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BIPOC MEDICAL STUDENT WELLNESS:

AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

A Chapter Style Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Education in Student Affairs Administration and Leadership

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We recommend acceptance of this dissertation in partial fulfillment of the candidate's requirements for the degree of Doctor of Education (Ed.D.) in Student Affairs Administration and Leadership.

The candidate has completed the oral defense of the dissertation.

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ABSTRACT

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Black, Indigenous, (and) People of Color (BIPOC) medical student wellness has been studied almost exclusively by utilizing quantitative research methods. Few studies have looked at BIPOC medical student wellness through qualitative research methods. Interpretative Phenomenological Analysis (IPA) was utilized to study BIPOC medical student wellness through interviewing, describing, and analyzing their lived experiences while in medical school. This is the first known study utilizing IPA to research the lived experience of BIPOC medical students. With this research, how BIPOC medical students experience personal wellness as they navigate systemic racism in medical schools was investigated. This study was guided by one main research question and two sub-questions. The main guiding question: How do BIPOC medical students make meaning of personal wellness as they navigate historically White medical school ecosystems? The sub-questions included: (a) How do BIPOC medical students define personal wellness for themselves? and (b) What resources do BIPOC medical students point to as their key support systems at predominantly White medical institutions? Intersecting identities, critical race theory (CRT), and ecological systems theory (EST) were considered, and four Group Experiential Themes (GETs) were identified. Conducting future qualitative studies on BIPOC medical student wellness, especially focusing on action-oriented research, is recommended.

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I would like to acknowledge past, current, and future Black, Indigenous, (and) People of Color (BIPOC) medical students. Despite the systemic racism you have faced, are now encountering, and will undoubtedly confront in the future, you have persevered and prevailed in an unjust system that you were forced to navigate. As a White researcher, while I admit to having an incomplete understanding of the trials and tribulations you have endured, are now undergoing, or will confront in the future as a BIPOC medical student, I have the greatest admiration and respect for your courage, fortitude, and tenacity in navigating oppressive White spaces. However, I realize that talk alone is cheap. What is needed is talk, followed quickly by effective action.

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you who helped me to remember I was running a marathon and not the 100-meter dash. But I must admit that it does feel great to finally have arrived at the finish line.

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Finally, last but certainly not least, to my profoundly supportive family, I thank you from the bottom of my heart. There have been countless times during the last three years when I felt like giving up. There was too much work to be done and often times I felt that I could not do it anymore. Many times I complained of being too tired. Yet, through it all, you encouraged me to stick with it. To my wife, who always encouraged me to keep on going and kept on reminding me that I was almost done, I love you. From her, I remember hearing over and over again, soothing words of encouragement. These words still echo in my mind and heart today, such lovely sounds like, “You can do this. You are doing this. You are getting so close. I believe in you.”

Without all of these people in my life, without your kindness, and your patience, I would never have finished this dissertation. This was truly a team effort. I dedicate this achievement, one that I will always treasure and never forget, to all of you reading this study, who have helped me during this part of my life’s journey. Thank you for your grace, God’s grace, shown to me during the last three years.

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INTRODUCTION

Perhaps nowhere else did tragedies surface for so many people, in such a short amount of time than with the beginning of the pandemic in March 2020. Prior to the arrival of COVID-19 in the United States, I remember reading stories in the news about Italy and other European nations and how so many people were dying as the pandemic was first unfolding. I never thought that the pandemic would claim over one million lives in the U.S., which accounted for 16.3% of COVID-19 deaths worldwide (Johns Hopkins Coronavirus Resource Center, 2023). This high percentage is particularly salient as the U.S. has only 4.3% of the world's population (United States Census Bureau, 2023). During the early part of the pandemic, I remember watching media clips which showed exceptionally horrid behavior of patients and their family members toward doctors, nurses, and other medical staff. I also noticed that most of the people with atrocious behavior patterns were White men.

I recall other turmoil from that chaotic year of 2020, including the highly publicized murder of George Floyd, an African American man whose death sparked outrage across the country. For me, that year was the tipping point of finally admitting what I have long known: that White people have a significant and unaddressed problem in the U.S. when it comes to acknowledging systemic racism. As I investigated my own work culture, where I am employed as a medical school academic advisor, I discovered that medical schools were also not immune from housing these oppressive systems.

While I was not witnessing physical harm toward Black, Indigenous, (and) People of Color (BIPOC) at my medical school, through conversations with BIPOC medical students, I started to notice reports that concerned the daily microaggressions they faced. They also mentioned a recurrent theme regarding a lack of attention from the institution for addressing and advocating wellness needs specifically for BIPOC medical students.

These observations prompted me to see how I could better understand ways to address and advocate for the wellness of BIPOC medical students. I felt that my work as a medical school academic advisor could serve as a platform for collaborating with BIPOC medical students. To undertake this work and share my findings, I knew that conducting research on this topic would enable me to serve as a more effective collaborator with BIPOC medical students. I also realized that carefully organizing this research would be important for the success of this study. Accordingly, at the beginning of every chapter, I have included an outline of the contents which effectively summarizes the organization for that chapter. Following the chapter outline, I then proceed to discuss the topics for that chapter in detail.

In Chapter I, the statement of the problem is first discussed. Second, the purpose of the study and the research questions are introduced. Third, I outline a brief overview of the study. Fourth, I discuss the rationale and significance of the research. Fifth, I describe my researcher positionality as it relates to the study. Sixth, I provide a brief outline of key definitions and terms for my study, including concepts pertinent to race and ethnicity and medical school terminology. Finally, I conclude Chapter I with a summary of the chapter and outline the organization of my dissertation.

Statement of the Problem

The United States has become more racially diverse during the last 20 years. According to the 2010 U.S. Census, 27.6% of the U.S. population was BIPOC. By 2020, there was a 10.8% gain in BIPOC residents, resulting in 38.4% of the overall population in the U.S. being BIPOC (United States Census Bureau, 2021). The overall numbers of U.S. medical school student enrollment, when White and BIPOC medical students are aggregated, also grew during the same period. According to the Association of American Medical Colleges (AAMC), overall medical school student enrollment in the U.S. has increased by 31% since 2002 (Kalter, 2019). However, when the medical school student enrollment numbers are disaggregated by race and ethnicity, and when taking into consideration BIPOC medical student numbers compared to White medical student numbers, the picture changes dramatically. Henderson et al. (2021) reported decreased enrollment of BIPOC medical students over the last 20 years. This signifies that BIPOC medical student enrollment has been going in the opposite direction when compared to the overall U.S. BIPOC population. During the last two decades, the number of BIPOC medical students decreased from 15% to 13%, resulting in a net loss of 2% of BIPOC medical students (Henderson et al., 2021). A major problem is that while medical schools seem to be doing well in terms of their overall enrollment numbers, when examining the disaggregated numbers of matriculating BIPOC medical students and White medical students, medical schools are losing BIPOC medical students, while gaining White medical students.

Supporting the disaggregated example of the decline mentioned by Henderson et al. (2021), King and Hines (2021) stated that “there are fewer Black men in U.S. medical schools today than in 1970” (p. 919). They went on to elaborate by explaining that, with

fewer Black men being admitted to medical schools, the outcome will be fewer physicians who are African American men. These data also reflect the reality that Black medical students are much less represented in medical schools when compared to the proportionate numbers of African Americans in the general population. African Americans represent 13% of the U.S. population, but only 5% of U.S. physicians are Black (Laws, 2021).

In addition to the declining numbers of BIPOC medical students, another problem is that there is only one known study, by Brennan-Wydra et al. (2021), which has examined the impact of faculty and staff on the wellness of BIPOC medical students. Since White faculty and staff comprise a substantial majority of the population at most medical schools across the U.S., they likely do not have a clear grasp of the challenges with systemic racism faced by BIPOC medical students. The most recent data from the AAMC shows that the largest proportions of medical school faculty are White, at 63.9%, and Asian American, at 19.2%. Only 3.6% of medical school faculty are Black or African American and only 5.5% are Hispanic or Latinx (Kalter, 2019).

Even when working alongside BIPOC medical faculty and staff, White medical school academic advisors may be at risk for ignoring the issue of systemic racism faced by BIPOC medical students. One of the goals of this study was to seek answers about how to create a more inclusive medical school environment, replete with wellness rather than distress, for BIPOC medical students. It was exceptionally challenging to find definitions of wellness pertaining specifically to medical students and as comprised of more than the presence or absence of mental, physical, or psychological distress. The definitions of student wellness offered by Basma et al. (2021) and van Dijk et al. (2017)

came closest to the holistic approach I advocated for in this study. Basma et al. (2021) defined wellness in graduate students as a "state of being that accounts for the balance of mind, body, and spirit and the achievement of personal fulfillment" (p. 75). Van Dijk et al. (2017) stated that medical student wellness is a "broader definition in which also characteristics of psychological well-being and coping are used to determine a person's mental health" (p. 2).

While these two definitions as formulated by Basma et al. (2021) and van Dijk et al. (2017) come closest to my perception of holistic medical student wellness, I also recognize that BIPOC medical students need to be intentionally included in creating their own definitions of personal wellness. These students may define and describe wellness in ways that have not yet been adequately articulated in the literature. Therefore, in my study I sought to understand how BIPOC medical students described their own wellness. Included as my central focus are detailed accounts of the systemic racism experienced by BIPOC medical students, as I reported on its impact to their wellness using thick, rich description found in my qualitative study.

There is no doubt that medical school is a universally stressful experience for all students. Topping this list are the following challenges: frequent high stakes exams (see Baldassin et al., 2008; Jenkins et al., 2018; Tewary et al., 2020; Thuma et al., 2020; Wimsatt et al. 2015); balancing outside interests against the intense demands of study time (see Byrnes et al., 2020; Hillard et al., 2011; Odom et al., 2007); and having to choose a specific medical career specialty and identify with that specialty within a few years of matriculating to medical school (see Monrouxe, 2010; Tewary et al., 2020). Studies of mental health outcomes of medical students have dominated the literature (see

Ahmed et al., 2009; Baldassin et al., 2012; Brazeau et al., 2014; Brennan-Wydra et al., 2021; Kötter et al., 2015; Wimsatt et al., 2015). However, BIPOC medical students have not been the focus of research on medical student wellness. Rather, discussions of race are often tangentially discussed and not seen as the most important factor contributing to challenging mental health conditions for BIPOC medical students.

Due to the universal challenges continually faced by medical students, most medical school administrators have focused on advocating for medical student wellness throughout the four years of medical school. However, what is lacking is a specific focus on BIPOC medical student wellness. While generic medical student wellness is sufficiently reviewed in the literature (see Dunn et al., 2008; Dyrbye et al., 2007; Hardeman et al., 2015; Hillard et al., 2012; Jenkins et al., 2018; Thuma et al., 2020; van Dijk et al., 2017), there is a dearth of studies which address systemic racism pertaining specifically to BIPOC medical students.

As the present study highlights the lived experiences of BIPOC medical students in facing systemic racism, it is also important to acknowledge that a few researchers have conducted studies originating outside of medical schools that have looked at systemic racism faced by BIPOC students. For example, Basma et al. (2021) studied burnout and wellness in BIPOC graduate counseling students. These authors reported a relationship between experiences of discrimination and decreasing reports of wellness. Basma et al. (2021) provided a critical perspective when reviewing future directions on this topic. They acknowledged the severe deficiency in understanding how BIPOC graduate students not only come to have experiences of racism, but also how the school setting itself could be restructured to create a warm and supportive environment for all students.

My review has highlighted a significant gap in the literature regarding BIPOC medical student wellness. While researchers have reported that BIPOC medical students experience racist acts, what is not focused on are the multiple causes of this racism, and specifically racism that is systemically based. Experiences of racism are usually implied to stem from isolated, individual interactions with White, racist individuals, rather than being part of the daily microaggressions experienced by BIPOC medical students. Therefore, representation of an oppressive social system is ignored and individual human pathologies are highlighted. Furthermore, advocacy for fostering BIPOC medical student wellness are lacking in the literature. That is, what would be most helpful for fostering wellness in BIPOC medical students? Are there actions which would be beneficial in pursuit of such wellness? How can the structure of medical schools be changed to become anti-racist, inclusive, and welcoming toward BIPOC medical students?

A few researchers have explored mentoring models for medical students (see Aagaard & Hauer, 2003; Andre et al., 2017; Hillard et al., 2017). While these studies do not specifically address BIPOC medical student wellness, there are possible applications from these studies regarding the impact of mentoring on BIPOC medical student wellness. While Aagaard and Hauer (2003), Andre et al. (2017), and Hillard et al. (2011) did not focus exclusively on BIPOC medical students, they studied the effects of mentoring on medical students. However, although mentoring was found in all of these studies to be effective for enhancing individual medical student wellness, it still raises the question of whether mentoring can be used as a tool for breaking down the systemic racism which exists in medical schools and perpetuates systemic inequities.

There are few known studies on academic advising models in medical schools (see Amini et al., 2018; Frosch & Goldstein, 2019; Santiesteban et al., 2022; Tekian et al., 2001; Tewary et al., 2020). Through my exhaustive review of the literature, I was only able to locate five such studies. While I will discuss each of these studies in greater detail in Chapter II, here I would like to mention that academic advising in medical schools could be used as a tool to highlight the wellness needs of BIPOC medical students.

Tekian et al. (2001) and Tewary et al. (2020) discussed how academic advising can foster holistic health in BIPOC medical students. Tekian et al. (2001) utilized academic advising to work with medical students who were deemed to be "at-risk" of having academic difficulty during medical school. This academic difficulty was due to failure on medical school course exams or on the initial medical school licensing board examination, the United States Medical Licensing Examination (USMLE), colloquially known as Step 1. The results of the study by Tekian et al. (2001) were inconclusive, since only half the participants reported their advising experiences to be helpful in their being able to overcome academic failure during medical school.

While Tekian et al. (2001) and Tewary et al. (2020) focused on highlighting the wellness of BIPOC medical students, they did not address the problem of whether academic advising could be implemented to further our understanding of the systemic racism experienced by these students. For example, Tekian et al. (2001) and Tewary et al. (2020) did not state whether academic advising could be a tool for dismantling systemic racism. In other words, could academic advising trouble the status quo in medical schools? Medical schools have historically ignored issues of systemic racism and its

immediate impact on the wellness of BIPOC medical students. Academic advising could raise such awareness of systemic inequities in medical schools and foster an emphasis on diversity, equity, and inclusion, thereby promoting the cause of social justice.

In summary, the problems which prompted the need for this study are as follows. First, BIPOC medical student wellness has been largely ignored in the literature. Second, almost all studies in the related literature have utilized quantitative research designs, thus providing a lack of depth on the lived experiences of BIPOC medical students. Third, researchers that have addressed BIPOC medical student wellness have largely targeted reactions and responses to individual, isolated racist incidents, rather than emphasizing the systemic causes of racism, which continually impacts BIPOC medical student wellness. Fourth, few solutions to addressing BIPOC medical student wellness have surfaced in the literature and any coverage that does exist of such wellness is sparse. Finally, no programs in the literature have been identified which have addressed the underlying, systemic causes of racism toward BIPOC medical students. No known studies have been conducted which have examined ways that programs in medical schools consistently foster, rather than hinder, BIPOC medical student wellness. I attempted to shed light on these issues with this study.

Purpose of the Study and Research Questions

The purpose of this study was to understand how BIPOC medical students experience personal wellness as they navigate systemic racism in medical schools.

The research questions for this study were as follows:

1. How do BIPOC medical students make meaning of personal wellness as they navigate historically White medical school ecosystems?

2. How do BIPOC medical students define personal wellness for themselves?
3. What resources do BIPOC medical students point to as their key support systems at predominantly White medical institutions?

Brief Overview of the Study

These research questions lead directly to the research design I implemented for this study. Although I will discuss my research design in greater detail in Chapter III, I have provided a brief overview here so that readers will be able to understand how these questions are pertinent to the research design. I will be describing the lived experiences of BIPOC medical students in predominantly White medical schools. Critical theory was the framework for my study. Critical theory has been described as a subjective examination of the research process and therefore it is often found in many qualitative research designs (Lincoln & Guba, 2000). At the heart of critical theory is its focus on issues pertaining to social justice.

Aligned with critical theory as the paradigm of inquiry, my study utilized phenomenology as its methodology, with the subtype of phenomenology being Interpretative Phenomenological Analysis (IPA). Moustakas (1994) has defined phenomenology as useful in helping us gain an understanding of the deeper meaning of the lived experiences of participants. Through the lens of phenomenology, researchers can provide thick, rich description in relaying the lived experiences of participants. I studied BIPOC medical students and set up my research design to be in alignment with critical theory and IPA. As I conducted qualitative interviews with current BIPOC medical students at two medical schools outside of where I am employed, I learned about their lived experiences in medical school, specifically regarding their conceptualizations

of wellness as they continue to navigate White medical school spaces. A total of seven BIPOC medical students were recruited for this study from two predominantly White U.S. medical schools.

I attempted to disrupt the current lens of generic medical student wellness by describing the lived experiences of systemic racism in BIPOC medical students, through their reports as relayed to me in qualitative, semi-structured interviews. By gaining an understanding of the perspectives of BIPOC medical students, I attempted to understand how BIPOC medical students described their own views of medical student wellness. In recommendations for future research that are described in Chapter V, I discuss how medical school academic advisors can collaborate with BIPOC medical students in advocating for the wellness of these students.

Rationale and Significance of the Study

There exists a patchwork quilt of solutions to the systemic racism experienced by BIPOC medical students. Even in rare cases, such as research by Jenkins et al. (2018) which highlighted BIPOC medical student wellness, there are often many questions left unanswered in terms of the systemic racism faced by these students. First, no known study has examined systemic racism experienced by BIPOC medical students. Second, harm to BIPOC medical students and threats to their wellness is viewed as being isolated incidents instigated by a few racist individuals, rather than ongoing, daily systemic occurrences in medical schools. Finally, intentionality and actions to change the systemically racist environments of medical schools are never brought forth in studies. I have speculated that this occurs because systemic racism is never acknowledged as being a problem in predominantly White medical schools in the first place.

Intentionality in actions to advocate for the wellness of BIPOC medical students is difficult to find in the literature. Small-scale mentoring models were explored by Aagaard and Hauer (2003), but their study was limited in scope to faculty interactions with a few BIPOC medical students. The focus of that study was on promoting individual wellness, rather than on fostering systemic change based on addressing racial inequities. As mentioned earlier, exploratory research has examined academic advising models with BIPOC medical students (see Tekian et al., 2001; Tewary et al., 2020), but those investigations were also built on the presumption that systemic inequities do not exist in medical schools. In this study, I attempted to incorporate an understanding of how academic advising in medical schools might be incorporated by faculty and professional advising staff to further highlight the racial and systemic inequities in medical schools. In doing so, I am hopeful that medical school academic advisors might then serve as more effective advocates for the wellness of BIPOC medical students.

Researcher Positionality

My past and current roles in higher education were critical in my decision to conduct this study. I have been in the field for 25 years in roles as an instructor and academic advisor. During my career, I have been privileged to work with undergraduate, graduate, and professional students, many from underrepresented backgrounds. Decades of listening to stories from advisees have driven me to this research. When I was a graduate student in the 1990s, I pleaded with my advisor to help me develop a dual skill set in teaching and academic advising. As it turned out, although I ended up teaching for over 10 years, I ultimately came back to my original career path as an academic advisor. In the desire to reaffirm my calling as an academic advisor, I went back to graduate

school for a third time in 2021, this time to pursue my doctorate in Student Affairs Administration and Leadership. I conducted this research while occupying twin roles: as an academic advisor and doctoral candidate.

I currently serve as an academic advisor at one of the largest medical schools in the United States. While I never anticipated returning to academic advising after spending over a decade teaching, I was nevertheless eager to go back to my earliest professional roots. The position I ended up taking at my current university was not one I had actively sought. There were other, non-medical academic advising positions I had applied for, but this was the position I was offered, a victory for serendipity. During my time as a medical school academic advisor, I have learned more medical terminology than I ever hoped to gain. My comfort level in this position is high, based not on a strong medical aptitude, but rather, due to my passion and motivation for pursuing inclusiveness in medical school academic advising.

Soon after beginning my position, I noticed that while I was hired to ensure the wellness of medical students, something felt missing from the traditional medical school perception of wellness. While BIPOC medical students whom I advised never complained about being openly mistreated or feeling a lack of belongingness in medical school, I could always sense unspoken frustration and disappointment in the institution itself during our conversations. To be clear, the medical school I worked at was not actively promoting an oppressive atmosphere. However, I began to wonder whether the wellness espoused by predominantly White medical schools was ineffectually colorblind in meeting the actual wellness needs of BIPOC medical students. The topic for this study was firmly cemented with this realization.

After serving as an academic advisor for over 10 years, I feel confident in my ability to provide a welcoming and inclusive environment to students. I am equally confident in expressing the belief that I am not an expert in fully understanding the lived experiences of BIPOC medical students. While I strive to further my expertise at listening to the stories of BIPOC medical students, I also realize I am a work-in-progress. As I listen to these stories, I continually seek to gain a deeper and more appreciative understanding of my role in advocating for BIPOC medical student wellness.

Despite my skin color and identification as a White man, I am often drawn more toward students who are BIPOC rather than those who are White and from higher socioeconomic families. My background could partly explain this tendency. I was raised in a working-class household where money was scarce. I could relate to my BIPOC friends at school whose families tended to be less well off financially. I could not understand most of my White peers, many of whose families were much better off financially than mine. From an early age, I learned to deeply appreciate our racial differences and diversity in backgrounds. It is natural for me to embrace and celebrate the uniqueness of every student I meet. Warmth fosters trust, which I hoped I was able to fully foster in my conversations with every participant in this study.

I am far from perfect in my role as a collaborator, supporter, and advocate for BIPOC medical students. But I am genuine, empathetic, and have a pure heart. Although I feel at least satisfactorily qualified for the role of advising BIPOC medical students, I also realize that I will never be perfectly qualified based on my White identity and White privilege. However, I feel I can still serve as a strong collaborator for BIPOC medical students. It is rare to have genuine White collaborators, working alongside BIPOC

students and BIPOC higher education professionals, to advocate for a deeper and more specific understanding of BIPOC medical student wellness. On a personal note, I am married to an Asian American woman and have four biracial children, Asian and White. Although this fact hardly makes me an expert on BIPOC experiences, I strongly believe this is yet another piece of my revealed identities that help me connect with BIPOC medical students. I take comfort in knowing that I have consistently received highly favorable teaching and academic advising evaluations from BIPOC students throughout my career. This feedback gives me the confidence that, even as a White man, I was a suitable person to carry out this research. Since participants were BIPOC medical students, much like my current work, I felt like this rapport was transferable as I conducted interviews for this study.

While recognizing the limitations of my White identity and White privilege for this study, I also point out its strengths. I believe that academic advisors can bring a receptive, listening, and empathetic ear to their conversations with BIPOC medical students. I feel that academic advisors can serve as strong advocates for BIPOC advisees, given our intensive individual interactions and involvement in counseling students throughout their four years in medical school. My aim is to collaborate with like-minded colleagues and students, BIPOC and White, to advocate for systemic change for all.

Definitions of Terms

In this section, I will explain the usage of terms presented in this study which may need further elaboration, explanation, and examples. I will describe terminology I have chosen when discussing race and ethnicity and medical school curriculum and practices. Terminology for describing race and ethnicity is continually evolving, so I will explain

currently favored terms and articulate the race and ethnicity terms I will utilize throughout the description of my study. As medical schools are replete with confusing acronyms and other often unfamiliar terms, I seek to add clarity and understanding from the murkiness and confusion that medical school language sometimes creates.

Race and Ethnicity Terminology

There are several terms found in this study which I will define at the outset. By far, the most frequent term in my study is *BIPOC* medical students. This acronym refers to "Black, Indigenous, (and) People of Color." According to the BIPOC Project (n.d.), emphasizing BIPOC comes with the acknowledgement that not all People of Color face similar levels of social injustice. Black and Indigenous people are most impacted by systemic racial injustices. Other frequently found terms in this study are *African American* and *Black.* While there may be a preference for one of these terms more than the other, in my study I will be intentional with my usage of these words. When authors of specific studies I am referring to mention *African American* participants, I will also include the same words. When they refer to *Black* participants, I will do likewise. Finally, I highlight *racial microaggressions* to refer to "brief and commonplace verbal, behavioral, or environmental indignities (whether intentional or unintentional) that somehow communicate negative or denigrating messages to people of color" (Constantine & Sue, 2007, p. 143).

Medical School Terminology

Medical schools are replete with acronyms. I have assumed that most readers are unfamiliar with such terminology. As such, I have deliberately chosen to be selective in my utilization of medical school language. I will only specify medical school

nomenclature if it is impossible to otherwise avoid doing so. However, there are a few medical school terms that I cite in this study that were unavoidable to mention, so I will clarify these terms here.

Non-clinical years of medical school refer to the first two years of medical school. During this time, students have maximum classroom exposure and limited clinical experience. *Clinical years of medical school* refer to the third and fourth years of medical school. In these years, students have maximum clinical exposure and limited classroom experience. *High stakes tests* refer to any major exam a medical student will take, whether for course exams, clerkship exams, or board certification exams. *Clerkships* refer to the third and fourth years of medical school, where students are trained in various medical specialties, including but not limited to: anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, psychiatry, radiology, and surgery. Note that some medical schools have more clerkship specialties than I have listed here. However, the specialties I have just mentioned are the typical clerkships found in most medical schools nationwide. *Board certification exams* are exams which medical students take to become board certified as a licensed physician. There are three board certification exams, the United States Medical Licensing Examinations (USMLE), the first two of which are colloquially referred to by those in the medical field as *Step 1* and *Step 2*. These exams, which last for eight to nine hours each, are taken after the second and third years of medical school, respectively. The third board exam, colloquially referred to as *Step 3,* is taken after graduation from medical school, during medical residency. *Medical residency* is the specialized training which occurs immediately following medical school graduation, and typically lasts between three to

seven years, depending on the specialty being pursued. Only after successfully passing *Step 1* and *Step* 2, graduating from a U.S. accredited medical school, passing *Step 3,* and completing a U.S. accredited residency training program, can a person become a fully licensed physician. These fully licensed physicians are also known as *attending physicians,* or more commonly in the medical field, as *attendings.* The *Association of American Medical Colleges (AAMC)* and the *American Medical Association (AMA)* are the major nonprofit organizations that represents those in the medical field, among many other medical specialty organizations. The *Liaison Committee on Medical Education (LCME)* is responsible for continual accreditation of medical school programs. As such, the LCME holds considerable authority and power over the livelihood and continued existence of each of the 155 allopathic medical doctorate (M.D.) schools in the U.S.

Chapter Summary

In this chapter, I have examined the following topics. First, I stated the problem for this study, namely an inadequate description and explanation of BIPOC medical student wellness, which I hope to address as I review my study. Next, I outlined the purpose of the study and research questions. Then, I provided a brief overview of this study as well as the rationale and significance for this research. Following these discussions, I stated my researcher positionality and provided detailed examples of what this looks like and how it is relevant to the study. Finally, I concluded Chapter I by addressing some of the key terms and definitions related to areas of this research, including race and ethnicity terminology and medical school language.

Organization of Dissertation

Chapter I provided an overview of the challenges experienced by BIPOC medical students, as they face daily threats to their wellness due to the systemic racism which exists at predominantly White medical schools. In Chapter II, I provide a review of the pertinent, substantive literature. Specifically, I address the following research regarding BIPOC medical student wellness: the role of academic advising in medical schools; systemic perspectives; asset-based frameworks; mentor advocates; and prevention of mental health issues. In reviewing the theoretical frameworks for this study, I highlight three theories: intersecting identities, critical race theory (CRT), and ecological systems theory (EST). In Chapter III, I detail the following elements: paradigm of inquiry; research design; methodology; research methods, including methods of data collection and data analysis; standards of rigor; and delimitations and limitations. In Chapter IV, I present my qualitative research findings. Finally, in Chapter V, I summarize the findings from Chapter IV as they pertain to my research questions outlined in Chapter I and discuss priorities for future research on this topic.

CHAPTER II

REVIEW OF LITERATURE

The experience of medical school is highly stressful for most students and many studies have been conducted on the mental health outcomes of medical students as they progress through medical school (see Ahmed et al., 2009; Baldassin et al., 2012; Brazeau et al., 2014; Brennan-Wydra et al., 2021; Kötter et al., 2015; Schindler et al., 2021; Wimsatt et al., 2015). While substantial research exists for examining medical student wellness (see Dunn et al., 2008; Dyrbye et al., 2007; Hardeman et al., 2015; Hillard et al., 2011; Jenkins et al., 2018; Thuma et al., 2020; van Dijk et al., 2017), most studies on medical student wellness do not highlight issues of systemic racism experienced by BIPOC medical students. Furthermore, research is lacking in terms of studying the wellness of BIPOC medical students.

Aagaard and Hauer (2003), Andre et al. (2017), and Hillard et al. (2011) reviewed the effects of mentoring on medical students, which can be informative when addressing wellness outcomes. There are also minimal studies that have examined academic advising models with medical students (see Amini et al., 2018; Frosch & Goldstein, 2019; Santiesteban et al., 2022; Tekian et al., 2001; Tewary et al., 2020). Of these known studies on medical school academic advising, Tekian et al. (2001) and Tewary et al. (2020) are the only known researchers who have looked at academic advising models with BIPOC medical students. However, even within the studies by Tekian et al. (2001) and Tewary et al. (2020), I was unable to locate discussions on systemic racism and

threats to wellness for BIPOC medical students. This present dissertation study was my attempt to help address this gap in the literature.

