaching*, *28*(3), 5-28.

Petersdorf, R. G., Turner, K. S., Nickens, H. W., & Ready, T. (1990). Minorities in medicine: past, present, and future. Academic Medicine, 65(11), 663-670.

Pierce, C. M., Carew, J.V., Pierce-Gonzalez, D., Wills, D. (1977). "An Experiment in Racism TV Commercials." *Education and Urban Society* 10(1): 61-87.

Plant, E. A., Peruche, B.M., Butz, D.A. (2005). "Eliminating automatic racial bias: Making race non-diagnostic for responses to criminal suspects." *Journal of Experimental Social Psychology* 41(2): 141-156.

Price, E. G., Powe, N. R., Kern, D. E., Golden, S. H., Wand, G. S., & Cooper, L. A. (2009). Improving the diversity climate in academic medicine: faculty perceptions as a catalyst for institutional change. *Academic medicine: journal of the Association of American Medical Colleges*, *84*(1), 95.

Portland State University Institutional Review Board (IRB). Retrieved from https://sites.google.com/a/pdx.edu/research/integrity/human-subjects

Posner, R. A. (1997). "Against ethical criticism." *Philosophy and Literature* 21(1): 1-27.

Pyskoty, C. E., Richman, J. A., Flaherty, J. A. (1990). "Psychosocial assets and mental health of minority medical students." *Academic Medicine* 65(9): 581-585.

Regents of the University of California v. Bakke, 438 U.S. 265 (1978) No. 7811 Argued October 12, 1977 and Decided June 28, 1978 438 U.S. 265. https://supreme.justia.com/cases/federal/us/438/265/ Accessed 12 Nov. 2022.

Reitzes, D. C., & Elkhanialy, H. (1976). Black students in medical schools. *Journal of Medical Education*.

Robles, J., Anim, T., Wusu, M. H., Foster, K. E., Parra, Y., Amaechi, O., & Washington, J. (2021). An Approach to Faculty Development for Underrepresented Minorities in Medicine. Southern medical journal, 114(9), 579

Rutter, M. (1993). "Resilience: Some conceptual considerations." *Journal of Adolescent Health* 14(8): 626-631.

Sabogal, F., Marín, G., Otero-Sabogal, R., Marín, B. V., & Perez-Stable, E. J. (1987). Hispanic Familism and Acculturation: What Changes and What Doesn't? *Hispanic Journal of Behavioral Sciences*, *9*(4), 397–412.

Saenz, V. B., & Ponjuan, L. (2009). The vanishing Latino male in higher education. *Journal of Hispanic Higher Education*, *8*(1), 54-89.

Saha, S., Guiton, G., Wimmers, P. F., & Wilkerson, L. (2008). Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*, *300*(10), 1135-1145.

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, *159*(9), 997-1004.

Saha, S., Taggart, S. H., Komaromy, M., & Bindman, A. B. (2000). Do patients choose physicians of their own race? To provide the kind of care consumers want, medical schools might be able to justify using race as an admissions criterion. *Health affairs*, *19*(4), 76-83.

Saldaña, J. (2013). The coding manual for qualitative researchers. Thousand Oaks, CA: Sage.

Saldaña, J., & Omasta, M. (2016). *Qualitative research: Analyzing life*. Sage Publications

Sánchez, G., Nevarez, T., Schink, W., & Hayes-Bautista, D. E. (2015). Latino physicians in the United States, 1980–2010: A thirty-year overview from the censuses. *Academic Medicine*, *90*(7), 906-912.

Sánchez, J. P., Poll-Hunter, N. I., & Acosta, D. (2015). Advancing the Latino physician workforce-population trends, persistent challenges, and new directions. *Academic Medicine*, *90*(7), 849-853.

Sánchez, J. P., Peters, L., Lee-Rey, E., Strelnick, H., Garrison, G., Zhang, K., Spencer, D., Ortega, G., Yehia, B., Berlin, A., Castillo-Page, L. (2013). "Racial and Ethnic Minority Medical Students' Perceptions of and Interest in Careers in Academic Medicine." *Academic Medicine* 88(9): 1299-1307.

Savitt T. (2006). Abraham Flexner and the black medical schools. 1992. *Journal of the National Medical Association*, *98*(9), 1415–1424.

Satterfield, J. M. and C. Becerra (2010). "Faculty and student support: Developmental challenges, stressors and coping strategies in medical residents: a qualitative analysis of support groups." *Medical Education* 44(9): 908-916.

Schommer-Aikins, M. and M. Easter (2006). "Ways of knowing and epistemological beliefs: Combined effect on academic performance." *Educational Psychology* 26(3): 411-423.

Segal, S. S., Giordani, B., Gillum, L. H., & Johnson, N. (1999). The academic support program at the University Of Michigan School Of Medicine. *Academic Medicine*, *74*(4), 383-5.

