6-25-2021

# The experiences of women as Latinx osteopathic medical students

Dana L. Weiss
*Rowan University*

# THE EXPERIENCES OF WOMEN AS LATINX OSTEOPATHIC MEDICAL STUDENTS

by

Dana L. Weiss

A Dissertation

Submitted to the
Department of Educational Leadership
College of Education
In partial fulfillment of the requirement
For the degree of
Doctor of Education
at
Rowan University
June 9, 2021

Dissertation Chair: Cecile Sam, PhD

Committee Members
Ane Turner-Johnson, PhD
Sylk Sotto-Santiago, EdD

## Dedication

I would like to dedicate this work to the six participants who so generously shared their life experiences and knowledge with me- I am deeply humbled and forever grateful.

## Acknowledgments

Without the patient support of my dissertation chair, Dr. Cecile Sam, I would not have successfully completed this journey. I would also like to thank my committee for their guidance and support of my research.

Although this dissertation is an individual work, I could not have completed it without the efforts of my "team".

To my husband and my daughter: Neil Broome and Madeline Broome- I know all of this would not have been possible without your understanding, love, and encouragement.

To my parents: Leigh Weiss and Dr. Donna Weiss- your unwavering support, love and occasional singing sustained and motivated me throughout my educational journey.

Lastly, to all my family and friends who supported me through this remarkable journey I offer my sincerest gratitude.

## Abstract

Dana L. Weiss
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2020-2021
Cecile Sam, Ph.D.
Doctor of Education

In existing literature, researchers have predominantly examined issues related to minoritized groups by juxtaposing differences and outcomes among groups without attention to the diversity of experiences, challenges and strengths. This has had a limiting focus on the experiences specific to women as Latinx medical students, and has created a gap which restricts knowledge about experiences of perceived support and barriers within osteopathic medical school. This research provided an opportunity to think more deeply and critically about the experiences for women as Latinx osteopathic medical students. The data collected in this qualitative phenomenological study was gathered from participants as they narrated their story, in their way, from their perspective. Rooted in the participants narratives are anecdotes in which they demonstrate abilities to leverage their power and resources in ways that are often unaccounted for in research and academic medicine. It is through these narratives that participants' everyday resistance and agency were made visible. This study is offered as evidence of how strength-based frameworks can make visible the power of women as Latinx osteopathic medical students in their advocacy for well-being and health equity of the patients they serve.



*Keywords: osteopathic medical students; women; Latinx; Phenomenology*

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# Chapter 1

## Introduction

Despite all the advances in health care and concentrated efforts to eliminate inequality within the healthcare system, racially and ethnically minoritized groups within the United States continue to experience significant disparities in health care quality (Dall & West, 2016; Jones et al., 2010; Silver, et al., 2019). One of contributors to the inequality of healthcare for minoritized groups compared with non- minoritized groups is the operational structure of the healthcare system (Silver, et al., 2019). Specifically, under-representation of minoritized groups in the pool of health care providers (Dall & West, 2016; Jones, et al., 2010). For example, the Latinx population is the fastest growing minority population in the United States; yet, it is one of the most underrepresented in medicine (Boulis& Jacobs, 2008; Capers et al., 2018; Chapman, et al., 2019).

While the diversity of the U.S. population is quickly expanding, the diversification within the physician workforce is moving at a slower speed. Evidence of this is seen in several medical and surgical specialties which have lower numbers of minoritized practitioners (Odom, et al., 2007; Xierali, et al., 2018). For example, approximately thirty percent of the population of the United States consists of minoritized groups, yet only six percent of practicing physicians are from these groups (Landry, et al., 2013). With population projections continuing to grow, if physicians are equally represented by the populations they serve, then close to thirty percent of all practicing physicians should be Latinx by 2060. This means that an additional six thousand Latinx doctors per year until that time would need to matriculate (Dall & West, 2016).

According to researchers in the field, there are many reasons why it is important to diversify the physician workforce (Cohen, et al., 2002; Whitt-Glover, 2019). Diversification is at the center of addressing issues of access and quality of care to medically underserved populations (Cohen et al., 2002; Martinez, et al., 2015; Talavera-Garza, et al., 2013). Access and quality of care can be defined as whether individuals and/or certain groups "can access the health structures and processes of care which they need and whether the care received is effective" (Campbell, et al., 2000, p. 1614). Research on healthcare access indicates that doctors from minoritized groups are more likely to practice in underserved communities and to treat larger numbers of minoritized patients than their white counterparts (Caceres & Perez, 2018; Cohen et al., 2002; Rao & Flores, 2007).

Developing a diverse and culturally competent physician workforce is believed to be a critical factor in decreasing inequalities related to access and quality of healthcare services (Whitt-Glover, 2019). For example, research demonstrates that staffing with physicians from diverse backgrounds improves access and quality of care for medically underserved populations, as well as populations from all racially and ethnically minoritized groups (Jones, et al., 2010; Poma, 2017; Whitt-Glover, 2019).

Limited English proficiency and low literacy can interfere with appropriate healthcare communications between Hispanic patients and the healthcare system (Martinez, et al., 2015; Shen et al., 2016). Inadequacies in the number of physicians, especially from underrepresented minoritized groups, have hindered efforts to provide extended healthcare access to underserved communities (Caldwell, 2015; Raymond-Flesch, et al., 2014; Smedley et al., 2003). This is problematic because, Latina/os, when

compared to other marginalized groups, outlive every other ethnic and racial group but have a higher incidence of longstanding health conditions such as diabetes. Therefore, this growing population of individuals face longer but sicker lives (Centers for Disease, 2012; Stern, 2015).

A disproportionate burden has been placed on minoritized healthcare providers to attend to the needs of underrepresented populations. This diminishes the collective responsibility of all providers to reduce inequities in health and healthcare (Cyrus, 2017). A proposed solution to address health disparities is training culturally competent healthcare providers (Capers, et al., 2018; Rodríguez et al., 2014). Cohen and associates defined cultural competency as the knowledge, skills, attitudes, and behavior required of a practitioner to provide quality healthcare services to persons from a diverse spectrum of cultural and ethnic backgrounds. As populations increase in their diversity, it is critical that healthcare practitioners are prepared to care for patients with varied belief systems, customs, language barriers, social structures, and other cultural differences (Cohen et al., 2002).

Empirical data also support the idea that diversity in medical classrooms creates a learning environment that provides students with exposure to varied ideas, experiences, and perspectives, which better prepares them inclusive navigation and interaction in a multicultural world (Saha et al.,2008). Saha and associates (2008) conducted a study to determine whether student body racial and ethnic diversity is associated with diversity-related outcomes among U.S. medical students. It concluded that having a diversified study body, both ethnically and racially, within US medical schools is associated with

outcomes aligned with the goal of preparing students to meet the needs of a diverse population (Saha et al., 2008).

The Accreditation Council on Graduate Medical Education (ACGME) also reinforces the importance of diversification efforts by actively engaging in dialog and initiatives to improve access and admission for underrepresented groups in medical education (Program Directors Guide, 2020). Therefore, creating a diverse environment within academic medicine aids in equipping a newly emerging generation of physicians with the skills to hear and serve members of marginalized groups (Hood & Boggs, 2014; Powell Sears, 2012; Rao & Flores, 2007).

Increasing the diversity of the physician workforce begins with the medical school admissions process. Medical schools work to educate and train the physicians of the future. All physicians must first apply to and be accepted by an accredited medical school to practice in the US. Therefore, the medical school entering class, and the subsequent physician workforce, cannot be more diverse than the pool of applicants (Garcia-Gonzalez, 2013; Hood & Boggs, 2014; Rodriguez, et al., 2014). Data from the American Association of Colleges of Osteopathic Medicine (AACOM) and the American Association of Medical Colleges (AAMC) show that minoritized students have lower matriculation and graduation rates in medical school compared to Asian and Caucasian applicants (AACOM, n.d; AAMC, 2016).

**Problem Statement**

While there are many studies which elucidate experiences of minoritized students pursuing a career in medicine, the research has been primarily deficit focused (Barr et al.,

2008; Hadinger, 2017; Levinson, et al., 2013; Miller-Matero et al., 2018; Rao & Flores, 2007; Thomas et al., 2011) and has typically combined these historically marginalized students into one large group). Research on educational inequities for Latinx students within academic medicine, tends to focus on students' traits, rather than oppressive structures, as the cause of failure (Franklin, 2013; Crisp, et al., 2015).

The research itself is problematic for several reasons. First, it places the burden on the students who are left behind for their predicament, rather than on the practices and policies which perpetuate inequitable systems. Second, it tends to assume all marginalized students have the same racial, gendered and cultural experiences regarding their education (Babaria, et. al., 2012; Chapman, et al., 2019; Miller-Matero, et al., 2018; Xu, et al., 1998). Turcios-Cotto and Milan (2013) provided an alternative view and found variations within the educational expectations and experiences of Latino students. The purpose of this research is to broaden the view provided by Turcios-Cotto and Milan and assist in the creation of a contextualized understanding of medical education experiences of women as Latinx osteopathic medical students. (Ovink&Kalogrides, 2015; Tucios-Cotto& Milan, 2013).

Eckstrand and associates (2016) found that there has been an over reliance on simplistic structural diversity related to underrepresented populations within academic medicine. The creation of a more inclusive environment for medical students, an appreciation of multidimensional aspects of identity and an understanding of how multiple identity experiences impact different individuals, from students to patients, is critical for improving health care education and delivery (2016).

While the Latinx population is quickly increasing, the number of physicians from these groups remains disproportionately small (Current Trends in Medical Education, n.d.; US Census Bureau, 2016). Research indicates that approximately four percent of medical students identify as Latinx (Current Trends in Medical Education, n.d). Further, there are few studies specifically focused on women as Latinx osteopathic medical students, consequently, there is a deficit in the understanding of their experiences. The research to be conducted explores the experiences of women as Latinx osteopathic medical students and contributes to the knowledge of the perceived supports and obstacles to their successful navigation of medical school. This information is imperative to ensure that the development of strategies to inform medical school curriculum consider the historical, structural and cultural factors of this population of students (Eckstrand, 2016; Rosenthal, et al., 2012).

**Purpose Statement**

The purpose of this phenomenological study was to explore the experiences of women who identify as Latinx and are completing their medical studies in Osteopathic Medicine in the Northeastern United States. The participants for this study are women, who identify as Latinx and are currently pursuing their medical studies within a medical school in the Northeastern United States. The information collected included participants' family background and history, educational history, peer relationships, interpersonal characteristics, cultural issues and experiences within medical school. This study is necessary because it provided new, qualitative information regarding the experiences of women as Latinx osteopathic medical students.

The study was informed by both Intersectional Feminist Theory and Latino Critical Race Theory. The use of Intersectional Feminist Theory (Carbin & Edenheim, 2013; Seabrook, 2019) helps to explore both a gender and racial contexts of experience, while Latino Critical Race Theory (Bernal, 2002) adds specific nuances of experience based on sociocultural practices. The combination of these two theories was used to help orient the phenomenological information and provide a fresh vantage point which may lead to improvement in the qualitative experience of women as Latinx osteopathic medical students, and possibly minoritized medical students in other categories as they matriculate through their medical studies.

The first objective was to provide a platform for women as Latinx osteopathic medical students to narrate their story, in their way, from their perspective. The next objective was to provide a lens to view the experience of female Latinx medical students. The third objective was to provide information that may be useful in understanding the experience of female Latinx osteopathic medical students as they move through medical school. Within a given minoritized group there is significant individuation- diversity within diversity (Covarrubias, 2011). As such, this study is not attempting to qualitatively examine an entire group, rather it will focus on providing an opportunity for women as Latinx osteopathic medical students to tell their stories through a series of interviews and explore the experience of being in osteopathic medical school. Thus, contributing to equity-focused, anti- deficit research in order to enrich the dialogue within education research devoted to disrupting the deficit narratives.

## Orienting Theories

Within phenomenology, the goal is to describe the meaning of an experience - both in terms of what was experienced and how it was experienced, versus imposing existing theoretical knowledge (van Manen, 2015). As such, I used both Intersectional Feminist Theory and Latino Critical Race Theory to provide and orientation of context, rather than for analysis. Both theories specifically address acknowledging the realities and complexities of intersectionality. An intersectional framework views identity as a whole, recognizing that one is neither minoritized or a woman, nor is one minoritized plus woman, but rather a minoritized woman. Therefore, "race is gendered, and gender is raced" (Walton, 2017 p.464) and life experiences are both racialized and gendered.