For this review of the literature, I conducted searches of scholarly resources through EBSCO host, with the following key words utilized as frequently searched criteria: academic advising in medical school; medical students of color; mentoring medical students; well-being in medical students; systemic racism in medical school; and wellness in medical students. While by no means an exhaustive list of the key word search terms found in this study, it does offer a glimpse of some of the most salient words which were utilized in conducting this search for the related scholarly literature. The disciplines represented in my search of the literature included: clinical medicine, academic medicine, graduate education, and the social sciences. Peer-reviewed journal articles comprise the bulk of my literature review, although I have also leaned on some scholarly books as well.

This review of the literature will encompass several themes. First, I introduce the role of academic advising in medical schools. Second, I examine systemic perspectives on BIPOC medical student wellness. Third, I explore the concept of existing models of medical student wellness. Specifically, I discuss how some studies are starting to look at wellness from an assets-based framework, rather than from a deficit-based lens. Fourth, I report how mentors can serve as advocates to enhance wellness. Fifth, I examine wellness through a focus on preventing mental health issues. Sixth, I review three theoretical frameworks found in the literature pertinent to this study, including intersecting identities (see Crenshaw, 1989; Jones & Abes, 2013; Monrouxe, 2010; Tsouroufli et al., 2011); critical race theory (see Bell, 1992; Bergerson, 2003; Bimper, 2017; Comeaux, 2013;

Crenshaw, 1988; Delgado, 1995; DiAngelo & Dyson, 2020; Foste & Irwin, 2020; Hernández, 2016; Ladson-Billings, 1998; Patton et al., 2007; Solórzano et al., 2020; Vargas et al., 2021); and ecological systems theory (see Bronfenbrenner, 1977; Tewary et al., 2020). Finally, I conclude my review of the literature by summarizing the main themes, theoretical frameworks, and contributions of the empirical literature to this study.

The Role of Academic Advising in Medical Schools

Vianden (2016) wrote about the importance of connecting students with their institutions and fostering feelings of belongingness through academic advising. Positive academic advising encounters were found to be critical to enhancing student satisfaction with academic advising. Vianden (2016) noted that academic advisors can play a substantial role in helping students feel accepted and have a corresponding sense of belonging to their institution. Although that study did not focus on medical students, the themes of acceptance and fostering a sense of belonging were found in later studies which highlighted academic advising in medical schools.

Frosch and Goldstein (2019) discussed a model of medical school academic advising which is centered in learning communities. The relationship-centered advising model that Frosch and Goldstein (2019) described in their study fostered a deep sense of belonging, connection to the medical school community, and reports of increased wellness in medical students. In the words of one student, the learning community structure of relationship-centered advising gave rise to an academic advisor who was an "absolutely outstanding listener who consistently asks me important questions that no one else asks" (p. 3). Another participant spoke of the holistic focus on wellness that their academic advisor brought forth during meetings. This student stated that "my advisor is

always very interested in how I am doing as a person. He is also a great person to talk to about nonschool topics" (p. 3). Finally, one person mentioned that their academic advisor "is always there when I need her, and checks in throughout the year to see how I'm doing" (p. 3). Clearly, themes of wellness permeated this study according to remarks from students. Unfortunately, no mention was made by Frosch and Goldstein (2019) regarding whether BIPOC medical students perceived their academic advisors to influence their wellness.

Santiesteban et al. (2022) described the importance of reflecting on the student support roles provided from faculty to students in medical schools. In their analysis, these roles were that of coach, mentor, and advisor. The role of coach was akin to helping students master academic achievement goals via data-driven performance metrics and targeting areas of weakness. Coaches also provided emergent formative feedback. The mentor role described by Santiesteban et al. (2022) included psychosocial qualities such as being a good, empathetic listener and providing holistic wellness support. In many respects, the description of the mentor role was similar to the advisor role portrayed by Frosch and Goldstein (2019) in their study. The advisor role as outlined by Santiesteban et al. (2022) was that of a provider of answers, solutions, and directions for assisting students in their completion of several academic steps during different phases in medical school. While Santiesteban et al. (2022) acknowledged that there could be overlap between the roles of coach, mentor, and advisor, with one person taking on different roles, for the most part these descriptions were said to be relatively self-contained. One area that was not emphasized by Frosch and Goldstein (2019) and Santiesteban et al. (2022) was the role of the student in the advisor-student relationship.

Amini et al. (2018) first described the flipped classroom model to utilize in providing academic advising to medical students. Amini et al. (2018) viewed medical school academic advising as a bilateral relationship, with full participation demanded from both advisor and student. Whereas the flipped classroom has been implemented for many years within classroom settings, it has only recently been applied to academic advising. When the flipped classroom approach is utilized in academic advising, students are provided information about an upcoming advising meeting ahead of time so they are better prepared for it. The belief here is that engaging in pre-work in advance of the advising meeting will enable the meeting time to be more efficient and effective.

Specific to academic advising meeting pre-work and illustrating the model reviewed by Amini et al. (2018), a document is provided for students to review and complete prior to their meeting. Topics found in the document reviewed in this study included student performance reviews, experience participating in tutor or learning specialist-led programs, United States Medical Licensing Examination (USMLE) Step 1 study plans, and student concerns about their current academic standing. A significant percentage of students found that this method helped them become more knowledgeable of topics to be covered during their upcoming meeting. Students reported feeling more engaged during their advising meeting when a flipped classroom approach was implemented.

While the work of Amini et al. (2018) was not specific to BIPOC medical students, it has strong potential in its applicability regarding advanced planning and preparation for advising meetings. This is particularly salient when considering that White academic advisors will actively encourage discussion on topics such as systemic

racism during these highly involved and BIPOC medical student-centered advising meetings. These are the times when White academic advisors should actively encourage hearing and learning more about the lived experiences of BIPOC medical students in matters of systemic racism and wellness. To prepare academic advisors and medical students for such a substantive, impactful advising meeting to discuss systemic racism and wellness in BIPOC medical students, the research of Amini et al. (2018) is valuable in its application.

Systemic Perspectives on BIPOC Medical Student Wellness

Predominantly White medical schools have a long history of racism and social injustice as discussed in the Flexner Report. The Flexner Report was a critique by Abraham Flexner in 1910 over the need in medical schools for a biomedical model of medical education focusing on the proper training of physicians and good citizenship (Duffy, 2011). However, as Laws (2021) pointed out, it was also an inherently flawed document replete with examples of systemic racism. As stated by Laws (2021), "Flexner emphasized Black physicians' duty to keep African Americans healthy enough not to contaminate nearby White people" (p. 272). Although Flexner reported on the importance of historically Black medical schools and the role African American physicians played in community health, his racist underpinnings cannot be overlooked or excused. Even if one believes that we have now moved past systemic racism in medical schools, as Laws (2021) further articulated, we only need to recognize that "a century later, funding remains a struggle for historically Black institutions and for increasing numbers of U.S. medical students, who are in substantial debt upon graduation" (p. 273). Evidence of systemic racism can also be highlighted by reiterating the fact mentioned in Chapter I

regarding the disproportionate underrepresentation of Black physicians in medicine compared to the representation of African Americans in the U.S. population. As Laws (2021) stated, “of those active in the physician workforce in 2018, 5% identified as Black, although Black people compose 13% of the U.S. general population” (p. 273).

While it is challenging to find studies which focus on understanding systemic racism and its influence on threats to wellness in BIPOC medical students, there are a few studies which have examined these issues in undergraduate and graduate students in fields outside of medicine. For example, Basma et al. (2021) studied burnout and wellness in BIPOC graduate counseling students. They found a relationship between experiences of discrimination and decreasing reports of wellness. El-Ghoroury et al. (2012) reported that, compared to White students, BIPOC graduate students in psychology had lower measures of wellness. Spurgeon and Myers (2008) found increased levels of isolation in African American undergraduate students as they experienced systemic racism.

Systemic racism is rarely addressed in terms of its impact on BIPOC medical student wellness. Instead, studies often discuss the generic wellness of medical students without highlighting race (see Dunn et al. 2008; Hillard et al., 2011; Kötter et al., 2015). However, Dyrbye et al. (2007) were among the earliest researchers to study BIPOC medical student wellness. Dyrbye et al. (2007) provided opportunities for BIPOC students to report on their experiences during medical school through a quantitative research study.

Dyrbye et al. (2007) extracted the following common themes related to racism and its impact on wellness: harassment due to race, experiencing discrimination, and

receiving inequitable performance evaluations. By comparison, White students noted a deficiency in the responsiveness of medical school administration and faculty in meeting their individual needs and career opportunities. No items related to race were mentioned by White students. When BIPOC students reported that experiences of racism had adversely affected their medical school experience, they were more likely to meet the criteria for burnout and be screened for depression.

Odom et al. (2007) explored the systemic barriers faced by BIPOC medical students and how students were able to transcend difficulties within a socially unjust system based on the social support they received. Similar to Kötter et al. (2015), Odom et al. (2007) also held several focus groups in their study. Participants were encouraged to discuss their views of success, which included both overcoming obstacles and welcoming opportunities as BIPOC medical students. Dyrbye et al. (2007), Griffin et al. (2016), and Tekian et al. (2001) also conducted similar studies with their exclusive focus on BIPOC medical students. Focus group participants identified social support as the most critical condition to their success in medical school.

In line with Odom et al. (2007), Griffin et al. (2016) conducted a qualitative study with 14 graduate diversity officers (GDOs) at 11 universities. Their study has potential repercussions for understanding possible impacts of systemic racism on BIPOC medical student wellness. Griffin et al. (2016) examined how GDOs promoted the retention of BIPOC graduate students and the factors identified by GDOs that influenced their ability to enact retention strategies. Griffin et al. (2016) reported that the GDOs consistently mentioned three themes in their efforts to retain BIPOC graduate students: developing one-to-one relationships with students, building bridges and collaborating with faculty

and students across campus, and developing a sense of community with the campus environment. These researchers confirmed what has long been known in higher education, namely that diversity, equity, and inclusion should never be a single initiative of a department, school, or unit. Rather, it should be a collaborative, campus-wide, and community-based effort.

Dunn et al. (2008) reviewed the entire four years of the medical student experience. During the first two years, known as the pre-clinical years of medical school, classroom environments are the typical setting for instruction, whereas the last two years of medical school typically take place in clinical locations such as outpatient facilities (e.g., doctor's offices) and inpatient facilities (e.g., hospitals). During the pre-clinical years, Babaria et al. (2011) reported disturbing behaviors toward pre-clinical BIPOC women medical students as they faced discrimination from instructors and peers. Examples of these behaviors from instructors toward BIPOC women medical students included hearing inappropriate lecture content and the avoidance of discussing medical topics specific to women. Discrimination from peers included the role that White men medical students played in dominating classroom discussions. Babaria et al. (2011) reported how one BIPOC women medical student in the study felt she needed to educate White patients and White staff about what it meant to be a BIPOC woman and working as a medical student training to become a physician.

Realizing the importance of advocating for systemic racial and gender equity in medical schools, Hardeman et al. (2015) expanded on the earlier study by Babaria et al. (2011) in their continued review of the intersection of race and gender. Racial disparities in mental health among Black and White medical students were studied by Hardeman et

al. (2015). According to Hardeman et al. (2015), African American medical students were at higher risk for academic problems in medical school, which resulted in higher depressive and anxiety symptoms. Psychosocial resources, such as coping style, social support, sense of mastery, and self-esteem all influenced wellness, but little was known as to whether these psychosocial resources were differentially distributed by race and gender. They hypothesized that Black women medical students would fare worse on their self-rated mental health, have fewer psychosocial resources for coping, and therefore be at greater risk for depression and anxiety than White men medical students. Hardeman et al. (2015) reported that Black women medical students exhibited more symptoms of depression and anxiety compared to their White men and White women peers. They concluded that future researchers should investigate the kinds of social support that would be most effective in terms of supporting the wellness of African American medical students.

While Hairston et al. (2018) did not study the wellness of African American medical students, their research with Black and White graduate students has implications for understanding systemic racism in medical schools. Hairston et al. (2018) reported how graduate counselor education students perceived wellness and mental health in Black and White graduate students, using a survey method and subsequent quantitative analyses and a concept they call "colorism." The term colorism refers to discrimination based on the color or tone of one's skin. For example, Hairston et al. (2018) cited the benefits of being a lighter-toned African American that were mentioned by the participants in their study. Students mentioned socially beneficial outcomes based on having a lighter skin tone, such as higher occupational status, incomes, and academic

success. They acknowledged that a deficit-based perspective of colorism, while useful in acknowledging the grave nature of the problem, has also severely limited our understanding of how colorism can be applied to perceptions of mental health. According to Hairston et al. (2018):

> The Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards require a focus on wellness, which is identified as a culturally defined state of being in which mind, body, and spirit are integrated. Therefore, a study of colorism's effects should include considerations of wellness and not only pathology. (p. 173)

Hairston et al. (2018) concluded their study by stating that, since few of their participants were Black, and most were White, they did not obtain the expected statistically significant differences in the experience of colorism among BIPOC graduate students. The researchers hypothesized that having a more balanced sample might have led to statistically significant results and medium effect sizes.

Assets-Based Frameworks of BIPOC Medical Student Wellness

Dunn et al. (2008) conceptualized one of the earliest models of BIPOC medical student wellness. These authors illustrated how students build up resilience and prevent burnout during medical school. Dunn et al. (2008) constructed a model of medical student well-being called the coping reservoir. Positive inputs (e.g., psychosocial support, social activities, and mentoring) and negative inputs (e.g., stress, internal conflict, and time and energy demands) are integral to the coping reservoir. They proceeded to list solutions for students who struggled with too many negative inputs, such as effective academic advising that demonstrates empathy and support. Dunn et al. (2008)

emphasized the importance for medical schools to collect data on medical student wellness by implementing an assets-based framework.

Dunn et al. (2008) never mentioned systemic racism as being an example of a "negative input" of the coping reservoir. They stated that hardship gives rise to medical student resiliency and that resiliency seen in BIPOC medical students should be labeled as an asset. However, their illustration raises a question as to the reason for BIPOC medical student resiliency. Dunn et al. (2008) did not state whether the systemic racism experienced by BIPOC medical students fosters resiliency, which in turn leads to persistence during medical school.

Building on the research of Dunn et al. (2008), there has been increased awareness of the need to examine BIPOC student wellness by studying factors which cause resiliency. Jenkins et al. (2018) conducted life story interviews with graduating BIPOC and White medical students. These researchers found that most students experienced burnout, with possible causes including having negative role models, experiencing difficult clerkship rotations, and taking their first major physician board licensure examination, the United States Medical Licensing Exam (USMLE) Step 1. Jenkins et al. (2018) cited the following strategies implemented by students promoted resiliency and diminished burnout: having positive role models, strong support networks, faith and spirituality, and passion towards achieving one's goals.

Vargas et al. (2021) added to the emphasis Jenkins et al. (2018) placed on the presence of positive role models and strong support networks. Vargas et al. (2021) examined the impact of mentors on BIPOC non-medical students. They reviewed a program designed to reframe mentor training for White faculty as they mentored BIPOC

students. Vargas et al. (2021) highlighted the power dynamics between White faculty and BIPOC students. One major issue raised in this study was whether having a White mentor who understands issues of systemic racism can serve as an effective mentor for BIPOC students.

Both Jenkins et al. (2018) and Vargas et al. (2021) highlighted the importance for students to have strong social support networks and effective mentoring as an avenue toward promoting wellness. However, both studies also further our understanding of BIPOC student wellness. Jenkins et al. (2018) revolutionized the study of BIPOC student wellness by implementing a qualitative, semi-structured interview guide in their study. They emphasized that future research should focus more on the experiences of medical students, before and during their time in medical school. This way, researchers will have a better understanding of how students experience burnout during medical school. For example, researchers could take time to listen to the lived experiences of BIPOC medical students as they go through medical school by using qualitative studies.

Unlike Jenkins et al. (2018), Vargas et al. (2021) did not study BIPOC medical students. However, similar to Jenkins et al. (2018), Vargas et al. (2021) also examined issues of systemic racism as they detailed an asset-based, mentor building program for BIPOC students at California State University, Northridge (CSUN). The program that Vargas et al. (2021) illustrated is one of ten NIH-funded BUILD sites, training students in applied research. BUILD PODER (the Spanish noun for power) was created, "to transform racist institutions" and "exposes faculty to the institutional facets of modern racism" (p. 1048). Through their participation in BUILD PODER, faculty:

> Learn that the power to institutionalize and reproduce inequity in higher education is made possible through a collective activation of social–political factors and corresponding institutions that include: (a) race-neutral or colorblind policies; (b) the ascription of individual-and deficit-based attributes to students of color; (c) the use of rigid definitions of "merit," which fail to integrate the strengths of students of color; and (d) the misuse of multiculturalism, which "otherizes" non-whites through superficial celebrations of cultural difference that neglect opportunities to critique the structural contributors to racism. (pp. 1048-1049)

Along with Dunn et al. (2008), Jenkins et al. (2018), and Vargas et al. (2021), Elks et al. (2021) also emphasized the importance of being aware of wellness issues long before BIPOC students begin medical school. Elks et al. (2021) reported that admissions requirements for BIPOC medical school applicants are often based on a deficit-based framework. Rather than looking at what BIPOC students will contribute to the medical school environment, concern is often expressed by medical school admissions committees that many BIPOC medical school applicants lack the desired requirements of having competitive Medical School Admissions Test (MCAT) scores, completion of challenging pre-medical science coursework, and high undergraduate grade point averages. Similar to Dunn et al. (2008), Jenkins et al. (2018), and Vargas et al. (2021), Elks et al. (2021) has also challenged the traditional deficit-based framework of BIPOC student wellness. Elks et al. (2021) provided a reminder that, even prior to medical school, BIPOC students have many assets they contribute to enriching medical school environments.

Mentor Advocates and BIPOC Medical Student Wellness

Mentor advocates can serve as effective "allies" and "accomplices" of BIPOC medical students, but distinction between these two concepts is not necessarily always clear. Therefore, I will detail what researchers have studied regarding them. According to Powell and Kelly (2017), the distinction between "allies" and "accomplices" is simple yet profound. Whereas "allies" denote passive, inactive benevolence on the part of White people, "accomplices" infer active risk-taking, anti-racist actions "to destabilize white supremacy" (p. 59). Powell and Kelly (2017) provided this example as a distinction between these two terms:

> White allies may claim allegiance to the communities of color through social media participation or by wearing symbols such Black Lives Matter t-shirts or a safety-pin (a symbol which emerged during the 2016 presidential election) yet fail to participate in any meaningful action. (p. 45)

On the other hand, Powell and Kelly (2017) reported that a White accomplice "would seek ways to leverage resources and material support…to further liberation struggles. An intellectual accomplice would strategize with, not for, and not be afraid to pick up a hammer" (p. 46). Therefore, their collaborative focus and risk tolerance might be the distinction between being a White ally and being a White accomplice. While Powell and Kelly (2017) provided a clear distinction between "allies" and "accomplices," Spanierman and Smith (2017) described characteristics of "allies" as invoking strong similarities to "accomplices" illustrated by Powell and Kelly (2017). For example, Spanierman and Smith (2017) stated that White allies will "engage in actions to disrupt racism and the status quo on micro and macro levels, participate in coalition building and

work in solidarity with people of color, and encounter resistance from other White individuals" (p. 609).

In one of the earliest known mixed-methods designs that focused on BIPOC medical students, Tekian et al. (2001) conducted interviews and analyzed demographic surveys to study the roles mentors had with BIPOC medical students. They examined how having a mentor led to successful academic outcomes. For example, students with a mentor reported experiencing less academic difficulty compared to students who did not have access to a mentor. Students were split on the effectiveness of their mentors, with only half of the students who found their mentors to be helpful. Tekian et al. (2001) stated that medical school administrators must determine whether their mentoring programs serve as an impediment or detract from building a successful mentoring relationship with BIPOC medical students.

In another early study on advocating for BIPOC medical student wellness, Aagaard and Hauer (2003) examined the impact of mentors on BIPOC and White medical students during clinical training in their third and fourth years of medical school. In this study, they found that BIPOC medical students were as likely to find a mentor as White medical students. However, mentors for BIPOC medical students were almost always White. Since advising and mentoring were both examined by Aagaard and Hauer (2003), these researchers controlled for the variable "satisfaction with advising" and found BIPOC students were as likely to report satisfaction with their mentor as were White students. Given there was a "minority advising program" at the institution where the research was carried out, Aagaard and Hauer (2003) speculated that BIPOC student satisfaction with mentoring could have been influenced by their participation in this

specialized advising program. They found that students with well-defined medical specialty career interests were more likely to have a successful mentor match than students with less well-defined career interests. They advocated for further research to discover systemic barriers that prevented BIPOC students from gaining access to a mentor.

Burgess et al. (2010) did not directly focus on examining systemic barriers faced by BIPOC medical students. However, they reported factors that could be implemented during medical school to create identity safe environments. Implicit in their study was that their findings would spur action toward fostering BIPOC medical student wellness. Through their conceptualization of "identity safe environments," Burgess et al. (2010) examined the effects of having strong BIPOC representation among students and overtly placing a high value on diversity. They also discussed that medical school administrators should increase their efforts to hire and retain more BIPOC faculty. They recommended having structured dialogue take place among all students, particularly in matters of race. Finally, Burgess et al. (2010) concluded that White faculty should be trained on how to provide more effective feedback to BIPOC medical students. This would include the emphasis that White faculty should place on stating the high confidence they have regarding the expected success of BIPOC medical students.

Based on widespread reports of systemic racism and sexism in their interviews with BIPOC medical students, Babaria et al. (2011) discussed the importance of mentoring BIPOC women medical students. Specific to their recommendation was having BIPOC women faculty members serve as mentors to BIPOC women medical

students. Enacting this practice would advocate for both racial and gender equity in medical school training.

While Tekian et al. (2001), Aagaard and Hauer (2003), and Babaria et al. (2011) examined mentoring from professional staff and faculty to medical students, Andre et al. (2017) studied the impact of utilizing peer mentoring to foster belongingness, cohesion, and professional identity growth in BIPOC medical students. Peer mentors also contributed during this study by sharing academic and career information from peer mentors to mentees. The results of this peer mentoring program were that students reported feeling more satisfied with their medical school experience. Students felt supported and more prepared to continue to face the rigors of medical school. Andre et al. (2017) stated that peer mentoring programs should exist alongside traditional faculty-led mentoring programs. While efforts were made to include a representative sample in the program based on students with diverse backgrounds, these demographics, as well as the potential outcomes for BIPOC students, were never mentioned in this study.

Prevention of Mental Health Issues for BIPOC Medical Students

Kötter et al. (2015) examined stressors that medical students face and how faculty and staff can prevent mental health issues from emerging or becoming more intense. Focus groups comprised of participants from the pre-clinical (years 1 and 2) and clinical (years 3 and 4) years of medical school. The results showed that pre-clinical students perceived stressors like weekly examinations as being more intense but also reported that peer groups and mentoring programs were beneficial to them. The researchers believed that the curriculum itself should be the focus of efforts from medical schools to enhance wellness in first and second year medical students. This would include offering course

electives such as “Health and Well-Being of Medical Students and Physicians” and other similar course selections which focus specifically on wellness by preventing the development of mental health issues. Kötter et al. (2015) reported a strong demand from students for more counseling services. Finally, they mentioned the importance of focusing on systemic elements, in addition to analyzing individual student cases. While these researchers did not have racially diverse participants, their acknowledgement of the need to implement a broader, sociological lens in future studies, set the stage for later research.

Brennan-Wydra et al. (2021) expanded on the ideas of Kötter et al. (2015) and focused on the urgency and investment needed in setting up a welcoming environment for BIPOC medical students to prevent the emergence of mental health issues. While Dunn et al. (2008) also examined ways to prevent emerging mental health issues in BIPOC medical students, they did not do so with the systemic lens espoused by Brennan-Wydra et al. (2021) and Dyrbye et al. (2007). Research by Dyrbye et al. (2007) complemented the study by Brennan-Wydra et al. (2021) and recommended specific action plans that medical schools should take to advocate for BIPOC medical students. These included becoming aware of medical student distress, checking for evaluation bias, and collaborating across campus in matters of tackling systemic racism.

Brennan-Wydra et al. (2021) examined systemic practices in medical school that contributed to maladaptive perfectionism, imposter syndrome, and suicidal ideation. Maladaptive perfectionism can be defined as being so obsessed with perfectionism in work as a medical student that nothing less than perfect accomplishments will suffice. While imposter syndrome is not unique to medical students, it is a widely known concept

within medical school circles. Imposter syndrome is defined by Brennan-Wydra et al. (2021) as feelings by medical students that they are not supposed to be in medical school. Reasons students typically give include feeling not smart enough or having arrived at medical school only due to special admissions factors, such as filling an admissions quota.

Brennan-Wydra et al. (2021) found that increased levels of maladaptive perfectionism positively correlated with an increased likelihood for showing signs of imposter syndrome, which in turn positively correlated with an increased risk for suicidal ideation among medical students. Reducing feelings of imposter syndrome may lessen the risk for suicidal ideation among BIPOC medical students. They mentioned that a focus on individual resiliency, such as that espoused in the earlier review of Dunn et al. (2008), may not be enough to promote the wellness of BIPOC medical students.

Although many medical schools may train students to develop strong individual resiliency, Brennan-Wydra et al. (2021) emphasized that advocating for systemic change within medical schools is a key missing ingredient needed to enhance BIPOC medical student wellness. They stated that the perfectionistic culture of medicine needs to first be addressed. Brennan-Wydra et al. (2021) found that BIPOC women medical students were at highest risk for showing perfectionism. However, this increased tendency towards showing perfectionism does not necessarily translate into higher rates of imposter syndrome and suicidal ideation. This may be due to differences between adaptive and maladaptive perfectionism, with maladaptive perfectionism placing students at higher risk for showing signs of imposter syndrome and higher suicidal ideation. Therefore,

perfectionism shown by BIPOC women students may be more adaptive in nature, thereby limiting the negative consequences of having imposter syndrome and suicidal ideation.

Due to few known studies which have examined the prevention of mental health issues in BIPOC medical students, Brennan-Wydra et al. (2021) recommended that more culturally informed models of imposter syndrome be studied. In doing so, the lived experiences of BIPOC medical students may be better captured. According to Brennan-Wydra et al. (2021), more research is needed to further understand how to enhance wellness in BIPOC medical students. They offered suggestions on how medical schools can reduce maladaptive perfectionism and imposter syndrome in BIPOC medical students, which would include having wellness workshops, mentoring programs which directly advocate for wellness, and student leadership programs with a central focus on wellness. While they did not emphasize one of these activities more than others, they pointed out that combining these elements is best suited for reducing suicidal ideation among BIPOC medical students. As suicidal ideation decreases, wellness reports should increase.

As apparent from the review of the literature thus far, it is imperative to advocate for meeting the wellness needs of BIPOC medical students. However, it is also important to have an active program in place that provides early identification of students with potential mental health issues, to prevent more serious mental health issues from emerging later. Hillard et al. (2011) created a program designed to help students in mild distress with issues of mental health and wellness. They trained faculty on how to provide wellness assistance to students during medical school. Rather than having faculty work only with students on academic and professional issues, faculty were also given extensive

formal training to help students with problems that affected their personal well-being, specifically in areas of their mental wellness. A triage system was set up to assist students with mild mental health issues, with the goal of preventing these issues from evolving into more serious problems. Faculty members were trained on how to refer students in need of further mental health support services. While Hillard et al. (2011) did not specifically highlight BIPOC medical students, their program could be redesigned to focus on this population. Academic advisors play an increasingly emergent role at many medical schools today. Therefore, along with faculty and other staff, they could serve in this consistent supportive capacity as they advocate for BIPOC medical student wellness.

Theoretical Frameworks

There are many theories which could frame this review of the literature. I have chosen to discuss three theories that I feel best capture BIPOC medical student wellness. These theoretical frameworks examine this research topic from diverse, yet congruent perspectives. For the theoretical frameworks of this study, I will examine the following areas. First, I present research on intersecting identities, which are essential to understand when highlighting BIPOC medical students, each of whom brings forth unique layers of identities. Second, I review the basic tenets of critical race theory (CRT) and its application to the current study. As CRT investigates the nature of systemic racism, it is imperative to include CRT as part of this research. Finally, as BIPOC medical students are immersed in a multitude of environments, I outline the basic principles found in ecological systems theory (EST) and connect EST to the present study.

Intersecting Identities

When studying ways to meet the wellness needs of BIPOC medical students, it is natural to examine the concept of identities. When a BIPOC medical student is more aware of their multiple, intersecting identities, they may be more likely to achieve their wellness needs (Monrouxe, 2010). The resiliency reserves that Dunn et al. (2008) discussed in their study are comprised of personality, coping mechanisms, and social support. In this model, inferred is the idea that understanding the complex layers of identities which make up one's personality can serve as a buffer against the stressors experienced by BIPOC medical students, due to systemic racism. In this review of the related literature on intersecting identities in BIPOC medical students, I was unable to locate studies which discussed the contributions of predominantly White medical schools on the identities of BIPOC medical students. The research on intersecting identities which I was able to discover addresses intersecting identities in BIPOC medical students from an individualistic, rather than systemic, perspective. Although it is understood from research by Dunn et al. (2008) and Monrouxe (2010) that individual resiliency is an important component of the intersecting identities of BIPOC medical students, left unaddressed is whether predominantly White medical schools negatively contribute to these intersecting identities due to their ongoing legacy of systemic racism. I address this idea further in Chapter V as it relates to the two predominantly White medical schools that were included in this study.