Seidman, I. (2006). Interviewing as Qualitative Research 3rd edition. Columbia University, *Teachers College Press.*

Shanafelt, T.D. (2006). "Personal life events and medical student burnout: a multicenter study." *Academic Medicine* 81(4): 374-384.Smedley, B. D., & Mittman, I. S. (2011). The diversity benefit: how does diversity among health professionals

address public needs? *Healthcare Disparities at the Crossroads with Healthcare Reform* (pp. 167-193).

Smedley, B. D., Butler, A. S., & Bristow, L. R. (2004). Increasing diversity in the health professions: A look at best practices in admissions. In *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*. National Academies Press (US).

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care: Washington, DC: National Academies Press.

Smith, W. A., Allen, W. R., & Danley, L. L. (2007). "Assume the Position . . . You Fit the Description": Psychosocial Experiences and Racial Battle Fatigue Among African American Male College Students. *American Behavioral Scientist, 51*(4), 551–578.

SparkNotes Editors. (2002). SparkNotes on Invisible Man. Retrieved April 3, 2020, Retrieved from http://www.sparknotes.com/lit/invisibleman

Solórzano, D., Ceja, M., Yosso, T. (2000). "Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students." *Journal of Negro Education*: 60-73.

Solórzano, D. G., & Bernal, D. D. (2001). Examining transformational resistance through a critical race and LatCrit theory framework: Chicana and Chicano students in an urban context. *Urban education*, *36*(3), 308-342.

Solórzano, D. G. and T. J. Yosso (2001). "Critical race and LatCrit theory and method: Counter-storytelling." *International Journal of Qualitative Studies in Education* 14(4): 471-495.

Solórzano, D. G. & Yosso, T. J. (2002). Critical race methodology; counterstory-telling as an analytical framework for education research. Qualitative Inquiry, 8(1), 23-44.

Solórzano, D. G. and O. Villalpando (1998). "Critical race theory, marginality, and the experience of students of color in higher education." S*ociology of education: Emerging perspectives*: 211-224.

Soto, E., Lewis, M., Estrada, C. A., Jorge, I., O'Beirne, R., Martin, C., & Corey, B. (2022). Barriers and facilitators for under-represented in medicine (URiM) medical students interested in surgical sub-specialties. *The American Journal of Surgery*.

Strayhorn, G. (1980). "Perceived stress and social support of Black and White medical students." *Journal of Medical Education* 55(7): 618-620.

Strayhorn, G. and H. Frierson (1989). "Assessing correlations between Black and White students' perceptions of the medical school learning environment, their academic performances, and their well-being." *Academic Medicine* 64(8): 468-473.

Suárez-Orozco, C., & Suárez-Orozco, M. M. (1995). *Transformations: Immigration, family life, and achievement motivation among Latino adolescents*. Stanford University Press.

Suárez-Ortega, M. (2013). Performance, reflexivity, and learning through biographical-narrative research. *Qualitative Inquiry, 19*(3), 189-200.

Sue, D. W., Nadal, K.L., Capodilupo, C.M., Lin, A.I., Torino, G.C., Rivera, D.P. (2008). "Racial microaggressions in the life experience of Black Americans." *Professional Psychology: Research and Practice* 39(3), 329.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist, 62*(4), 271.

Sullivan, L. W. (2004). Missing persons: minorities in the health professions, a report of the Sullivan Commission on Diversity in the Healthcare Workforce.

Sullivan, L. W., & Mittman, I. S. (2010). The state of diversity in the health professions a century after Flexner. *Academic Medicine*, *85*(2), 246-253.Sowell, T. (2003). Damaging Admissions: Increasing Faculty Diversity. Capitalism Magazine.

Stahnisch, F. W., & Verhoef, M. (2012). The flexner report of 1910 and its impact on complementary and alternative medicine and psychiatry in North America in the 20th century. *Evidence-based complementary and alternative medicine: eCAM*, *2012*, 647896. https://doi.org/10.1155/2012/647896

Steinecke, A., & Terrell, C. (2010). Progress for whose future? The impact of the flexner report on medical education for racial and ethnic minority physicians in the United States. Academic Medicine, 85(2), 236-245.

Tate IV, W. F. (1997). Chapter 4: Critical race theory and education: History, theory, and implications. *Review of research in education*, *22*(1), 195-247.

Tekian, A., Jalovecky, M. J., & Hruska, L. (2001). The Impact of Mentoring and Advising At-risk Underrepresented Minority Students on Medical School Performance. Academic Medicine, 76(12), 1264.

Thomas, B., Manusov, E. G., Wang, A., Livingston, H. (2011). "Contributors of black men's regents' success in admission to and graduation from medical school." *Academic Medicine* 86(7): 892-900.