### *Intersectional Feminist Theory*

First discussed by Kimberle Crenshaw (1991), Intersectional Feminist Theory arose from her belief that studying gender and race as separate issues was incorrect, as neither could be isolated from the other. For example, women of color face double discrimination (Thelandersson, 2014). In Crenshaw's (1991) call for intersectional feminism, she argued that rather than getting mired in diverging interests, the goal should be to value and encourage individual differences, while working as one larger group. As Crenshaw states, "through an awareness of intersectionality, we can better acknowledge and ground the differences among us and negotiate the means by which these differences will find expression in constructing group politics" (1991, p.1299)

Intersectional Feminist Theory was selected because it provides an additional level of understanding regarding the boundaries of gendered experiences. Intersectional Feminist Theory also examines the enormous diversity of experiences, stories, and narratives of all

women (Babaria, et al., 2012; Sharma, 2019; Riska, 2011). One of the concerns discussed by Bernal (1998) was that traditionally feminist theory has omitted the perspectives and experiences of women of color. The use of Intersectional Feminist Theory affords a level of perspective to a vulnerable segment of the population, and by extension, allows for overlooked and marginalized groups to benefit from the information (Carbin&Edenheim, 2013).The utilization of Intersectional Feminist Theory can serve to counteract and resist the hegemonic worldviews that can distort or omit the experiences and knowledge of Latinx women. Ladson-Billings (2000) argues that the production of knowledge, created in schools and society serves to create and reinforce dominant worldviews. Of great importance is the need to be aware of the power, ethics and politics encountered by Latinx women, which if ignored, can surreptitiously create epistemological racism (Singer & Singer, 2005).

### *Latino Critical Race Theory*

Latino Critical Race Theory (LatCrit) has been defined as "the emerging field of legal scholarship that examines critically the social and legal positioning of Latinas/Latinos, especially Latinas/Latinos within the United States, to help rectify the shortcomings of existing social and legal conditions" (Valdes, 1997, p. 3). Epistemologically, LatCrit views the experiential knowledge of people of color as instrumental in knowing and naming racism and other forms of oppression (Solorzano& Bernal, 2001). As such, there is a need to recognize that cultural and lifeworld experiences which inform epistemological thoughts are local- not universal (Kubota, 2019). This paradigm is supported by Ladson-Billings (2003) who argues that epistemology is not only the nature, status, and production of knowledge, but it is also

interconnected and linked to worldviews based on the conditions under which people live and learn.

Moreover, LatCrit offers an important analytical intervention— as it places race and other socially constructed categories at the center of investigation (Bernal, 2002). In this way, race is not considered peripheral or incidental; rather, race, racialization, and racism are central and contribute significantly to the context of the narratives (Huber, 2010). Therefore, Latino Critical Race Theory (LatCrit) provides a necessary orienting lens for this research, as it seeks to explore experiences and structures of oppression specifically focused on Latinx concerns (Solorzano & Bernal, 2001).

**Research Question**

While there are numerous studies which highlight the challenges, barriers, and successes of minoritized students pursuing careers in medicine (Agrawal et al., 2005; Barr et al., 2008; Odom et al., 2007; Rao and Flores, 2007; Thomas et al., 2011) there is less information specifically regarding women as Latinx osteopathic medical students, especially in the northeastern region of the United States. The research will focus on the first year of medical school, as this is a period in which there is a sizable adjustment for many students due to the fast pace of the curriculum and demanding course load (Keith &Hollar, 2012). Therefore, the principle question guiding this study is: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

## Definition of Terms

In order to provide context and facilitate the understanding of the study's content, relevant and key terms are listed below.

**Access**: For the purposes of this study, the term access is used to refer to the removal of barriers to entry to both higher education and healthcare (Sanders &Higham, 2012).

**MCAT:** The Medical College Admission Test (MCAT) is a standardized examination that "assesses fundamental knowledge of scientific concepts, critical reasoning ability, and written communication skills" (Davis et al., 2013 p.593). MCAT scores are used by medical school admission officers, along with other measures to select the applicants they consider the most likely to succeed in medical school.

**Comlex Exam**: The Comprehensive Osteopathic Medical Licensing Examination of the United States, is a multi- level sequential grouping of nationally standardized examinations for licensure to practice osteopathic medicine. Each of the exams are created to assess competency in several areas such as specific osteopathic medical knowledge and clinical skills. Each level must be passed before a candidate can advance to the next exam. Students can begin taking these exams after completion of their second year of medical school providing they are in good academic and professional standing (https://www.nbome.org/exams-assessments/comlex-usa/).

**Diversity**: This term is defined as differences in people from a dissimilar background relative to racial, ethnic, geographic, socioeconomic, and professional backgrounds (Hadinger, 2017).

**Graduate Medical Education** (GME): Refers to a medical school graduate requirement to continue their education through a graduate medical program (AACOM, n.d.).

**Health Care Disparities**: Health care disparities are defined as differences in the occurrence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among certain populous groups in the U.S. (National Institute of Health, 2009).

**Health Inequalities**: This term is synonymous with the term health care disparities. It is described as differences in health status or in the delivery of health determinants between different populations (National Institute of Health, 2009).

**Latinx (Borica/Chicana/Hispanic/Latina)**: The U.S. Census Bureau defines the ethnonym Hispanic or Latino to refer to "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race" and states that Hispanics or Latinos can be of any race, any ancestry, any ethnicity (Choldin, 1986; Thompson & Hoffman-Goetz, 2009). Because of the growing diversity within the United States, individuals with cultural roots in Mexico, Puerto Rico, Cuba, the Dominican Republic, Spain or a variety of other locales makes it difficult to adequately capture the unique and changing identities to one single category (Thompson & Hoffman-Goetz, 2009). For the purposes of this research, the term Latinx will be utilized as a means to be inclusive as possible to all gender and ethic identities. Once data has been collected, further discussions will be reflective of participant's self- identified identity.

**Osteopathic Medicine**: This term is defined as the practice of medicine subscribing to a holistic approach, which provides all the benefits of modern medicine inclusive of surgery, drugs, and the use of technology to diagnose and treat the patient. Developed by Andrew Taylor Still in 1885, this practice follows the osteopathic philosophy. The osteopathic philosophy has four central tenants 1) The human being is a dynamic unit of function 2) The body possesses self-regulatory mechanisms that are self-healing in nature 3) Structure and function are interrelated at all levels 4) Rational treatment is based on these principles (Penney, 2013; Paulus, 2013).

**Underrepresented in Medicine**: This term is defined as ethnic, gender and racial populations that are underrepresented in the medical profession relative to their statistics in the general populace (AAMC, 2013).

**Minoritized:** This term, unlike the term minority will be used purposefully to disrupt deficit thinking present in educational research. Using this term gets at the contextual nature of oppression, systems and processes entrenched in power that affect these populations, and reality that identities and experiences are not objective (Patton Davis &Museus, 2019).

## Overview of Research Design

I adopted a qualitative approach to this study, as qualitative research provides an insight into how people make sense of their experiences (Creswell, 2013). Medical school is an emotionally charged learning environment that is academically rigorous. Medical students are frequently surrounded by crisis, despair and death (Zappetti& Avery, 2019). Additionally, studying student experiences warrants a need to seek a deeper

understanding and description of human meaning by getting as close as possible to the experience of the phenomenon (Heinonen, 2015). As such, “phenomenological research is well suited for studying affective, emotional, and often intense human experiences" (Merriam, 2009, p. 26).

For the purposes of this research, it is necessary to find a particular type of person who has had the type of experience being investigated and is able to articulate this experience. In this case “the phenomenon dictates the method (not vice-versa) including even the type of participants” (Hycner, 1985 p.49). I chose purposeful sampling, considered by Patton (2002) as the most important kind of non-probability sampling to identify the primary participants. As an option to secure additional participants, snowball sampling may be employed.

Snowballing is a means of expanding the sample by asking one participant to recommend others for interviewing. This may be useful, as some students may be hesitant to participate due to their immigration status and being invited to participate by their peers may mitigate this trepidation (Creswell, 2013; Lahman, et al, 2011a; Maxwell, 2013; van Manen, 2015). To find these participants, an email will be sent to members of all the cohorts at the medical school to ask if they would be willing to participate in this study. More details about the specific design of the study are provided in Chapter three.

**Significance**

This examination is important to medical educational research and practice and policy for multiple reasons. This research can assist in creating a strength focused narrative about women as Latinx osteopathic medical students. Primarily research on

minoritized medical students have taken deficit approaches, manifesting in erroneous beliefs that students who in any way do not belong or conform to "traditional" or "privileged" backgrounds are less likely to succeed. This leads to lower expectations as well as an ignorance of their strengths (Portelli, 2010; Yosso, 2005). This mindset can be difficult to recognize as it is pervasive in the research (Sharma, 2019; Valencia, 1997). In addition to filling the void of strength based research on this topic, this study may also serve as a catalyst for future research by revealing additional information about culturally responsive curriculum development. In this way, rather than having educators attempt to channel learning in ways defined by a hegemonic society, students become the informants of the learning environment. This perspective is highlighted in Yosso's (2005) exploration of cultural wealth, discussing the tremendous talents, strengths and experiences that minoritized students bring with them to their college environment. This is of great importance as diversity in health requires an understanding of the mindset of patients within a larger context of culture, gender, sexual orientation, religious beliefs, and socioeconomic realities (Goode et al., 2018).

Diversity in medical education is pivotal to addressing the access to quality care by the medically underserved population (Martinez, et al., 2015; Talavera-Garza, et al., 2013). Examining access and quality of care establishes whether individuals and/or certain groups "can access the health structures and processes of care which they need and whether the care received is effective" (Campbell, et al., 2000, p. 1614). Research indicates that doctors from minority groups are more likely to practice in underserved communities (Caceres & Perez, 2018). Therefore, diversity in the physician workforce is

essential for high-quality medical education, patient care, and access to healthcare for the underserved (Rao & Flores, 2007).

Considering the existing information regarding racial, ethnic and gender minorities along the educational pipeline often does not focus on the multidimensional aspects of identity, it is critical that research examines the specific experiences and potential barriers women as Latinx medical students encounter as they pursue their medical education and career (Arias, 2017; Babaria, et al., 2012; Eckstrand, et al., 2016). Administrators and faculty in osteopathic medical schools have articulated a heightened understanding of the need for a culturally diverse and responsive medical workforce to combat the access and inequitable practices in American healthcare. They can become advocates within their own institutions by championing policies which support and prepare students to meet the rapidly changing health care needs of the community.

## Trustworthiness: Credibility, Transferability, Dependability, Confirmability and Delimitations

The purpose of trustworthiness in qualitative research is to support the argument that the inquiry's results are worthy of attention. There are no instruments with established metrics about validity and reliability within qualitative research. Lincoln and Guba (1985) suggested that the value of a research study is strengthened by its trustworthiness. As established by Lincoln and Guba (1985), trustworthiness involves establishing: Credibility (confidence in the 'truth' of the finding); Transferability (showing that the findings have applicability in other contexts); Dependability (showing that the findings are consistent and could be repeated) and Confirmability (a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and

not researcher bias, motivation, or interest). Once these conditions have been met, then the results are presumed to be trustworthy/rigorous (Amankwaa, 2016)

### *Credibility*

Credibility is the element that allows others to recognize the experiences contained within the study through the interpretation of participants' experiences. Creswell (2009) describes credibility as the determinant of whether the findings are accurate from the standpoint of the researcher and the standpoint of the participants. Techniques for establishing credibility as identified by Lincoln and Guba (1985) are: prolonged engagement, persistent observation, triangulation and member-checking.

**Prolonged Engagement.** Prolonged engagement refers to the length of time spent within the field learning and understanding the phenomenon of interest. This involves spending adequate time observing and speaking with a range of participants and developing a rapport (Lincoln &Guba, 1985).

**Persistent Observation.** Persistent observation is another strategy to establish credibility, in which characteristics and elements are identified that are most relevant to the problem or issue under study. If the purpose of prolonged engagement is to render the inquirer open to the multiple influences - the mutual shapers and contextual factors - that impinge upon the phenomenon being studied, the purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. If prolonged engagement provides scope, persistent observation provides depth (Lincoln &Guba, 1985, p. 304).

For example, I constantly read and reread the data, analyzed them, developed the codes, the concepts and the core categories to help me examine the characteristics of the phenomenon under investigation.

**Triangulation.** Triangulation aims to enhance the process of qualitative research by using multiple approaches (Rossman& Rallis, 2017). Two strategies of triangulation are methodological and data. Methodological triangulation is achieved by gathering data using different collection methods, such as in- depth interviews and field notes. While data triangulation is achieved by using different types of data sources such as artifacts and different participants (Thomas &Magilvy, 2011).

**Member Checking.** Member-checking involves returning to the participants to ensure that the descriptions accurately represent their experiences. Typically member checking is viewed as a technique for establishing the validity of an account. Lincoln and Guba posit that this is the most crucial technique for establishing credibility. However, Kleiman (2004) argues that revisiting participants' experiences with them for verification suggests:

> the descriptions of experiences that were given during the first visit are no longer pre-reflective. They are instead meta-reflective, that is, focused on what was said about the experiences, rather than describing the experiences as they came to presence. (p. 18)

Similarly, Webb (2003) suggests phenomenology is incompatible with the validation of interpretation by participants. While there is no consensus on approach, literature consistently has shown that researchers must select and follow an appropriate

methodological framework (Pringle et al., 2011; Kleiman, 2004; Webb, 2003). In light of the conflicting viewpoints, I determined I would provide a summary of the transcript to the participants during the second interview for feedback and comment in order to confirm the accuracy of the findings. This member-checking provides a mechanism to establish credibility and enhance rigor, while remaining true to the goals of this research study.