Prior research on medical students has failed to adequately capture the issue of the intersecting identities of BIPOC medical students. Crenshaw (1989) provided an early definition of intersecting identities as being connections between two general concepts such as race and gender. Tsouroufli et al. (2011) added layers to this definition as being

"the interactions between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies, and the outcomes of these interactions in terms of power" (p. 214). Jones and Abes (2013) published a book widely known in student affairs circles on the intersecting identities of college students. Earlier, other researchers within the medical field (see Monrouxe, 2010; Tsouroufli et al., 2011) also examined the nature of intersecting identities. By acknowledging intersecting identities, we take into consideration the outcomes of the multiple identities of BIPOC medical students and how these identities affect a person's developmental trajectory.

Monrouxe (2010) conducted one of the first attempts to study intersecting racial and gender identities in BIPOC medical students. The key issue first raised in their study was that rather than exploring just one identity, researchers should be examining the multiple, intersecting identities that students carry throughout their time before, during, and after medical school. Here, I use race, gender, and socioeconomic class as being the most salient and well-studied identities of medical students. However, these identities have traditionally been studied individually, rather than through an intersecting lens. Monrouxe (2010) mentioned that the professional identity development of medical students has been researched for quite some time. However, they also stated that the impact of the intersecting identities of race, gender, and socioeconomic class on the corresponding personal and professional identity development of BIPOC medical students have not been examined in-depth. Monrouxe (2010) reported on the importance of examining the intersecting identities of gender and race in studies of BIPOC medical students. One of the concepts reviewed in their study was the finding of what was called

"identity dissonance." This idea by Monrouxe (2010) emphasizes the trauma that may be faced by "women, members of lower socio-demographic classes, and non-Whites" as they strive to incorporate a doctor-in-training professional identity with their co-existing identities of gender, race, and class (p. 42).

Tsouroufli et al. (2011) stated that researchers need "to problematise the foregrounding of inequities and discrimination in medical education based on one category of social difference alone," such as gender (p. 215). As an example, one BIPOC woman participant in their study, given the pseudonym "J," underscored the importance of using an intersecting identities lens when studying BIPOC medical student identities. "J" shared the following experience while trying to educate one of her patients about her identity as a BIPOC woman medical student: "The patient has been calling you honey...And that's another place that where at least, if I can leave having educated them a bit more about what a woman can do, what a woman of colour can do…" (p. 214).

Tsouroufli et al. (2011) also critiqued a study by Babaria et al. (2011), which failed to consider intersecting identities when discussing their findings on gender inequities in medical schools. To further illustrate, Tsouroufli et al. (2011) argued that medical education research has essentially ignored the issue of intersecting identities, even while advocating for research on studying singular issues of social disparities in race, gender, or socioeconomic class. They pointed to the fact that, unlike the field of medicine, research in the social sciences is filled with examples of studies which have examined the impact of intersecting identities on student outcomes. Tsouroufli et al. (2011) advocated for future research on the intersecting identities of BIPOC medical students.

Critical Race Theory

Critical race theory (CRT) provides an excellent complement to the concept of intersecting identities. Perhaps no single theory currently debated in the United States is as widely condemned, or as much misunderstood, as CRT. This is unfortunate, as early CRT scholars, such as Bell (1992), Crenshaw (1988), Delgado (1995), and Ladson-Billings (1998), have long advocated for a more complete understanding of systemic racism and the corresponding need for social justice. Through the expansive lens of CRT, not only can we hope to gain a better understanding of systemic racism, but by doing so, we may also be empowered to advocate for issues of social justice. Pushback is to be expected from those who misunderstand the purpose and reasoning of CRT, but sometimes an unexpected accomplice emerges in the drive to educate others about CRT. To this end, I have chosen to highlight the words of an older White man who was the highest ranked military officer in the U.S. at the time of this study.

In the following excerpt, the chair of the U.S. Joint Chiefs of Staff, General Mark Milley responds to scathing comments made by U.S. Representative Matt Gaetz of Florida. Gaetz was sharply disapproving of what seemed to him to be an open embrace of CRT and a "woke" acceptance of CRT by the U.S. military. Milley, however, was equally disapproving of Gaetz's closed-mindedness when it came to CRT, with Milley (2021) replying to Gaetz:

> I've read Mao Zedong. I've read Karl Marx. I've read Lenin. That doesn't make me a communist. So what is wrong with understanding — having some situational understanding about the country which we are here to defend? And I personally find it offensive that we are accusing the United States military, our

> general officers, our commissioned, noncommissioned officers of being, quote, 'woke' or something else, because we're studying some theories that are out there. I want to understand White rage, and I'm White, and I want to understand it. So what is it that caused thousands of people to assault this building [the United States Capitol building on January 6, 2021] and try to overturn the Constitution of the United States of America? What caused that? I want to find that out. (Milley, 2021, 05:17-07:32)

Bergerson (2003), Harper (2012), Patton et al. (2007), Solórzano et al. (2020), and Vargas et al. (2021), along with many other CRT researchers, have extensively studied how CRT can be applied to higher education. These authors help White Americans like Milley, and like me, who are open in their search for discovering the truth about our country's racist past and present, to begin the journey on our quest for answers. While I will not provide an exhaustive review of CRT here, as interested readers are encouraged to investigate the powerful studies on CRT from the researchers just cited, as well as from those I will present shortly, I will nevertheless provide a brief overview of CRT to set the stage for my study. Patton et al. (2007) outlined basic tenets of CRT to guide future theory development and practice in higher education student affairs. These authors also pointed to the importance of highlighting intersecting identities when using a CRT lens.

To understand how CRT can be applied to intersecting identities, we must first understand the basic principles, or five tenets, of CRT as originally proposed by Crenshaw (1988), Bell (1992), Delgado (1995), Ladson-Billings (1998), and other early CRT scholars. Most of these CRT tenets cover aspects of intersecting identities. Vargas

et al. (2021) has also more recently extrapolated on these original tenets. The first tenet articulated by Crenshaw (1988), Bell (1992), Delgado (1995), Ladson-Billings (1998) and others, is the normality of racism in U.S. society. Rather than viewing racism as an exception, these early CRT scholars argue that racism is a fixture in U.S. institutions. In examining the first tenet of CRT, Vargas et al. (2021) emphasized that most BIPOC students and scholars do their work at predominantly White institutions. As such, due to the sheer availability of being greatly outnumbered, BIPOC students are typically paired with White faculty for mentoring. To better understand the normality of racism as the first CRT tenet applied to education, we need to recognize that predominantly White institutions operate under a colorblind philosophy, where race is not seen, heard, or acknowledged.

In discussing the second tenet of CRT, Delgado (1995) emphasized how storytelling is utilized to examine the myths and commonly accepted wisdom that are accepted as fact in White U.S. society. Vargas et al. (2021) discussed the reality of "White fragility" which surfaces whenever these myths and this commonly accepted wisdom first articulated by Delgado (1995) are focused upon. Here, White fragility is described by Vargas et al. (2021) as consisting of the uncomfortable feelings that Whites often experience when confronted with issues of social justice framed by racial inequities. According to DiAngelo and Dyson (2020), these feelings of White fragility that are experienced by many White people often include anxiety, discomfort, defensiveness, and beliefs about threats to one's identity and are based on superiority and entitlement. Vargas et al. (2021) pointed out that because most BIPOC students are paired with White mentors, this serves to increase the potential for White fragility to

develop. In looking at the second tenet of CRT, both the sheer outnumbering of White faculty compared to BIPOC students, along with the acceptance of the White status quo, all but guarantees the perpetuation of racial systemic inequities (Vargas et al., 2021). In their CRT-based program, BUILD PODER, which was described earlier in this chapter, Vargas et al. (2021) stated that BUILD PODER "exposes faculty to the social–political properties of racism by linking to mentorship the deleterious effects that come with unequal power, the elevation of whiteness, the erasure of non-dominant social identities, and racist policies" (p. 1049).

Ladson-Billings (1998) discussed how the third tenet of CRT provides a critique of liberalism. Crenshaw (1988) mentioned that it is misguided to positively relate civil rights to a critique of liberalism, as civil rights have not been the slow, but upward trend, as has been historically assumed by White people. Rather, Crenshaw (1988) stated that our current legal paradigms do not constitute a legal catalyst for social change in their failed critiques of liberalism. Vargas et al. (2021) added later consensus to this view espoused by Crenshaw (1988) and stated that oppressive systems tend to be reproduced because the status quo of liberalism is acknowledged as being the best pathway in the minds of White people. Even when the defensive posture of the White status quo fails to achieve positive results, resistance to changing the philosophy of liberalism is strong and inequality is therefore maintained.

The fourth tenet is race/racism centrality. Ladson-Billings (1998) mentioned that civil rights legislation have ironically mostly benefited White women. It is White women who have gained the most from affirmative action hiring policies. With this fourth tenet, there is advocacy for understanding critical history, with "Whiteness as property" being a

central component (Vargas et al., 2021). Here, the issue of the myth of individualism is confronted head on. Challenges are immediately evident with the fourth tenet, as the U.S. was founded upon notions of individualism, which often lends itself to colorblindness and the maintenance of the White status quo.

Finally, the fifth tenet concerns social justice. Freire (1970) had a profound impact on advocating for social justice within educational environments. Through his philosophy of critical pedagogy, Freire (1970) advocated for empowerment in propelling social justice through education. Yosso (2002) advocated for this fifth tenet of CRT of social justice, as first discussed by Ladson-Billings (1998), to be utilized to challenge racism within educational settings. According to Vargas et al. (2021), anti-racist and critical mentor training are necessary elements in advocating for social justice. Along with this advocacy is the active stance of dismantling colorblindness and racism at predominantly White institutions. Finally, with this fifth CRT tenet of social justice comes an appreciation for the need to have BIPOC faculty serve as mentors to BIPOC medical students (Vargas et al. 2021).

According to Patton et al. (2007), CRT carries several assumptions interwoven with the tenets of CRT, which are as follows: First, racism is embedded into the social fabric of American life, making it difficult for White people to recognize the damage that racism has caused and continues to cause in our society. Second, race is a socially constructed concept and is used to marginalize those who are BIPOC. Even though race is socially constructed, it has been used to stigmatize and demonize BIPOC throughout US history. Third, listening to and truly hearing the lived experiences of those who are BIPOC is essential so that those who are White can gain a much needed and deeper

understanding of racism. Finally, colorblindness needs to be constantly challenged. Colorblindness, which ignores skin color and focuses on our "common humanity," does nothing to advocate for BIPOC and fight for social justice. Colorblindness, when it comes to race, assumes White innocence in the oppression of those who are BIPOC. Patton et al. (2007) continues by discussing that, because CRT moves beyond a staunch individualistic stance and advocates for systemic perspectives of racism, it has long received strong pushback from many White people. Colorblind Whites often view CRT as a threat to their individualistic identities and as targeting their comfortable existence in the White status quo. CRT is one avenue to understanding White fragility.

In concluding their review of CRT, Patton et al. (2007) provides readers with five recommendations to student affairs professionals. First, we are called to continue to advocate CRT as a framework within student development theories. Second, we must move beyond the White status quo and be able to see the entrenched racism embedded in our higher education social structures. Third, faculty must think deeply and proactively about what their curriculum does and does not teach about race and racism. Fourth, higher education professionals are strongly encouraged to incorporate CRT perspectives into their daily professional practice. Finally, White higher education professionals are called upon to become more aware of their own racial identity and be able to make an honest assessment of their current racial awareness and its effects on student development outcomes, particularly their impact on BIPOC students.

Student development theories emerged in the late 1970s. In recent years, CRT has made its way into the student development literature. As recently as the first decade of the 21st century, Patton et al. (2007) stated that no major student development theories

had examined systemic racism in their respective theoretical frameworks. Thankfully, this situation changed dramatically during the second decade. Researchers finally began to examine the impact of CRT on student development theories (see Bimper, 2017; Comeaux, 2013; Foste & Irwin, 2020; Hernández, 2016).

Comeaux (2013) was one of many researchers who have focused on CRT and student development theories during that decade. Their research examined the academic accomplishments of Black and White college students based on faculty perceptions of their achievements. While White faculty were usually supportive of students regardless of their race, they were prone to colorblind racism, which "accepts liberal ideas of meritocracy, equality, and fairness as guiding principles, yet systemically ignores racial inequalities that are embedded in our social structures" (pp. 455-456). These social structures include higher education institutions.

Aligned with this view from Comeaux (2013), Hernández (2016) stated that we need to "shift the developmental vantage point from the individual, to the individual in relation to her political, racialized, environment" (p. 171). The problem, as Hernández (2016) views it, is not that we have ignored that individual acts of racism exist, but rather, we have ignored the racism that is systemically embedded within our higher education institutions. Foste and Irwin (2020) confirmed the views of Comeaux (2013) and Hernández (2016) when they stated that "college student development theory and research have increasingly shifted from an exclusive focus on individual development toward a more explicit emphasis on how systems of power and oppression influence these processes" (p. 439).

Mentoring is one area of student development theories where CRT can be effectively applied to higher education institutions. Studies on mentoring can illuminate the systemic racism embedded in higher education institutions, as also reported by Comeaux (2013), Foste and Irwin (2020), and Hernández (2016). Bimper (2017) found that Black student athletes benefited from a BIPOC mentor who was able to serve as a guide to assist them in navigating the Whiteness of their university. One Black woman student athlete spoke of trying to understand the challenges inherent in the colorblindness of her predominantly White university:

> The idea of Whiteness really makes sense to me as I think about it. While everyone accepts me, people also make me feel different. It's more like they [Whites] choose not to see race or talk much about it so that we're accepted … kind of like their Whiteness encourages them to avoid race in order to make us feel accepted. But this makes me feel like I have to cater to them and their feelings. (p. 184)

In a later study, Vargas et al. (2021) reviewed the theoretical foundations of CRT and espoused its use in mentoring relationships. As with Bimper (2017), Vargas et al. (2021) conducted a study on how mentoring relationships developed between faculty and students. In their study, Vargas et al. (2021) examined BIPOC and White students and faculty mentors. Vargas et al. (2021) reported that BIPOC students were more likely to be paired with White faculty rather than BIPOC faculty, due to low numbers of BIPOC faculty at most institutions. Vargas et al. (2021) emphasized that, due to pervasive systemic racism, White faculty need to become better educated in how to effectively reach their BIPOC students. Training and understanding in CRT is an initial step that can

be taken to help make these mentoring relationships more effective. After reviewing a mentoring program for BIPOC students, Vargas et al. (2021) discussed how White faculty can be educated on how modern racism is institutionalized within higher education. White faculty can also be taught what they can do to help dismantle systemic racism in medical schools and advocate for social justice.

Ecological Systems Theory

Intersecting identities and CRT are both powerful lenses in which to study the systemic racism experienced by BIPOC medical students and resulting threats to their wellness. Outside of these two theoretical frameworks, BIPOC medical students have often been described in the medical school literature as having racism "happen" to them. While racism and resulting poor wellness outcomes can and does impact BIPOC medical students, ecological systems theory (EST), first developed by Bronfenbrenner (1977) and more recently reviewed by Tewary et al. (2020), can help to further contextualize and understand the reasons why BIPOC medical students experience this oppression within their ecosystems and how racism at predominantly White medical schools is systemic in nature.

While Bronfenbrenner (1977) did not specifically develop EST for application to BIPOC medical students, EST has direct applicability for understanding how the psychological and sociological environments impact the development of these students. Briefly, the five ecosystems of EST are as follows: first, the microsystem consists of the relationships between the person and their immediate environments, such as home, school, or work; second, the mesosystem has interrelations among two or more major settings in a person's life; third, the exosystem extends the mesosystem by including

social structures that by themselves do not contain the person but have an impact on that person; fourth, the macrosystem are patterns of the culture, such as economic, social, education, and political structures; and fifth, the chronosystem includes changes that occur over the lifetime of the person, such as through major life transitions.

Tewary et al. (2020) provided a comprehensive review of major theories in medical student advising. One of the theories these authors studied was EST. The theoretical approaches they discussed included learning theories (e.g., behaviorism, cognitivism, social learning, and constructivism) and macro theories (e.g., acculturation and ecological systems theory). According to Tewary et al. (2020), medical school academic advisors can serve as a valuable resource for students by being able to implement a specific theoretical approach to academic advising that best matches a particular advisor-advisee relationship. They did not focus their review exclusively on BIPOC medical students, but rather, students who were struggling academically in medical school. However, they argued that EST could be useful for advising BIPOC medical students.

EST applied to academic advising presents medical school academic advisors with a comprehensive set of tools to be found in their advising toolboxes, including listening to the experiences of BIPOC medical students regarding racism and threats to their wellness, topics often shunned in most advising meetings, specifically among White advisors. Tewary et al. (2020) applauded the application of EST as being important to academic advising, as this theory builds directly upon the interaction of the individual within the larger social system, or environments faced by students. Through the framework of EST, the lived experiences of BIPOC medical students, the racism they

experience, and the existential threats to their wellness, can be clearly highlighted by these students while being heard loud and clear by their academic advisors.

Chapter Summary

The following are the main areas I have addressed from my review of the related literature. First, I looked at the role of academic advising in medical schools. Within this area, I reviewed recent literature on the influence of academic advisors on the wellness of medical students. Second, medical student wellness from a systemic perspective was reviewed. I examined studies that looked at negative outcomes of BIPOC medical students due to their experiences with systemic racism. Third, I reviewed asset-based frameworks of medical student wellness. The medical school literature has traditionally examined wellness from the standpoint of either negative qualities that medical students possess or the absence of positive qualities. Most frequently, medical student wellness has been studied from a deficit-based lens, so this study aims to examine BIPOC medical student wellness from an asset-based framework. Fourth, I looked at ways to advocate for BIPOC medical student wellness mainly by means of effective faculty and peer mentoring. Finally, I reviewed studies that have focused on medical student wellness by examining how to prevent mental health issues from emerging, such as through participation in mentoring programs for BIPOC medical students.

Theoretical frameworks for my study were also addressed. First, I focused on intersecting identities as one way to inform my study. I explained how researchers have argued for a more comprehensive and realistic portrait of identity development. This process occurs through the concept of examining multiple identities. Second, I discussed critical race theory (CRT). CRT is utilized to inform my study through interviews with

BIPOC medical students, as they shared stories with me of their lived experiences dealing with systemic racism in medical school settings. Finally, ecological systems theory (EST) was reviewed. I included EST to inform my study as it relates to the interaction of BIPOC medical students within the larger social ecosystem, or macroenvironments, as well the smaller ecosystem of medical school, or microenvironments. As is the case with intersecting identities and CRT, lived experience is the key to understanding EST. Advising systems were mentioned as one of the crucial components in applying EST to practice, along with the intersecting identities framework and CRT. All three frameworks serve as an entry point in advocating for academic advisors to intentionally listen to and learn from the lived experiences of BIPOC medical students.

The empirical literature, along with the theoretical frameworks I have just reviewed, informed my study by illustrating the typically colorblind view of wellness in BIPOC medical student advising. My hope is that there will now emerge a better understanding of the reality that, not only does systemic racism exist within medical school environments, but there are also remedies that could be implemented to provide empowerment, resources, and support for BIPOC medical students. For example, while research is lacking in the medical school literature in terms of program development that focuses on combating systemic inequities in medical schools, recently established programs may be useful to examine in future research. One such medical school has a program which was implemented to help BIPOC medical students gain further empowerment, resources, and support during their transition to medical school. This program will also serve to educate White faculty and staff on their necessary journey to become anti-racist accomplices in collaborating with the entire medical school

community. This way, more equitable, diverse, inclusive, and socially just environments for BIPOC medical students may be created. In the end, it is hoped that the wellness of BIPOC medical students may be holistically and relevantly supported, and that medical school academic advisors can lead the way in advocating for this long overdue work.

CHAPTER III

METHODS

In Chapter III, I restate the purpose of the study and research questions. Next, I introduce the theoretical framework of the paradigm of inquiry, followed by a discussion of the methodology that will guide the study. After this discussion, I describe the research design and the research methods for the study. Finally, to conclude Chapter III, I cover standards of rigor, including issues of trustworthiness, ethical considerations, delimitations, and limitations.

Purpose Statement and Research Questions

The purpose of this study was to understand how BIPOC medical students experience wellness as they navigate systemic racism in medical schools. The research questions for this study were as follows:

1. How do BIPOC medical students make meaning of personal wellness as they navigate systemic racism in medical school ecosystems?
2. How do BIPOC medical students define personal wellness for themselves?
3. What resources do BIPOC medical students point to as their key support systems at predominantly White medical institutions?

Paradigm of Inquiry

Okesina (2020) provided a detailed analysis of the four components found in paradigms of inquiry, as first outlined by Lincoln and Guba (2000). These components consist of ontology, epistemology, axiology, and methodology. According to Okesina

(2020), ontology is the nature of reality in terms of the social phenomenon that is being investigated. Ontology is comprised of historical realism, which looks at social, political, and economic oppression throughout history to highlight emancipation and social justice. Okesina (2020) describes epistemology as being how we come to know truth and the reality of the social world. Knowledge is subjective and transactional with epistemology, meaning that there are multiple realities and that it is important for the researcher to maintain emphasis with what they and participants are bringing to the study. The axiology, or values and ethics in a study, states that research will be value-laden, biased, and culture-sensitive (Okesina, 2020).

In examining the wellness of BIPOC medical students, I will be focusing on the philosophical worldview of critical theory. Lincoln and Guba (2000) present paradigms of inquiry as being comprised of positivism, post-positivism, critical theory, and constructivism. For this study, I will focus on critical theory. Critical theory has been described as a subjective examination of the research process, highlighting social inequities. Therefore, it is often found in many qualitative research studies (Lincoln & Guba, 2000). Subjectivity and social construction of our world is paramount to understanding critical theory, given its emphasis on fostering social justice.

Although critical theory has become more widely known in recent decades, critical theory as a paradigm of inquiry can be traced back to the 1920s, to German philosophers Max Horkheimer, Thedor Adorno, and other leading scholars collectively known as “The Frankfurt School” (Morrow & Brown, 1994). Although this early approach was meant to provide an interpretivist tool for Marxist theory, critical theory is no longer associated exclusively with Marxist theory or even with the Frankfurt School

itself. Morrow and Brown (1994) discuss that, while critical theory supports a strong sociological perspective, it in fact encompasses many other perspectives that include all the social sciences and education.

While critical theorists acknowledge that the world and our experiences within it are subjective and socially constructed, it is more than just this understanding that shapes critical theory. Importantly, the focus of critical theory is on social justice, particularly in areas such as education. For example, Freire (1970) was a widely acclaimed critical pedagogist whose early work was steeped in critical theory. The scholarship of Freire (1970) focused on espousing issues of social justice, particularly in the field of education (Roberts, 2000). According to Bloomberg and Volpe (2019), critical theory includes an openly activist and unapologetic political agenda that forces an acknowledgement of the need for systemic change due to social inequities. My study highlighted critical theory as the framework I utilized to question current assumptions that the social order within predominantly White medical schools is both just and equitable, specifically in matters pertaining to BIPOC medical student wellness.

Methodology

The methodology of a study encompasses both philosophical and theoretical assumptions (Okesina, 2020). As stated in the previous section on the paradigm of inquiry, the framework for this study was critical theory. According to Okesina (2020), the paradigm of inquiry directly influences the methodology, research design, research methods, and ethical considerations. The research design, research methods, and ethical considerations for this study are presented in detail in separate sections of this chapter.

The methodology I chose for this study was Interpretative Phenomenological Analysis (IPA). IPA has its origins in phenomenology (Smith, 1996). While the term "phenomenology" was in use as early as the 18th century, scholars such as Moustakas (1994) have pointed out that modern phenomenology dates to 1912, to Edmund Husserl and his Frankfurt School colleagues. Ahmed (2012) expanded on this earliest conceptualization of phenomenology, also known as classical or transcendental phenomenology, by applying it to the study of institutions. Ahmed's concept of "institutionality" helps us to "theorize how a reality is given by becoming background, as that which is taken for granted" (p. 21). Further extrapolating from this concept of institutionality, Ray (2019) described organizations as being inherently racialized structures. For this current study, these organizations consist of predominantly White U.S. medical schools.

Phenomenological research methods are types of qualitative research designs where researchers strive to obtain thick, rich description from participants (Moustakas, 1994). Typically, this is done through semi-structured interviews, which I will further detail in the section on research methods. According to Moustakas (1994), with phenomenological research methods, researchers investigate the essence of the lived experiences of participants using semi-structured interviews and obtain thick, rich description from the descriptions provided by participants. While there are several different types of phenomenology, it is my belief that IPA was ideally congruent to match my study, for reasons which I detail next.

Smith (1996), the founder of IPA, described a deep, psychological, and wellness-based component regarding the origins of IPA. According to Smith (1996), this

methodology is theoretically based in phenomenology. Classical phenomenology, also known as transcendental phenomenology, is associated with Edmund Husserl and is concerned with a subjective, personal account or perception of an object or event. In Smith's view, individual meanings occur due to social interactions. As researchers attempt to get closer to the worldview of participants, they need to continually engage in critical reflexivity. This is done so that researchers can understand how their own positionality relates to making sense of the worldview of participants through extensive interpretation of the lived experiences of participants. Smith (1996) argued that the emergent use of IPA in studies of wellness, which originated in the field of health psychology, is one example of how IPA has been implemented as a methodology. For example, rather than viewing disease as a general happenstance that does not need firsthand description from a suffering individual, researchers utilizing IPA encourage individuals who have been through, or are currently suffering from a disease, to relate their lived experience with thick, rich description. The individual is encouraged to retell their personal experiences of that event, regardless of whether their lived experience involves stories of hardship, resiliency, or both.

As I sought to describe and interpret the lived experiences of BIPOC medical students and their wellness, IPA enabled me to move beyond the quantitative research designs which are nearly exclusively utilized in research with medical students. In fact, Smith (1996) emphasized this need in the introduction to his conceptualization of IPA. Biggerstaff and Thompson (2008) also stated that, while medical schools have not necessarily erred in relying almost exclusively on quantitative research methods, they have missed many opportunities to further develop a deeper understanding of the lived

experiences of BIPOC medical students. Biggerstaff and Thompson (2008) described IPA as a rigorous qualitative research methodology that is ideal for use with all health care professions and settings where the focus is on wellness. They noted that IPA as a methodology allows researchers within these settings to have a more multi-layered, complex, and nuanced perspective of the biological-psychological-sociological contexts of participants, therefore lending a deeper understanding of their lived experiences. As my research focused on understanding the wellness of BIPOC medical students from an ecological systems perspective, IPA was well aligned with the purpose of my study.

In my review of the literature, the studies I detailed earlier did not adequately address how BIPOC medical students made meaning of and interpreted their lived experiences. This lack of understanding BIPOC medical student wellness could be due to the absence of thick, rich descriptions in quantitative research designs. Along with working in a health care education setting, this is another reason I chose to utilize IPA. Next, I will discuss how I sought to obtain quality assurance with IPA as the research methodology for this study.

Quality assurance is an often unheralded, but attractive, component of IPA. Nizza et al. (2021) described four qualities which they detail as being indicators of high-quality implementation of IPA. The first marker of IPA excellence according to Nizza et al. (2021) is "constructing a compelling, unfolding narrative" (p. 371). A story line, and a sense of developmental progression, should evolve with the thick, rich descriptions of the lived experiences of participants, as detailed by the researcher. To achieve excellence with this marker, researchers should alternate quotes from participants with carefully considered analytic interpretation. The second marker of IPA excellence is "developing a

vigorous experiential and/or existential account" (p. 374). To develop high quality with this marker, researchers should strive to turn mere descriptions of an event told by participants into substantive, narrated experiences. In other words, they need to understand the depth of the situation for the participant and accurately relay that depth to readers. Third, researchers should strive for a "close analytic reading of participant's words" (p. 375). Rather than only citing quotations from participants, they should employ their own analytical skills to reflect and relate the meaning of these experiences of participants to readers. Finally, researchers should constantly be "attending to convergence and divergence" (p. 376). In other words, they should strive to achieve a balance between relaying the uniqueness of individual stories and the need for sharing the relatedness of common themes as gleaned from participants. Smith et al. (2022) refer to such themes being developed from clusters of "experiential statements" (p. 94).

As a type of phenomenological research method, IPA directly utilizes certain vital concepts from classical phenomenology. According to Pearl (2018), we can and should appreciate classical phenomenology for its emphasis on understanding the "essence" of the human experience. This appreciation can be felt across various subtypes of phenomenology, including IPA. "Imaginative variation" is one concept from classical phenomenology that may have direct relevance to IPA. Pearl (2018) described imaginative variation in their research, which was originally conceptualized by Husserl. In Pearl's view, while Husserl was correct to conceptualize imaginative variation, opportunities for advocating for social change and social justice have long been missed by neglecting a wider usage of imaginative variation within various subtypes of phenomenology. Social change and social justice advocacy can naturally stem from an

application of the concept of imaginative variation, utilizing IPA methodology to elicit thick, rich descriptions from BIPOC medical students.