Toretsky, C., Mutha, S., & Coffman, J. (2018). Breaking barriers for underrepresented minorities in the health professions. *University of California San Francisco: Health force Center*.

Umaña-Taylor, A. J., & Updegraff, K. A. (2007). Latino adolescents' mental health: Exploring the interrelations among discrimination, ethnic identity, cultural orientation, self-esteem, and depressive symptoms. *Journal of adolescence*, *30*(4), 549-567.

U.S Department of Health and Human Services. (2010). Patient protection and affordable care act. *Public Law*, 111-148.

U.S. Department of Health and Human Services (2009). *Code of Federal Regulations. Title 45 Public Welfare. Part 46: Protection of human subjects*. Retrieved from http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html

US Census Bureau Quick Facts: United States. (2021). Census Bureau Quick Facts.

Vaishnavi, S., Rao, V., Fann, J.R. (2009). "Neuropsychiatric problems after traumatic brain injury: unraveling the silent epidemic." *Psychosomatics* 50(3): 198-205.

Valdez, F. (1996). Forward: Latina/o ethnicities, critical race theory, and pot-identity politics in postmodern legal culture; from practices to possibilities. La Raza Law Journal, 9, 1-31

Vargas, R. (2008). A Decade Later: The Attack Against Critical Race Theory in Defense of Reason. Retrieved July 2, 2022 from http://works.bepress.com/raul_vargas/1

Varpio, L., & Meyer, H. (2017). A lesson from the qualitative rip out series: let go of expectations for universally applicable “gold standards” for qualitative research. *Journal of Graduate Medical Education*, *9*(2), 154-156.

Villalpando, O. D. (1996). *The long-term effects of college on Chicano and Chicana students'" other-oriented" values, service careers, and community involvement*. University of California, Los Angeles.

Werner, E. E. (1993). "Risk, resilience, and recovery: Perspectives from the Kauai Longitudinal Study." *Development and Psychopathology* 5(04): 503-515.

Werner, E. E. and R. S. Smith (1989). *Vulnerable, but invincible*, Adams, Bannister, Cox.

Wheeler, M., de Bourmont, S., Paul-Emile, K., Pfeffinger, A., McMullen, A., Critchfield, J. M., & Fernandez, A. (2019). Physician and trainee experiences with patient bias. *JAMA internal medicine*, *179*(12), 1678-1685.

Whitcomb, M. E., & Macy Jr, J. (2009). *New and developing medical schools: motivating factors, major challenges, planning strategies*: Josiah Macy, Jr. Foundation.

Whitlock, J. (2022) Resident vs. Attending Physician: What’s the Difference? How they compare and fit in the overall hospital hierarchy. Retrieved October 12, 2022 from https://www.verywellhealth.com/types-of-doctors-residents-interns-and-fellows-315729

Williams, D. A., Berger, J. B., & McClendon, S. A. (2005). *Toward a model of inclusive excellence and change in postsecondary institutions* (p. 39). Washington, DC: Association of American Colleges and Universities.

Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist*, *57*(8), 1152–1173.

Williams, D. R. (1997). Race and health: basic questions, emerging directions. *Annals of epidemiology*, *7*(5), 322-333.

Wingrove-Haugland, E., & McLeod. “Not Minority” but Minoritized. Teaching Ethics, 21(1),1-11.

Yin, R. K. (2002). "Applications of case study research. Sage, 2011.

Yin, R. K. (2009). *Case study research: Design and methods* (Vol. 5). Sage.

Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race ethnicity and education*, *8*(1), 69-91.

Weiss, J., Balasuriya, L., Cramer, L. D., Nunez-Smith, M., Genao, I., Gonzalez-Colaso, R., & Sharifi, M. (2021). Medical students’ demographic characteristics and their perceptions of faculty role modeling of respect for diversity. *JAMA network open*, *4*(6), e2112795-e2112795.

Xierali, I. M., & Nivet, M. A. (2018). The Racial and Ethnic Composition and Distribution of Primary Care Physicians. *Journal of health care for the poor and underserved*, *29*(1), 556–570.

Xu, G., Fields, S. K., Laine, C., Veloski, J. J., Barzansky, B., & Martini, C. J. (1997). The relationship between the race/ethnicity of generalist physicians and their care for underserved populations. *American Journal of Public Health, 87*(5), 817-822.