### *Transferability*

Transferability concerns the aspect of applicability. Lincoln and Guba (1985) define transferability as the ability to transfer research findings to fit into contexts outside the study situation. One of the methods to achieve transferability is to providing a rich account of descriptive data, such as the context in which the research was carried out, its setting, sample, sample size, sample strategy, demographic, socio-economic, and clinical characteristics, inclusion and exclusion criteria, interview procedure and topics, and excerpts from the interviews. The intent is to provide sufficient descriptive data to allow for comparison in order to address issues of transferability.

### *Dependability*

Dependability is important to trustworthiness because it establishes the research study's findings as consistent and repeatable (Beck et al., 1994). Dependability occurs when another researcher can follow the decision making used by the original researcher (Thomas &Magilvy, 2011). This structured path is called an audit trail. An audit trail is achieved by (a) describing the specific purpose of the study; (b) discussing how and why the participants were selected for the study; (c) describing how data was collected and

how long the data collection lasted; (d) explaining how the data was reduced or transformed for analysis; (e) discussing the interpretation and presentation of the research findings; and (f) communicating the specific techniques used to determine the credibility of the data (2011). A strategy used to establish dependability is to provide a detailed description of the research methods. For example, in Chapter 3, I have provided a detailed progression of the research study which includes: purpose of the study, the purposeful sampling process, the data collection and data analysis details, thus providing a detailed audit trail and enhancing the rigor of this research study.

### *Confirmability*

Confirmability occurs when credibility, transferability, and dependability have been established (Thomas &Magilvy, 2011). Confirmability is concerned with establishing that data and interpretations of the findings are clearly derived from the data.

Qualitative research must be reflective, maintaining a sense of openness to the study and its unfolding results. As such, reflexive practice becomes crucial (Johns, 2009). This practice requires a self-critical attitude on the part of the researcher about how one's own preconceptions affect the research. For example, the creation of memos and notes regarding my personal feelings, biases and insights will help my self-critical practice. Additionally, making a conscious effort to follow, rather than lead, the direction of the interviews by asking the participants for clarification of definitions, slang words, and metaphors aids in ascertaining their experience of the phenomenon.

### *Delimitations*

A delimitation for this study is that I am conducting research in medical school where I am currently employed. This creates validity issues related to conducting "backyard research". I will need to be acutely aware of issues related to my interpretive lens as a researcher-practitioner. The challenge with this implicit or insider knowledge is that I could assume to know more, or know the answer, and therefore not fully probe or reframe what the participants are seeing (Coghlan& Casey, 2001).

Furthermore, I am researching the experiences of individuals with different racial and ethnic backgrounds than my own. It is critical to consider that no experience will be the same for two people, and that intersecting identities play out in different ways depending on the context. To provide the effectiveness and rigor to this qualitative research, I must continually examine how my specific racial and ethnic identity might impact my experience as well as my understanding of the participants' experiences because I am both at once, the tool which implements both the data generation with participants, and the analyzer-interpreter of the data (Nicholls, 2019; Wiles, et al, 2013).

## Organization of the Dissertation

This dissertation will be divided into five chapters. Chapter one has been designed to situate the current study within the context of medical education (higher education). Chapter two provides an overview of the relevant literature used to inform the study. Chapter three contains a detailed discussion of the methodological framework employed for this study. Chapter Four will contain the results found during this study. Finally, Chapter Five will contain a discussion of these results and future considerations.

# Chapter 2

## Literature Review

A limited number of studies conducted over the last several decades have examined minoritized students' medical school experiences (Barr et al; 2008; Ona et al, 2020; Orom et al, 2013). Almost unanimously, they revealed that minoritized students have experienced barriers within their learning environments and have been more likely to perceive that their race negatively affected their medical school experiences, compared with non-minoritized students (Dickins et al, 2013; Hadinger; 2017). These findings have been beneficial in improving our understanding of ways in which students' medical school experiences are influenced by race or ethnicity. However, research on minoritized medical students have historically focused on African American students or combined underrepresented students into one undifferentiated group (Hood & Boggs, 2014; Miller-Matero et al., 2018; Morgan et al., 2013). Moreover, the research conducted has primarily been deficit focused, which views people as "problems" versus the system in which they are situated (Patton Davis &Museus, 2019; Portelli, 2010; Sharma, 2016).

Through the deficit thinking lens, minoritized students and their families are viewed as at fault for poor academic performance because: 1) students enter school deficient in normative cultural knowledge and skills; and 2) students' families neither value nor support education (Patton Davis &Museus, 2019).These racialized assumptions about minoritized students and their families often lead educational systems to default to the "banking method of education". This approach to education, critiqued by Paulo Freire (1973), the world is seen as static and unchangeable, and students are simply

supposed to fit into it as it is. “As a result, schooling efforts usually aim to fill up supposedly passive students with forms of cultural knowledge deemed valuable by dominant society”. (Yosso, 2005 p. 75)

Offering an anti- deficit framework, Harper’s (2014) research shifted the focus away from individual traits and centered on systemic influences related to the experiences of Black men and college attainment. This “refocusing” is at the core of the anti-deficit view, which advocated placing less emphasis on individual traits, and a greater focus on how to re-envision and transform the larger systems and structures that perpetuate inequities in educational outcomes (Patton &Museus, 2019). Because the existing research has had a limiting focus on the experiences specific to women as Latinx medical students, a gap has been created, which restricts knowledge about experiences of perceived support and barriers to their successful completion of medical school. The central research question is: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

This chapter includes a review of the literature centering the following topic areas: 1) Latinx and education 2) factors contributing to the under –representation of minoritized groups in the medical profession 3) Strengths- Community Cultural Wealth. This chapter will provide an orienting framework using both Intersectional Feminist theory and Latino Critical Race theory to address the research problem.

The purpose of this study is to explore the experiences of women as Latinx osteopathic medical students, specifically those in the northeastern United States, who are completing their first year of osteopathic medical school. The above areas of literature

and the contributions they have to offer to the orienting framework of the study assist in creating a context of the experiences of women as Latinx osteopathic medical students.

**Ethnonym Choice: Latinx**

This study will be incorporating the use of the ethnonym "Latinx" as a means to capture the wide range of participant ethnicities and gender preferences. "Latinx" has recently been suggested as a means to move away from gendered terms such as "Latino," "Latina," "Latino/a," (Juárez Pérez et al., 2018). The proposal of replacing the "o" and the "a" with an "x" was initiated by gender non-conforming, transgender, queer and agender individuals of Latin American origin who felt excluded because of their gender identities (Juárez Pérez et al., 2018; Milan,2017 ).

The use of the ethonym within this research "Latinx", serves two important benefits: first, in challenging traditional norms of inclusion and bringing new awareness and understanding to intersectionality (Salinas & Lozano, 2017). Recently, there has been movements toward inclusive language, with the University of Oklahoma approving a Latinx and Latin American Studies major, and several other universities creating Latinx centers, such as Northeastern University and Humboldt State among others (Juárez Pérez et al., 2018).

Secondly, Juárez Pérez and associates (2018) as well as Salinas and Lozano (2017) argue that the concept of Latinx extends beyond gender and sexuality to incorporate the inclusion of multiple facets of identity, such as language, indigeneity, race, ethnicity and other identities that have been historically underrepresented. Since Latinx is a still a relatively new term, there is a gap in usage of Latinx with much of the

existing research utilizing the traditional labels of Latino, Latina, or Latino/a (Salinas & Lozano, 2017), therefore the ethnonyms of Hispanic, Latino, Latina, and Latino/a were used when conducting the literature review, but will only be used when discussing works that utilize these terms in their analyses (Garcia, 2017; Salinas & Lozano, 2017; Ramirez & Blay, 2016). Within later chapters of this research, for clarity, the term Latinx will be used as an overarching description of the participants or for those who opt into its usage individually.

## Latinx Education: Histories

In order to have a full discussion about Latina/os in higher education, attention should be given to the historical legacy of these individuals within the educational system (Hood & Boggs, 2014). Specifically, beginning with practices that privilege certain student groups and alters structural representation (number of Latina/o students) within the educational pipeline (Hurtado et al., 2009). Looking at the full educational history of Latinx students provides a backdrop to the challenges faced within the educational pipeline and subsequently, medical school.

### *History of Latinx within American Educational System*

From the earliest days of their arrival in the Americas, Mexicans, Puerto Ricans, Cubans, and other members of the Latin American diaspora have valued higher education as a means of economic, political and social advancement (MacDonald, 2012). Historically, equitable opportunities and access to quality educational experiences have had formidable barriers such as segregated practices and limited financial, political and cultural support (MacDonald, 2012). For example, during the late 1800's through World

War I, segregated practices limited access to funding and teaching resources, contributing to inequitable educational experiences for Mexican American students who were not provided with the same level of education as their white peers (MacDonald, 2012). Many Mexican Americans failed to progress further than the eighth grade, thereby reducing the number of students who could attend secondary schools (Contreras &Valverde, 1994; MacDonald, 2012).

While the G.I Bill Act of 1944 provided an increase in higher educational opportunities for Hispanic males, there were still continued restrictions on campus such as inclusion in social clubs, and female Hispanic students remained underrepresented (MacDonald, 2012). In 1954, one week prior to *Brown v. Board of Education*, *Hernandez v. Texas* affirmed the fourteenth amendment which in effect broadened civil rights laws to include Hispanics and all other non-whites (MacDonald, 2012). Despite this "ruling", two technical loopholes remained in that the court offered no prescriptive plans on how to effectively implement desegregation school and Hispanics were classified as "white" for desegregation purposes. The "loophole" remained as the Department of Health, Education and Welfare (HEW), who set up rudimentary guidelines and whose office of civil rights monitored reports of discrimination, were only ever availed of statistics and data in categories of "white" and "black". Since members of the Hispanic population were legally defined as "white" it was easier for school districts to claim desegregation by enrolling more Hispanic students at formerly all black schools, all while continuing to assign white children to all white schools. By acting in this way, under the loose guise of "desegregation" the minority groups continued to be excluded

from accessing better facilities, staff and resources. (Contreras &Valverde, 1994; Hernandez, n.d.).

In 1968, in an effort to remediate English language barriers for minority students, specifically Latina/o, President Lyndon B. Johnson signed into law Title VII of the Elementary and Secondary Education Act: the Bilingual Education Act, Pub. L. No. (90-247), 81 Stat. 816 (1968) (Wiese & Garcia, 1998). The act primarily focused on students from disadvantaged socio-economic and educational backgrounds due to the inability to speak English, by providing funding for educational programs (Wiese & Garcia, 1998). The overall intent of the law was to give Latina/o students an equal chance to succeed (Contreras &Valverde, 1994).

However, it wasn't until the 1970 case *Cisneros v. Corpus Christi* that the principles articulated in the 1954 ruling *Brown v. The Board of Education* would apply to Hispanic students. The Cisneros ruling was important because it declared, for the first time, that Mexican Americans were an identifiable ethnic minority group for the purposes of public school desegregation (Contreras &Valverde, 1994). Further, it was the first circuit court case to hold that the principles enunciated in Brown apply to Latinos as well as African Americans, which in effect, helped to close the legal loophole which had continued to perpetuate inequitable treatment (MacDonald, 2012). Latinos took advantage of the improved access to higher education in the 1970's, and there was an increase of Latina/os students enrolling in community colleges, state universities, and Ivy League campuses (MacDonald, 2012).

### *History of Latinx in Medical Education*

The history of Latina/os in medicine and medical education in the United States has been difficult to examine since there is little data on the participation of these individuals in the formal medical establishment (Evans & Evans, 2004; Fernández-Cano et al., 2016). While there is an abundance of literature on the history of women physicians in the United States and England, the research primarily focuses on the experiences of white women in medicine (Bishop, 1977; Blackwell, 1977; Gkegkes et al., 2017). Because of this, there is a paucity in literature on non-white women physicians during the same period (Borst, 2002; Morgan et al., 2013). Historical entries related to Hispanic women start in the early 20th century, with Mary Headley Trevino de Edgerton becoming among the first Tejanos to attend medical school in Texas when she enrolled at the University of Texas - Medical Branch in Galveston. In 1909, she graduated at the top of her class and earned the highest grade on the state medical exam, however, she was only permitted to practice in one county (Fernández-Cano et al., 2016).

Historically, Hispanic women involved in science and medicine in the United States, practiced medicine in their communities using knowledge they acquired in their native countries. (García-González, 2013). For example, Felicitas Provencio, an expert midwife with more than 60 years of successful experience, was imprisoned in 1935 for practicing without a license (Mckiernan-González, n.d). Her presence in the annals of American historical record is of importance, as her status is shown to be criminal, rather than medical.

### *Latinx Educational Attainment: Undergraduate and Medical Education*

**Undergraduate**. For Hispanic students, the educational experience leading to their undergraduate enrollment is "one of accumulated disadvantage" (Schhneider, et al., 2006 p179) as many Hispanic students begin formalized schooling without the economic and social resources that many other students receive, and schools are often ill equipped to compensate for these initial disparities (Gramlich, 2017). In addition, Hispanics have lower degree attainment compared to all adults and lower graduation rates compared to Whites in almost all states/locations. In looking at the data from New Jersey, Pennsylvania and New York, only 23% of Hispanic students in those states have obtained an associate's degree or higher compared to 42% of all other students (Latino College Completion; n.d). Thus, educational attainment, the highest level of education completion, remains a salient issue for Latinas/os in the United States (Schneider et al., 2006).