Moustakas (1994), whose own work echoes that of Husserl, wrote that within imaginative variation "there is a free play of fancy; any perspective is a possibility and is permitted to enter into consciousness" (p. 98). Pearl's (2018) vision of imaginative variation is congruent with Husserl and Moustakas. However, unlike these scholars, Pearl strongly advocated for the use of imaginative variation to usher in a more socially just environment. According to Pearl (2018), "just as the imagination can serve as a conduit for power in social and political situations, so too can the imagination, when employed in a rigorous manner in imaginative variation, serve in the project of refashioning political reality" (p. 480). This statement is a reminder that having IPA as my methodology will not restrict me to only describing lived experience, or limiting me to only providing thick, rich description and interpretation of events as relayed by participants. Rather, IPA can also highlight, when utilized in combination with classical phenomenological concepts such as imaginative variation, how lived experiences of BIPOC medical students may be transformed by a questioning of the social order. According to Moustakas (1994), such use of imaginative variation, or "free play of fancy" where "any perspective is a possibility and is permitted to enter into consciousness," is allowed "to reign free" (p. 98). It is my hope that this study has incorporated the liberating ideal of "to reign free," so that redemptive social change and social justice can be strongly prompted to be enacted, and not merely articulately described.

Highlighting the framework of critical theory while utilizing the methodology of IPA reminded me of why I conducted this research in the first place, namely to highlight

BIPOC medical student wellness. I will share what I have learned from my participants about their lived experiences before and during medical school and their expected journeys after medical school. In this study, I examined ways to effectively advocate for BIPOC medical student wellness. My advocacy includes my analysis of the thick, rich descriptions by BIPOC medical students of their past and current experiences of wellness, along with hearing stories of their expected wellness in the future.

Research Design

Bloomberg and Volpe (2019) defined research design as the strategy that researchers implement in planning, articulating, and setting up how they will conduct their study. There are three reasons why I chose a qualitative research design for my study. First, nearly all known research on BIPOC medical student wellness has utilized quantitative research designs (see Dyrbye et al., 2007; Hardeman et al., 2015; Thuma et al., 2020; van Dijk et al., 2017). Studies which have implemented qualitative research designs are rare in the medical school related literature, although a few such studies do exist. For example, Jenkins et al. (2018) focused on reporting the life stories of medical students to further understand their well-being. While Jenkins et al. (2018) did not focus exclusively on BIPOC medical students, their study was nevertheless promising considering the overwhelming dearth of qualitative research designs in the medical school related literature.

Unfortunately, due to overreliance on quantitative research designs, the voices of BIPOC medical students have been silenced because of the lack of detailed feedback from participants. My qualitative research design centers the voices of BIPOC medical students and I have provided thick, rich description to detail their lived experiences while

in medical school. The second reason I utilized a qualitative research design is because I aspired to adhere to critical theory as the theoretical framework for this study. Researchers who highlight critical theory rely almost exclusively on qualitative research designs. The third reason for conducting a qualitative research design was based on the purpose of my study and research questions as outlined earlier.

According to Okesina (2020), qualitative research designs consist of the following interrelated elements: research purpose, research strategy, research methods, time horizon, credibility of choices and findings made, ethics, and limitations. In the opening section of Chapter III, I restated the research purpose for my study and research questions. Research methods, including the research environment, recruitment of research participants, data collection methods, and data analysis and synthesis, will be described in detail in a later section on research methods. Credibility of choices and ethics are detailed separately in a future section of this chapter on standards of rigor. Limitations are described toward the end of Chapter III, in the section on delimitations and limitations. Now, I will briefly discuss the research strategy and time horizon.

My research strategy was based on conducting semi-structured interviews with BIPOC medical students from medicals schools outside of the one where I am employed as a medical student academic advisor. I will discuss my research strategy in more detail in later sections of Chapter III on the participant sample and data collection methods. Regarding time horizon, I interviewed each participant two times during the data collection phase. Data analysis and synthesis of the data occurred upon commencement of data collection and after the transcripts had been checked for accuracy and cleaned up.

Initial data analysis commenced in August 2023 and final data analysis and synthesis concluded in October 2023.

As mentioned in the previous section on methodology, my study implemented the qualitative, phenomenological research methodology of IPA formulated by Smith (1996). IPA allowed me to gain further understanding of the perceptions and experiences of BIPOC medical students as it pertains to their wellness. As I have already mentioned, past research that has focused on BIPOC medical students has been almost entirely quantitative in nature, which has not allowed for a deeper, more contextualized understanding of the experiences of these students. With IPA, I gained more thorough, detailed, and descriptive explanations of the lived experiences of BIPOC medical students. As IPA requires researchers to provide thick, rich description, I was able to detail more descriptive analyses of the lived experiences of BIPOC medical students. My analyses will address common themes related to wellness that BIPOC medical students expressed during each of their two interviews.

Research Methods

I included the following components for the research methods. First, I describe the sample of BIPOC medical students, with a discussion of sampling type and recommendations of sample size based on best practices in IPA research. Participant recruitment will also be addressed in the section on participant sample. Next, I outline my data collection methods, which included gathering a sample of participants from two U.S. medical schools. The virtual nature of interviews, number of interviews, timing of interviews, and transcription of data collected will be described. Finally, I discuss the process of data analysis and data synthesis, including the steps of data analysis in IPA.

Participant Sample

The participant sample consisted of seven BIPOC medical students enrolled at two U.S. medical schools in different geographical regions, each selected through the recruitment method I will describe shortly. Data collection took place during June and July 2023. I recruited rising second year medical students and current third and fourth year medical students from the Classes of 2026, 2025, and 2024, respectively. I utilized purposeful sampling to conduct the research. According to Jones et al. (2013), purposeful sampling (also referred to as purposive sampling, see Bloomberg & Volpe, 2019) requires the qualitative researcher to "select participants to observe or interview who know the information (or have had or are having the experience) in which you are interested in studying" (p. 107). This type of sampling is also known as "intentional sampling" and refers to researchers being mindful of selecting participants who will best fit the criteria for the research questions under consideration (Terrell, 2016).

The procedure for how I recruited participants is detailed in the next section. Included with purposeful sampling are different variations, such as snowball sampling. According to Terrell (2016), snowball sampling consists of research participants who in turn help to recruit future participants. The idea is that, after identifying a small number of participants who agree to take part in the study, these participants are then asked to recruit other participants, thereby making the "snowball" bigger. As I successfully recruited each participant, I asked each student for a referral to another peer who might be interested in participating in this study.

In adhering to the recommendation set forth by Smith et al. (2022) for conducting up to 10 interviews for professional doctorate research, my original plan was to recruit

five BIPOC medical students and interview each participant two times, for a total of 10 interviews. However, I decided to keep the seven BIPOC medical students I was able to recruit for data collection, analysis, and synthesis. I interviewed each of the seven participants two times, yielding a total of 14 interviews. Prior to data collection, I had sought to recruit students from U.S. medical schools in five geographical regions, located in the Northeast, Southeast, Midwest, Southwest, and West. By early June 2023, after I had reached out to 44 of the 155 U.S. allopathic medical schools from across these five regions, I was successful in recruiting participants from two of these regions. I ended up consolidating the Southeast and Southwest regions into a single geographical region, the South. The two geographical regions I was able to recruit participants from was the Midwest and the South. One of my initially selected medical schools targeted for recruitment was removed from my outreach list due to challenges in obtaining contact information from their medical school student affairs website. Therefore, the total number of medical schools I was able to successfully contact by early June 2023 was reduced to 43 from the initial number of 44. Information about how the study was first communicated to prospective expert nominators is included in the email template located in Appendix A. Although I initially attempted to recruit participants via the expert nominator process described next, after two weeks of being unsuccessful in utilizing that approach, I chose to send out an open call to students. The open call student email is shown in Appendix B.

According to Jones et al. (2013), expert nominators are also known as "gatekeepers" and "key informants" and are those who know and are very familiar with prospective participants that would meet the sampling criteria outlined by the researcher.

The expert nominator approach served as my initial primary recruitment strategy for acquiring the needed participant sample. I decided upon a wait time of two weeks, in the event I was unsuccessful in recruiting via the expert nominator process, after which time I would conduct an open call for participants.

The expert nominator process calls for either the prospective participant to contact the researcher if they wish to participate in the study or the researcher needing to contact the participant upon nomination. I initially had planned to contact participants upon receiving recommendations from expert nominators. In keeping alignment with the qualification of strong familiarity with prospective participants by expert nominators set forth by Jones et al. (2013), I contacted medical school administrators in student affairs whom I deemed as potentially being familiar with the qualifications of prospective participants. For this study, I asked these medical school administrators for their thoughts as to the ideal prospective participants for this study. As mentioned earlier, the email to prospective expert nominators is shown in Appendix A. Included in this sample email are characteristics I was seeking from prospective participants for the study. Upon my decision to switch to an open call for participants, the sample email shown in Appendix B was sent to student affairs staff at the 43 medical schools I contacted, requesting their assistance in communicating information about my study to students and that any student who met the criteria described in the email would be qualified to serve as a participant.

Data Collection Methods

Interviews were conducted with seven BIPOC medical students at two U.S. medical schools in the Midwest and South geographical regions. Due to the distance from the interview site, all interviews took place virtually on Zoom. Two interviews were

conducted with each participant, with the interviews taking place during June and July 2023. Prior to the first interview, participants were emailed the information shown in Appendix C, requesting them to complete a short demographic survey and informed consent document. The demographic survey is in Appendix D and the informed consent document is in Appendix E. Table 1 and Table 2 shows the demographics of the participants from the information that was collected in the demographic survey.

Table 1

Participant Demographics: Age, Gender, Race/Ethnicity, Year, and Medical School

Pseudonym	Age	Gender	Race/Ethnicity	Year	Medical School
Arya	21-24	Female	Asian Indian	MS2	South Region
Chantelle	25-28	Female	Black/White	MS2	Midwest
Isaac	21-24	Male	Black	MS2	Midwest
Kiara	21-24	Female	Black	MS3	Midwest
Tiana	29-32	Female	Black	MS4	South Region
Oscar	25-28	Male	Black/Asian	MS4	South Region
Zuri	29-32	Female	Black	MS4	South Region

Seidman (2006) recommended that qualitative researchers utilize three interviews for each participant so that thick, rich description can be developed. However, as Smith et al. (2022) advised having 10 interviews for professional doctorate research, rather than 10 participants, I attempted to strike a balance between the advice of Seidman (2006) and Smith et al. (2022). Therefore, I conducted two interviews with each of the seven participants, for a total of 14 interviews for this study.

Table 2

Participant Demographics: First Generation Medical Student and Intended Residency

Pseudonym	First in Family in Medical School	Intended Medical Residency
Arya	Yes	General Surgery/Internal Medicine
Chantelle	Yes	Psychiatry
Isaac	Yes	Ophthalmology/Internal Medicine
Kiara	No	Family Medicine/Internal Medicine
Tiana	Yes	Psychiatry
Oscar	Yes	Internal Medicine
Zuri	No	Family Medicine

The interviews ranged from 40 to 78 minutes each, closely approximating the recommended 60 minutes duration as set forth by Seidman (2006), as each interview averaged 56 minutes. I felt this was a satisfactory amount of time for data collection for the following reasons. First, students were asked to participate in two separate interviews, so I had additional opportunities for follow up discussion after the initial interview. Second, the resulting interview time frame respected the time participants had set aside for each interview and made it easier to schedule than if three interviews been conducted. Finally, the limit of two interviews likely reduced participant attrition from the study based on possible fatigue with an additional interview demand.

Interviews were recorded utilizing Zoom and then transcribed using the Zoom transcript option. Upon the conclusion of each interview, I manually reviewed each of the transcripts for written accuracy. When in doubt as to the accuracy of an item on the

transcript, I utilized the corresponding audio recording to determine the precise wording of the transcript and made the needed corrections on the transcript.

After obtaining informed consent and reminding participants that the two interviews would be recorded and transcribed, I started the recording and had it on for the duration of each interview. My interview questions were drawn from my research questions. I had nine interview questions for the first interview and 10 interview questions for the second interview, for a cumulative total of 19 interview questions for both interviews. During the interviews, participants were asked the same questions in the same order, although there was time allotted for open-ended questions from participants, follow up questions from the researcher, and participant feedback. The interview questions are in Appendix F. Paraphrased sample questions included, "What are some of the best stories you would like to tell of your life before starting medical school?" and "What are some of the biggest challenges you have faced as a student of color in medical school?"

Correspondingly, in keeping with additional recommendations from Seidman (2006), I conducted the interviews in the following format. I utilized semi-structured interview questions for each interview and these questions asked participants about their past, present, and expected future experiences as a BIPOC medical student. The first interview consisted of questions revolving around gathering the life history of the participant, including precipitating factors in their decision to attend medical school, and some of their present-day experiences in medical school such as memorable stories and their present-day feelings as a BIPOC medical student. In the second interview, I asked each participant about their lived experience, including issues of racism and wellness

during medical school, and their expected experiences as a medical school graduate and physician.

Data Analysis and Data Synthesis

Participant data was collected prior to, during, and upon the conclusion of each interview. After data collection, I began the process of data analysis and synthesis. As mentioned previously, I utilized the Zoom transcription option to construct written transcripts of the 14 interviews. I did not utilize any software for the data collection, analysis, and synthesis, relying instead on manual procedures for IPA data analysis as detailed by Smith et al. (2022).

Smith et al. (2022) described seven steps for data analysis in an IPA study. These steps are listed in chronological order, outlined here as follows and then described in further detail immediately following this outline. These steps include: (a) intense focus on raw data of the transcript; (b) exploratory noting; (c) construct experiential statements; (d) make connections across experiential statements; (e) label personal experiential themes (PETs); (f) continue analysis of remaining cases; and (g) develop group experiential themes (GETs) across all cases (Smith et al., 2022).

First, the researcher focuses intently on the raw data, the transcript of the first participant interview. During this first step, the researcher needs to consciously slow down and reread the interview transcript, making notes of any details they may have overlooked earlier. As recommended by Smith et al. (2022), I printed off copies of the transcripts and carefully read through each of them, making notes of errors or omissions from each of the transcripts. After reading through each transcript, I then listened to the audio recording for each participant, cleaning up the transcript as needed in conjunction

with the audio recording. I made the necessary edits for each of the transcripts and printed out new copies of the clean, edited versions of the transcripts.

For the second step of the analysis, the researcher maintains an open mind and notes anything of interest as they detail the entire transcript. This second step is designated by Smith et al. (2022) as "exploratory noting" and is not intended as a theme-gathering expedition at this point, but rather, as initial hunches and reactions that the researcher has as they comb through the transcript. For this step, I conducted exploratory noting on each of the printed copies of the transcript, starting with the first participant and working through the transcripts for each of the subsequent participants. Smith et al. (2022) have likened exploratory noting found in the second step as being similar to conducting a free textual analysis. I created 2 ½" margins on the right side of each transcript page to make it easier to write these exploratory notes, which consisted of my intuitive reactions, comments, questions, and thoughts on the material found in each transcript. Following the advice of Smith et al. (2022), I considered the linguistic aspects of the conversation such as repetition, tone, hesitancy, emotionally charged language, and conceptual noting in which I asked questions of the data.

The third step of an IPA analysis is to construct experiential statements for each participant. Here, the researcher strives for seemingly contradictory aims, to reduce the volume of transcript detail while still maintaining its complex nature. With this step, the exploratory notes that I had made in the second step assisted with the third step, as I tried to produce what Smith et al. (2022) refer to as "an attempt to produce a concise and pithy summary of what was important in the various notes attached to a piece of transcript" (p. 87).

After completing the third step and prior to the fourth step, I printed off a copy of the experiential statements I had typed up and saved these experiential statements on my password-protected personal laptop computer. With this printout in hand, I next took the route recommended by Smith et al. (2022) with the fourth step in the analysis and opted for a manual working with the experiential statements to make connections across experiential statements. The manual method for conducting this fourth step of the analysis consisted of cutting up the printouts of the experiential statements and placing each of the separate experiential statements, consisting of relatively thin strips of paper, on a large surface, such as on a floor or desk. Prior to cutting up each experiential statement, in the manner shown by Smith et al. (2022, pp. 92-93), I made sure to record the pseudonym of the participant, page number of the transcript, and lines numbers from the pertinent area of the transcript, onto each of the experiential statements. This served as an important marker so that I would be able to trace the constructed experiential statements to the data in the original transcript.

With the fifth step of the analysis, I attached names to groups of the experiential statements, known as Personal Experiential Themes (PETs), consolidating and organizing these PETs into a Word document, which I then saved on my personal laptop and printed out for future reference in preparation for the seventh and final step of the IPA analysis, which is described shortly.

The sixth step of the analysis was to repeat the first five steps of the IPA analysis in continuing the individual analysis of each of the other cases. Since I had seven participants for my study, and conducted two interviews each, it took me several weeks to complete the sixth step.

Finally, the seventh step of the analysis was to take the PETs created for all participants and develop Group Experiential Themes (GETs). This step of developing GETs involved going through the PETs I had created for the seven participants and examining common themes across participants. Once common themes were established, I created a document containing all GETs for the study, which are detailed in Chapter IV.

Standards of Rigor

In qualitative research, issues of trustworthiness and ethical considerations are paramount to these studies (see Bloomberg & Volpe, 2019). Included in trustworthiness are four criteria outlined by Lincoln and Guba (2000) as being comprised of credibility, dependability, confirmability, and transferability. Ethical considerations are also a vital component of qualitative studies (see Terrell, 2016). In my discussion of standards of rigor, I will describe issues of trustworthiness first, followed by ethical considerations.

Trustworthiness

In qualitative research, issues of trustworthiness ensures that a study contains evidence that the manner in which the researcher describes and interprets the findings appropriately encompasses the problem, purpose, and research questions which were presented (Bloomberg & Volpe, 2019). Unlike quantitative research, which utilizes standards of reliability and validity to judge research quality, qualitative research relies on the following criteria proposed by Lincoln and Guba (2000) to assess the quality and trustworthiness of a study. These criteria are credibility, dependability, confirmability, and transferability.

Credibility takes prime consideration of whether the perceptions of participants and how the researcher highlights these perceptions are congruent (see Lincoln & Guba,

2000). It is analogous to internal validity in a quantitative study (see Terrell, 2016). Here, accurate portrayal of the words of the participants is vital. Since researchers will be interpreting the significance of the words spoken by the participants, it is imperative that researchers strive to accurately represent those words as much as possible (Lincoln & Guba, 2000; Bloomberg & Volpe, 2019). In this study, while there are many views on which efforts best demonstrate credibility on the part of the researcher, my focus on providing such evidence was through taking the following actions: prolonged engagement of having two interviews averaging one hour for each participant (Terrell, 2016), using thick, rich description of participant responses during interviews (Lincoln & Guba, 2000; Bloomberg & Volpe, 2019), and listening to the recording while examining the written transcript and making any needed grammatical corrections.

Dependability has been likened to the repeatability and consistency of the findings of the study, akin to reliability in quantitative studies (Terrell, 2016). Lincoln and Guba (2000) and Bloomberg and Volpe (2019) elaborated on the concept of dependability by stating that having a way to track the procedures used for collecting and interpreting the data is vital to the process of ensuring dependability. To meet this goal, I kept thorough records and explanations for how I collected and analyzed the data, as well as maintaining careful records of my interview transcripts. Through this "audit trail" and by having my data available for review by other researchers, I can demonstrate that my findings are dependable.

Confirmability allows the reader to ascertain that the findings and interpretations from the researcher have definitively emanated from the data (Lincoln & Guba, 2000; Bloomberg & Volpe, 2019). In demonstrating that a study has confirmability, the

researcher shows how they have come up with the conclusions of their study. Terrell (2016) discussed how confirmability rests with the idea of researcher neutrality and how the findings of the study were obtained without influence from outside the study. As a caveat, most qualitative researchers might object to the word "neutrality" to describe the role of the researcher, as the neutral and uninfluenced research is the domain of most quantitative studies. While Terrell (2016) reported three types of confirmability influences as consisting of confirmability audits, audit trail, and reflexivity, Lincoln and Guba (2000) and Bloomberg and Volpe (2019) mentioned the audit trail, triangulation, and reflexivity through journaling. To reconcile these slight differences, in my study I have an accessible audit trail consisting of a step-by-step accounting of the research procedures undertaken. I also engaged in ongoing reflection and reflexivity throughout the data collection and analysis processes by having kept a researcher journal.

Transferability is the final step needed to ensure the trustworthiness of a qualitative research study. Terrell (2016) described transferability as analogous to external validity in quantitative research. Transferability shows that our study can apply in other contexts. While Terrell (2016) specified that researchers should include "thick, rich description" in their qualitative data analysis, Lincoln and Guba (2000) and Bloomberg and Volpe (2019) also included purposeful sampling and providing detailed participant information on their list of research strategies. Thick, rich description consists of deep and elaborative descriptions from the researcher which are included in the study (Bloomberg & Volpe, 2019). My study included the thick, rich description that Lincoln and Guba (2000), Bloomberg and Volpe (2019) and Terrell (2016) each discussed, as

well as purposeful sampling as described by Lincoln and Guba (2000) and Bloomberg and Volpe (2019), and as reviewed in an earlier section of this chapter.

Ethical Considerations

Ethical considerations are paramount in any research study with human subjects. The first principle of ethical considerations is the principle of not harming participants in any physical or psychological manner (Terrell, 2016). Any harm that is done to a participant can be difficult, and sometimes impossible, to undo. Therefore, during each interview I was highly cognizant that I was, in fact, doing no harm to my participants. To accomplish this goal, in addition to my informed consent document clearly outlining the voluntary nature of participation, I also verbally reminded each participant, prior to starting the recording for the interviews, of the voluntary nature of participation in the study and that participants were free to end the interview at any time. During my application for obtaining required Institutional Research Board (IRB) approval, I had an informed consent document attached to my IRB request, which thoroughly detailed the voluntary nature of my study and the ability for participants to leave the study at any time.

Ethical considerations do not end upon termination of the data collection. I have ensured that data are stored on my personal computer without public access and that the data are properly encrypted and secured with password protection. After data analysis had concluded, I then had an ethical obligation to my participants to maintain confidentiality of the data. I did this by giving every participant in my study an unidentifiable pseudonym. I also utilized an unidentifiable pseudonym for each of the

two medical schools from where I recruited my participants. I will not seek to publish my work without the express written consent of each of my participants in this study.

In my discussion of safekeeping of participant responses and protecting identifying information, I am referring to the responsibility that I have as a researcher to ensure that the anonymity of my participants is respected. In keeping with this element of responsibility, I respected the time of my participants by arriving for each interview on time and did not cancel any appointments, although some of the participants ended up asking for a different interview time, requests that I promptly granted to any participant who asked to reschedule their interview. I strove to ensure that the time of my participants was respected by adhering to the time limit that was mentioned of having each interview last for approximately one hour. Finally, I was flexible in my scheduling of interviews and worked diligently to fit the schedule of my participants rather than what worked best for me as the researcher. Interviews were held both during weekdays and weekends, during the daytime as well as evening hours, according to the times that worked best for each participant.

Delimitations and Limitations

Delimitations are defined by Terrell (2016) as being boundaries that the researcher deliberately puts into place. The author states that this is done so that the researcher can control for factors that might otherwise affect the results of the study. Terrell (2016) defined limitations as being boundaries of a study that are outside the researcher's control and that could affect the generalizability of the findings. In this section, I first describe the delimitations of my study, followed by the limitations.

Delimitations

As one of the delimitations, the Class of 2023 was not included in this study, as graduation for medical schools is in May. Therefore, it would have been difficult to recruit recent medical school graduates, as they were making a major, time-consuming transition from medical school to medical residency during the data collection phase in June and July 2023. Likewise, incoming first-year medical students, the Class of 2027, were not included in the study, as they had not yet matriculated to medical school during the time of data collection. The two medical schools where I was able to successfully recruit participants began the academic year for first-year medical students in August 2023, thereby eliminating any possibility of including medical students from the Class of 2027 in the study.

The second delimitation to this study is that I only interviewed BIPOC medical students, rather than conducting additional interviews with White medical students. This delimitation means that there may be an incomplete picture regarding the influence of White medical students on the wellness of BIPOC medical students, as I did not hear from White medical students regarding their views of racism and wellness. Furthermore, although academic advising is mentioned in Chapter I and Chapter II as a tool to highlight systemic racism in medical schools, academic advisors were not interviewed in this study. I openly acknowledge these delimitations as being areas to explore in future research on this topic.

Limitations

Some of the greatest strengths of qualitative research designs are paradoxically sources of its greatest challenges. Due mostly to time constraints, financial considerations, and the logistics of recruiting participants from two geographically

distinct medical schools, my study likely overlooked some of the characteristics found only at certain medical schools located in certain geographical regions. Although I attempted to recruit participants from as many different geographical regions of the U.S. as possible, I was only able to capture two medical schools from two geographical regions of the U.S., the Midwest and South.

An additional limitation of my study was that I may not have been able to completely capture the lived experiences of BIPOC medical students because all of the interviews took place on Zoom. While I do not feel that the virtual format hindered my ability to establish quick rapport with participants, this remote format may have inadvertently caused me to miss certain nonverbal cues from participants, such as body gestures, due to the limited view of the video camera. Furthermore, in instances of imperfect video or audio recordings, I may have missed important visual cues and auditory explanations from participants. Finally, one of the interviews took place during a thunderstorm in the participant's area, causing minor disruptions and occasional distortions in the audio recording.

A final limitation of this study is my reliance on one research method, that of conducting semi-structured, qualitative interviews using IPA. I relied on extensive, descriptive answers from participants in my study, but I was not able to witness from firsthand observations the daily situations encountered by BIPOC medical students. I was also not able to learn of the lived experiences of these students in larger interactive contexts, such as through utilizing focus groups. Future research could address these limitations.

Chapter Summary

Chapter III details the philosophical framework adhered to and the procedures I implemented in the study. In this chapter, I have restated my purpose for this study and the research questions. I have described my paradigm of inquiry as being centered on critical theory. Next, I discussed how my methodology of utilizing phenomenology, specifically the subtype of phenomenology known as Interpretative Phenomenological Analysis (IPA), is informed by the critical theory paradigm of inquiry. I then reviewed the research design, which was a qualitative study using semi-structured interviews. While research methods, credibility, ethics, and limitations are a part of research design, I discussed these elements in separate sections of Chapter III. Next, I described my research strategy and time horizon. After completing my discussion of the research design, I then described my research methods in detail, including my methods of data collection, data analysis, and data synthesis. Standards of rigor, including coverage of issues of trustworthiness and ethical considerations, were then reviewed. Finally, Chapter III concluded with a discussion of the delimitations and limitations of this study.

CHAPTER IV

FINDINGS AND ANALYSIS

In Chapter IV, I present the findings from the study and provide an analysis of these findings. The purpose of the study was to understand how BIPOC medical students experience wellness as they navigate systemic racism in medical schools. Supporting the purpose of the study, the research question was, "How do BIPOC medical students make meaning of personal wellness as they navigate systemic racism in medical school ecosystems?" With this as the guiding question, two sub-questions followed, "How do BIPOC medical students define personal wellness for themselves?" and "What resources do BIPOC medical students point to as their key support systems at predominantly White medical institutions?" Next, I share brief biographical sketches of the seven participants I interviewed, providing a perspective for their inclusion in the study. Following this, I detail the steps for arriving at the construction of the Group Experiential Themes (GETs). Then, I describe the GETs that were seen across all participants, highlighting their lived experiences. Finally, I conclude the chapter with a summary of topics covered.

Participants

Smith et al. (2022) referred to the importance of intentionally selecting participants when conducting an Interpretative Phenomenological Analysis (IPA) study. Specifically, they stated that participants "are selected on the basis that they can grant us access to a particular perspective on the phenomena under study" (p. 43). As an idiographic approach, IPA rests on gathering small sample sizes that will yield rich,

descriptive data. Smith et al. (2022) made the specific recommendation of six to ten interviews for professional doctorate research. I interviewed each of the seven participants twice, corresponding to a total of 14 interviews. The sample of participants included five women and two men, including four participants identifying as Black or African American, two participants identifying as biracial African American/White and African American/Asian, and one participant identifying as Asian Indian. The name of each participant has been changed to a pseudonym that respects their racial and gender identities, while preserving their anonymity. Furthermore, the medical schools of each participant are identified solely on the basis of their geographical region. I was successful at recruiting participants from two U.S. medical schools, in two geographically distinct regions, with neither of them being the U.S. medical school where I was employed at during the study. These schools hereafter will be referred to as Midwest School of Medicine and South Region School of Medicine.

Arya

Arya was the first participant in the study and identifies as an Asian Indian woman. Arya was in her early-20s and a second year medical student at South Region School of Medicine at the time she was interviewed. While she spent much of her childhood growing up in California, more recently she has lived in the South, where she has resided for the last several years while completing her undergraduate degree and first year of medical school. Prior to medical school, Arya gravitated toward the sciences, especially math and physics. She was an engineering major during her first two years in college. However, volunteer opportunities that surfaced during those summers gradually steered her toward developing an interest in medicine. Arya stated that “through each of

these opportunities, I think that I slowly started to realize that no matter what I did, I was more interested in the medical aspect than what I was actually doing." Arya mentioned several times about the pressures that Asian Indians often face in medicine, as many Asian Indian medical students try to meet the assumptions of extreme excellence placed upon them. As Arya noted, "there's like a huge stereotype associated with Indian doctors, and I feel like, because of that, people just inherently expect you to do well, but like not just do well, they expect you to be one of the best." Arya's medical specialty interests include general surgery and internal medicine. She is the first person in her family to attend medical school and reported mostly positive experiences at South Region School of Medicine.