Appendix A: Participant Consent

This study is designed to help understand the experiences and observations of Latinos/Hispanics medical students through their training at the Pacific Northwest Medical University. Very little is known about the experiences of Underrepresented Minority Students in medicine. I am a doctoral student in the Graduate School of Education at Portland State University conducting this study to learn and document of the lived lives of Latino medical students in their trajectory in medical school. You may know or recognize me as an administrator at the PNWMU. However, for this research project, my role will be as a PSU doctoral student collecting data for my dissertation, not as an administrator or employee of PNWMU. The separation of my position role at PNWMU is important for you to understand, as any information is shared during the interviews will only be used for research purposes related to this dissertation study, and not for PNWMU purposes. If you chose to participate in this in this study, it will require some of your time. I will ask to meet with you for three interviews and a fourth meeting to review the transcripts for accuracy. The interviews will be conducted in mutually agreed upon location that is safe, quiet, secure, comfortable, and accessible to you at your preferred location. The interviews will be audio recorded. There is minimal risk and few discomforts that might be anticipated form your participation in this research study. Potential risks may include inconvenience of time, sensitivity, discomfort with questions related to educational equity, treatment, and or perception of differences as Latinos medical students in predominate white institution. You may decline to answer any uncomfortable questions at any time during the interviews. In addition, you may withdraw from participating in the study at any time, without penalty or repercussion. The possible benefits form participation in this research study will be the opportunity to freely share your experiences, perceptions, and recommendations related to your experiences as a Latino medical student. The participants and location of the study will not be identified in the summary

or in the completion of the dissertation to protect the participants of this study. There will not be compensation to your participation in this study. Please note that your participation will remain confidential. All information gathered will be kept in secure and password-protected location. Only I will have access to the study data and information and there will be no identifying names on the audio recordings or files. Your names will not be made available to anyone to main your anonymity. I will keep the recordings for three years after the completion of the study. The results of the study will be published in my dissertation. Your signature indicates that you have read the above information and agree to take part in this dissertation study. As a participant, you may withdraw from the research study at any time, you may refuse to answer questions with no consequences for your withdrawal from the project. I will provide you a copy of this form your records.

_____Signature _____Date

Appendix B: Participant Recruitment Email

Email invitation for Latino medical student participation

Dear Student (Name to be inserted)

I am a doctoral student in the Ed.D. for High Education and Leadership Program at Portland State University. As part of my research, I am conducting a study about Latino medical students (3rd and 4rth year) in medicine, and I would like to enlist you as a participant in this research. Your participation would consist of at least 4 hours and 45 minutes interviews during the winter term. There will be a total of three interviews. Participation is voluntary, confidential, and anonymous. If you do choose to participate, your experiences as a student will remain confidential with any information that you share and will not use any identifying information in the final study. As a Latino medical student, your experiences and perceptions in medical school are an integral factor in this research and your participation will assist us with better understanding the experiences and observation of the barriers and facilitators you experience as a student. If you are interested in participating, please contact Leslie García by date. I appreciate your support in this important research study.

Best,

Leslie García

Appendix C: Interview Questions

1) Interview questions for Latino medical students:
2) Interview One: Focused Life History: This will put the participant's experiences in context by asking them in detail about their experiences as a URiM medical student.
    a. How and when did you consciously want to study medicine?
    b. What aspects of the MD program have been most challenging? Why?
    c. What aspects of the MD program have affirmed your passion for medicine? Why?
    d. What personal qualities do you attribute to your success in medical school?
    e. How do you thrive academically, socially, mentally and emotionally as a Latino medical student?
    f. How would you define racism?
    g. What is it like to be a Latino medical student in a predominantly White institution?
    h. Is there a significant event(s) that stands out in your mind about it?
3) Interview Two: Focus on Concrete Participant Experience: Participants will be asked for details about explicit details of their experiences rather than their opinions.
    a. Can you recall a situation in the classroom or clinical setting where you witnessed a racist incident? Describe this situation in detail. (Who was involved, etc.,)

b. Can you recall a situation in the classroom or clinical setting where you experienced a racist incident? Describe this situation in detail. (Who was involved, etc.,)
c. Can you recall a situation in a social setting related to the MD program where you witnessed a racist incident involving another URiM medical student? Describe this situation in detail.
d. Can you recall a situation in a social setting related to the MD program where you experienced a racist incident? Describe this situation in detail.
e. In your interactions with patients, have you witnessed a racist incident directed at a URiM student? Describe this situation in detail.
f. Have you personally experienced a racist incident directed at you by a patient? Describe this situation in detail.

4) Interview Three: Reflection on the Meaning: Participants will be asked to reflect on the meaning of their experience and make sense of their experiences. Participants will be asked about the factors that influence the participants' present lives as URiM medical students.
    a. Regarding incident X where you personally experienced racism, how did you respond?
    b. What do you remember feeling like, after you responded in that particular manner?
    c. Would you do anything differently? If so, how and why?
    d. Regarding racist incident X that you witnessed, how did you respond

5) This process will use open-ended questions to build upon the participant's responses the posed questions. The goal is to reconstruct the participant's experience within the topic understanding?
6) What coping and adapting practices have you/are you developing for your personal responses to racial bias?
7) What institutional resources are needed to provide social support for Latino medical students who have experiences or witnessed racial bias?