Including the U.S. and citizens of Puerto Rico, there are almost 50 million Latinos and Latinas, accounting for about 18% of the total population. This number is projected to grow to 102.6 million by 2050 (Moreman, 2019; U.S. Census Bureau, n.d). This means the United States has the third largest Hispanic-origin population in the world (after Mexico and Colombia). While college enrollments rates at two and four year institutions have been increasing, Hispanic students are less likely than all other ethnic groups to enroll in a four year college (Gramlich,2017). Following, Talamantes and associates (2016) found that many Latino premedical students often begin their studies at the community college level. However, these students frequently were ill prepared to navigate the pathway to medical school citing limited resources like: direct connections

to four year universities and medical schools as well as limited funding for enrichment programs.

Furthering disparities in attainment, research has demonstrated that Latina/o students continue to be "pushed out" of the educational pipeline at the highest level of all the major racialized groups in the United States. "Push out" refers to practices that contribute to students dropping out of school (Covarrubias, 2011). Regardless of class, data shows a 13% push out rate for Whites, 16% for African Americans, 38% for Latinas/os, and 44% for Chicanas/os (2011). These numbers have a ripple effect and demonstrate that while Latinas/os battle to gain access to participate in higher education, they must also battle to remain in school and successfully complete their education (Huerta, 2012). Thus, the struggle to matriculate and graduate from college has a significant impact on the diversity of potential medical students who can enter into the field.

**Medical Education**. A great preponderance of research is dedicated to Pipeline programs, which have been largely contributory to the recruitment and matriculation of minoritized students into medicine (Covarrubias, 2011; Dickins, et al., 2013; Gadson, et al., 2018). Pipeline programs are intended to target, enroll and support the matriculation and graduation of certain students. Most often these programs are specifically designed to address underrepresented students including minorities, women and socioeconomically disadvantaged individuals with the goal of increasing their representation in certain fields (Barr et al., 2008; Katz et al., 2016). For instance, in health sciences and academic medicine the goal of pipeline programs is to increase graduation and career attainment in research and medical degrees of underrepresented students (Freeman et al., 2016).

Pipeline programs often employ strategies which address improving awareness and knowledge of academic medicine. Additionally, these types of programs support students as they navigate the rigors of medical school both educationally as well as professionally through the use of mentorship (Katz et al., 2016). However, the success of these programs is being challenged by the ability of medical schools to retain and provide a system of support for students to successfully proceed after matriculation (Odom et al., 2007). To date there is a limited number of studies exploring these factors specifically for women as Latinx students, giving little voice to these student experiences.

Currently, the numbers of Hispanics applying to, matriculating, and graduating from osteopathic medical school remains extremely small (American Association of Colleges of Osteopathic Medicine, n.d.). Osteopathic (DO) and Allopathic (MD) both focus on the instruction of a solid scientific foundation to become a licensed physician, but they take different approaches. Allopathic medicine focuses on diagnosing and treating medical conditions, while osteopathic medicine has a more holistic approach and focuses heavily on prevention (Orenstein; 2017; Paulus, 2013).

As of 2018-2019, U.S. osteopathic medical schools had 9.6% of applicants identifying as Hispanic however, only 6.6 % of Hispanic students matriculated. Further examination of the data reveals distinct differences in gender and medical school application, matriculation and graduation. According to the American Association of Colleges of Osteopathic Medicine (AACOM), women comprised slightly more of both applicants and matriculants when compared to men but their graduation rates fell below that of men by approximately 12%. In 2017, AACOM reported that out of 6,416 graduating osteopathic doctors, 64.9% identified as White, with 25.8% of those students

identifying as female. Within the same cohort, 4.9% were Hispanic and only 2.1% identified as female Hispanic. Further, when matriculation and graduation rates are compared between White and Hispanic female students, White students show approximately a 2% difference with the number of students dropping from matriculation to graduation while Hispanic students show an 8% difference, indicating that underrepresented minority medical students, specifically female Hispanic, appear more vulnerable than their non-minority counterparts in relation to likelihood of delayed graduation, repeated terms or withdrawal (AACOM, n.d.; Dyrbye et al., 2007; Lewin & Rice, 1994; Orom et al., 2013).

### *Medical Education: Experience*

Research into the experiences of medical students has roots dating back several decades (Rosenthal et al, 2012). However, this research has not adequately accounted for the experiences specific to women as Latinx osteopathic medical students (Dyrbye et al., 2007; Orom et al., 2013). In light of this, the themes presented within the existing research on the medical student experience are gathered from a broad medical student perspective.

Enrolling into medical school represents the start of a demanding and stressful period for students (Gadson et al., 2018). Research has consistently demonstrated that during the first year medical students often experience increased psychological burden and decreased health promotion activities which contribute to burnout and attrition (Miller-Matero et al., 2018; Voltmer et al, 2010). Studies reveal medical students have substantially lower psychological quality of life compared with similarly aged individuals

in the general population (Bugaj et al., 2016; Glauser, 2017; Voltmer, et al., 2010), with females almost 1.5 times more likely than males to experience distress (Bullock, et al., 2017). Additionally, the first year appears to be a critical period, as over 60% of medical school attrition happens within this time frame (Maher et al, 2013). Further, in a 2018 study by Vergel and associates, it was found that 74% of medical students left the program during the first two years of studies, and that by the end of the third year the percentage of drop out declines dramatically (2018).

Osteopathic medical students are also required to pass a series of examinations called the Comprehensive Osteopathic Medical Licensing Examination-USA (COMLEX). The preparation for board examinations typically have an additional level of anxiety in that students have the knowledge that a poor score could negatively impact their future career. Therefore, students often find themselves isolated as they study for exceptionally long periods of time while they prepare to take their examination (Reddy & Sindhu, 2019).

Coupled with emotional challenges and rigors of medical school, research has shown that minoritized students were more likely than their non-URM counterparts to experience considerable social and educational challenges (Isik et al., 2017). For example, studies have shown that URM medical students report emotional distress related experiences of racism perpetuated by both peers and faculty members (Drybye et al, 2007). Recently, Rojek and associates (2019) found racial bias in how medical school faculty members described Black students in evaluations compared to non-Black students. Additionally, when looking at the experiences of women in medical school, research has shown a high prevalence of sexual harassment and intimation

(Kristoffersson et al., 2016). In further elucidating the experiences of marginalized groups in academic medicine, Hill and associates (2020) investigated a large, nationally representative sample, focusing on connections between group membership and experiences of mistreatment. Key findings from this research indicate that minoritized female students reported the highest levels of discrimination and bore a disproportionate amount of the burden of mistreatment reported in medical school (2020). Thus, it becomes apparent that the process of becoming a physician includes many subtle practices related to racial and gender inclusion and exclusion, which have important implications for medical students' study and working conditions (Soliman et al, 2019).

## Factors Contributing to Underrepresentation of Latinx in Medical Education

According to the literature, there are many factors that contribute to the underrepresentation of Latinx in medical education. Access; limited support both familial and financial; limited exposure to medicine and policy and politics have been cited by scholars as contributing factors (Garces& Mickey-Pabello, 2015; Odom et al., 2007; Rao & Flores, 2007; Rodriguez, et al., 2017; ). To challenge the existing deficit narrative which exists within the existing literature, counter narratives from Yosso's (2005) strength based, community cultural wealth model, will also be presented.

### *Access Challenges*

A graduate medical education is a large academic challenge for all students. However, URM students face barriers during, specifically in the over reliance on standardized testing as a metric for admission (Odom et al., 2013). While the Medical College Admission Test (MCAT) a standardized test taken by all prospective medical

students, has been shown to be a strong predictor of performance in medical school, there have been observed differences in the average scores of test takers from different racial backgrounds (Davis, et al., 2013).

Research has shown that the mean MCAT scores are lower for Black and Latino students than for white students (Davis et al., 2013). Even when all other parts of the application are strong, a low score on the exam makes it harder to secure entry into a United States medical school (Sternberg, 2008). Though the MCAT is only one component of admissions, studies have shown that URM students were more likely than non-URM students to experience graduation delays or attrition for academic reasons (Orom, 2013; Soto-Green, et al., 2005). This reliance on metrics from standardized admissions tests as well as higher attrition rates has contributed to the underrepresentation of medical students and, subsequently, physicians from underrepresented backgrounds (Kreiter et al., 2009; Sternberg, 2008; White, et al., 2009).

### *Limited Support: Familial and Financial*

Familial support is an important contributor to a student's ability to cope with the challenges of medical academics, with students considering family as their main source of support in overcoming academic barriers (Klink et al., 2008). Conversely, lack of familial support creates conflicts for students. Latino students are more likely to be first generation, and have a limited family tradition for higher education (Talamantes, et al., 2016). Conflict may arise from families wanting them to succeed but also not understanding the educational and training process (Barr et al., 2008; Freeman, et al.,

2016). Furthering familiar barriers, financial barriers constitute an additional challenge for URM students pursuing a career in medicine.

In a study exploring barriers experienced by minority medical students, these students felt the need to provide financial support to their families while they were completing their studies (Odom et al., 2007). Participants in the Odom et al. study also felt the lack of monetary support from their family and reliance on student loans provided a more difficult situation for them than non-URM colleagues (Odom et al., 2007).

### *Exposure to Medicine: Health Care Careers and Educational Mentors*

The lack of exposure to medicine both occupational and educational contributes to the dearth of URM trainees (University of Pennsylvania, 2019). The pathway through academic medicine can be further complicated as there is a smaller percentage of URM who have undergone medical training (Butler et al., 2010; Jeffe et al., 2019; Morgan et al., 2013). Therefore, there is a lack of practicing minoritized role models from which direct care exposure can happen. Additionally, the lack of individuals in practice contributes to a limited number of individuals who could offer mentor support (Rodriguez et al., 2014; Talamantes et al, 2016).

**Health Care Careers**. Lack of exposure to healthcare careers and medicine hinder the exploration and matriculation into medical school for minoritized students (Rao & Flores, 2008). For example, an identified barrier for minoritized students is lack of mentors who are racially or ethnically concordant (Toretsky et al., 2018). For Hispanic students, many are the first in their families to go to college, and may only come into contact with healthcare providers when they or other members of their family require

treatment. The majority of the professionals practicing medicine today are of other racial or ethnic backgrounds thus reducing the chances of exposure to minoritized individuals in the field of medicine (Odom, et al., 2007).

**Educational Mentors**.The advantage of having a sound educational and occupational network should not be underestimated (Toretsky et al., 2018). Based on existing literature, exposure to medicine and mentors within the medical education field is a powerful tool to ensure the matriculation and completion of medical school for URM students (Alfred, et al., 2011; Guerrero, et al., 2015; Smith, et al., 2009). For example, in a study to investigate the efficacy of support and mentoring programs found that participants of these programs were more likely to matriculate into medical school (Cantor et al., 1998).

### *Policy and Politics*

One barrier to acquiring a more diverse minority presence in medical school, especially for Latina/o students, is the increasingly more stringent political climate on immigration (Arias, 2017; Johnson &Janosik, 2008; King &Punti, 2012; Poll-Hunter, et al., 2017). Immigration laws and policies have also contributed to the decline in URM students, specifically Hispanics, entering the medical education pipeline. About 73% of the nation's unauthorized immigrant populations are Hispanics (Gonzalez-Barrera, et al., 2020).

On June 15, 2012, the Obama administration established the Deferred Action for Childhood Arrivals (DACA) policy. The DACA policy provides that eligible undocumented young people who were brought to the United States as children can request a two-year stay to remain in the country with the proviso that they obtain work or

educational authorization and participate in the Social Security Program. However, on September 5, 2017, the Trump administration moved to end DACA, eliminating new applications and stating that DACA-eligible individuals whose permit expires after their two-year stay will lose all protections from deportation and their authorization for employment (Ramos, et al., 2019).

Currently, there has been a temporary stay placed on terminating DACA, though this leaves the long-term future of the DACA program and the people it protects unclear. Unstable citizenship could potentially reduce the number of qualified Hispanic students in the "pipeline", thereby reducing the number of culturally competent healthcare providers as well as representation of minority faculty in academic medicine (Rodriguez,et al., 2014; Talamantes, et al., 2016).

**Reframing the Deficit Narrative**

The framework employed by educational researchers of minoritized students as inherently lacking, has resulted in a lengthy history of educational literature which ignores the strengths that these students gain from their racial and cultural heritage (Nicholson & Cleland, 2017).This deficit thinking puts the onus for poor achievement among minoritized students on their families due to their inability to send their children to school with the "normative cultural knowledge and skills" they will need to succeed (Yosso, 2005, p. 75. I purposefully chose to capitalize on Yosso's Community Cultural wealth in the following pages to provide a counter deficit discourse which highlights the contributions and strengths of these groups and communities and fills in the gap which has been created.