Chantelle

Chantelle was the second participant in the study and identifies as a biracial Black/White woman. Chantelle was in her mid-20s and a second year medical student at Midwest School of Medicine at the time she was interviewed. Given her biracial heritage, Chantelle reported being very aware of the challenges she faces in spaces which are predominantly Black or predominantly White. While she mentioned having Black friends and White friends, she also reflected on how many of these friends could not fully relate to her because of her biracial background. Chantelle reported that she "got bullied a lot, so definitely a lot of the issues I have today stem from middle school and high school." College was a turning point for Chantelle, as she related that she "met a ton of people that I'm still friends with now. And I think that really set the tone for my college experience." Prior to medical school, Chantelle had hopes of going into cosmetology as a career. She also described herself as "being really passionate about animals" and is hoping to foster

kittens that need homes after she graduates from medical school. Her medical specialty interest includes psychiatry. She is the first person in her family to attend medical school and reported a very challenging first year at Midwest School of Medicine.

Isaac

Isaac was the third participant in the study and identifies as a Black man. Isaac was in his early-20s and a second year medical student at Midwest School of Medicine at the time he was interviewed. One of the memories he spoke of during his first year revolved around the fun he experienced even while studying intensive medical school content. Isaac recalled one class session where the instructors encouraged the creative learning of students by having them present topics to the instructors and peers in an open-ended manner. Isaac and his small group peers took the liberty to pretend they were professors delivering a lecture, "so, like we're sitting here learning. This is like one of the mandatory classes. Everybody's here, and the professors are laughing at some of the things that we're doing. And we're acting like this professor." Isaac's medical specialty interests include ophthalmology and internal medicine. While he is the first person in his immediate family to attend medical school, he mentioned the influence of his uncle, who is a physician and has had a profound impact on Isaac on his decision to pursue becoming a doctor. Isaac spoke highly of his uncle and the influence he has had on Isaac since elementary school and into medical school. He reflected on his first year at Midwest School of Medicine in exceptionally glowing terms.

Kiara

Kiara was the fourth participant in the study and identifies as a Black woman. Kiara was in her early-20s and a third year medical student at Midwest School of

Medicine at the time she was interviewed. Kiara mentioned that she was an athlete from childhood through college and she was a Division I athlete in college. She reported that while she loves the theatre, her Black peers do not share this same enthusiasm, but her White peers will not let her into their social circle even though they have a strong affinity for the theatre. As Kiara notes, "that's something that I brought up to some of my Black classmates about Broadway shows, and sometimes I get like a weird look for weird judgment." Kiara mentioned her father, a physician, several times during the interviews. It was evident that her father's background has had a profound impact on Kiara's decision to pursue becoming a doctor. She recalled an experience she had during a "take your child to work day" at her father's office, during which time a lot of people in her community expressed their gratitude for her father. Kiara remembered that many people remarked "Dr. (last name), like you delivered my such and so, and they pull out a picture of their kids and like you always just associated with, like something that made their life so much better." Kiara also recalled meeting a BIPOC female physician when she was a teenager and this doctor also had a substantial influence on Kiara's decision to become a physician. She recalls that this physician sat down with her and talked about the realities of having a healthy diet and a healthy body image, as the doctor herself was a former high school and college athlete and therefore understood the pressures that female athletes faced regarding body image. Kiara's medical specialty interests include family medicine and internal medicine. Kiara reported some personal challenges during her first two years at Midwest School of Medicine.

Tiana

Tiana was the fifth participant in the study and identifies as a Black woman. Tiana was in her late-20s and a fourth year medical student at South Region School of Medicine at the time she was interviewed. Tiana was the only participant who was not born in the United States and grew up in two different countries before coming to the U.S. as a child. Tiana has a twin sister who also attends medical school. However, Tiana and her sister attend different medical schools. Tiana mentioned during the interviews how, being a twin, she closely confides in her sister and stated that her "family itself is very close, and we've kind of, like in the Caribbean culture, we're very determined to succeed, and so my parents always kind of like, encouraged my sister and I to pursue things that we like." This pursuit ended up being medicine for both Tiana and her twin sister. Tiana's passion for the arts was strongly felt during the interviews, at one point she mentioned that, "I love the arts, anything art related. I pretty much love drawing, love plays, music, stuff like that." She underwent a serious health crisis during her second year of medical school that required emergency surgery and Tiana received substantial support from her peers, instructors, and administrators at that time. Her medical specialty interest includes psychiatry. Outside of her twin sister, she is the first person in her family to attend medical school and reported generally positive experiences during her time at South Region School of Medicine.

Oscar

Oscar was the sixth participant in the study and identifies as a biracial Black/Asian man. Oscar was in his late-20s and a fourth year medical student at South Region School of Medicine at the time he was interviewed. While in high school, Oscar wanted to pursue a career in computer science due to his love of gaming. However, he

strongly disliked his computer hardware class and knew he needed to expand his career search. In college, he took psychology and neuroscience courses. While he liked "talking to people, diagnosing through just talking and all these different criteria and things" psychology was not enough of a "hard science" for him. He considered pursuing a Ph.D. in neurology after college, but recalled that he was repelled by the thought of doing extensive academic research, so he eventually came to medicine where he could focus on doing clinical work. In every area of our conversation, friends were constantly mentioned by Oscar, as was travel, whether the topic was about his experiences growing up, or if the conversation focused specifically on wellness. Unlike most participants in the study, Oscar has a strong desire to relocate after graduation to a highly specific region outside of the geographical area of his medical school, specifically mentioning Washington, D.C as his preferred medical residency location. His medical specialty interest includes internal medicine. He is the first person in his family to attend medical school and reported an overall positive experience at South Region School of Medicine.

Zuri

Zuri was the seventh participant in the study and identifies as a Black woman. Zuri was in her early-30s and a fourth year medical student at South Region School of Medicine at the time she was interviewed. Zuri mentioned that she has been residing in the geographical area of her medical school for "quite a long time" and stated the mascot of her university specifically to indicate her strong affiliation and longevity with her institution. As an only child, Zuri was involved with sports while growing up, although video games played a stronger role for her since "that was one of the ways I entertained myself." While she did not experience a health crisis requiring emergency care, she did

become frequently sick early on in medical school. Thereafter, she started to take her wellness more seriously, carefully watching her diet, exercising, and getting adequate sleep. Since medical school, Zuri reported that she has now taken her "interests indoors, playing mostly video games, watching cooking shows, and travel shows." Her medical specialty interest includes family medicine. She deliberately extended her time in medical by pursuing two graduate degrees in addition to her medical degree. As a result of this voluntary extension, she reported seeing many changes take place during her time at South Region School of Medicine.

Group Experiential Themes

Each of the seven steps of the IPA analysis was detailed in Chapter III. The final stage of developing Group Experiential Themes (GETs) involved going through each of the Personal Experiential Themes (PETs) and examining common themes across all participants. There were four GETs that emerged and were related to the research question and sub-questions, with the GETs being derived from the PETs. While the PETs were ascribed to specific participants and did not necessarily coincide with the experiences of all participants, some of these themes were prevalent across all participants and therefore were included as GETs. Table 3 depicts the four GETs listed below and ascribes their relatedness to the research question and sub-questions:

1. Belongingness to find one's place in medical school.
2. Healing oneself to be able to heal others.
3. Cheerleaders: Family, faculty, mentors, and advisors.
4. Hope for change despite systemic inequities.

Table 3

Themes Related to Research Question and Sub-Questions

Group Experiential Themes (GETs)	Research Relatedness
Belongingness to Find One's Place in Medical School	Personal wellness definitions; key support resources; navigating systemic racism in predominantly White medical school ecosystems.
Healing Oneself to be Able to Heal Others	Personal wellness definitions; navigating systemic racism in predominantly White medical school ecosystems.
Cheerleaders: Family, Faculty, Mentors, and Advisors	Key support resources; navigating systemic racism in predominantly White medical school ecosystems.
Hope for Change Despite Systemic Inequities	Key support resources; navigating systemic racism in predominantly White medical school ecosystems.

Belongingness to Find One's Place in Medical School

All participants shared how they had a profound desire to foster social connections during medical school. This overarching theme centered on their feelings of belongingness as participants grappled with personal wellness as BIPOC medical students. In illuminating the first GET of belongingness to find one's place in medical school, I describe the lived experiences of participants whose voices shed profound light on this journey.

Aspects of belongingness encompassed descriptors such as adaptation, anticipation, attitude, identity, intentional, and realized. While many of these terms came directly from the words of participants, others were ascribed to participants upon my conceptualization of what they were describing to me with respect to their thoughts regarding how they fit in or did not fit in with a social group. In addition, there were

many statements articulated by participants that may not have included these descriptors in the interview transcripts. However, upon further reflection and my conceptually driven pre-analysis exploratory notes, I decided to incorporate these statements into the belongingness theme. These statements conveyed a deep awareness by participants of their self-awareness and self-knowing their identities in relation to the social world and their desire to belong and find their place in medical school.

The self-awareness inherent among all participants regarding the belongingness theme was inescapable. Each participant showed keen insight in terms of what it meant to experience being a BIPOC medical student in relation to their social world in medical school. Some participants reflected on how they felt a profound lack of belongingness in medical school, particularly with challenges in establishing connections with peers. Others felt a strong sense of belongingness to certain peer groups, while feeling estranged from others. Chantelle, a biracial Black/White woman shared:

> There's just a lot of pressure on myself to like, make friends and be part of a group so that I could go into medical school having that, you know…I don't know, like group connection with people. So that was the big, the biggest stressor I had. And I think I've just always felt this. I just don't feel like I belong in, like, any setting.

As she shared more of this experience, Chantelle also acknowledged the complexity inherent in developing a sense of belongingness in medical school, including her personality that she brought with her to social situations, as she related:

> But, you know, it's sometimes I'm like, outside looking in, and I know part of that is because I tend to seclude myself a little bit, and I think it's harder to get to

know me, because I'm not as open. I think a lot of the social things that I went to, you know, people will go because they're social and I go because I'm trying to force myself to be social. So it was easy for me to compare myself with people who were like, you know, just talking away, you know, having a great time, whereas for me, I'm kind of like more in my head a bit.

Chantelle did not mention whether her feeling this lack of belongingness at Midwest School of Medicine was due more to her introverted personality or being a biracial Black/White woman. Kiara shared that she too felt a lack of belongingness since starting at Midwest School of Medicine. However, Kiara ascribed her experience to being a Black woman whose family was economically privileged. Many of Kiara's social interests were more congruent with those of her White peers, such as Kiara's enjoyment of the theatre, but her White women peers never permanently invited her into their social circle. While Black women peers did accept Kiara due to shared racial and gender identities, Black women peers did not accept her interests and were not at all enthusiastic about her enjoyment of theatrical performances, as Kiara recalled:

So she (a White peer) invited me to the studying room. And they (the White peer group) were just talking about some of their experiences over the past year. And they talked about, like, having a Broadway night at some, like, club, and how they all got dressed up. And that is, like, in Broadway is something that's more of an interest, for like people who have the money to see Broadway shows. So that's like a socioeconomic thing, which tends to be not just like the Black community. And even my parents like, I like, Broadway. And so like, that's something that I

> brought up to some of my Black classmates about Broadway shows, and sometimes I get like a weird look for weird judgment.

Kiara highlighted her socioeconomic status as being the primary driving factor for not fully fitting in with her Black peer group, due to her family's economically privileged status. She also mentioned her Black identity as being the reason for her not being accepted into a White women peer group:

> But my point being is that like this is my third year. And there's this group of girls who are doing things, who are White females, who are like doing things that I would have loved to be doing, but because like, we didn't gravitate toward each other, for whatever reason, on the first day of school, I didn't get to have those commonalities and that sense of community, even though I would have enjoyed it. And the people who I do have community with kind of look at me like a weirdo for thinking that.

Zuri, a Black woman, reflected on how her unique experience earning two graduate degrees, including a Ph.D. and a master's degree at South Region School of Medicine, has set her apart from her peers in a negative way. In essence, her longevity in medical school and her extended time in graduate school fields made it more difficult for her to establish strong feelings of belongingness with her peers in either medical school or graduate school. Few medical students have traveled down Zuri's path, making relatable connections challenging. Zuri shared:

> But I feel like for me in particular not having a support system that understood that I didn't understand it that made it a little more difficult. So, granted everyone

has been very nice, but it was just very difficult, it was just difficult for me, because, like, I don't know what I don't know kind of thing.

Zuri was the only participant in the study who did not report experiences with friendships during her time in medical school.

Chantelle attributed difficulties to developing feelings of belongingness to her biracial background, as well as to her introverted personality:

> I'm half Black and half White, so I feel like I never felt like I fit in with White people, because, you know, we were always different. And there were things that I experienced that they couldn't relate to. And, in terms of other Black people, sometimes I feel like I can't fit in with them, because they have experiences that I can't relate to. So, I think part of it is that I will say the group of Black girls in my class, we made it a point to like, kind of support each other and, like, be there for support if we ever needed it. So that was something that you know, I never felt like I didn't belong with that group, but you know they're all so very kind and everything.

Kiara also emphasized how peer groups at Midwest School of Medicine tend to be racially segregated, leading to feelings that one can never belong to a group they are currently not a member of, as she shared:

> And the groupings tend to be very racially segregated. And it's very much like, interesting. So I would say loneliness of like community has been one of my biggest challenges that I've like constantly been working on trying to expand. But at a certain point I do feel like it's really hard to make new friends in medical school, because we all need to be studying and not socializing as much.

The experience of Isaac, a Black man, was vastly different than Kiara and Chantelle. Isaac shared that he has always felt a sense of belongingness throughout his life, including his experiences at Midwest School of Medicine, as he reflected:

> I think that I've been predominantly around, like, a group of people who are willing to be around other people and are open to differences in people and what someone may either have or not have, or prefer, or not prefer. I think that I've had always a good balance of people around me who are just comfortable being around most anybody.

Isaac also shared that Midwest School of Medicine is intentional about fostering an atmosphere of belongingness to all medical students, as he mentioned:

> There's a new thing that has been implemented only for the medical students. So they have cookouts and stuff and gatherings at the start of the year for all of the students to get together and meet each other throughout the year. Some of the organizations put on events here and there to kind of just keep in with my community, and sharing those, like struggles, that you know slight trouble that we may see or experience and go through sharing that in a community-based way.

When asked to elaborate on whether he had any experiences in medical school which had ever given him pause, Isaac emphatically stated that he did not. He recalled his positive social interactions with his professors as evidence for his sense of belongingness at Midwest School of Medicine:

> No, I can't say anything, like, anything in my face, no. Nothing I've noticed. I think quite the opposite. And for them, like I said, I've always, like, I've had people around that are just welcoming to anybody. So you know, going to the

> office hours with professors, it didn't feel uncomfortable. They feel like they were there trying to help me, going above and beyond in the anatomy lab, working very well with my anatomy group in class you know, working well with students.

Arya, an Asian Indian woman, also mentioned the importance of feeling a strong sense of belongingness in an academic setting, as she highlighted the vital role of small groups within the classroom at South Region School of Medicine, and reflected:

> I think group activities might actually be beneficial. But group activities with maybe people that you trust or like or a small group that you've already grown accustomed to. I think that would be a better way to go about it just because I think that a lot of people of color also just struggle with being vulnerable in a group setting. And I think that's really what it boils down to with the one-on-one sessions, for being with a group of people that you're comfortable with.

In adding to the value of small groups in the classroom with fostering a sense of belongingness, Arya mentioned the pivotal role that leadership plays in developing ideal group cohesion:

> In terms of fostering that trust in a small group, I think just having, like some form of guidance, is really important, because, again, like the small groups, we have around 30 of them here. And some of them are a lot closer to each other, like I consider my small group to be very close, and the reason for that is our leader is very open minded. He doesn't hesitate to like, ask us personal questions. And like, things like that, I think we have grown really open to each other.

Oscar, a biracial Black/Asian man, pointed out that sometimes just having a safe place to go to can help BIPOC medical students feel like their school is trying to foster a

sense of belongingness. For example, Oscar mentioned that not only is the Office of Diversity, Equity, and Inclusion (DEI) at South Region School of Medicine a safe place for BIPOC medical students to go to, but it also serves as a venting place where community can be fostered among BIPOC medical students, knowing that they are not alone when navigating a predominantly White medical school. As Oscar shared:

> That (DEI) office to us pretty much serves as somewhere we can go where, if we, you know, if we've experienced something to talk about it, and one, it's like a venting session or like a counseling session, and two, these are people who are deans in the college, so they can then take administrative action whether that be, you know, having the offender like, do some classes on racial inclusivity, or something like that, or, you know, just talking to them, or something like that. So, I think, having kind of a centralized location that students of color feel safe to go to whenever if something happens, that is the most important thing.

Imposter syndrome is the mistaken belief held by some medical students that they do not belong in medical school due to several false ideas. These notions include being admitted to medical school by accident or, in the case of BIPOC medical students, feeling like the reason they are in medical school was due to legal policies such as affirmative action, rather than based on their qualifications alone. While imposter syndrome can affect any medical student, BIPOC medical students at predominantly White medical schools are particularly prone to this feeling due to being greatly underrepresented at their medical school. Tiana, a Black woman, explained:

> And again, like, I know no one's voicing this out loud, but I think this also ties in with the whole kind of like imposter syndrome, and the fact that, like people of

color, just naturally, unfortunately, you know have this sort of nagging notion that like oh, we're just here kind of by accident, you know, and I don't know. I feel like that thought a hundred percent was there in my pre-clinical years.

Kiara also shared her experience of imposter syndrome from her first year at Midwest School of Medicine. She described how an increasingly demanding study schedule eventually made it next to impossible to have the social connections when these relationships were most needed, as she described:

> Your weekends, they're spent studying, and your Monday nights are only days off. So there's not a lot of time to really build connection at that point. So when you start to really start to feel some of the struggle of medical school, and like, wow, this is harder, like, wow, I'm not good enough to be here, or I'm not smart enough to be here. Or like, is everyone else feeling this way? You've only just begun to build enough friendships where you may or may not feel like vulnerable to share those things.

The need for having friends in medical school was paramount in fostering a sense of belongingness. Friends were mentioned by all participants except for Zuri as playing a highly significant role in feeling like they could fit into the environment of medical school. Chantelle acknowledged the importance of friendships for her in fostering a feeling of belongingness at Midwest School of Medicine. However, she admitted that her social reluctance has made it difficult to make the friends that she knows would be beneficial to her as she goes through medical school. Chantelle shared:

> I think after undergrad, it's really hard to make friends, and I do notice, like, groups of people, like, they've all made friends and like similar interests and stuff.

> And I don't really have a group of people that I, you know, study with or hang out with a lot or do things with.

Tiana mentioned how she recognized even before medical school that she needed to set up a friendship network, so she preemptively engaged in making this happen. Tiana had convinced her best friend in college to apply to South Region School of Medicine Not only did her friend apply there, but she was also able to join Tiana as they began medical school together, continuing a friendship they had built over the years:

> I was truly just trying to find anybody. And like, if I like them, I was…okay, I think you should go to school. And actually, my closest friends, that one of my closest friends is, that's literally how I dragged her here, as I was like…hey, I really like you. I think you should go to this school. She's like, no. So I was like…great, so I'm going to see you in the fall. She was like, okay, sure. That's how I made some of my closest friendships.

Tiana also mentioned how feelings of belongingness shifted for her during her pre-clinical and clinical years at South Region School of Medicine. Given that the first two years of medical school, the pre-clinical years, revolve mostly around classroom experiences, it was easier for Tiana to make and keep friendships strong throughout that time. However, once she entered her clinical training with clerkships during her third year of medical school, all of that shifted as Tiana had a work schedule that did not coincide with that of her peers, as all were on clerkships at different sites:

> You get really close, knock on wood, like with people, especially in the first two years, because you're just truly learning, like you're always constantly in lectures every day, and that's pretty much your life. Versus like third year, where you're

all doing different things and you're all on different rotations and the fourth year you're truly just not seeing anybody, because now you're trying to do what you want to do.

Oscar reported exceptionally close physical ties to his friends, describing them as being nearly inseparable from him and a major key support resource during his time at South Region School of Medicine. He shared many stories during his interviews about how he has built strong connections with his friends, including one that made him reflect on the contributions of friends to his sense of belongingness and his personal wellness:

So my one big memory about that is me and then one of my other friends had never seen the Twilight series. So when we were doing our neurology block, my friend decided, hey, let's watch a movie a week. There's exactly the number of movies that line up with the number of weeks there are in neuro (class). And, you know, it'll just be end of the week, don't think about neuro. Just watch this, really not good movie, and have a fun time. So that's one of my favorite ones. And that's one of my favorite memories. And we got really, really close doing that.

After that bonding experience took place between him and his friend, Oscar later started to prioritize what was most important to him in medical school, which was making lasting memories with friends, rather than worrying about putting in more study time:

We were like, going to go study, like, for the third time that week. And we just like studied for an hour, we were like, in five years, when we're in residency, are we going to remember studying this enzyme, or are we going to remember going out to eat? And we're going to remember going out to eat. So fuck it, let's go. And that's kind of how I've tried to live through medicine since then.

Summary of Belongingness Theme

Multiple layers of belongingness were reported by participants. For some, belongingness centered on whether peers accepted them when their race was different than that of their White peers. A few participants mentioned their personality types as being driving factors in the ease or difficulty with which they experienced belongingness. Others shared that a mismatch between cultural stereotypes and individual interests thwarted their feelings of belongingness in social circles at their medical school. Trust-building activities, whether through classroom activities or from having convenient access to Diversity, Equity, and Inclusion (DEI) staff, was reported by some participants as being critical in fostering their sense of belongingness to their medical school. Imposter syndrome, a common psychological condition for many first-year medical students, was mentioned by most as being a hurdle which prevented them from feeling that they belonged in medical school as a BIPOC medical student. Finally, participants spoke of the powerful impact that early friendship formation in medical school has had on helping them experience a feeling of belongingness in medical school.

Healing Oneself to be Able to Heal Others

Participants reported having emotional trauma that ranged from mild to severe while in medical school. The second theme, of healing oneself to be able to heal others as a future physician, was common among participants. They all spoke of the need to recognize the emotional challenges they routinely faced as BIPOC medical students and the importance of directly confronting and dealing with these challenges to avoid emotional turmoil and sometimes physical illness. In essence, each participant shared their story of how they recognized their emotional health as being vital to both their

mental state and physical health. During the times they did not prioritize their emotional health, their physical well-being also suffered. Conversely, when they chose not to focus on their physical well-being, they experienced emotional turmoil. Prioritizing self-care so that they could then care for others, including keeping their social networks intact, was reported by all participants.

The images participants provided of their mental health included descriptors such as anxiety, burnout, depression, and stress. So too were other descriptors illustrating emotional health, such as: difficult, happiness, loneliness, negative, optimistic, positive, scared, relief, and trapped. Vivid emotional experiences shared by participants were positive and negative, uplifting and threatening, and good and bad. In addition, many other statements that participants focused on did not include these specific descriptors in the interview transcripts. However, upon reflection and my conceptually driven pre-analysis exploratory noting, I decided to incorporate these statements into this second theme of healing oneself so as to be able to heal others. Such statements conveyed the deep awareness from participants of knowing the self, and especially caring for the self, although the chosen words of participants did not always follow the previously described emotional health word list.

Medical school is mentally daunting for most students, so negative reports of participants as they reflected on their emotional health was congruent with this challenging time. Many participants reported that positive experiences, which had enhanced their self-care, were approximately equal in number to negative experiences, which they felt had depleted their emotional health. In sharing their illustrations of these aspects of emotional health and self-care, I first report on noteworthy negative emotional

states, interwoven with coping mechanisms participants utilized when faced with negative emotional states. Then, I describe positive instances of their emotional states, situations they reported as being helpful for their emotional health. These positive emotional states were mentioned by participants as making their experiences as BIPOC medical students more fulfilling and meaningful than would have otherwise been the case.

Stressful experiences were frequently reported by participants. Zuri described how she anticipated a need for continued balance with monitoring her well-being and keeping stress to a tolerable level as she entered her final year of medical school, with the need to immediately prepare for the transition to more intense future stress during her medical residency training:

> Saying that you've figured it out is that it's always changing. But I feel like, especially with training, because with medical school literally every month you're doing something different. And then with residency, and in particular family medicine, you're doing something different every month, with the schedule difference, work, requirements, and whatnot. And so it's a constantly moving target which makes it even that much more stressful. And so I'm very much looking forward to a little bit more stability after training, so that it doesn't move every month.

As she reflected on her experience, Zuri recognized the rising tension between completing one major pathway, medical school, and her anticipation of another equally if not more arduous journey in the near future, medical residency. Zuri described how, even

when being highly cognizant of her wellness in the moment, additional stressors still awaited her in medical residency.

Chantelle mentioned the significant challenge of having to repeat her first year at Midwest School of Medicine. She shared:

> The negative side is medical school has been very hard for me, like it was definitely not an easy journey at all. I had to retake my first year, so I think the challenges that I've dealt with, I think, are more so emotionally than school related. I think that has been, like, very memorable for me, like, I don't think I'll ever forget that.

When she revisited this experience again during the second interview, Chantelle reiterated that the memory of failing her first year of medical school was completely devastating to her emotional wellness. Her memories of medical school are permanently intertwined with this highly impactful and negative experience of academic failure:

> But I think I learned the most about myself than I have ever. I mean, I've learned about how to take care of myself like, and I'm still learning it. But how to take care of my mental health and actually asking for help and stop being so stubborn, and, you know, like actually see a doctor and talk to them about the issue.

While Chantelle's experience was unique to this study, she had in common with other participants a proclivity for turning around a highly negative event into a positive learning experience. The deep introspection and focus on self-care that Chantelle described was typical among other participants. For example, Kiara shared feelings of battling intense feelings of loneliness during her first two years of medical school, as she lived far away from her family, all of whom lived out-of-state. Kiara remarked that,

despite the depth of loneliness she experienced during that time, she was still able to dig deep with her reserves of internal strength and succeed academically at Midwest School of Medicine, as she recalled:

> I think a negative prong, different from college, was I think I will remember kind of like a lot of the times that I felt really lonely and kind of felt really like on my own a bit, at least like tangibly being here and kind of, like, the times that I push through and I just wasn't really happy, or wasn't really like thriving mentally. But I was still able to like produce results that were like good and kind of keep pushing forward.

Kiara mentioned that through her relentless persistence, she was able to get the exam results that she needed to establish a good track record halfway through her medical school journey.

While Kiara was dealing with mental challenges stemming from loneliness at Midwest School of Medicine, Zuri reported mental health hurdles at South Region School of Medicine, due to her battles with chronic worry and stress during much of medical school. This emotionally draining experience stemmed from illnesses that Zuri had been enduring since starting medical school several years earlier. In fighting chronic worry and anxiety, Zuri utilized internal mental discipline and external mental health support in overcoming these mental battles, as she shared:

> In terms of the stress domain, trying through things, like counseling and just meditating and prayer like, through all of those things, acknowledging the things that are out of my control, and things that are in my control. And so, being able to distinguish those two a little bit more I feel like has been a huge stress relief,

> rather than worrying about everything under the sun. So concepts like that, I feel like it's been improving my stress, which is improving my wellness.

As Zuri stated how she has relied on her internal mental health thermometer via meditation and prayer and external wellness gauge through obtaining counseling, Arya shared a different perspective. Arya described the need to distance herself from formal medical school activities at South Region School of Medicine that were designed to foster mental health and self-care. Arya confided that sometimes BIPOC medical students just need time to process negative emotional events away from others, rather than dive into the wellness activities that are intended to serve as a resource of emotional support:

> And like, I've also noticed this and in a lot of others, like a lot of my friends who are also people of color, and they just sort of like, I think I'm not really sure why that is, but I think that a lot of the times when we're stressed out or like feeling emotional and things like that, we do prefer to be alone rather than with a group. And again, like, I know, that's going vary from person to person as well. So it just sort of depends.

As she relayed her experience of how she has focused on enhancing her emotional health, Arya shared that "one thing that my school offers that we really do appreciate is just having a counselor available, and this counselor, she's also a diversity liaison." While not all participants sought mental health services when dealing with emotional health issues, all of them described ways they turned a negative and challenging experience into something positive for their future growth and self-care.

Oscar provided an optimistic outlook as he reflected on his emotional health journey. The story Oscar shared took place at the beginning of the pandemic in 2020.

Despite his generally positive outlook, Oscar relayed how he still experienced inner turmoil when it came to reflecting on whether he should have been having negative emotions during such a turbulent time, as his focus was on fostering self-care and participating in events that made him happy:

> During the first two years, or at least the first year, that was when George Floyd, and, like all that stuff was kind of blowing up and honestly to me, wellness, at that point was doing the fun things and trying not to think about that. Which at the time I felt pretty guilty because I was like, I should be, you know, fighting this fight too. It's also my fight. But at the same time, I was like, I have things to do that are in my life now, and I need to, you know, keep myself grounded by honing in on the things that really make me happy, and not trying not to spend the effort and mental energy on things that will, might, hurt my mental health, if that makes sense.

While Oscar was deeply aware of the turmoil happening all around him, including the most deadly pandemic to strike the U.S. in over 100 years, the murder of George Floyd, and rising political discord, he remained committed to following a pathway of nurturing his own emotional wellness by seeking out friendship and fun. In doing so, Oscar expressed guilt, but then went on to discuss why it was important for him to prioritize his own self-care despite the life-changing events during that exceptionally challenging year.

As Oscar reflected on his past positive experiences despite the social turmoil happening around him, Isaac projected toward the future and anticipated positive experiences in the realm of his own emotional wellness. Despite facing the racism that he

will likely experience as a BIPOC physician, Isaac expressed only positive expectations of his future in medicine:

> I have like a positive outlook on it, as far as now, being treated similar to like anybody else, coming through in kind of trying to sort out what's being done, because you're the first year intern who doesn't know anything and kind of you, you know, still an operation down, we're trying to get you caught up as fast as you can. That versus like something being directed towards somebody specifically because of their identity or color of skin.

Although Isaac routinely recalled having nearly universal positive emotional experiences from his earliest years through his present time at Midwest School of Medicine, Kiara remembered having challenging bouts of negative emotions in college that finally turned positive when she started her studies at Midwest School of Medicine. In fact, Kiara mentioned how medical school, despite the loneliness she has experienced, has been more positive overall in terms of her emotional well-being than college had been, as she related:

> And then, like, I feel like we're just now kind of coming back up to being on the root of like positive trajectory, for, like my sense of self and who I am and goals for the future because, like in college, I had to recover a bit.

Kiara's nonlinear trajectory goes back to high school, when she had many positive memories and her emotional health cup was filled to the brim. In college, the intense pressures she faced as a Division I athlete quickly depleted her overflowing cup. During her first two years in medical school, Kiara has been able to slowly replenish and fill up her emotional health cup so it is once again rising toward the brim.

Zuri recalled how struggling with past illnesses during her time at South Region School of Medicine has helped her to learn empathy, which in turn she was able to show to her patients during their own challenges with illnesses. What was once a negative event, the stress of dealing with extended bouts of illnesses, quickly became a positive emotional experience of developing deeper empathy. In turn, this newfound empathy was something Zuri has been able to give back to patients in her community. She reflected:

> Being forced to be a patient, like feeling like not well, being consistently ill, it gave me the perspective that I needed to be able to approach wellness as a necessity and put it as a priority. And I also felt like it gave me a way to have some empathy for my patients, like I feel like people, the doctors who have themselves been patients and have struggled with their own health journey, those tend to be providers that are very empathetic towards their patients and can help them a little more towards their journey.

Zuri's experience dealing with the negative emotion of stress, stemming from her continual battles with physical illnesses, illustrates the interconnectedness of the mental state and physical well-being of the participants. While some experiences relayed by participants focused more on mental health and others centered on physical well-being, there were clear interconnections between these two domains of self-care. Not surprisingly, most participants who shared experiences of one domain also mentioned the other one. In other words, the combination of mental and physical health as it related to self-care was inescapable.

Tiana demonstrated this interweaving of the physical and emotional aspects of her health during her time at South Region School of Medicine, as she shared:

> And you know, getting your heart rate above a certain level, I think those are two different things, because you know physical activity, obviously, you know exactly why, you know, like it does a whole bunch of lovely things for your brain. But I also think that, that's like, it's also something good for your mental health because, you know, now you're focusing on something else.

Here, Tiana reflects on how getting her physiological state to where she wanted it to be not only resulted in her enhanced physical wellness, but also made a positive impact on her emotional state.

Zuri's revelation of how her physical state intersected with her mental health was also evident as she shared how her experience living with an absence of physical health, namely her mental battle with stress due to extended physical illnesses. This forced her to pay better attention to herself and her need to develop self-care during medical school:

> Yeah, so I would say that being aware, being forced to become aware, that wellness is what's needed to maintain and sustain a complicated career, realizing that early on, I think has only helped me. I feel like it would have whatever physicality issues that the stress had brought on would have ended up getting me later, and probably would have been more detrimental to my progress.

Zuri recalled how she became aware of the consequences of not paying attention to her physical well-being. Her illnesses while at South Region School of Medicine have caused her to focus on getting better physically so that she can reap the rewards of healing both her body and mind.

Managing one's time is typically associated with work productivity and achievement motivation. Thoughts of time management typically revolve around goal

setting and overcoming procrastination. However, given that goal setting and battling procrastination often cause anxiety and stress, and can lead to physical illness, it is easy to picture how time management can make its way into a discussion on healing oneself and self-care. Tiana shared how focusing on her schedule and allowing time for wellness activities influenced her physical health. She related:

> This is another thing I realized, especially when I was studying for my first board exam that I wanted to try to incorporate, now studying for my second one, which actually has got a little bit better because I learned my lesson from studying for the first board exam, really integrating some of those things that I value in terms of wellness into just a daily like lifestyle habit because you do feel so much better. It's like, it gives you a break. And like I said, I learned my lesson after that old emergency surgery. So after all of this, I'd like to go back to physical activity and the stuff I enjoyed just like at work.

In sharing her story, Tiana reflected on the counterintuitive belief that sometimes spending more time on self-care activities actually helped her to better manage time. She expressed her belief that by engaging in more forms of physical exercise, not only did this allow her to heal from her surgery, but it also helped Tiana to increase her enjoyment of life. Ultimately, this brought her back to a positive mental state of enjoyment with activities that she had relished engaging in prior to her emergency surgery.

Isaac mentioned the role that reframing has had on his being able to thrive at Midwest School of Medicine despite the inherent challenges that are endemic to the experience. These challenges have included intense volumes of information required to be learned within a very brief amount of time, frequent high stakes exams, and lurking

demands of medical residency that lay ahead, even after medical school was completed. As Isaac noted:

> Oh, I think I was expecting all the stuff that you see in movies, that they kind of portray how hard it is and how much you have to study, all the material that you get, and even to a degree I even say it's like kind of anticipating how tough it would be, how hard would be, and kind of wanting to get there in order to go through that and still come out on the other side having, going through a hard battle, but still being able to prevail.

Isaac reflected here on the anticipated difficulties he thought he might encounter at Midwest School of Medicine. For him, one of the keys to balancing mental and physical stress and engaging in preemptive self-care, was his anticipation that the challenges of medical school would be plentiful, but surmountable. Despite the mental hurdles associated with going through the rigors of medical school, Isaac felt optimistic that ultimately his hard work would pay off. He reflected that, "I've noticed that through the hardest thing that you go through sometimes, once you're finished with it, you have an appreciation for it, you really enjoy it."

Similar to Isaac, Tiana expressed satisfaction in being able to overcome the volume of information she needed to master at South Region School of Medicine. Her focus on self-care was built on her not being intimidated by the massive amounts of academic information she faced, but tackling it head on and confronting any present lapses in achievement with dedication, hard work, and persistence. By rising to these challenges, Tiana was able to preserve her mental and physical well-being. While originally intimidated by the amount of material she would need to master to do well on

exams, Tiana continued to refine her study skills and later came to appreciate the academic challenges she has successfully overcome:

> So in the beginning of med school, just my luck would have it that, like everything bad like, happened like I remember. And the first year, first of all, it was, it was a real struggle to try to acclimate for me personally to medical school. Just by the sheer amount of information I thought I was getting hang of it first semester. I was like, really proud of myself. Second semester, I was like, okay, now, this is not so bad like in the spring semester starting off, I didn't think it was that bad, because now we were like focusing more on specific subjects.

Reports of physical well-being commonly revolved around narratives concerning the release of a negative emotional state, such as anxiety or stress, or the need to obtain physical rest, such as adequate sleep, to prevent a negative emotional state. Kiara recalled how she often turned back to the sports she had excelled in high school and college, cross country and track and field, to help her cope with the negative emotions she has experienced in medical school:

> Whenever I'm like, in a really hard workout, or a really hard run, I can pretty much kind of figure out how much it matters to me or not, kind of by like how much I'm willing to sit with the discomfort of the problem and the discomfort of the pain and usually it can kind of help with that and it usually gives me clarity about, like, what's important.

Here, Kiara illustrated the interconnectedness of paying close attention to her emotional state and recognizing the need for a physical release whenever she has felt burdened by a negative state of emotion. In turn, this release freed up her mind so that she was then able

to reflect on what she needed to pay attention to for her self-care, and the areas that she could discard if it was not adding positive value to her well-being.

Along similar lines of recognizing the negative emotional state that impinged on her physical health, Zuri noted the primary importance for her of simply getting an adequate amount of sleep each night:

> And so I, since then just been educating myself and learning about myself, about what I need to do in terms of my diet and exercise to be well, sleep as well (laughs) actually. Turns out I do need more than five hours of sleep to function. So I've been very intentional about it. If I'm sleepy, I will sleep. On rare occasions, like maybe three times since I've started, I've pulled, like where I've slept like three or four hours, because I really so much, my body needs to sleep, to function.

Participants discussed the importance of being physically away from medical school for a short time, such as through travel, and how this physical absence from medical school enhanced their well-being. Arya mentioned how "since we're obviously studying so much, we're spending so much time on campus, it's really nice to be able to get away from that for a little bit, as a form of wellness." Kiara anticipated the pleasure that being able to take time off from medical school would bring her as she traveled around to different places:

> I really have this desire to kind of make my way across the country, to kind of see new places, see new people, get to taste different types of like food, or even just see like how different parts of the country operate. And just little differences or

big differences, because I just thought what it might be like to see different things between regions of the country or different places.

Summary of Healing Oneself to be Able to Heal Others Theme

Multiple layers of self-care were reported from participants. For some, this involved forecasting the stressors they expected to encounter as BIPOC medical students so that they would be better prepared to tackle challenging issues as they arose. Many participants reflected on how they were able to recognize feelings of isolation and loneliness during their medical school journey and how this recognition allowed them to tap into resources they needed to overcome these feelings, such as through friendship networks, counseling, prayer, and meditation. Participants also spoke of lessons they had learned about failure and setbacks in medical school and how their attempts at self-care reflected their understanding that it was okay to not be in perfect mental health, but they could allow themselves grace while searching for better ways of self-care. Time management was spoken of by many as a tool which helped them to prioritize self-care despite the intense demands of medical school. Finally, knowing when they needed to take a break and allowing themselves permission to do so was a way many participants found as a means of promoting self-care.

Cheerleaders: Family, Faculty, Mentors, and Advisors

Outside of their peer group, participants unanimously expressed gratitude for the support of cheerleaders that included family, faculty, mentors, and advisors. Participants shared how these individuals impacted their sense of wellness and how they leaned on them as key sources of support. Cheerleading from the outside included descriptors such as accessible, celebrate, honest, memories, proud, qualified, support, and trust. While

many of these terms came directly from the words of participants, others were ascribed to participants upon my conceptualization of what they were describing to me with respect to their thoughts regarding how they felt supported from cheerleading from outside their peer group. In addition, there were many statements articulated by participants that may not have had these specific descriptors in their interview transcripts. However, upon further reflection and my conceptually driven pre-analysis exploratory notes, I decided to incorporate these statements into the theme of cheerleading from the outside.

Forecasting her future as a BIPOC physician, Arya predicted that "moving forward, I think the only expectations that I would really pay attention to is my family, or like my friends, and I already know that they would be extremely proud of me." Similarly, Chantelle remarked that upon graduating from medical school, "I hope that I feel relieved. I think I will feel relieved and proud of myself and excited. I think you know my family will be very proud of me." Isaac frequently mentioned the substantial impact that his uncle, a prominent Black physician in his hometown community, had on Isaac's decision to become a doctor. Isaac also discussed the influence of his two older sisters, as he reflected on what his life will look like with family after medical school:

> Just having people around that like, surrounded by family and as of now, I don't have family in this area. So surrounded by you know, mom, dad and sisters and uncles and stuff like that. Having a support system, being able to, being able to go home.

Chantelle spoke of her desire to remain close to family and how much positive influence they have had on her life during medical school, as she recalled:

> So that is a big part of wellness, and I hope to stay here in my area. So I'm hoping that if that does happen, a big part of my wellness will be family, and just spending time with them and watching my nieces and nephews grow up. That will be a big part of it.

Like Isaac, Kiara expressed the immense value that she has placed on family throughout her life, but particularly now during medical school, since she is acutely aware of their physical absence. Kiara reminisced how she wished the distance with her family were closer. In her close-knit family, Kiara's father is a prominent physician in her hometown community. Kiara also shared similar sentiments with Isaac, believing that if her family were physically closer, this would lend support for her wellness. Kiara's unhappiness with her current physical distance from her family has caused her loneliness and stress since starting medical school, as she shared:

> Everyone knows medical school is like trying and difficult in many ways, but it's a lot. And like, I've always known this, I just have known it more since being here. Like my family is still in (the state where she is from), which is not like an easy drive or even an easy flight from (the state where she is attending medical school), so I have to connect somewhere, or connect and drive, so family is far away.

Kiara also reported leaning heavily on her family for psychological support, although they were separated by a considerable physical distance, as she expressed:

> I talk to my parents a lot (emphasis). I talk to my mom a lot. I mean, I talk to my dad, like my dad before my mom is probably a bit more of the just day to day, like

little things I go through, and just little weirdness and gossip, just kind of having her talk to me, kind of like affirming my experiences.

While family was unanimously regarded as a major source of support for participants, some of their reflections on the influences of family stopped either at participants' entrance to medical school or shortly thereafter. As Zuri recalled:

So I think, you know, family was all very proud (emphasis) that I was accepted (to medical school). I guess they weren't really too surprised, since that they're not familiar with how competitive it is. And since I had been on that trajectory to apply, and they already knew how hard I had worked for it, it wasn't like too much of a surprise to them, although it was quite a bit of work. (laughs)

Oscar also reported similarities in reaction from his parents and others to his getting accepted into medical school, but he made no mention of family influence or support once he started medical school:

And so they were excited. And they're happy for me, but I think they just kind of assumed like I knew it was going to happen anyway, right? It wasn't like they don't know how difficult it is to get into med school right? They were like, because, like I said, things came easy to me, and like a lot of things that I applied to. I just got in (on the) first try, like from clubs to college, to all this stuff. So they I think, they kind of assume, that I would get in anyway.

Medical students have a considerable amount of contact with faculty during their pre-clinical time, the first two years of medical school. Most participants spoke in glowing terms about their experiences with instructors being encouraging cheerleaders. While medical school is known to be an arduous and often times tedious journey, Isaac's

experience of connecting with faculty at Midwest School of Medicine clearly shows that these expectations are not the reality for all students. Isaac recalled how, toward the end of his first year in medical school, he and his peers were encouraged by their instructors to present a lecture on the material to both the faculty and peers, but to keep it lighthearted and fun:

> So prior to, or the last day of class for our first year, we were presenting topics about like, neurology, delirium. We had to make a presentation and it's kind of a fun thing that you we're presenting, and it's going to be on the test. And I remember like every group that went up, like they were imitating or doing something similar to what like, you know, professors, they have like ways about them and things that they do. And so, anyway, it's kind of like, in a good way, but like mocking some of the professors. But everybody had a good laugh about it.

Isaac further explained during his interviews at how accessible and friendly his professors were during his first year in medical school, as he shared:

> I've always like I've had people around that are just welcoming to anybody. So you know, going to the office hours with professors, it didn't feel uncomfortable. They feel like they were there, trying to help me going above and beyond in the anatomy lab, working very well with my anatomy group in class you know, working well with students.

Here, Isaac mentions that not only can he rely on instructors for support, but also that his instructors value him and are intentional in their interactions with him.

Arya related how she has appreciated the intentionality of the professors she has worked with at South Region School of Medicine. She mentioned how their investment

in implementing equity in medical school curriculum has made her feel like they are on the side of BIPOC medical students, cheering for their success as they train to become physicians. Arya mentioned:

> And I think that's another thing that is really nice to see is professors who are well educated about diversity and health care. We've had a couple of really amazing ones, for instance. We recently had her, you know, course, and our professor spent about a half a week telling us about why talking to us about why race should be taken out of the equation for I think it was acute kidney injury. And just really with little things like that, we're knowing that these professors or we've had a few other professors sort of in cardio point out that certain symptoms like bruising won't show up to people of color. It's hard to see.

Tiana recalled an experience of having to have emergency surgery midway through her second year at South Region School of Medicine. Her support was not limited to family, friends, faculty, mentors, and advisors. Tiana reported having everyone cheering for her and helping her through this very difficult time, as she shared:

> Like I tell people, you know, especially for medical schools like everyone will tell you like, oh, well, this is good blah, blah, blah. But it's like another thing when the school actually shows you through action like that they actually care about wellness and the well-being of their students. So the fact that people like the administration was like, don't worry about it, like, if you need anything just like let me know, and like even my classmates too, like there are some people I've never talked to and like, hey, if you need anything, you know, just let me know if you do want me to do your laundry. (laughs)

As participants left their parent's homes to attend medical school, some staying in the same city but moving to their own apartments, with others relocating out-of-state, they began to establish relationships with mentors and academic advisors. While these relationships did not substitute for family relationships, these connections still served as important bonding figures for participants. Zuri described how she has leaned on a strong mentoring support system throughout her long-term dual degree programs of medical school and graduate school, a journey that has taken her nearly 10 years to complete.

Reports on the influence of mentors during Zuri's time in these programs came early on during our first interview and continued throughout much of the second interview. Zuri recalled how, upon learning that she had been admitted to medical school, "in terms of mentors, they actually, I'll never forget one of my mentors, who's in the college of medicine now, she like, she gave me a hug." She continued by recalling that, "once I was able to tell her, granted she already knew, but when I brought it up to her, she still gave me a hug."

Due to the nature of her dual degree program, Zuri has found it challenging to secure mentors, but through her determination and persistence, she has succeeded in finding the ones she needed. Zuri described leaning on these mentors for support throughout the arduous twin roles of being a graduate student and medical student, having already completed two graduate degrees in addition to her soon-to-be-awarded medical doctorate:

> So I feel like if I didn't intentionally seek out mentorship, if I wasn't the type of person to willingly send cold emails, like go into like, I'll just go into Random Professor's office and be like, you have five minutes to talk to me about this or

> that multiple times, if I wasn't that type of person then yes, I think it would be impossible to find mentorship that's not a of, a standard mentorship.

While Isaac did not share whether he had a mentor at Midwest School of Medicine, he did mention the uniqueness of having a BIPOC counselor at his medical school, a person who was readily accessible for consultation:

> Yeah, they have a counselor on campus for students, he's for all students, but he is a person of color, he's a Black guy. And so I remember when my friend was joking, saying he would just go there just because, you know, no problem or not, just because it is kind of cool to have a Black therapist at the school.

Isaac expressed the sentiment that having a BIPOC counselor helps draw BIPOC medical students to seek the counselor's services, even if they are not experiencing any type of psychological distress. In essence, the BIPOC counselor serves as a cheerleader for BIPOC medical students, regardless of their mental health.

Arya echoed Isaac's sentiment regarding the importance of having a counselor or advisor as a key support resource in medical school as she expressed:

> So just having someone that is free to talk, having those, like, one-on-one sessions, I think that is something that would be really beneficial. But also making sure that that person has the knowledge to work with a wide range of students, I think is also something that is beneficial.

While mentors and advisors were mentioned frequently by participants as cheerleaders who enhanced their wellness and served as a valued resource of key support, it was academic advisors who received the lion's share of commentary regarding their role as key support figures. Most participants sought the counsel of an academic advisor

during medical school and some of them had particularly strong views regarding the qualifications needed to serve as an effective medical school academic advisor. Tiana focused on the credentials needed to be a highly qualified medical school academic advisor. Zuri related that the nature of academic advising at South Region School of Medicine had changed radically during the last several years.

Although Tiana mentioned that academic advisors at South Region School of Medicine were not always effective in their professional roles, her view was tempered with her perspective that academic advisors could still serve as a key resource of support for BIPOC medical students. For Tiana, the caveat that academic advisors could be effective cheerleaders within their official advising duties came with the expectation that they were qualified to do their job. In other words, not only was cheering necessary, but so too was role competency. Tiana felt that many medical school academic advisors have usually not been well-qualified for this role, as her experiences with medical school academic advisors at South Region School of Medicine has been mixed. Since she views that many of her academic advisors were not qualified for this role, she has found it challenging to place validity on their cheering for her success, considering the unique professional role they occupy within medical school. Tiana mentioned that in their cheering for her success, academic advisors "try their best" but she felt:

> They need to get academic advisors that actually have either like experienced, like medical school, or yeah, no, they just have to get them that have experienced med school. I think somebody who's gone through medical school, and is familiar with the resources can advise me way better than someone who isn't in medical school,

> and I say that because, like our advisors here, none of them have gone through medical school.

For Tiana, the key element of whether academic advisors can serve as effective cheerleaders of BIPOC medical students is connected to the idea that they have established legitimacy as highly qualified professionals. For Tiana, the main qualification that academic advisors need for effectively advising medical students is having completed medical school, as she shared:

> I feel like sometimes like in the type of advice that he gives, it's very much based off of what other people have told him or what other students have told him. And that's because, again, like he's not somebody who's gone through medical school gone through, you know the classes or have done like, UWorld (a medical school exam preparation program), that knows, like, okay, maybe doing so many questions of UWorld is going to kill me. You know what I mean.

For Tiana, a critical issue is that because most medical school academic advisors have not completed medical school, they are not able to truly understand, and therefore cannot empathize, with actions medical students need to take to succeed in medical school. This makes cheering within their professional role challenging, as they may not be truly aware of what it feels like to experience the obstacles that medical students face. Advisors who have not gone through medical school themselves may not know when to cheer and when to back off. Tiana reflected that, "I think there's always a lot of resources that people can talk about that are really useful for the profession. But, like, people, no one ever tells you like how to use those resources." Provided that academic advisors are well qualified, including having gone through medical school, Tiana believed that they can serve as

highly effective cheerleaders. Medical school academic advisors can be a valuable resource for medical students "if they can tell people how to use those resources and how to like actually integrate into like the school's curriculum."

Oscar also appreciated the cheerleading from his academic advisors if they were able to provide him with a highly qualified and realistic portrait of his career path. He appreciated their support even more when they respected him enough to tell him the truth, even when he might feel hurt by it, as he explained:

> Yeah, the biggest thing is just being realistic, because so my advisor is our, she's a dean of something. I forget her exact title. But I went to her, I don't know, a couple of months ago, and I like laid out my grades and all this stuff, and like my extracurriculars, and I told her where I wanted to go (for medical residency). And she was like, okay, you're good for these programs and not these programs. Still try for it anyway, because there's always a chance, but it's less likely. But I liked (emphasis) hearing that, that was important for me to hear.

Zuri's own experience with medical school academic advisors has also been mixed, but less so regarding issues over her qualifications and more with the absence or presence of academic advisors. She has experienced extremes in academic advising since starting medical school almost a decade ago. Zuri has been in medical school for a much longer time than is typical, due to her completing two graduate degrees while simultaneously pursuing her medical degree. Her early experiences in medical school during her first two years did not include any academic advising since it simply did not exist at her medical school at the time. However, as she nears her graduation, Zuri mentioned that during the last few years, South Region School of Medicine has made a

substantial investment in providing academic advising to all medical students. This relatively recent resource has made a major difference in Zuri's medical school experience, as she shared:

> So previously, there wasn't really much advising. It was more so if you have a problem, here are the people you can talk to. And we did each get assigned a physician, and we met with the physician in groups once a week. And it was more so to get through, like, academic assignments. And you would spend like 10 minutes discussing if there were any problems. So in terms of advising, we didn't really have much the first two years.

While Zuri was navigating this academic advising desert, she recalled:

> I didn't really know who to talk to other than an upperclassman, and they're not, really, you know, the best suited for some types of questions and how to actually like, do test-taking, and how to like the problems in the context of like a learning problem and for things like that.

While she managed to do well in her coursework, lacking an academic advisor during the first half of medical school was a substantial hardship for Zuri. However, the situation changed radically during the last two years and she is now thriving with this additional resource:

> Now it's very much, it's a much more organized structure. We have an educational advisor. So I've gone to that person multiple times when I'm struggling with shelf exams and things like that. So now that we have like it, a person we can go to for educational advising, that's been like a game-changer for me personally, and I know other students as well.

Tiana's experience regarding her perceived lack of quality with medical school academic advising illustrates the importance of not only providing the resource of academic advising, but having the type of academic advising that really matters and makes a difference in the lives of BIPOC medical students. Zuri's experience with an initial lack of medical school academic advising emphasizes the importance of having such a system in place so that BIPOC medical students have a point person, whether for regular check-ins or emergency situations. BIPOC medical students benefit from cheerleaders who effectively know the system of medical school and have lived the experience as a medical student as well, being able to impart their own wisdom to BIPOC medical students who are just starting out on their own journey.

Summary of Cheerleaders Theme

Multiple cheerleaders were reported to be influential in the lived experiences of participants as they journeyed through medical school. For most, family had a strong past influence on cheering them on, up until they reached medical school. For a few participants, the influence of family remained strong while they were in medical school, while others reported leaning more heavily on friends. Participants unanimously praised faculty as being influential cheerleaders since they began medical school. They spoke of how faculty provided encouragement, belief in their ability to succeed, accessibility, and intentionality in desiring success for them in medical school. While formal mentors were mentioned by only one participant as being influential cheerleaders, all participants reported mentoring-type relationships with faculty and academic advisors. Academic advisors were seen as highly effectively cheerleaders if they were deemed as qualified for

their role, were accessible, and were honest in their feedback regarding academic performance.

Hope for Change Despite Systemic Inequities

As gatekeepers to almost everything in medical school, including the conferral of the medical doctorate, liaisons with future medical residency programs, and the professional contacts that medical students will need to develop to thrive in their future careers, the stakes of developing strong interpersonal relationships with medical school administrators are high. For BIPOC medical students, faced with systemic racism as they battle countless microaggressions and daily overt acts of racism, the stakes are astronomical.

As participants shared stories of how they had questioned and pushed back against systemic inequities at their medical school, they described words such as access, afford, authentic, biases, depicting, difficult, diverse, evaluations, incidents, out of place, racism, racist, relevant, supplement, and tone deafness to illustrate their experiences dealing with systemic racism in medical school. While many of these terms came directly from the words of participants, others were ascribed to participants upon my conceptualization of what they were describing to me with respect to their feelings regarding systemic inequities at their medical school. In addition, there were many statements made by participants that may not have had these specific descriptors in their interview transcripts. However, upon further reflection and my conceptually driven pre-analysis exploratory notes, I decided to incorporate these statements into the theme of questioning and pushing back against systemic inequities.

Participants voiced concern over how medical school administration responded to the systemic racism that impacts BIPOC medical students. Isaac's voice was relatively mild, acknowledging that systemic racism exists at his medical school, but expressed that he did not feel damaged by it even if it did occur. All others felt strong discontent over the problem of systemic racism at their medical school. Participants especially pointed to a chronic lack of response by medical school administrators when faced with racial inequities in curriculum and grading. In particular, Chantelle and Kiara shared vivid memories of their experiences with racial inequities at their medical school. Both spoke of the need for systemic reform in medical education, but voiced concern that the colorblindness which exists at their predominantly White medical school has prevented much needed reform. Chantelle discussed how, when she expressed a concern over racial inequities in the curriculum at Midwest School of Medicine, she was quickly admonished by an administrator:

> And, as I've said, I've been through this twice. So, I noticed from year to year, there was no change in like the pictures of Black people because we learn about, like, different skin conditions. And, you know, how you treat people, and there's not a lot of examples of that. So I brought this up to the course director. I sent like a really long email, and I spent a lot of time on the email, you know. I made sure it didn't come across like accusatory or anything. I was just kind of voicing my disappointment, and we all had disappointment with the lack of changes because I know the year before we did ask them to add more pictures and examples. So I was met with this really, just like angry, upset email from the director, like, just accusing me of just being, I guess, like degrading.

Here, Chantelle experienced an unexpectedly stern reaction from the director, as if she was directly attacking a person rather than a system that needed to change. After receiving this news, Chantelle and her peers decided to make the needed curriculum changes. They went underground without the support of administration. Chantelle and her peers opted to provide diversity in visual media being shown in the curriculum:

> I know at the beginning of my second first year, we, you know, we're complaining about the lack of pictures in our first class, and we wanted to put together a (shared) drive of different resources that we found that had darker skin and specifically like the skin conditions we were talking about.

Chantelle also discussed the need for Midwest School of Medicine to have BIPOC faculty give lectures, since "there have been times where we've gotten lectures about diversity or a specific issue that mostly people of color deal with, and it's coming from most of the time a White male." Chantelle stated that she and her BIPOC peers are "not getting the authentic experience that we need to supplement the education." Above all, she has been struck during her medical school experience by questions such as, "why do we (students) have to do that? Like, why are we the ones that have to do that work to get, like, you know, equal education opportunities?"

Kiara also shared the important role that administrators hold in leading efforts to confront systemic racism in predominantly White medical schools. She mentioned how the climate at her medical school had recently changed, as BIPOC administrators at Midwest School of Medicine, who had been key systems of support for her, suddenly began to leave under mysterious circumstances:

> There was a lot of turnover in administration, and like the first two years of medical school, it felt like a lot of diverse voices were being pushed out for, like not explicit reasons. I don't know what was happening in the administration, but like, I think the chief of diversity, and it's like a person who was like a head for like 22 years, like, they were leaving. Then, a few months later, like the dean of, I think they were they were the dean of something, I don't know if you know the whole medical school, like one of the departments, like that. But they were, they had a very big, like, mission to, like, make the school diverse, and they had like done our interviews, and then they kind of left for, like, unclarified reasons. And there's been a lot of turnover in the department heading of like diversity, equity, and inclusion.

After these changes had been made in administration, Kiara noted that the admissions of BIPOC medical students at Midwest School of Medicine dropped precipitously the following year, from the 20s to the single digits. According to Kiara, one solution to this newfound problem with lack of diversity in administration is to simply reverse the trend:

> So I think that's probably one of like just having diversity administration just to kind of voice other opinions, as opposed to like just the standard, like highest test score and highest GPA people, because there's always that argument of like, oh, you want people to be smart to get into medical school, but also like there is a difference in like if I can afford SAT prep, or MCAT prep. That's like hundreds or thousands of dollars versus someone who can't like, I'm going to get a better test score. And so those things I don't think it's taken into account as much when thinking about the differences in minority groups, how they're doing despite, like,

the environment that they grew up in or the things that they had to overcome, to try to get to the same level.