## Community Cultural Wealth

Community cultural wealth, as defined by Yosso (2005), challenges the interpretation of traditional Bourdieuean cultural capital theory, which posits that some communities have cultural wealth, while others are deficient. In cultural capital theory, white middle class culture is exposed as the standard of accumulated knowledge, skills and abilities by which all others are judged (2005). Yosso (2005) expands on this myopic view of "capital" moves to include six categories of wealth: aspirational capital, linguistic capital, familial capital, social capital, navigational capital, and resistant capital. These six powerful and valuable portions of students' cultural heritage are, "an array of knowledge, skills, abilities and contacts possessed and utilized by Communities of Color to survive and resist racism and other forms of oppression" (Yosso, 2005, p. 72).

Aspirational capital refers to the ability Communities of Color have to maintain their hopes and dreams for a better future even when faced with real and perceived barriers (p.77). Derived from the work of Patricia Gandara (1993) this form of cultural wealth draws on the idea that while Chicanas/os experience the lowest educational outcomes compared to every other group in the US, the level of aspiration that parents have for their children's educational future is consistently high. This narrative harnesses the power of possibility as a tool to disrupt the connection between parents' current occupational status and their children's future academic attainment (Gándara, 1993). Additionally, strength comes from a sense of "communal goals" of which there is increasing evidence that having a higher level of a prosocial and communal goal orientation was predictive of retention within biomedical sciences (Allen et al., 2015).

Linguistic capital includes all of the intellectual and social skills which have been attained through communication experiences in any and all languages or styles (Yosso, 2005, p. 78). For example, linguistic capital can be developed through various experiences, such as acting as an interpreter for members of their family or through cultural being present in storytelling which enhances "memorization, attention to detail, dramatic pauses, comedic timing, facial affect, vocal tone, volume, rhythm and rhyme." (p. 79). Linguistic capital becomes exceptionally important when looking at the importance of cultural resources and skills within clinical interactions (Shim, 2010). These cultural resources, skills, dispositions and interactional styles impact patients and providers alike in their ability to obtain and deliver patient-centered care (Dubbin et al., 2013).

Familial capital refers to the social and personal human resources students have, drawn from their extended familial and community networks. This capital reflects a commitment to community level well-being and an understanding of caring and collaborative practices (Luster et al., 2009; Naidoo et al., 2017). The value of familial capital can parlay into significant strengths for medical students who are increasingly moving toward working on multidisciplinary teams to provide quality patient care (Mayo & Woolley, 2016)

In line with the idea of collaborative practices, social capital, which Yosso (2005) described as "networks of people and community resources" (p. 79). These networks often include peers and mentors (2005). "These peer and other social contacts can provide both instrumental and emotional support to navigate through society's institutions" (Yosso, 2005 p. 79). These connections also foster a sense of belonging,

coupled with professional interactions with colleagues, mentors and peers which have been shown to shape graduate students' experiences and career advancement O'Meara et al., 2017).

Navigational capital is students' skills and abilities in successfully traversing "social institutions," including educational spaces. Yosso (2005) further explains that students' navigational capital empowers them to maneuver within unsupportive or hostile environments. This capital is an important strength, as studies have acknowledged that institutions, both their structure and culture, have a history of, and may still in many ways be unsupportive and/or hostile to marginalized students (Allen et al., 2015; Estrada et al., 2016; Garcia, 2019).

Resistant capital is built upon foundations of securing equal rights and collective freedoms for communities of color (De Graca& Dougherty, 2015). According to Yosso (2005), the sources of this form of capital come from parents, community members and an historical legacy of engaging in social justice. This historical legacy of resistance leaves minoritized students particularly well-positioned to leverage their medical education to enter society prepared to solve challenging problems regarding equitable health and other social outcomes (Awosogba et al., 2013).

**Importance of Diversity: Medical Education**

Diversity in medical education is critical to the advancement of the healthcare system as it addresses the issues of inequitable health care access and cultural competency (Bollinger, 2003; Cohen et al., 2002; Starfield et al., 2005). One factor that addresses inequity in healthcare access is that underrepresented minority health

professionals have a greater tendency than their nonminority counterparts to care for underserved populations (Morrison et al., 2018 Soto-Green, et al., 2005). The literature suggests that when physicians and patients share race/ethnicity and/or language, they may then have shared life experiences that will, in turn, have the potential to enhance vulnerable population access, increase satisfaction and ultimately improve related health outcomes (Morrison et al., 2018).

However, there is a danger to relying on utilitarian arguments for diversity. On one hand, it may be seen as a dually beneficial arrangement: opening the door to expanding the representation of minoritized groups in medicine while simultaneously being responsive to improving healthcare access. The caveat is that it ignores the potential for professional limitations on the future of minoritized groups in medicine (Cyrus, 2017). For example, it is important to recognize that there is a disproportionate emphasis on service expectations for minoritized students over their white counterparts (Barret, et al., 2017). Suggesting that minoritized health professionals have a unique obligation to care for such populations or to otherwise narrow the scope of their practice to a public service specialty. Such interpretations not only are unfair to minoritized health professionals, but they also risk unfairly absolving all health professionals of the collective responsibility for eliminating inequities in health and health care (Cyrus, 2017; Kelly-Blake et al., 2018; Rodriguez et al., 2015).

In an effort to eliminate inequity, there has been strong advocacy to adopt more patient- centered approaches to the delivery of healthcare (Dubbin et al., 2013). One such approach has been the development of Cultural health capital. Cultural health capital is defined as a specialized collection of cultural skills, attitudes, behaviors and

interactional styles that are valued, leveraged, and exchanged by both patients and providers during clinical interactions (Shim, 2010).

However, the use of this approach is not meant as an individual intervention per se, as such strategies may in fact exacerbate health inequalities by heightening the demands and expectations placed on individual patients and providers (Dubbin et al, 2013). The strength of this approach is its ability to direct attention "beyond the factors of individual characteristics, attributes, and experiences, to the socially constituted structural patterns that affect the development of habitus and, subsequently, interactions in health care settings" (Dubbin et al., 2013, p.115). This equitable pattern of patient care is not just based on beliefs, but through the repeated exposure to complex interactional processes during clinical encounters (Shim, 2010). Therefore, the presence of a diverse body of students within the academic medical environment serves to reinforce these practices.

Given the strengths and challenges for minoritized groups in medical school, specifically those who identify as women and Latinx, coupled with the lack of information known about this population, this study contributes to educational scholarship by investigating the experiences of women as Latinx osteopathic medical students during their first year. This study, through the elucidation of participants' experiences, including their life stories and educational choices seeks to provide a better understanding of the complex interrelationship between medical school and society as well as to provide administrators and faculty with insights and recommendations on how develop enhanced cultural competence in order to best support students and the patients they will serve.

## Orienting Theories

A conceptual framework as Levering (2002) explains, affects how a qualitative study is developed and designed and "provides not knowledge of hard facts but, rather, soft interpretation of all intentions" (p. 38). Further, Jabareen (2009) adds that the principles that constitute a conceptual framework should support one another, and establish a framework-specific philosophy that guides the entire study with "interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena" (p.49). For the purposes of this study I will refer to the conceptual framework as the orienting network of interlinked concepts that provide a better understanding of how I made decisions regarding the exploration of the phenomenon under examination (Jabareen, 2009; Levering, 2002).

In this study I explored the phenomenon of women as Latinx osteopathic medical students in their first year of osteopathic medical school. I chose to take an epistemological standpoint rooted in social constructivism. Using this viewpoint, meaning is believed to be socially constructed by culture (Charmaz, 2000; Crotty, 1998). In this perspective, culture is highly emphasized, and relevant for increasing understanding of this medical student population. As such, the social phenomenon of being a woman- Latinx osteopathic medical student is complex and linked to multiple bodies of theoretical knowledge. This study seeks to examine how the singular and multiple identities of intersectionality serve to highlight the full diversity of women as Latinx experiences in osteopathic medical school. For this reason, a better understanding requires a multi theoretical approach (Ravitch & Riggan, 2017) as such, I created an

orienting context for this studying using both Intersectional feminist theory and Latina/o Critical Race Theory.

### *Intersectional Feminist Theory*

Intersectional feminist theory, built upon insight derived from Black feminist thought, was created in an attempt to dismantle the perception of focusing on a particular group of individuals (Costanza-Chock et al., 2018; Crenshaw, 1991). This theory suggests that gender is neither a complete identity nor universally experienced in the same way. As such, it becomes necessary to consider each of the overlapping or "intersecting" layers of identity so that one particular group does not dominate or become representative of all women (Davis, 2008). When focus is only on one group of people, it ignores a greater portion of the population. This is especially true when looking at the idea of hegemonic feminism. This type of feminism imposes a European patriarchal view and creates a restrictive lens in which women of different ethnicities, sexual orientations, gender, cultural or religious identities are left excluded (Carbin &Edenheim, 2013; Nixon &Humpreys, 2010). The aim of Intersectional Feminist theory is to bring awareness to identities of all kinds that intersect with one another and how those intersections impact the way in which people live (Davis, 2008).

In response to the noted gaps in the literature, this study takes an intersectional approach, as it looks at the complete and complex experiences of female Latinx osteopathic medical students – drawing from the influences of gender, ethnicity and other intersecting components. In Crenshaw's (1991) definition of intersectionality, there is a highlight on the structures of power and privilege specifically as they relate to

discrimination based on socially constructed identities such as gender and ethnicity. Building upon this definition, Davis (2008) describes the universal applicability of the theory for appreciating the complexity of any social practice, individual group experience, structural arrangement and cultural configuration. The appreciation of the dynamic and complex processes of intersection are also echoed by Thornton-Dill (2009) and Luft (2009) who purport that the use of this theory provides a systematic approach to the exploration and analysis of experiences.

However, Davis (2008) cautions that this framework is not a prescribed method, rather it helps to create a "focus" to deal with the complexity inherent in experience and assists in the stimulation of creative engagement with assumptions in the interest of reflexive and accountable feminist inquiry. At the heart of this inquiry is the use of qualitative approaches to understand the overlapping spaces of intersectionality (Perry, 2009). Further, space must be provided to create and listen to the experiences of women with intersecting identities. This does not mean a passive conversation, but a platform for which individuals can present their own narratives (Carbin &Edenheim; Dill, 2009; 2013; Illomen, 2020) to examine how the singular and multiple identities of intersectionality serve to highlight the full diversity of women as Latinx experiences in osteopathic medical school.

### *Latina/o Critical Race Theory*

Epistemology often refers to the production of knowledge and the way one develops an understanding of the world. However, Ladson-Billings (2000) argues that this definition is lacking and is more clearly defined as a "system of knowing" that is linked to worldviews which are derived from the conditions and circumstances under

which people live. Further, students of color possess and create knowledge from their histories, experiences, languages and cultures which they feel have been largely ignored in educational settings (Bernal, 2002). Thus, employing the use of Latina/Latino critical theory (LatCrit) supports critical race epistemologies that recognize students of color as holders and creators of knowledge.

Built upon the theoretical foundations of Critical Race Theory (CRT), the creation and development of LatCrit initially came as a response to the Black-White paradigm within the work of CRT, which tended to construct and limit the discussion on race to issues pertinent to Black and White individuals (DeCuir & Dixon, 2004; Olden, 2015). Latina/Latino Critical Race Theory (LatCrit) adds a further enhancement to this understanding of inequality by adding additional more focused lenses which are salient to the Latina/o experience such as oppression from immigration status, language, ethnicity and culture (Cooper et al, 2018; Huber, 2010). LatCrit affords a unique lens by which to view multidimensional identities including the intersectionality of gender which can serve to address concerns related to both "internal and external relationships" in the world which have contributed to marginalization (Bernal, 2002).

LatCrit theory provides a complementary framework that examines issues specific to the Latinx community. For example, Covarrubias (2005) highlights the utility of this theory within education and describes how it helps to historically contextualize resistance within marginalized communities. Laura Padilla's (1997) work on LatCrit Praxis supports challenging scholars to engage in advocacy, scholarship, and practice to improve consciousness, support commitments to social justice, and assist in the development of the skills and tools to create change.

Additionally, complimenting the research innovations stemming from Critical Race Theory (CRT) (Bernal, 2002; DeCuir & Dixon, 2004; Morgan et al., 2013; Olden; 2015), LatCrit adds a new level of experience regarding the historical impact of inequity in education, particularly the educational experience of Latinx students. LatCrit theory affords the opportunity to employ the lenses of race, class, sexuality, and gender simultaneously when examining a greater system of marginalization (Olden, 2015). Moreover, LatCrit helps to frame a research space which can provide a "thick description" of osteopathic medical educational experiences of female Latinx students as well as provide scholarship with new problematics, viewpoints and viable solutions which have not been afforded through current research (Padilla, 1997).