Participants reported frequent negative experiences with the curriculum and grading biases and, in fact, most participants had predicted that this would occur when they first started medical school. They were not surprised to see this situation manifest itself as they progressed through medical school. One exception to this view was Isaac, whose perspective on his expected experiences coming into medical school and actual journey through medical school took a decidedly optimistic tone. Regardless of how often such encounters occurred, these anticipated encounters exacted a deep impact on their lives as BIPOC medical students.

Biased curriculum was reported by some participants, mainly in terms of a lack of representation of BIPOC faculty and White-centric educational materials during the non-clinical first two years of medical school. Participants nearly unanimously mentioned grading biases during their third and fourth year clinical clerkships.

Arya spoke of the importance of fostering equity in the curriculum by making sure that the materials being disseminated were not White-centric and that South Region School of Medicine incorporated diversity into all of the lessons. She shared that, “in terms of resources, the first thing that comes to mind is academics in terms of racism, so things like making sure you’re having different color skin, the images you’re using for different lesions and stuff like that.” Arya’s view was echoed by Chantelle, as Chantelle discussed including more diversity in the curriculum at Midwest School of Medicine. Chantelle mentioned that, in terms of curriculum changes, “I think the first one is definitely just like more media, I think, like when we’re learning and more examples in

terms of like videos or pictures." When asked how to bring about these changes, Arya shared:

> I think the best resource for that is actually the students. Just because, again, there are a lot of students that know a lot about racism within medicine. There are a lot of students who have done research on it, either currently or in the past, and what South Region School of Medicine has done is that every summer they put together like a diversity task force of students where these students will go out and maybe like throughout the year, they'll make note of things that could be improved in terms of diversity in our education or just various research studies that are coming out that'll just help better inform the curriculum.

Chantelle held a similar view described earlier, in which she and her peers at Midwest School of Medicine put together a shared drive containing "different resources that we found that had darker skin and specifically like the skin conditions we were talking about." As she reported on this student-led initiative, Chantelle expressed frustration that no one else other than her and BIPOC medical student peers seemed to care about confronting these White-centric biases in the medical school curriculum. Chantelle reported that there was no evident concern from faculty and administration or any type of commitment to attacking such inequities. As shared earlier, Chantelle described:

> Sometimes I feel like, why do we (medical students) have to do that? Like, why are we the ones that have to do that work and to get, like, you know, equal education opportunities? So I think something like that would be super helpful,

> and also just like having the pictures in the Power Points. And granted some people do. But it's not enough.

Chantelle offered suggestions on how Midwest School of Medicine could begin to eradicate the White-centric bias in their curriculum. In addition to the materials themselves, medical schools could focus on the professionals they hired to teach the course content. Chantelle related:

> And I think another thing personally, for our school, would just be having more people of color give lectures because I mean, there have been times where we've gotten lectures about diversity or a specific issue that mostly people of color deal with, and it's coming from most of the time a White male. And I just feel like we're not getting the authentic experience that we need to supplement the education.

In addition to Chantelle's observation that more BIPOC faculty are needed in medical school, Kiara also mentioned the role that BIPOC administrators can play in confronting White-centric biases and assumptions and the importance of BIPOC voices being heard at every level in medical education:

> I think, like the easiest one is just to have a bit more of like diversity in like administration, even if it's not like, the people who are, like, holding the high positions. Like having just diversity in the conversations that departments are having about like even just, like, curriculum changes, or like tuition changes.

Systemic inequities were not confined to the classroom for participants after they completed the first two years of pre-clinical medical school curriculum. If anything, reports of negative biases grew steadily as students began their third year of clinical

clerkships. Oscar expressed concern regarding grading biases against BIPOC medical students at South Region School of Medicine. However, he reported during his first interview that he was not sure whether he had been directly impacted by rumors he had heard regarding clinical clerkship grading biases against BIPOC medical students:

> And then something that I had kind of heard like through the grapevine on, like some social media or something like that, is that when everything gets to the graded point, like the third year, fourth year, graded stuff, it's all subjective, and the system is inherently racist. So it's historically known to be that more difficult for women and students of color. But again, at that point, I was like, I don't care about my class ranking, I just want to be a good doctor, so that was on my mind, but it didn't stress me out a whole lot.

During his second interview, Oscar expressed that while he still did not care about his class ranking at South Region School of Medicine, he had considered the possibility that he may have experienced clerkship grading biases as a BIPOC medical student:

> And then the other big thing is grading is very arbitrary, so I try not to like think, oh, I got this grade just because of like being a student of color. But that's always in the back of my mind is like, would my subjective eval have been better if I like, didn't look how I do? And I, you know, I try to kind of throw that away, because that's not something I can change. I can't change somebody's like implicit biases right away. So I don't care, which is another reason I don't really care for like being top in the class, or anything like that is because it's so, it's so subjective. And I've acknowledged that it's just not something in my control.

Isaac's expectations of grading biases were vastly different from the rest of the participants. Like Oscar, he had learned of instances of biases reported by BIPOC medical student peers at his own medical school, Midwest School of Medicine. Isaac mentioned that he had "heard stories from other students after being here without things that weren't going as well their way. But they're kind of, they're few, there are not that many of those stories." When reassured that his responses would remain confidential, Isaac reflected that during all his time in school, from the earliest years up until his present time in medical school:

> I never really anticipated too many people trying to hold me back. This is from mostly White teachers. I didn't have too many Black teachers growing up. I don't think I had my first Black teacher until sophomore or junior year high school. So, I mean, through that whole time, I'm interacting with people who aren't Black, and they, they are encouraging me and pushing me ongoing. So, coming into medical school, it didn't seem like it, I was set up facing things too much more than just like somebody being a butt because, like, that's their personality. I can't say that I anticipated anything going bad. I haven't had any experience of anything going bad. I mean, I've had the exact opposite.

The women in the study raised serious concerns regarding grading biases during clerkships based on race and gender. Tiana expressed:

> Like, as somebody who I didn't, I don't think I felt it as much as the beginning, until I was like, literally on a rotation with, like, these two girls. And you know I was doing the same exact stuff, but they were more liked. I don't know. I feel like again, I'm also an introverted person too, but I was still doing like the same

> amount of work, and I feel like, like their evals, or how people perceive them, was totally different from myself. Thankfully, I don't think it impacted like my evals too much. Because again, like I said, I'm somebody who, because I'm introverted and I care more about like the one-on-one relationship, I'm still able to, like make that up in those one-on-one interactions. So my evals weren't bad. But I do think grade-wise there was definitely a disparity when it came to those grades.

Tiana's experience at South Region School of Medicine reflected the tension she felt in predominantly White medical spaces, with three of her identities being Black, a woman, and an introverted personality type. Tiana did not discuss whether she felt the evaluation bias was based specifically on race, gender, personality, or a combination of these identities. While the women in the study did not always raise the issue of the intersection of race and gender, Isaac spoke fervently of the double bias in medical school faced by BIPOC medical student women. He reflected:

> I do feel like on the gender side of things, a lot more is allowed to let go and not correct it, or seen as just a joke or not. You know, it's like a different culture around making a joke about somebody's end or saying something inappropriate is different than saying something inappropriate or making a joke about somebody's race. It's totally different.

Before the second interview concluded, when I asked if he had any open-ended comments that were not necessarily tied into a specific interview question, Isaac again spoke about the importance of acknowledging the extra layer of bias faced by BIPOC medical student women. He shared that, "a Black woman, or you know, any minority

woman, I'm one to say that I'm just a Black man, you will find that they have like this extra on top of them as being a woman and being Black."

Participants fully anticipated that they would encounter negative biases once they began their third year in medical school with clinical clerkships. Specifically, their expectations were that these unwanted events would come mostly from interactions with White patients, and to a lesser extent, with higher status White physicians. Tiana shared:

> In terms of like being both a medical student and a student of color, I think the biggest challenges definitely happen in third year, which is when you start doing the rotations and clerkships, because now you're in a different environment. In general, medicine is a predominantly homogeneous field in terms of race, and especially the institution I go to is predominantly White.

Oscar mentioned shock at his not yet having faced discrimination from White patients, as he shared:

> And then I, surprisingly in medical school, I haven't had much issue from patients giving me that. I like, I was waiting for it (being discriminated against) for all third year, and surprisingly, it never really happened, although I have had some classmates who did experience that from patients and patients, families and all.

In fact, in anticipation that he would one day run into such biases from White patients during his clerkships, Oscar related how he plans to deal with the situation when it comes up, knowing that he will have the support of BIPOC patients and BIPOC physicians. He also noted that White patients would have the right to refuse his care:

> But on that same note, I expect my patients that are people of color to really appreciate that there is somebody that looks like them, you know, on the other

side of the hospital. And I think that's more important than the negative reactions I'll get from other (White) patients, because if they want to ask for another physician, they have that right. If they don't want care, they have that right. I think it'd be silly, and I can get some, you know, to not try to stop having care. But they can make that decision.

Isaac related how his positive mental outlook has helped him to believe that he will emerge unscathed from any future racist incidents he will experience:

So as far as like color-wise, I don't foresee anything bad happening. But I wouldn't be damaged if it does. I kind of just know to prepare for that and, I think as a person of color, you always are like, prepared for that, and in a way expecting it, just so that you're not caught off by it.

Chantelle mentioned she has been thinking about how patients will react to her once she begins her third year clerkships next year, and starts to have extensive interactions with patients. She reflected that:

Sadly, I feel like I'm kind of preparing myself to experience like, from (White) patients, kind of like, apprehensiveness, especially as a resident. If they know I'm a resident, but also, I know I am like lighter skinned, so I might not be, you know, judged as much as others. But I do feel like there will be some sort of judgment a little bit, even if it's not explicit.

Kiara shared that not only is she anticipating negative biases from White patients, but she also mentioned that she has already received such biases in non-clinical community settings, when others doubt that she could even be in medical school:

> I was at my boyfriend's apartment. He had a roommate and his roommate's girlfriend, she was like, oh, what are you in school for? And like his roommate's girlfriend asked me what I was in school for, and I was like, oh, I'm in medical school. And she was like, oh are you gonna be a nurse? And I was like, no, I'm going to be a doctor.

This was not an isolated incident, as Kiara recalled an incident that took place while she was shopping at a local retail clothing store:

> And then, two days ago, like I was at like Ross, looking for like, some business clothes. This cashier, we're talking about how I always get so cold where I work, and I just call going to a clinic work, because it's like I'm not getting paid. But it's just easier if I say, work, this makes sense. I am working but I'm just not getting paid for it. And she was like, oh, where do you work? I was like, well, actually, I'm a medical student, and I like work at the hospital. And she was like, oh, are you in nursing school? I was like, no, I'm going to be a doctor. (laughs)

Kiara noted with both incidents, the first involving the girlfriend of her boyfriend's roommate, and the second with the cashier, had exactly the same outcome, although the situations and actors were different. Kiara reflected that, "I don't feel like people usually respond to medical school with saying, oh, you're going to be a nurse unless you're either a female or a minority female."

Like others, Zuri anticipated that she would be perceived negatively in clinical settings as a BIPOC medical student at South Region School of Medicine. Her assumption was that, going into medical school, she would experience biases and

encounter similar problems that she has experienced with racism since elementary school:

> So I kind of alluded to that, just being put in clinical settings, where I am the only Black person, like I said, we have to do a clinic in like a very rural setting, and so you could tell with a few of the (White) patients they were like, just the overall air of mystery and uncertainty of what's going on and kind of like questioning judgment.

Despite all the negativity, there were many positive reflections that participants shared as a result of either their anticipation or their actual experience of being mistreated due to being a person of color. Zuri also mentioned that, on the flip-side of her patient interactions, she has experienced times when "the patient, like, will say at the end of their visit like, you transformed my visit, like you were very helpful." Zuri reflected on a particularly powerful moment when she knew that what she did made a difference, regardless of the "questioning judgment" she received at times from her White patients, as she shared that "a patient told me they were about to leave if, like, if I wasn't on the (medical) team. I was like, wow, I actually, like, made a difference in this person's life because they definitely needed it."

As shown by Zuri's reflection on being commended by a patient as a valued member of the medical team, Kiara also shared how being a Black woman had given hope not just to her BIPOC patients and team members, but hope in the promise of positive systemic change, of what equity in health care could actually look like in the future. To that end, Kiara reflected on the sheer joy of being able to see beyond the stark

reality of negative assumptions and biases that she has faced as a BIPOC medical student and will continue to face as a BIPOC physician:

> I do think that there will be a sense of, like, relief, and a sense of hope, because I have had patients who were like elderly, and they were Black, either Black male, Black female, couples, or even just like Hispanic, and they get like some joy when I come into the room if I'm the only person of color on the team because, one, it's like they've lived through different times where possibilities were limited or weren't as attainable. And so they have, like, they can see hope for change manifested in me.

Summary of Hope for Change Theme

Systemic inequities were widely recognized by participants as being a problem in medical school that negatively impacted their experiences as BIPOC medical students. Some participants spoke of medical curriculum biases in a White-centric classroom, which utilized lessons that did not take into consideration the experiences of BIPOC medical students or BIPOC medical patients. While some spoke out against these biases to administration, none of these issues was satisfactorily resolved and sometimes even resulted in punitive responses from administration. Participants felt that while students need to play a role in addressing these inequities, administration should also step up, acknowledge the need for change, and help institute recommended changes. Turnover in diverse faculty and administrators was reported by some participants, resulting in less diverse medical student classes. Grading biases during clinical clerkships were reported by almost all participants as being problematic for BIPOC medical students. Women reported double biases in grading and in negative reactions from White patients based on

their racial and gender identities as BIPOC women. Although some participants had not experienced racism from White patients in clinical settings, all anticipated that this was likely to occur. Despite these challenges, participants shared how they felt hope that their BIPOC patients would feel inspired that they had a BIPOC health care provider who could relate with their shared identity.

Chapter Summary

Chapter IV opened with brief biographical sketches of each of the seven participants in this study: Arya, Chantelle, Isaac, Kiara, Tiana, Oscar, and Zuri. These participants were BIPOC medical students at Midwest School of Medicine and South Region School of Medicine. After providing brief introductions of the participants, the four Group Experiential Themes (GETs), which were constructed from the Personal Experiential Themes (PETs) of each participant, were outlined. The GETs included four themes: belongingness to find one's place in medical school; healing oneself to be able to heal others; cheerleaders: family, faculty, mentors, and advisors; and hope for change despite systemic inequities. Each of these GETs was described by highlighting the most pertinent, illuminating, and powerful excerpts from the lived experiences as shared by participants.

CHAPTER V

FINDINGS SUMMARIES, IMPLICATIONS, AND CONCLUSIONS

In Chapter V, I present summaries of the findings in connection with the research question and sub-questions, literature review, and theoretical frameworks. The purpose of the study was to understand how BIPOC medical students experience wellness as they navigate systemic racism in medical schools. Supporting the purpose of the study, the research question was, "How do BIPOC medical students make meaning of personal wellness as they navigate systemic racism in medical school ecosystems?" With this as the guiding question, two sub-questions followed, "How do BIPOC medical students define personal wellness for themselves?" and "What resources do BIPOC medical students point to as their key support systems at predominantly White medical institutions?" In arriving at the purpose of the study and research question and sub-questions, I turned to the relevant literature and the theoretical frameworks of intersecting identities, critical race theory (CRT), and ecological systems theory (EST).

As the findings were analyzed, it became clear that the research question and sub-questions, relevant literature, and theoretical frameworks supported the reports of the lived experiences of participants. After making these connections, I then discuss implications stemming from this study, which include centering the wellness of BIPOC medical students; finding the most effective key resources as part of advocating for BIPOC medical student wellness; and uncovering systemic racism in medical schools. Finally, I conclude Chapter V with recommendations for future research, including the

creation of action plans to build more equitable medical school environments for BIPOC medical students and therefore support BIPOC medical student wellness.

Analysis of Findings

In this section, I first review how I arrived at the findings for this study. Then, I discuss how the themes that were revealed relate to the research question and sub-questions. Next, I describe how the findings correspond to the relevant literature. Finally, I discuss how the findings for the study connect to the theoretical frameworks of intersecting identities, CRT, and EST.

BIPOC medical students shared their lived experiences with me during two interviews. The interview questions were asked of each participant in the order shown in Appendix F. The purpose of the interviews was to understand the lived experiences of participants before and during medical school, as well as their anticipated experiences after medical school. Specifically, the interview questions asked participants about their experiences of personal wellness, key resources of support, and experiences of systemic racism in medical school. Regarding their personal wellness, participants touched on experiences of cognitive, social, physical, and emotional wellness. Participants also spoke of key resources of support from friends, family, faculty, mentors, and advisors. Finally, conversation turned to ways in which participants had experienced systemic racism in medical school. Participants included their suggestions on how to improve the medical school environment and therefore make the experience of BIPOC medical students more equitable.

With Interpretative Phenomenological Analysis (IPA), Group Experiential Themes (GETs) are drawn from Personal Experiential Themes (PETs) of participants.

Smith et al. (2022) detailed the construction of PETs and GETs in IPA studies. Chapter III reviewed the premise behind the construction of PETs and GETs for this IPA study. While PETs are critical in the development of GETs, individual PETs from this study are not discussed in detail here or elsewhere, as doing so would make the scope of this analysis too unwieldy. Rather, I focused my efforts in keeping with the recommendations from Smith et al. (2022), by detailing the GETs in the findings for this IPA study in Chapter IV. In Chapter V, I further discuss the idea that was first introduced in Chapter IV of how the GETs connect to the research question and sub-questions. Then, I describe how the GETs correspond to the related literature and theoretical frameworks of intersecting identities, CRT, and EST. In doing so, the focus of Chapter V is on proposing ways to improve the lives of BIPOC medical students by applying theory-to-practice, thereby taking the findings of this study to emphasize the importance of conducting future applied research on this topic. I forecast how my findings may be related to improving the wellness of BIPOC medical students as systemic inequities in medical schools are recognized, highlighted, and acted upon.

These were the previously stated GETs in Chapter IV that were drawn from the PETs:

1. Belongingness to find one's place in medical school.
2. Healing oneself to be able to heal others.
3. Cheerleaders: Family, faculty, mentors, and advisors.
4. Hope for change despite systemic inequities.

Analysis of Findings in Relation to Research Questions

As mentioned in Chapter IV, the GETs contained elements of personal definitions of wellness, key resources of support, and experiences of systemic racism. There was some uniqueness from each GET and these experiences. For example, the first theme mainly addressed the personal wellness of participants in their experiences of belongingness, or lack thereof, in medical school. The second theme looked at ways that participants sought to engage in self-care so that they could heal themselves and care for others, which also highlighted their focus on personal definitions of wellness. The third theme spoke of the importance of having cheerleaders support their efforts in medical school, which focused predominantly on accessibility to key resources. Finally, the fourth theme provided a challenge to participants as well as the larger medical school environment regarding utilization of key resources. With this last theme, the emphasis was on how the medical school environment is embedded with assumptions and biases that make the medical school experience inequitable for BIPOC medical students due to systemic racism embedded in predominantly White medical schools. Additionally, participants provided suggestions on ways to improve the medical school experience for BIPOC medical students so that equity in medical education can be pursued.

Analysis Findings in Relation to the Literature

The findings from this study corroborated with the related literature. Here, I will discuss how the findings corresponded with previously conducted studies. First, I review how the literature in academic advising connected to this study. Then, I examine the findings in relation to the literature on systemic perspectives and BIPOC medical student wellness. Next, I discuss how asset-based frameworks tied into the findings. Afterwards, I address how the literature on mentor advocates in support of BIPOC medical student

wellness connected to this study. Finally, I examine the relation of the findings from this study to the existing research on the prevention of mental health issues in BIPOC medical students. Table 4 illustrates the connectedness of the research findings to previous studies in the related literature.

Table 4

Findings Connected to the Related Research Areas

Related Research Area	Author Citations	Connectedness
Academic Advising	Vianden (2016)	Academic advisors help connect students to their institutions and foster feelings of belongingness.
	Santiesteban et al. (2022)	Multiple roles of academic advisors and different descriptions of academic advisors by students.
Systemic Perspectives on BIPOC Medical Student Wellness	Duffy (2011); Laws (2021)	Persistence of systemic racism in predominantly White medical schools.
	Dunn et al. (2008); Hillard et al. (2011); Kötter et al. (2015)	Colorblindness persists at predominantly White medical schools, perpetuating systemic racism.
	Dyrbye et al. (2007); Odom et al. (2007); Babaria et al. (2011); Hardeman et al. (2015)	Mental health repercussions for BIPOC medical students from systemic racism.
Asset-Based Frameworks	Dunn et al. (2008)	Coping reservoirs of support.
	Jenkins et al. (2018)	Student assets focus for current medical students.
	Elks et al. (2021)	Student assets focus for medical school admissions.

Related Research Area	Author Citations	Connectedness
Mentor Advocates and BIPOC Medical Student Wellness	Powell and Kelly (2017); Spanierman and Smith (2017)	White allies and accomplices.
Prevention of Mental Health Issues for BIPOC Medical Students	Brennan-Wydra et al. (2021); Kötter et al. (2015)	Imposter syndrome; maladaptive perfectionism.
	Hillard et al. (2011)	Faculty and advisors can help medical students who have mild mental distress.

The Role of Academic Advising in Medical Schools

This study illustrated that academic advising was important in the lives of the BIPOC medical student participants, made a positive difference in their definitions of personal wellness, and served as a key resource of support. As reviewed in Chapter II, while Vianden (2016) did not study medical students, he found that it is important for academic advisors to connect students with their institutions and foster feelings of belongingness. Many participants in the present study reported that their academic advisors helped them to foster connections and feelings of belongingness to their medical school.

Academic advisors have many roles in medical school advising, including acting as coach, mentor, and advisor. The participants in the present study shed light on these overlapping roles, as they described their academic advisors by words such as "counselor," "mentor," and "therapist." Santiesteban et al. (2022) validates this perspective as they reflected on the many support roles advisors provide to students. Santiesteban et al. (2022) described academic advisors as "coaches" who assisted students as they mastered academic achievement goals. Coaches were honest in their

feedback and assessment of students, as they targeted areas of strengths and weaknesses. Advisors also gave formative feedback. Both findings are strikingly similar to earlier descriptions of academic advisors from participants in the present study. According to Santiesteban et al. (2002), advisors were also good listeners and provided wellness support, characteristics of which were also seen in this study.

Systemic Perspectives on BIPOC Medical Student Wellness

Although medical schools have made strides in becoming more diversified and equitable institutions, clearly systemic inequities that were overflowing in the Flexner Report from 1910 (see Duffy, 2011; Laws, 2021) are still alive today at the two predominantly White medical schools included in this study. Participants were quick to point out racial biases in their curriculum, clerkship grades, and patient encounters. Unfortunately, they also discussed that little is being done by medical school administration to create a more equitable medical school environment. In other words, although students frequently reported instances of inequity to administration, it did not result in equitable changes being made. The view that colorblindness persists at these predominantly White medical schools, and therefore perpetuates systemic racism, was expressed by nearly all participants. The colorblindness of predominantly White institutions has also been corroborated in the literature (see Dunn et al., 2008; Hillard et al., 2011; Kötter et al., 2015).

The mental health impact of systemic racism on participants also corroborated with findings stemming from the literature. Dyrbye et al. (2007) found that one outcome of systemic racism in medical school was that BIPOC medical students reported receiving inequitable performance evaluations. This was the same experience all clinical

phase, third and fourth year, participants shared in the present study. While participants did not report that they felt burned out or were depressed, Dyrbye et al. (2007) found that one possible consequence of experiencing systemic racism was increased risk for meeting the medical criteria for burnout and depression. Although negative experiences were commonplace with participants in the present study, the presence of key support systems through friends, family, faculty, mentors, and advisors was critical to fostering wellness despite facing adverse environmental conditions. Odom et al. (2007) found that, although BIPOC medical students faced many systemic barriers at their medical school, what made the difference in their wellness was the quality of social support that they received.

BIPOC women medical students are confronted with systemic inequities based on race and gender. Babaria et al. (2011) reported that BIPOC women medical students faced discrimination from instructors and peers. The participants in the present study verified that it happened both within the curriculum and social networks of racially segregated peer groups. Babaria et al. (2011) stated how BIPOC women medical students in their study felt the need to educate patients and staff about what it meant to be a BIPOC woman medical student training to become a physician. This experience was typical for BIPOC women medical students in the present study who were in their third or fourth year in medical school and were now working with patients and hospital staff.

Hardeman et al. (2015) found that African American women medical students were at higher risk for academic problems in medical school, which resulted in higher depressive and anxiety symptoms. They also reported that psychosocial resources, such as coping style, social support, sense of mastery, and self-esteem all influenced the wellness of these students. Hardeman et al. (2015) stated that Black women medical

students would fare worse on their self-rated mental health, have fewer psychosocial resources for coping, and therefore be at greater risk for depression and anxiety than White women medical students. In the present study, BIPOC women were more likely to report instances of negative mental health. However, it cannot be determined whether they experienced more of these negative instances than men, due to the self-reported nature of these interviews.

Asset-Based Frameworks of BIPOC Medical Student Wellness

One of the encouraging findings from this study was that BIPOC medical student participants had an abundance of key support from many resources, including friends, family, faculty, mentors, and advisors. Despite the challenges with systemic racism these participants faced at their predominantly White medical schools, they also reported a substantial investment from others in helping them to replenish their "coping reservoir." Dunn et al. (2008) conceptualized the "coping reservoir" as a model of medical student well-being comprised of positive inputs (e.g., psychosocial support, social activities, and mentoring) and negative inputs (e.g., stress, internal conflict, and time and energy demands). Dunn et al. (2008) stressed that medical schools should focus their efforts on formally implementing an assets-based framework based on a network of positive inputs. The participants provided many examples throughout their interviews of instances where their "coping reservoir" was replenished due to support from friends, peers, family, faculty, mentors, and academic advisors.

In Chapter I, the scarcity of qualitative studies on BIPOC medical students was discussed. Such studies, which also examined BIPOC medical student wellness based on the positive inputs as postulated by Dunn et al. (2008), are nearly non-existent. In one

landmark study, Jenkins et al. (2018) conducted life story interviews with graduating BIPOC and White medical students. During these interviews, they found that feelings of burnout were mentioned by most students. However, Jenkins et al. (2018) went on to cite the following strategies (i.e., positive inputs) that can be utilized by BIPOC medical students to combat impending or actual burnout: having positive role models, strong support networks, faith and spirituality, and passion towards achieving one's goals. In the present study, although only one participant spoke of the importance of faith and spirituality to their personal definition of wellness, all participants reported substantial investment in seeking positive role models, strong support networks, and passion toward achieving their goals. In other words, the participants mentioned experiences that were clearly aligned with the findings of Jenkins et al. (2018).

Asset-based perspectives are important not just during medical school, but also prior to it, as wellness lies on a continuum rather than at a single end point. Elks et al. (2021) emphasized that medical school administration needs to re-examine their admissions requirements for BIPOC medical school applicants, as these are usually based on a deficits-based framework rather than the positive inputs model advocated by Dunn et al. (2008). Medical school admissions committees fail to examine how BIPOC medical students will contribute to the medical school environment. Instead, they focus on issues of "lack" such as not having a desired cutoff score on the Medical College Admissions Test (MCAT), significant pre-medical coursework, and near-perfect undergraduate grade-point average. Elks et al. (2021) has challenged the traditional deficit-based framework of BIPOC student wellness. While a couple of participants in the present study reported high MCATs, significant pre-medical coursework, and near-perfect undergraduate grade-point

averages, most of them did not. In fact, they often expressed concern that their White medical student peers might stereotype them as being an "affirmative action admission" or given a place in medical school to fulfill a medical school admissions quota. The fact that Midwest School of Medicine was reported by one participant to have dramatically decreased their numbers of admitted BIPOC medical students was profoundly disturbing. However, it also supports the view of Elks et al. (2021) that medical schools need to enact a high priority on implementing an assets-based framework in BIPOC medical student admissions.

Mentor Advocates and BIPOC Medical Student Wellness

One unexpected finding from this study was the lack of mention of a formal mentor by most participants. While one participant did cite their mentor as having a profound influence during their time in medical school, most participants cited the influence of friends, family, faculty, and advisors as having substantially more influence on their personal and career trajectories than did formal mentors. In keeping with the diverse meaning of the word "mentor" as mentioned earlier in this chapter, perhaps it could be that faculty and advisors also served in mentoring roles to participants, but did not carry this formal title (see Santiesteban et al., 2022).

Reports of White allies and White accomplices were rare in this study. Only one participant mentioned that White faculty had served as a mentor and were intentional about supporting them. No one else reported White allyships or White accomplices. Spanierman and Smith (2017) described "allies" as similar to the "accomplices" mentioned by Powell and Kelly (2017). For Spanierman and Smith (2017), White allies "engage in actions to disrupt racism and the status quo on micro and macro levels,

participate in coalition building and work in solidarity with people of color, and encounter resistance from other White individuals" (p. 609). Clearly, the development of White ally and accomplice mentorship with BIPOC medical students, as advocated by Tekian et al. (2001), Aagaard and Hauer (2003), Burgess et al. (2010), Babaria et al. (2011), and Andre et al. (2017) needs to be addressed in future research.