**Summary**

As frameworks, Intersectional Feminist theory and Latina/o Critical Race Theory assist in orienting the experiences of women as Latinx osteopathic medical students. Using these two epistemological paradigms allows for the experiential knowledge of this community to elucidate and orient the content and meaning of their multidimensional identities "by situating it among groups of people traditionally unheard and spaces continually unexplored" (Galvan, 2001 p. 607). Historically Latina/o students have been disenfranchised within the educational system resulting in fewer opportunities in higher education. A lower representation of Latina/o students reaching high levels of educational attainment has resulted in fewer doctors of Latina/o descent (Raymond, 2017).

Although medical schools are expanding their efforts to recruit minorities, the pool of qualified minority applicants is limited and the medical education pipeline remains problematic (Agrawal et al., 2005; Cohen, et al.). Academic, social, financial and

political factors serve as the barriers and challenges minoritized students encounter when considering or pursuing a career in medicine (Arias, 2017; Babaria et al., 2012; Barr et al., 2008; Evans & Evans, 2004; Hadinger, 2017; Harris et al., 2012; Rao & Flores, 2007). Additionally, much of the literature related to minoritized students and medical education is related to African American or minority students in general (Hood & Boggs, 2014; Miller-Matero et al., 2018; Morgan et al., 2013). Very few studies focus solely on women as Latinx medical students (Price, et al., 2005). Further, research on academic medical culture historically has ignored the value of the differential social capital of students from minoritized groups (Nicholson & Cleland, 2017).

Current literature regarding racial, ethnic and gender minorities in the educational pipeline is often homogenized into one group creating a limited perspective on which cultural resources have value. Broadening the understanding of cultural capital, such that it contributes to cultural congruence between education institutions and marginalized students, can support an important shift to a strength-based orientation (Samuelson & Litzer, 2016).Of critical importance is the need to understand how the capital that marginalized students have acquired through families and communities – their community cultural wealth – contributes to successful navigation of medical educational systems (2016). This knowledge can assist in replacing the deficit-oriented approaches to supporting marginalized students, whereby students, rather than institutions, are seen as needing to be fixed (Gharabaghi & Anderson-Nathe, 2017).

This research will provide a close examination of the experiences for women as Latinx osteopathic medical students as they pursue their medical education and career (Arias, 2017; Babaria, et al., 2012). Collecting stories from the participants about their

experiences provide “counter” stories which challenge the dominant narratives present in educational literature (Solórzano &Yosso, 2016). This study is important to medical educational research and practice as it assists in creating a more comprehensive research narrative about Latinx in medical education, in which there is a shift toward recognizing students' cultural resources and how they contribute to student persistence and success. This research can also contribute to curricular innovation, which can maximize the skills, knowledge and resilience of these students thereby contributing significantly to shaping the future medical workforce (Nicholson & Cleland, 2017). This research is guided by the central question: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

# Chapter 3

## Methodology and Research Design

Chapter three outlines the methodology for a phenomenological study, using the method of interviewing, to explore the experience of osteopathic medical school in the northeastern United States for individuals who identify as women and Latinx. Sections of the chapter include the purpose of the study; research rationale; research questions; methodology, sample; description of participants; data collection procedures; data analysis; positionality, ethical considerations and summary.

### Purpose

The purpose of this study is to focus on the research problem by exploring the experiences of osteopathic medical school students who identify as both, women and Latinx in the northeastern United States. Primarily this data came from "thick descriptions" (Sacks, 2015) and personal insights gleaned from interviews with participants as they describe their medical education stories while in their first year of school.

There are many studies, both qualitative and quantitative, that explore experiences and factors that contribute to underrepresented minority populations in U.S medical schools and in the physician workforce (Andriole & Jeffe, 2010; Dickins et al., 2013; Dyrbye et al, 2007; Gadson et al., 2018; Orom et al., 2013; Rao & Flores, 2007). However, there are very few studies that focus exclusively on students who identify as female and Latinx, especially those from the northeastern United States. Consequently, this has led to a gap in the understanding of the distinctive experiences of these students

and limits the knowledge of perceived facilitators and barriers to their successful navigation of osteopathic medical school.

**Research Rationale**

The existing literature dedicated to the study of the underrepresentation of minorities (URM) in medical school consists primarily of studies exploring African American or all minority students broadly (Price, et al., 2005). Thus, there is a gap in understanding experiences specifically to women as Latinx osteopathic medical students, which limits understanding of their perceived facilitators and barriers in their navigation and completion of osteopathic medical school.

My goal for conducting this study was to examine the experiences of current women as Latinx osteopathic medical students in their navigation of osteopathic medical school. The findings of this study will contribute to knowledge, theory, and practice related to the osteopathic medical student experience. With respect to knowledge, I present information useful for those interested in learning more about the experiences of women as Latinx osteopathic medical students, thus adding new strength based knowledge to fill the gap created by deficit centered research. The data of this study will be oriented with using lenses provided by Intersectional Feminist and Latino Critical Race theories (Bernal; 2002; Cooper Stein et al., 2018; Costanza-Chock; 2018; Huber, 2010; Ilmonen, 2020). Additionally, the research findings may provide medical school administrators and faculty with information that can be used to develop enhanced culturally competent curriculum to assist emerging physicians support the rapidly expanding and diversifying population.

## Research Approach

Researchers use qualitative approaches when they are attempting to understand the complexities of how people experience particular settings or contexts (Creswell, 2013; Merriam, 2009). The aim of qualitative methodology is to develop new knowledge based on participants' own beliefs and experiences (lifeworld), not on pre-defined, testable hypotheses. This is precisely the experience, under investigation in phenomenological research (Giorgi, 1997). Therefore, I chose to employ a phenomenological approach for this study. A phenomenological researcher is “interested in describing a person’s experience in the way he or she experiences it, and not from some theoretical standpoint” (Bevan, 2014, p136). Phenomenology is a means by which researchers can study a person’s world as they live it, seeking to obtain a more complete understanding of their experiences and perspectives (Teherani, et al., 2015; van Manen, 2015).

Medical education adds a dynamic to the already complex construct of higher education. Medical school is difficult, not just with academic rigor, but the emotionally charged learning environment. Medical students are frequently surrounded by crisis, despair and death (Zappetti& Avery, 2019). Additionally, studying student experiences warrants a need to seek a deeper understanding and description of human meaning by getting as close as possible to the experience of the phenomenon (Heinonen, 2015). As such, “phenomenological research is well suited for studying affective, emotional, and often intense human experiences" (Merriam, 2009, p. 26).

To create a richer context for the phenomenon, life stories will be gathered using a structured phenomenological interview process (Bevan, 2014). While a

phenomenological approach focuses on the content of stories, using a structured phenomenological interview process aims to investigate how stories get told (Bevan, 2014; Moen, 2006). Therefore, the aim of in-depth interviews in this research is to generate a robust body of information on the topic of investigation from the perspective of an individual to answer the question "What is this phenomena like for you" (van Manen; 2015; 2017). The combination of both the content and the context, will assist in developing a deeper understanding and appreciation of the overall accounts and experiences of the participants.

**In-Depth Interviews**

In-depth interviews will be employed to gather information from participants. Phenomenological interviewing should be practical as well as remain true to the phenomenological method to ensure methodological consistency and trustworthiness (Bevan, 2014; Zahavi, 2020). However, within phenomenological scholarship there is no consensus on how interviews should be conducted (Bevan, 2014; Englander, 2012). Giorgi (1997) implies that the phenomenological interview is approached in a two-phased method, by getting the descriptions of the context followed by an interview for eliciting meaning. However, Giorgi offers no advice as to how to conduct the interviews, other than broad open ended questions. Conversely, van Manen (2016) cautions against using open-ended interviewing and favors a more conversational approach which is "semi-structured". vanManen (2016) describes interviewing as having two main purposes: 1. as a means to explore and develop a rich understanding of the phenomenon; 2. to develop conversation around the meaning of experience. What is highlighted in these approaches for interviewing is the necessity of ascertaining the context or "lifeworld" of the person

which is of critical importance as experience and context are intertwined (Scott &Tuana, 2017).

I used a model of interviewing based on the guidelines proposed in Bevan's (2014) method of phenomenological interviewing. This structured approach is guided by questions which are based on three main domains: contextualization (lifeworld), apprehending the phenomenon (modes of appearance) and its clarification (meaning) (2014). These interviews use a method which requires preparation, planning and structure. Each interview requires a series of instantaneous decisions about what direction to take. Entering an interview situation without a plan, structure or a sense of purpose is problematic when it comes to supporting the rationale for a researcher's decision making (Beck et al., 1994; Chan et al., 2013; Seidman, 2006).

Without thoughtful structure and guidelines for the interviews, I may run the risk of distorting information from participants and imposing my own sense of the world on their responses, rather than eliciting theirs (Seidman, 2006). It is imperative that I work to ensure that I am getting the essence of the experience from the participants, as the overall aim of this study will be to gain a better understanding of the medical school educational experiences of women as Latinx osteopathic medical students.

**Research Question**

The use of phenomenology as the methodology enables the participants to become co-directors of the research and allows participants to direct the study based on their telling of their own stories (Suárez-Ortega, 2013). However, the following question

will provide guiding direction for this study: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

**Sample**

For the purposes of this research, it is necessary to find a particular type of person who has had the type of experience being investigated and is able to articulate this experience. In this case "the phenomenon dictates the method (not vice-versa) including even the type of participants" (Hycner, 1985 p.49). I chose purposeful sampling, considered by Patton (2002) as the most important kind of non-probability sampling to identify the primary participants because it directly hones in on a specific type of participant in order to get the richest data. Further, Patton (2002) elaborates on the power and usefulness of purposeful sampling in that;

> The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling. Studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations (p.230).

For the purposes of this research, participants will be required to meet the following criteria in order to be considered as candidates:

1. All participants needed identify as a women
2. All participants needed identify as one or more of the following:
    1. Afro-Latina, Chicana, Boricua, Hispanic, Latina/x, Central American, South American

3. All participants must be enrolled in one osteopathic medical school in the northeastern United States

As an option to secure additional participants, snowball sampling was employed. Snowballing is a means of expanding the sample by asking one participant to recommend others for interviewing. This may be useful, as some students may be hesitant to participate due to their immigration status and being invited to participate by their peers may mitigate this trepidation (Creswell, 2013; Lahman, et al, 2011a; Maxwell, 2013).Women as Latinx students from one osteopathic medical school in a northeastern state were selected to participate in the study, serving as a representation of female Latinx osteopathic medical students in the northeastern United States.

Although the sample size of participants for this study was small, Patton (2002) indicates that small sample size is most suitable for homogenous research participants. Within phenomenological research studies small sample sizes are appropriate as the focus is on perspective rather than population (Miles &Huberman, 1994).As such, the recommendation is to obtain a rich quality of data. Morse (2015) asserts that the more useable data are collected from each person, the fewer participants are needed. Sandelowski (2001) elaborates further, recommending that qualitative sample sizes should be large enough to allow the unfolding of a 'new and richly textured understanding' of the phenomenon under study, but small enough so that the 'deep, case-oriented analysis' (p. 183) of qualitative data is not precluded. "For this depth to be achieved, it is much more important for the research to be intensive, and thus persuasive at the conceptual level, rather than aim to be extensive with intent to be convincing, at least in part, through enumeration" (Crouch & McKenzie, 2006 p. 494). Thus, lending

itself to the concept of information power, as introduced by Malterud et al. (2016) which suggests that the more information power or robust information the sample provides, the smaller the sample size needs to be, and vice versa (2016).

**Recruitment**

Two medical schools located in the northeastern United States were invited to participate in the study. However, one institution declined participation citing policies prohibiting external researchers. Additionally, I utilized social media and posted electronic flyers in doctoral groups as well as doctoral groups targeting Latinx women. Only the one consenting medical school yielded responses from students. The participants who volunteered for this study were recruited using an emailed letter which came from a gatekeeper within an institution. Gatekeepers were academic advisors, physician preceptors and academic support staff.A recruitment letter (Appendix A) and an informed consent form (Appendix B)were e-mailed to the students who volunteered to participate in one-to-one interviews online. In order to maintain anonymity, the participants were identified by pseudonyms.

**Data Collection Procedures**

An important tool in the practice and art of qualitative research is the researcher themselves (Given, 2008). Operating in this capacity allows the researcher to develop relationships not only with the participants but within the real life of raw words and data (Given, 2008). While these relationships are often forged within face to face contexts, the current status of global health has prompted the addition of technology to be added to the relationship. While technology and online interaction was not initially part of the phenomenon under investigation, due to the onset of a global health crisis, it is something

that has changed the course of data collection. Due to travel restrictions and social distancing requiring the use of facial coverings, interviews were conducted online. Conducting interviews online allows both the researcher and participant to remain safe, as well as clearly see each other's facial expressions (Wilkerson et al., 2014). The following sections describe the Data that was collected such as semi- structured interviews, analytic memos and personal artifacts, as well as the challenges and mitigating elements of online interviewing.

### *Interviews: Online*

The in-depth interview was selected as the most appropriate method to achieve an understanding of the participant's experience (Hycner, 1985). The use of interviews will allow me to describe the experience of the participants using their own words. Creating a context is important to the interpretation of data (van Manen, 2015). Therefore, all aspects of participant's responses both verbal and non- verbal during the interview related to emotions, strategies or experiences within osteopathic medical school were considered a level of interaction.