Prevention of Mental Health Issues for BIPOC Medical Students

Imposter syndrome was frequently cited by participants, particularly at the beginning of their medical school experience. Brennan-Wydra et al. (2021) defined imposter syndrome as feelings by medical students that they are not supposed to be in medical school. Students typically give reasons such as feeling that they are not smart enough to be in medical school or that the only reason they are in medical school is due to an admissions quota. The longer students are in medical school, the less frequently they report imposter syndrome. Regardless, nearly all participants in the present study reported feelings of imposter syndrome during their first year of medical school, as described by Brennan-Wydra et al. (2021).

A large part of the problem with the presence of imposter syndrome has to do with "maladaptive perfectionism" being prevalent in BIPOC medical students. Brennan-Wydra et al. (2021) found that higher levels of maladaptive perfectionism positively correlated with a higher likelihood of experiencing imposter syndrome. They reported that BIPOC women medical students were at highest risk of showing maladaptive perfectionism. In turn, this positively correlated with an increased risk for suicidal ideation. Brennan-Wydra et al. (2021) discussed that, while reducing feelings of imposter syndrome should decrease the risk of suicidal ideation among BIPOC medical students,

we should also look to the root cause of the problem. They discussed that the problem of maladaptive perfectionism originates from an elevated focus on individual resiliency.

Application is clearly needed here to change the perfectionistic culture of medical school, which is much easier said than done. Although it may seem impossible to reverse such a deeply embedded cultural mindset, this maladaptive approach clearly needs to change. Initiatives such as those proposed by Kötter et al. (2015), as reviewed in Chapter II, focused on changing the medical school curriculum to be more intentional and aligned with the mental health and self-care advocacy of BIPOC medical students. The program developed by Hillard et al. (2011), also described in Chapter II, shows how a substantial part of the medical school community can become involved in the wellness of medical students. In the program by Hillard et al. (2011), faculty and advisors help students who are suffering from mild distress with issues pertaining to mental health and wellness. They trained faculty on how to provide wellness assistance to medical students. Similar training could be provided to academic advisors and other key medical school staff and could focus on centering BIPOC medical student wellness.

Analysis of Findings in Relation to the Theoretical Frameworks

The findings from this study clearly connect with the three theoretical frameworks outlined in Chapter II. First, I discuss how the findings work in relation to intersecting identities, specifically when it comes to examining the role of multiple identities and experiences with systemic racism. Second, I emphasize how CRT directly relates to the findings for this study. In doing so, I also shed light on the need for future applied research. This research should be constructed for starting the systemic changes that must take place in colorblind, predominantly White medical schools. Finally, I focus on how

the environments mentioned in EST relate to understanding the contexts of the participants in this study, therefore guiding efforts to promote BIPOC medical student wellness. Table 5 illustrates the connectedness of the research findings to previous studies in the theoretical frameworks of intersecting identities, CRT, and EST.

Table 5

Findings Connected to the Theoretical Frameworks

Theoretical Framework	Author citations	Connectedness
Intersecting identities	Dunn et al. (2008); Monrouxe (2010)	BIPOC women medical students have an additional challenge when compared to BIPOC men medical students due to their gender. BIPOC women medical students may have to rely more on individual resiliency due to lack of institutional support for their race and gender.
Critical race theory	Crenshaw (1988); Bell (1992); Delgado (1995); Ladson-Billings (1998); and Vargas et al. (2021)	Racism is embedded in all predominantly White institutions, which by inference, includes all predominantly White medical schools.
	Delgado (1995); DiAngelo and Dyson (2020); Vargas et al. (2021)	White fragility is prevalent in all predominantly White institutions, which by inference, includes all predominantly White medical schools.
Ecological systems theory	Bronfenbrenner (1977)	We are all impacted by ecosystems.
	Tewary et al. (2020)	Through understanding ecosystems, advisors can be more effective.

Intersecting Identities

In Chapter II, the concept of individual resiliency as it relates to intersecting identities was introduced. Dunn et al. (2008) and Monrouxe (2010) found that individual resiliency is an important element in understanding the intersecting identities of BIPOC medical students. However, the literature is silent when it comes to the issue of whether predominantly White medical schools negatively contribute to intersecting identities due to their ongoing perpetuation of both racism and sexism. In the present study, most participants reported that being a BIPOC woman resulted in more experiences with discrimination than as a BIPOC man.

The experience of BIPOC women participants illustrates how predominantly White medical schools are contributing to negative perceptions of them based on their race and gender. All BIPOC women in this study raised serious concerns regarding grading biases during their clerkships, biases with race and gender. Although the women in this study reported the type of individual resiliency described by Dunn et al. (2008) and Monrouxe (2010), they should never have had to experience such a situation. This forced reliance on individual resiliency (see Dunn et al., 2008; Monrouxe, 2010) only serves to highlight the systemic inequities that give rise to BIPOC women medical students needing to rely on individual resiliency in the first place (see Brennan-Wydra et al., 2021). The BIPOC women participants in this study reported that, although they had completed tasks at the same level of mastery as their White men and women peers, they still experienced grading biases. Discriminatory grading practices were directed toward them based on their intersecting racial and gender identities. The BIPOC medical student

men in this study acknowledged that BIPOC women are confronted with an extra layer of discrimination.

Experiences with discrimination for BIPOC medical students in this study was not limited to medical school. Their reports indicated not only the importance of examining BIPOC medical student wellness through the lens of intersecting identities, but also provided support for EST. For example, being a BIPOC woman medical student was felt not only within one's role at a predominantly White medical school, but also how people in the community perceive BIPOC women medical students based on stereotypes about their race, gender, and occupational choice of studying to become a physician. Future studies could shed additional light on the impact of community perceptions of occupational roles of BIPOC women medical students.

Critical Race Theory

Crenshaw (1988), Bell (1992), Delgado (1995), Ladson-Billings (1998), and Vargas et al. (2021) posit that racism is a normal part of U.S. society and that racism is embedded in U.S. institutions. Vargas et al. (2021) emphasized that most BIPOC medical students do their work at predominantly White medical schools and that these medical schools are perpetually colorblind, meaning that race is never centered but is ignored. Much of the conversation that took place with participants spoke of how CRT can help to critique and examine the systemic racism that exists at predominantly White medical schools.

As described in Chapter IV, some participants pushed back against the White-centric curriculum that they encountered at their predominantly White medical school. A few of them even took their complaints of this White-centric bias to administration but

were met by defensiveness and hostility. It was not the case that BIPOC medical students were not fighting back against systemic racism in medical schools. Rather, it was the reality that as they pushed back against systemic inequities, they were ignored at best, or met with blatant hostility at worst. It was discouraging to discover that when BIPOC medical students brought awareness of racial inequities to those in senior administrative positions who could have done something about enacting needed change, leadership failed to do so.

Many participants noted that one obvious solution to dismantling systemic racism in medical school is to simply increase BIPOC professionals and BIPOC students in medical schools. Participants at one of the medical schools in this study reflected on the unpleasant reality that, in recent years, their institution had been showing signs of improvement by increasing the numbers of BIPOC administrators, faculty, and students, but recently chose to reverse course, with devastating consequences.

All participants came to medical school expecting to encounter grading biases due to being a BIPOC medical student. The unpleasant finding here is that although this problem has been widely reported in medical schools for decades, it nevertheless persists. It may be a problem that extends beyond the two medical schools in this study, based on how all participants at two very geographically distinct medical schools reported grading biases as being a direct event either for themselves or for other BIPOC medical students they knew at their medical school.

Given that the two medical schools included in this study are predominantly White institutions, it was somewhat surprising that participants rarely reported encountering the “White fragility” first described by Delgado (1995) and later

extrapolated by DiAngelo and Dyson (2020) and Vargas et al. (2021). My role as a White researcher, explained both in Chapter I, as well as in a later section of this chapter, could account for the hesitancy by participants in reporting instances of White fragility. White fragility is described by Vargas et al. (2021) as consisting of uncomfortable feelings that White individuals experience when confronted with issues of social justice framed by racial inequities. DiAngelo and Dyson (2020) stated that feelings of White fragility exhibited by White individuals often include anxiety, discomfort, defensiveness, and beliefs about threats to one's identity and are based on presumed superiority and entitlement. White fragility could be a major reason why predominantly White medical schools remain colorblind institutions, due to the belief that directly confronting these threats will put the impetus for initiating change on White administrators who themselves are likely experiencing White fragility and contributing to systemic inequities.

Another reason why predominantly White medical schools are colorblind could be due to the firm entrenchment of individuality that is inherent in these institutions. Vargas et al. (2021) suggested that the notion of stark individualism must be confronted head on if substantive systemic change is to occur in predominantly White medical schools. As the U.S. was founded on ideals of individualism, this quality is endemic to all institutions. Therefore, changing the colorblindness and challenging the White status quo at predominantly White medical schools demands that the culture of medical school itself be changed.

Ecological Systems Theory

BIPOC medical student participants were part of not just the predominantly White medical school environment itself, referred to as the "microsystem" by Bronfenbrenner

(1977), but also the larger systems surrounding it. For example, participants had interactions between two or more major settings, which consisted of relationships between the medical school classroom, hospital clinic, home, and communities outside of medicine. In fact, many participants reported experiencing a major transition as they moved from the classroom to the clinic between their second and third years of medical school. The health care system directly impacts the wellness of BIPOC medical students and could serve as the next level in Bronfenbrenner's model, which is the exosystem. Being a BIPOC medical student in the United States is a much different experience than being a White medical student and this experience corresponds to the macrosystem. Since being a BIPOC medical student in the 21st century looks different than it did in the 20th century, Bronfenbrenner's chronosystem was also relevant for participants.

Tewary et al. (2020) provided an updated look at EST and their research applied EST to academic advising in medical schools. These authors emphasized that medical school academic advisors can be valuable resources for medical students if they are able to implement a specific theoretical approach to academic advising that best matches a particular advisor-advisee relationship. The work of Tewary et al. (2020) speaks loud and clear to the observations of participants reported earlier in this study, which was that medical school academic advisors need to be highly qualified for their role. Some participants mentioned that medical school academic advisors must be able to provide relevant advice by having lived through the experience as a medical student themselves, which is a high bar that is unlikely to be achieved by most medical schools due to economic considerations and the numbers of BIPOC physicians who would be willing to take on this role. In the Tewary et al. (2020) study, they looked mostly at White medical

students, but articulated that EST could be useful for more effectively advising BIPOC medical students.

Implications and Recommendations

Jenkins et al. (2018) emphasized that future research should study the lived experiences of medical students through qualitative methods, rather than relying on quantitative studies, as has traditionally been the case. This way, researchers will have a better understanding of how BIPOC medical students create definitions of personal wellness and not just quantify who their key support figures are during medical school. How and why these individuals are important in their lives, not just who they happen to be, are crucial questions that should be addressed in future research. Jenkins et al. (2018) paved the way in helping to highlight the importance of utilizing qualitative studies to glean rich, descriptive data which sheds light on how medical students experience medical school. A central missing element with the Jenkins et al. (2018) study was that BIPOC medical students were not the focal point, as most of their participants were White medical students. This lack of centering BIPOC medical students risks perpetuating the colorblindness in medical schools that needs to be eradicated. Still, research by Jenkins et al. (2018) was noteworthy in that it described lived experiences of medical students, BIPOC and White, through qualitative interviews, a research method that is still rare in studies with medical students today.

The first implication of the present study is the importance of conducting further qualitative studies on BIPOC medical student wellness. Although IPA is not a requirement for conducting qualitative studies, the present study utilized IPA based on the rich, descriptive data it generated as well as its historical focus on studying the

wellness of participants. Indeed, my background in psychology and this study's focus on centering the wellness of BIPOC medical students made IPA an ideal qualitative method. While future studies on related topics could utilize other methods besides IPA, qualitative research methods are highly recommended due to the rich, descriptive findings they will generate regarding the how and why of the personal wellness experiences of BIPOC medical students.

As a second implication in this study, academic advising could serve as a tool to center the wellness of BIPOC medical students. As previously shared, predominantly White medical schools are colorblind institutions and the lived experiences of BIPOC medical students are unique from those of White medical students (see Vargas et al., 2021). From my perspective and following along with what has already been reviewed in the present study, medical school academic advising is also colorblind, as it is located within the larger ecological context of colorblind, predominantly White medical schools (see Tewary et al., 2020).

A third implication of this study is the importance of expanding beyond a generic view of medical student wellness. Related to this is the idea of tailoring each academic advising session so that academic advisors can begin conversations with BIPOC medical students by asking for their personal definitions of wellness. White academic advisors should never assume that wellness is going to look the same for BIPOC medical students as it does for White medical students. That way, more appropriate collaboration with BIPOC medical students may be created within medical school academic advising spaces. White academic advisors need to ask, and continually learn from, BIPOC medical students. That is a predominant way that key resources of support for BIPOC medical

students can be determined as they journey through systemically racist environments at predominantly White medical schools.

Stemming from the implications of this study, the following recommendations can be implemented. First, the status quo of White medical school spaces can be challenged through utilizing advising models as a platform for such discourse. Ways in which medical school academic advisors can call out the systemic racism that exists at predominantly White medical schools should be explored. To this end, predominantly White medical schools need to examine how their colorblind status quo focuses on individual causes of racism (i.e., "a few bad apples spoiling the bunch"), but omits discussion of the systemic causes of racism, thereby perpetuating White supremacy within these White medical school spaces. In keeping alignment with CRT, White medical school academic advisors can begin to acknowledge their own complicit role in perpetuating an unjust system that continues the experience of systemic racism for BIPOC medical students. There also needs to be further investigation as to whether there are predominantly White medical schools which have specific training programs already in place to prepare White advisors to better understand the wellness of BIPOC medical students. If these training programs are currently not in existence, there needs to be inquiry into ways that medical schools can actively and creatively construct such training programs. Investigating ways in which advising sessions can be tailored for advisors to clearly hear the stories of BIPOC medical students should be explored.

Second, medical school student affairs administrators, including deans, associate deans, assistant deans, and directors, must take the lead with ensuring their complete support for encouraging academic advisors to focus on advocating for the wellness of

BIPOC medical students. Third, as a test of which professionals from medical school student affairs administration to include, these administrators should be in positions of senior leadership, responsible for overseeing the delivery of high-quality medical student education. This would include intentionally focusing on medical student wellness that does not ignore BIPOC medical students or otherwise lump BIPOC medical students with all medical students into a generic category when it comes to matters of wellness. Fourth, academic advisors must be given psychological safety and diversity training from administrators to fully listen to, advocate for, and support BIPOC medical student wellness. Finally, barriers of systemic racism at predominantly White medical schools can be disrupted and dismantled through advocating for advising systems that highlight these inequities and foster social justice. For this final layer, administrators, faculty, staff, and students within the entire medical school ecosystem will need to be involved. Senior leadership must take the lead in announcing this vision to the medical school community through town hall meetings, other open forums, and a robust social media presence. From this vision, faculty, staff, and students can then collaborate with administrators on ideas to effectively implement wellness initiatives for BIPOC medical students.

Limitations

Like any study, this one is not without its limitations. In Chapter I, my researcher positionality statement was detailed. In that statement, I mentioned my dual insider and outsider statuses. While my experience as a medical school academic advisor allows me insider knowledge in hearing stories from BIPOC medical student advisees, I am equally cognizant of my outsider status as a White man. While I deeply appreciate stories told to me by BIPOC medical students, I can never fully understand what it is like to be a

medical student of color at a predominantly White medical school. As such, I recognize that it is possible that some participants may have been reluctant to share more details about their medical school lived experiences as a BIPOC medical student, particularly regarding their experiences witnessing White fragility, due to my being a White man.

As there were only two medical schools which positively responded to my inquiries by referring me to participants (48 out of 155 U.S. allopathic medical schools were contacted), these two medical schools may not necessarily represent the experiences of all BIPOC medical students at predominantly White medical schools. However, this may be somewhat compensated by the fact that, although these two medical schools were in two different geographical regions, similarities of reported experiences among participants at Midwest School of Medicine and South Region School of Medicine were comparable. Still, given the small participant sample, the findings of these seven BIPOC medical students cannot be generalized to the wider population of BIPOC medical students.

Due to time constraints, each of the two interviews per participant lasted one hour, which provided a substantial amount of detail into the lived experiences of participants, but certainly did not shed complete light on all their stories in medical school. There simply was not enough time to cover every detail of their medical school journey. As interviews were conducted virtually via Zoom, certain nonverbal cues, body gestures, and body postures were likely missed. Finally, although the interview questions were reviewed by another researcher, my dissertation chair, it is probable that additional questions could always have been chosen in their place. Having different interview questions may have yielded findings which could have diverged from what was reported

here. Nevertheless, I hold up the limitations of this study as a challenge for future researchers to investigate, with the aim of providing an even greater depth of knowledge into the lived experiences of BIPOC medical students.

Conclusions

My hope is that I have shared the lived experiences of these BIPOC medical student participants in such a way that accentuates both the positive support and the significant systemic challenges they have faced at their respective predominantly White medical schools, Midwest School of Medicine and South Region School of Medicine. In taking this journey, I have discovered that their experiences are not all gloom and doom. However, it would be naïve and erroneous to suggest that they have not dealt with challenges of confronting daily microaggressions and overt racism. These obstacles exist due to BIPOC medical student participants studying at predominantly White medical schools that are also colorblind institutions. Such institutions do not acknowledge the hurdles that they continue to place in front of BIPOC medical students.

Given their central, frontlines, and one-stop-shop role in medical schools, academic advisors serve as the primary starting point through which the voices of BIPOC medical students can not only be strongly heard, but also powerfully felt. To this end, the goal and aim of future work in this area should be to discover ways to implement real and lasting change for BIPOC medical students starting with the frontlines, academic advising, and then infiltrating on a system-wide level throughout the rest of the medical school ecosystem.

To journey toward this vision, future studies could focus on the effectiveness of utilizing academic advising in predominantly White medical schools to advocate for the

wellness of BIPOC medical students. This will include having conversations on how to dismantle racial systemic inequities in medical schools, therefore promoting the interrelated causes of diversity, equity, inclusion, and social justice. No cure was found in this study for dismantling the systemic racism that exists at the two predominantly White medical schools included here. While I cannot verify whether other predominantly White medical schools are bastions of systemic racism, from what CRT researchers have found regarding the perpetuation of systemic racism at predominantly White institutions (see Crenshaw, 1988; Bell, 1992; Delgado, 1995; Ladson-Billings, 1998; Patton et al., 2007; and Vargas et al., 2021), it is likely very safe to assume that systemic racism exists at all predominantly White medical schools.

We are left with several questions that should be addressed in future research. One question is how can predominantly White medical schools become anti-racist, inclusive, and welcoming environments for BIPOC medical students? This question is followed by another one. Given their frontlines nature, accessibility, and visibility, how can medical school academic advisors challenge systemic racism and advocate for the wellness of BIPOC medical students? Finally, future researchers need to ask what are practical ways to change how medical school academic advising is provided to BIPOC medical students? Can academic advisors assist with how BIPOC medical students construct their personal definitions of wellness? How can academic advisors not only serve as a key resource of support for BIPOC medical students, but how can they assist BIPOC medical students in finding additional advocates in administrators, faculty, and staff?

There is still a long road to travel in understanding BIPOC medical student wellness. This study has begun the work on this highly important but long neglected topic. I am hopeful that I have demonstrated that it is far past the time to begin exploring ways to make medical schools equity-centered, welcoming, inclusive, and welcoming places of study for BIPOC medical students. Doing so will enhance the personal wellness of BIPOC medical students and therefore benefit the entire medical school community. It will also serve to advocate that BIPOC medical students can have increased confidence in utilizing the key resources of support that are intended for their wellness and success in medical school.

Chapter Summary

Chapter V began by describing the focus of this chapter, which was to present summaries of the findings connected to the research question and sub-questions, relevant literature, and theoretical frameworks. Next, the purpose of the study, the research question, and the research sub-questions were revisited. After the Group Experiential Themes (GETs) were restated with Interpretative Phenomenological Analysis (IPA) as the methodology, summaries of findings connected to the research question and sub-questions were reviewed. Then, it was discussed how the findings of the present study corroborated with that of the related literature. The connection of the findings of the study to the theoretical frameworks of intersecting identities, critical race theory (CRT), and ecological systems theory (EST), was then described. Next, implications, recommendations, and limitations of the study were detailed. Finally, Chapter V concluded with a discussion of how action-based applied research may be helpful in

dismantling systemic racism in predominantly White medical schools and fostering wellness in BIPOC medical students.

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APPENDIX A

EXPERT NOMINATOR RECRUITMENT EMAIL

Dear (title and last name of medical school administrator),

My name is Mark Mach and I am a student in the Ed.D. program in Student Affairs Administration and Leadership at the University of Wisconsin-La Crosse.

I am conducting research for my dissertation and seeking medical students of color to participate in two, individual and virtual interviews.

I would like to ask if you would be willing to share this recruitment with medical students of color at the (name of medical school). If there is a specific person whom I should contact regarding my inquiry, I would very much appreciate it if you could please let me know this as well.

Participants will take part in two Zoom interviews, lasting approximately 60-90 minutes each, for a study on how medical students of color experience personal wellness as they navigate systemic racism in medical school. I am seeking participants at high-ranked U.S. medical schools.

The participants I am seeking for this study will:

1. Identify as a medical student of color

2. Be an MS2, MS3, or MS4 (i.e., Classes of 2024, 2025, or 2026)

I will keep all Zoom recordings saved until the final defense of my dissertation is complete. After the final defense, I will permanently delete all recordings.

Participants will be reassured during the informed consent debriefing that I will not share any recordings or transcripts of these interviews with (name of medical school). All identifying information in each interview will be recoded to ensure total participant anonymity. The (name of medical school) will not be named or identifiable in any way in this study.

Participants who complete both interviews will receive a $40 Amazon gift card. There is no partial compensation given for completing less than the two interviews.

This research has met with formal approval from the Institutional Review Board (IRB) at the University of Wisconsin-La Crosse.

If you have any questions about my project, I can be reached at mach0077@uwlax.edu. The chair of my dissertation committee, Dr. Adele Lozano, may be reached at alozano@uwlax.edu if you have any questions or concerns regarding the study and/or IRB approval.

Any assistance you can provide for me in recruiting medical students of color at (name of medical school) for my study would be very much appreciated.

Thank you for your time and consideration.

Sincerely,

Mark

**

Mark Mach
Ed.D. Candidate, Student Affairs Administration and Leadership
University of Wisconsin-La Crosse
mach0077@uwlax.edu

APPENDIX B

OPEN CALL EMAIL FOR PARTICIPANTS

Dear Medical Student,

My name is Mark Mach and I am a student in the doctoral program in Student Affairs Administration and Leadership at the University of Wisconsin-La Crosse.

I am writing to invite you to participate in two Zoom interviews, lasting approximately 60-90 minutes each.

During the interviews, I will ask questions about your perceptions of wellness. I will also ask you to talk about any experiences with racism you may have had before and during medical school, and any anticipated experiences with racism after medical school.

I will keep all Zoom recordings saved until the final defense of my dissertation is complete. After the final defense, I will permanently delete all recordings.

Your participation in this study is completely voluntary. I will not share any recordings or transcripts of your interviews with the medical school you attend. All identifying information in each interview will be recoded to ensure total participant anonymity.

Participants who complete the two interviews will receive a $40 Amazon gift card. There is no partial compensation given for completing less than two interviews.

If you are interested in participating, please let me know your available days and times by replying to this email.

If you have any questions about my project, I can be reached at: mach0077@uwlax.edu

Thank you for your consideration of participating in my study.

Sincerely,

Mark

**

Mark Mach
Ed.D. Candidate, Student Affairs Administration and Leadership
University of Wisconsin-La Crosse
mach0077@uwlax.edu

APPENDIX C

EMAIL TO PARTICIPANTS REQUESTING COMPLETION OF DEMOGRAPHIC SURVEY AND INFORMED CONSENT

Hi (name of medical student),

Thank you for your interest in my research!

I have attached an Informed Consent form. If you could please digitally sign and date it and email it back to me that would be great. Additionally, if you could please complete this short, less than five minutes demographic survey, I would appreciate it. Here is the link to the survey:

https://docs.google.com/forms/d/1iMq5DqTp5khSnBTEIues4zA6gpfWzzHaNlGyBPTibAQ/edit?pli=1

Sincerely,

Mark

**

Mark Mach
Ed.D. Candidate, Student Affairs Administration and Leadership
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APPENDIX D

DEMOGRAPHIC SURVEY

Medical Student Wellness – Demographic Survey

I would appreciate it if you could please complete this short survey before our first interview. It should take less than 5 minutes to complete. Thank you in advance!

Year in Medical School

- MS2
- MS3
- MS4

Age

- Under 21
- 21-24
- 25-28
- 29-32
- 33-36
- 37-40
- Over 40

Geographical Location of Your Medical School

- Northeast
- South
- Midwest
- West

Gender

- Male
- Female
- Non-binary
- Prefer not to state

Race/Ethnicity (may check multiple items)

- African/African American/Black
- Asian/Asian American
- Hispanic/Latinx
- Indigenous/Native American
- Native Hawaiian/Other Pacific Islander
- White/European American
- Other/not listed

First Person in Immediate Family (counted as father, mother, brother, or sister) to go to medical school?

- Yes
- No
- I don’t know/not sure

Medical Specialty After Medical School (may check multiple items)

- Anesthesia
- Diagnostic Radiology
- Emergency Medicine
- ENT
- Family Medicine
- General Surgery
- Internal Medicine
- Interventional Radiology
- Neurological Surgery
- Ob-Gyn
- Ophthalmology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Psychiatry
- Other specialty not listed

APPENDIX E

INFORMED CONSENT DOCUMENT

Informed Consent

Protocol Title

BIPOC Medical Student Wellness: An Interpretative Phenomenological Analysis

Principal Investigator

Mark Mach

Contact Information

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Emergency Contact

Dr. Adele Lozano
alozano@uwlax.edu
608-785-6871

Purpose and Procedure

- The purpose of this study is to understand how BIPOC medical students experience personal wellness as they navigate systemic racism in medical schools.
- My participation will involve two interviews held on different dates.
- Each interview will take place virtually, on Zoom, between June 1-September 30, 2023.
- Each interview will be recorded. I agree to have my video and audio on at all times during each interview.
- Each interview will last between 60-90 minutes. The total time required will be 2-3 hours for both interviews combined.
- I will be asked between 8-10 open-ended questions during each interview.

- My interview environment should be free from any distractions, such as interruptions. I agree that other people or animals will not be present in the room during my interviews.

- Interview topics will revolve around my experiences as a medical student of color. Specifically, I will be asked questions pertaining to racism and my experiences of wellness as a medical student of color.

- Prior to, during, and at the conclusion of each interview, I am free to ask any questions that I would like to ask regarding this study.

Potential Risks

- I may experience mild discomfort when questions specific to racism are asked during the interviews.

- It is very unlikely that I will experience moderate or high levels of discomfort, as I will be free to redirect the conversation or take a break if I feel heightened discomfort or anxiety during the interviews.

- I will be given counseling referral information in the very unlikely event of excessive discomfort and/or anxiety from participating in this study.

Rights and Confidentiality

- My participation is voluntary. I can withdraw or refuse to answer any question without consequences at any time.

- I understand that I can withdraw from this study at any time for any reason without penalty.

- I understand that the results of this study may be published in scientific literature or presented at professional meetings using grouped data only.

- My individual data from participating in this study will be protected and will not be personally identifiable.

Possible benefits

- I may experience increased meta-cognitive awareness of my wellness in the medical school environment.

- I may desire to learn more about how to take advantage of existing related resources, such as wellness programs, as a result of participating in this study.

- I may become an advocate for developing relevant wellness programs at my medical institution.

Participant Incentive

- I will receive an incentive of a $40 Amazon gift card after participating in both interviews.

- Questions regarding study procedures may be directed to the primary investigator, Mark Mach, mach0077@uwlax.edu. Questions regarding the protection of human subjects may be addressed to the UW-LaCrosse Institutional Review Board for the Protection of Human Subjects, 608-785-8044 or irb@uwlax.edu

Participant_____

Date_____

Researcher_____

Date_____

APPENDIX F

INTERVIEW QUESTIONS

Interview Questions

First Interview: Life Prior to Medical School/Life During Medical School

1. Could you please tell me about yourself – your hobbies, interests, activities, what you hope to do after medical school, etc.?
2. What were your most memorable stories of school before starting medical school?
3. What did wellness look like to you in school before starting medical school?
4. How did people react to you when you told them you were accepted to medical school?
5. What is your story of why you decided to go to medical school?
6. What were your hopes and dreams before you started medical school?
7. What were the biggest challenges you felt you would face as a student of color in medical school?
8. What have been your most memorable stories since starting medical school?
9. What has wellness looked like to you as a student of color since starting medical school?

Second Interview: Life During Medical School/Life After Medical School

1. What are your hopes and dreams as you go through medical school?
2. What have been the biggest challenges as a student of color that you have faced in medical school?
3. How can your academic advisor help you during your time in medical school?
4. What resources would be helpful to combat racism in medical school?
5. What will be your most memorable stories after graduating from medical school?
6. What will wellness look like to you after you have completed medical school?
7. How do you anticipate people reacting to you as a physician of color after you have completed medical school?
8. How do you think you will feel after you have completed medical school?
9. What are your hopes and dreams after you have gone through medical school?
10. What will be the biggest challenges as a physician of color that you will face after medical school?