The audio and video aspects of all interviews were recorded within the online meeting platform and transcription and coding was completed by the researcher who conducted the interview. Capturing both the audio and video of the interviews ensured that I captured the verbal and nonverbal responses (Salmons, 2012). Additionally, having both the audio and video recordings ensured that data directly targeted the topic (there is no chance of confusing who said what) (Muswazi & Nhamo, 2013).

### *Online Interviews: Challenges and Mitigating Factors*

However, online interviewing brings forth unique challenges (Eynon et al., 2016). Engagement and rapport are key components within the interview process (Im& Chee, 2006). While you can observe facial expressions and images via online platforms, you are only able to view what is in range of the camera. Therefore, it may be difficult to see the full range of body language as you would if you were face to face. One such way to mitigate the narrowed view of body language is to encourage the participant to sit back from the screen slightly, so that their upper body is more visible on camera (Jenner, 2018; Salmons, 2012). Additionally, paying close attention to facial expressions, rate of speech and rhythm of speech can help to overcome this limitation (Gregory, 2018; Jenner, 2018; Weller, 2017). One of the primary challenges within online interviews can be cross-talk, especially if technology being utilized has any connectivity issues. To overcome this limitation, careful attention should be paid to not speaking when the participant is speaking- which is good practice within any modality of interviewing (Jenner, 2018; Weller, 2017).

A key concern for qualitative work conducted online is whether there are differences between the way the researcher and participant relate to, understand and trust one another within a virtual meeting space (Guillemin & Heggen, 2009). In order to have a good relationship with participants, the researcher needs to establish a good rapport with them (Jenner, 2018). Rapport is the ability to connect with others in a way that creates a climate of trust and understanding (Leach, 2005). The purpose of establishing rapport between researcher and participant is to both generate rich data while at the same

time ensuring respect is maintained between researcher and participant (Guillemin & Heggen, 2009).

As a Researcher, there are several qualities one must develop and nurture to successfully build rapport and engagement with participants. Leach (2005) lists qualities such as open mindedness, flexibility, supportiveness, friendliness, genuineness, sincerity, respectfulness, sensitivity and empathy in encouraging rapport. Leach (2005) also presented behaviors to avoid, as they diminished rapport. These behaviors include: passing judgement, jargon and technical language and an authoritarian demeanor. In addition to the qualities listed by Leach (2005), Hull (2007) suggested employing active listening through both verbal and non-verbal cues. These cues include such things as verbal acknowledgment of statements, maintaining appropriate eye contact and using body language that communicate interest like nodding and leaning forward (2007).

**Interview Process: Phenomenological Structure**

In coming to know an experience, van Manen (1997) offers the reflection on four lifeworld "existentials" of lived body, lived time, lived space, and lived human relations. He suggests that many experiences can be understood as corresponding to these four lifeworld "existentials", thus, they can be used as helpful guides through which to explore a phenomenon under investigation (Rich et al., 2013; van Manen, 1997). Lived body refers to our physical bodily presence in the world in which we live. It "is through our lived body that we communicate, feel, interact, and experience the world" (Rich et al., 2013 p. 501).Lived time is a subjective understanding of time rather than a more objective or factual sense of time, such as what is measured on a clock. van Manen

(1997) asserts that the way we may feel influences our experience of time. For instance, the way time seems to pass quickly when we are interested and engaged and appears to move slowly when we are bored. Lived space, like lived time, is subjective in its understanding. Lived space is the reciprocal interaction of the way a space we find ourselves in affects how we feel and how we feel affects how we experience a particular space (1997).Lived human relations refers to the "relations we maintain with others in the interpersonal space we share with them" (van Manen, 1997 p. 104). While each of the four lifeworld existentials offers unique foci which can be differentiated, they are not exclusive; rather, they are intricately unified as the lifeworld.

As a means to learn more about the phenomenon under investigation, interviews will be one of the means of data collection within this study. I used Bevan's (2014) structured phenomenological interview as the method for data collection within the interviews. The following discusses the three main domains of the method: contextualization (lifeworld), apprehending the phenomenon (modes of appearance) and its clarification (meaning). This structure supports the assertions made by van Manen's (2016) that interviews serve as a means to explore and develop a rich understanding of the phenomenon as well as develop conversation around the meaning of experience.

### *Contextualization*

An individual's "lifeworld" is set against a backdrop of context- both objects and experiences which are interconnected. Personal narratives provide meaning to those objects and experiences and as such, the use of contextualizing questions assists the participants in their reconstruction and description of these experiences in a narrative

form (Bevan, 2014; Seidman, 2006). For example, I could ask the participant if they could describe what it was like to become an osteopathic medical student. The application of this line of questioning requires flexibility on the part of the researcher to formulate questions that are relevant to the participant (Bevan, 2014).

### *Apprehending the Phenomenon*

Apprehending the phenomenon is where the researcher more narrowly focuses on the experience, and does so by using more descriptive questions. This is important because the experience is not limited to one person, the implication here is that utilizing just one type of question may not adequately capture the experience (Seidman, 2006). In this event, if the participant offers an interpretive narrative of the experience, then I would pose a more structural question to tease out the meaning (Bevan, 2014). For example, if the participant were to indicate they had a concern about their progress within their osteopathic medical program, I would then ask the participant to describe what they meant by "concern".

### *Clarification of the Phenomenon*

Following the idea that the experience of osteopathic medical school for women as Latinx provides contexts and narratives which may have significant variations, it is important to further refine the experience. The clarification of the phenomenon is an active process between the researcher and participant which takes place in situ, rather than within the reading of the transcripts (Seidman, 2006). Here, the researcher is required to use their judgment to identify the aspect of experience for clarification. For example, if participants were to identify a distinction, such as the presence of a professor

within their class, I would ask how the presence or absence of this individual would change their experience (Bevan, 2014). The aim is to have the participants identify invariants by describing how the experience would change and ultimately get descriptions that are clear, detailed and unambiguous as possible (Høffding & Martiny, 2016).

**Interviews: First and Second**

Prior to beginning the interview, participants were provided with an electronic informed consent document that they were asked to read and sign. A version of this form will be placed in the appendix (see Appendix B) for reference. An open-ended semi-structured interview protocol based on a modified version of the protocol as described in Johnson (2014). (See Appendix C) was utilized to allow participants unconstrained elaboration on the experiences they saw as especially important (Nigel, et al., 2017). Interviews took place during a mutually agreed upon time via online platform.

***First Interview***

During the first interview a loose agenda was presented to the participant, which reiterates the time allotted for the session as well as the topic of investigation. During this first interview worked to gain information about the participants "lifeworld" and create a context for each individual. This came from personal narratives which serve to show the complexity and interconnectedness of different contextual elements within the experience (Suárez-Ortega, 2013). At the conclusion of the first interview, I spoke with each participant about the subsequent interview and schedule a follow up interview. The time period between the first and second interviews was approximately one week. This

allowed for a small period of time between the initial and follow up interviews to provide for my transcription, reflection and development of additional follow up clarification questions (Seidman, 2006). In addition, the spacing of both interviews over a period of a week may lessen the impact of any idiosyncrasies of daily living- such as a bad day, illness or distractions that may affect the quality of an interview (Seidman, 2006).

### *Second Interview*

In the second interview, participants were asked clarifying questions to verify that the essence of the experience has been captured correctly, and which necessitated modification of the information based on participant's responses (Bevan, 2014; Groenewald, 2004; Høffding & Martiny, 2016). The second interview provided clarification and uncovered invariant parts- or "essences" of the experience which actually assisted in the clarification of the structure (Heinonen, 2015; vanManen, 2015). This clarification primarily came from the common experiences of the participants. For example, it means that all experiences have an underlying structure (pain and grief are universal experiences- regardless of how these feelings have developed). In doing this, I was able to better develop a descriptive passage, conveying a better understanding of how it may be for an individual to experience a certain phenomenon (Creswell, 2013). Since it is not my intention to develop any theory of a phenomenon, my goal was to show while the presentation of experience could vary, the structure of the phenomenon remains stable.

**Interview Process: Meeting Times and Duration**

Participants were asked engage in one initial interview and one follow- up interview each lasting approximately ninety minutes (Englander, 2012; Seidman, 2006). There is no one prescribed time frame for interviews. However, when deciding on a time, sixty minute interviews can potentially feel rushed and may leave participants anxiously "watching the clock", while two hour interviews are a long period of time to request someone to sit (Seidman,2006). Because the purpose of this research is to discuss a participant's experiences, place the experience within the context of their lives and reflect upon its meaning, anything shorter than ninety minutes would appear to be too limiting (Lauterbach,2018;Seidman,2006).

**Recording**

Each interview (initial and follow-up) was recorded using a digital recording application within the online meeting platform. The audio file was be transcribed verbatim through the use of a digital software application, Temi, which converts audio into text. I further edited each transcription by listening to the entire interview to ensure the accuracy of the spoken words, and making corrections. Editing the transcription of all interviews by re-listening and entering the data manually allowed deeper familiarity between the interview data and myself (Maxwell, 2013).

In support of this process Tessier (2012) argues that the combination of transcripts, recordings and notes provides a stronger foundation for analysis if only one of the methods is used, because the combination provides both specific details (transcripts and notes) and contextual elements (notes and recordings), resulting in a more complete

understanding of the phenomenon under investigation. Additionally, Halcomb and Davidson's (2006) comprehensive approach of combining the methods was considered in the structure of the research methodology. First, during the interview notations were centered on impressions versus content, as the recordings can be referred to (Salmons, 2012). Second, the analytic memos were completed immediately after the interview to expand on the initial notes taken. Lastly, recordings were transcribed and revisited to ensure accuracy and completeness, and any amendments or entries were made distinguishable (by use of color) (Halcomb and Davidson, 2006). All transcriptions were placed into a Microsoft Word document for editing.

**Notes and Memos**

Notation and Memoing are effective tools that can be used to enhance the research experience in all qualitative methodologies (Creswell, 2013). Central to this research, as most qualitative research, is the exploration and interpretation of human experience within the social environment (Birks et al., 2008). As such, notes and memos assist in the production of self and shared meaning that characterize a robust qualitative study (Groenewald, 2004).

During the interviews I made handwritten notes which were later incorporated in my analytic memos (Bevan, 2014; Salmons, 2012). The notes taken during the first interview were made of issues or elements that were useful for clarification in follow- up interviews (Bevan, 2014). Analytic memos were be utilized and included my noted observations of the participants as they answered my questions. I made these memos immediately after my interviews with each participant (Groenewald, 2004). During the

both interviews I made handwritten notes which were later incorporated in my analytic memos. Analytic memos were utilized and included my noted observations of the participants as they answered my questions and shared their narratives. I made these memos immediately after my interviews with each participant. I also made notes on each reading of the transcribed interviews. Each round of notations on transcripts was color coded to differentiate initial and subsequent iterations of the research process.

**Documents and Personal Artifacts**

The last portion of data was documents/personal artifacts collected from the participants. The personal artifacts consisted of personal notes, images of items and participant selected pictures, which assisted in the triangulation of data (Rossman& Rallis, 2017). Collecting visual data can be particularly helpful when researchers want to go beyond purely verbal constructs. As participants use visual images to help describe their identities, experiences, and practices, researchers are able to obtain more detailed narratives (Radley, 2011; Wilkerson et al, 2014). Just as I engaged in the interview process, personal artifacts were also a point of conversations, and discussing the items revealed information, history, purpose and meaning to its owner (Radley, 2011) (See Appendix E). Capturing these additional sources of data, outside of the collected interviews, ensured that I fully captured the complexities involved in human interaction (Nigel, et al., 2017; Phillippi & Lauderdale, 2018; van Manen, 2015). Artifacts were obtained through the video recorded interview. For example, asking participants if there is anything they would like to share with me prior to beginning the interview (Hooley et al., 2013).

## Data Analysis

As I was interested specifically in discovering the commonalities among the experiences of participants, I analyzed the data using a phenomenological approach. Drawing from van Manen's approach to research, the goal is to apprehend what it means to be in the world. van Manen (2015) articulates an example of this endeavor stating " to understand what it means to be a woman in our present age is to understand the pressures of the meaning structures that have come to restrict, widen, or question the nature and ground of womanhood" (p12).

Specifically, the phenomenologist is concerned with understanding social and psychological phenomena from the perspectives of people involved (van Manen, 2015). This approach aims to describe as accurately as possible a holistic view of a phenomenon, refraining from applying any existing frameworks or constructs and remaining true to the facts as presented by the participants (Creswell, 2013; Groenewald, 2004). Therefore, the phenomenological analysis process consists of investigating the constituents of the phenomenon, finding the essential features and relationships and then transforming data through interpretation. Essentially, there is a move from descriptive to an interpretative understanding (van Manen, 2015).

Since there is no single prescribed method of data analysis for phenomenology, I used a modified version of Hycner's (1985) process as articulated in Groenewald (2004). The simplified version has five steps, which are 1. Phenomenological reduction. 2. Delineating units of meaning. 3. Clustering of units of meaning to form themes. 4. Summarizing each interview, validating it and where necessary modifying it. 5.

Extracting general and unique themes from all the interviews (Groenewald, 2004). In this study, focus will be placed on the aspects of the experience that were common among individuals sharing the experiences of women as Latinx osteopathic medical students.

An important part of the phenomenological process is how the researcher intentionally examines each part of the experience. I used a process derived from "hermeneutic phenomenology" (Lindseth & Norberg, 2004). In this method, cyclical process called "hermeneutic cycles", take place, which involves the intentional examination of each part of the experience as compared to a particular component of the experience, and then moving back again to examine another component continuously through the data analysis process (Hycner, 1985; van Manen, 2015). Within these cycles, a process of "reduction" occurs, in which researchers reflect on their preunderstanding, framework and biases in a critical and self- reflective manner (Heinonen, 2015; van Manen, 2015). Heinonen (2015) importantly notes that the process of reduction is not done in isolation, rather it seeks to restore the "contextual and existing meaningfulness of the world. In particular, it aims to bring into focus the uniqueness of the phenomena which interests us" (p 40).

In regards to the first step phenomenological reduction, interview transcripts were read and reread several times to gain a general sense of the feeling of participants' accounts. During the interpretive process of examining the interview data, the hermeneutic cycle will be used as a strategy to compare parts of the interview data with the whole. This approach not only aims to uncover what is experienced, but more specifically to uncover how it has been experienced (Heinonen, 2015).The process of "hermeneutic reduction" was an ongoing process in this research.

Second, delineating units of meaning, is a critical phase of analyzing the data, in that those statements that appear to focus on the researched phenomenon are extracted or separated out (Creswell, 2013; Groenewald, 2004; Hycner, 1985). In this process there is a need for the researcher to be conscious of their own presuppositions and biases to avoid making subjective judgments. While there are multiple and alternative ways of understanding and practicing this Adams and van Manen (2017) promote the writings of Amedeo Giorgi to model an approach. Giorgi (2008) discusses what researchers must do to ensure they are attempting to conscientiously "bracket" their personal past knowledge. To do this, Giorgi states that the researcher should:

> bracket personal past knowledge and all other theoretical knowledge not based on direct intuition, regardless of its source, so that full attention can be given to the instance of the phenomenon that is currently appearing to his or her consciousness; and the researcher withholds the positing of the existence or reality of the object or state of affairs that he or she is beholding. The researcher takes the object or event to be something that is appearing or presenting itself to him or her, but does not make the claim that the object or event really exists in the way that it is appearing. It is seen to be a phenomenon (p. 3).

I used a method of "focusing" discussed by Klagsbrun (2007) and Antonio (2010). Focusing promotes an engaged method of listening, in which my only task is just to deal with "pure conditions of possibility" (Antonio, 2010). In this case, actively listening to the descriptions from participants.

To create the units of meaning, I again read the transcripts and viewed the video recordings and listed the units which are relevant to the phenomenon being investigated. To do this, I considered the literal content, the number (significance of times a meaning was mentioned and how (non -verbally) it was stated. The list was evaluated once completed and reviewed to eliminate the clearly redundant items. Since the lifeworld existential provided a coding framework, I used van Manen's (1997) work to define the four existentials and how they related to this study. By examining the data, I found examples of data from the interview transcripts related to the definitions. In Table 1, I have summarized the definitions of each existential (1997), including the descriptors of how each term was operationalized for this study with data from the interview transcripts.

**Table 1**

*Lifeworld Codes Operationalized*

| Lifeworld Codes | van Manen's Descriptors | Operational Definitions | Examples of Participants' Words |
|---|---|---|---|
| Lived Time | Lived time is a subjective understanding of time rather than a more objective or factual sense of time, such as what is measured on a clock. Past, present, future; a person's timeline | Life history about preparation for academic medicine and osteopathic medicine knowledge & expectations experiences; future aspirations; how those aspirations were enabled | deciding to go forth with my dream of pursuing medicine, um, because of my grandpa, uh, he got diagnosed with dementia and I was his caregiver (Tiffany) |
| Lived Space | Lived space is the reciprocal interaction of the way a space we find ourselves in affects how we feel and how we feel affects how we experience a particular space. one's world, profession, interests; places transmit values & history | Contexts of learning-inside & outside of a setting; Academic Medicine learning contexts as places that transmit values | I was like, there'sgotta be some more Latinos in here. (Julia) |
| Lived Body | Lived body refers to our physical bodily presence in the world in which we live. A person's initial contact w/someone is through their physical presence; one's physicality reveals something about themselves | experience with peers; mentors, professors, within academic medicine and health professions; gender, culture in learning contexts; stereotypes | I have to work harder in order to be validated for something that my male colleague that's standing right next to me, just did the exact same thing if not with less humanism, but just still somehow got a higher grade than me (Laureana) |
| Lived Human Relations | Lived human relations refers to the relations we maintain with others in the interpersonal space we share with them. communal & community life; commonalities between people | Support from educators & academic medicine community encouragement & interactions; recognition & responsiveness from others | we're our own little community (Maria) |

In regards to the third step, clustering units of meaning, clusters of themes are formed by grouping units of meaning together (Creswell, 2013; Moustakas, 1994) which are then reviewed and reduced to identify units of significance (Sadala& Adorno, 2002). Both Groenewald (2004) and Hycner (1985, 1999) emphasize the importance of the researcher cycling between the list of non-redundant units of meaning and the recorded interview to create the clusters of meaning. For example, there were a number of units of relevant meaning whose essence pointed to the importance of family support which occurred during the experience being investigated, those units of meaning were then placed together under the cluster of "family support." Hycner (1999) notes that overlap in the clusters should be expected due to the nature of human phenomena, however, through the vigorous examination of the meaning of the various clusters, central themes can be formed, “which expresses the essence of these clusters” (Hycner, 1999, p. 153).This process requires a significant amount of judgment and skill on the part of the researcher. Colaizzi remarks about the researchers creative insight, “Particularly in this step is the phenomenological researcher engaged in something which cannot be precisely delineated, for here he is involved in that ineffable thing known as creative insight” (as cited in Hycner, 1999, p. 150-151).

The fourth step, summarizing each interview, consisted of the incorporation of all the themes elicited from the data to create a holistic context (Groenewald, 200). This is important because the overall goal is the reconstruction of the constellation of experience for the participants. It is imperative that I maintained a vigilant awareness of any of my presuppositions so that I may remain true to the experience of the participants. As such,I engaged in a validity check, by returning to the participants to verify that the essence of

the experience has been captured correctly, and modified the information accordingly (Hycner, 1999).

The fifth step, extracting general and unique themes from all the interviews occurred once the process outlined in steps one through four had been completed for all the interviews. I looked across all the interviews for common themes as well as the individual variations. Once the first four steps were completed for all transcripts, I looked across the interviews for common themes and individual differences. By using this process, I attempted to understand the essence of the medical school experiences as it was understood by the participants, primarily through socially constructed meaning.

Lastly, I wrote a comprehensive summary which describes the context from which the themes emerged (Moustakas, 1994). Here, the researcher "transforms participants‟ everyday expressions into expressions appropriate to the scientific discourse supporting the research" (Sadala& Adorno, 2002 p.289), which is further elaborated on in Chapter Four.

**Reflexivity**

The "basic datum of phenomenology is the conscious human being", or the experiences of the participants in the research (Groenewald, 2004 p.49). A qualitative researcher conducting data analysis should be aware that their particular perspective is likely to influence their choices of coding and thematic analysis. Through constant and critical self-scrutiny, reflexivity becomes vitally important as a means to validate the data being collected (Blair, 2016).

To support my reflexive practice I used journaling, memos and field notes to track my own thoughts and reactions throughout the research process. Journaling, memos and field notes should serve the goal of "making emerging interpretations apparent so that a researcher can use this self-awareness either to limit unconscious attempts to confirm expectations or to make such efforts explicit" (Morgan, 1997 p. 57-58). Creating field notes during the research process compels the researcher to further clarify each interview (Miles et al, 2020). My journaling consisted of different types of documents: Observational notes, theoretical notes, methodological notes and analytical memos. The use of four types of documents helps me to engage with the research to a greater degree than would otherwise be possible. Additionally, they assisted me in forming a more holistic relationship with the data, with the understanding that memoing and note taking are not just restricted to the analytical phase of research, but as methods to clarify thinking on the process of the investigation (Birks et al., 2008). Further, capturing various aspects of thought, feelings and impressions related to the research, regardless of how inconsequential they may initially seem, create a detailed record to ensure the preservation of such ideas that may later prove significant in reflexive practice and analysis (Groenewald, 2004).

Observational notes, were notes that I wrote during the interviews to capture in the moment experiences that were at the time important enough for me to jot down. Theoretical notes were the journal entries about my reflections of the experience and my attempts to derive meaning. Methodological notes were my notes regarding my own critiques on and about the research process and lastly, analytical memos, were my reflective summaries of the experience at the completion of each interview. It is

important to note that creating journals, memos and field notes is part of the analysis rather as well as the data collection (Groenewald, 2004). As a researcher, I worked to remain cognizant of not allowing my own bias to lead to premature categorization of data or conclusions regarding the experiences of the participants.

In Table 2, I have summarized the procedural activities and steps engaged in during the data collection, analysis, and writing.

**Table 2**

*Model of Phenomenological Process*

| | |
|---|---|
| Investigation | 1. Exploring the phenomena generating "data" |
| | a. Obtaining experiential descriptions from participants |
| | b. Consulting phenomenological literature |
| Analysis | 2. Conducting Phenomenological Analysis |
| | a. Phenomenological Reduction |
| | b. Delineating Units of Meaning |
| | c. Clustering units of Meaning to form themes |
| | d. Summarizing |
| | e. Extracting Themes |
| Writing | Hermeneutic Phenomenological Writing |
| | a. Reading |
| | i. Attending to the language within the narratives |
| | b. Reflective Writing |
| | i. Memoing |
| | ii. Reflective Writing |
| | iii. Conferring with Participants |
| | iv. Revising |

## Credibility, Validity and Reliability

To be accepted as credible, qualitative researchers must demonstrate that data analysis has been conducted in an explicit and exhaustive manner. This can be achieved

through a systematic methodological process and rich description of the methods of analysis which would enable readers to determine whether the process is credible (Nowell, et al., 2017). Credibility also addresses the "fit" between respondents' views and the researcher's representation of them (Tobin & Begley, 2004).

Lincoln and Guba (1985) suggest triangulation as a means to address credibility. Triangulation is a primary method of addressing both reliability and validity within qualitative research. Triangulation occurs when "a variety of different data sources and different perspectives are pitted against each other to cross check data and interpretations", (Guba& Lincoln, 1985 p 247). The use of a participant and committee review process will also validate the phenomenon and preliminary findings and interpretations will be brought back to the participants for clarification and validation (Groenewald, 2004; Lincoln &Guba, 1985; Moustakas, 1994).

In research, there is an emphasis on truthfulness or validity (Beck, et al., 1994). To further achieve validity, I used a "thick description". Thick description is described by Lincoln and Guba (1985) as a means of achieving a type of external validity through its robust and detailed description of a phenomenon, which then can then be used to evaluate the extent to which the conclusions drawn are accurate. For a researcher this means that the description is not only of action, but the interpretation of that action within the context. In other words, a "thick description" goes beyond a record of surface appearances and presents "detail, context, emotion, and the webs of social relationships that join persons to one another." (Denzin, 2001, p. 100).

"Thick description" integrates details of social interaction with broader cultural patterns that provide meaning to specific actions (Sacks, 2015). Through the use of open-ended data collection methods, the creation of thick descriptions allowed me to contextualize the experience of individuals who identify as women and Latinx in osteopathic medical school. Lastly, outlining the methodology and providing clear documentation of the material generated during the study helps to make replication and reliability possible. Having these materials and methods clearly defined allows for the external examination of the research to determine if the research was conducted in a systematic and reliable manner (Forister& Blessing, 2020).

**Positionality**

When I began deliberating on research topics, I knew I wanted to focus on students in medical school, specifically, inequities in medical education. Throughout my educational and occupational career I have continuously read literature related to the subject, during which, I have kept three considerations in mind: Who is writing the story? Who benefits from the story? Who is missing from the story? The last question was the one that brought me to my current research.

I was teaching a technology course to a class of medical residents, when the topic of inequity in medical education surfaced. The students engaged in a discussion and shortly thereafter the class went on break. One student remained, she approached me and thanked me for engaging in the discussion. She identified herself as Latina and said that throughout her medical school experience- she never felt as if she had been included in the "story" that she rarely saw or heard about experiences like her own. She also

discussed that as a Latina in Medicine, born to immigrant parents, she has had many struggles that she felt none of her classmates could relate to (S. Silberman, personal communication, November 26, 2019). It was a brief conversation and almost as soon as she disclosed her feelings, the other students returned and I resumed instruction. I had not realized how profound the conversation was until days later, I was still thinking about it. I wanted to know more: What is it like to be in osteopathic medical school and identify as female and Latinx? As much as I tried to twist away from the research, thinking perhaps someone else was better suited to examine this experience, I was continually brought back to it. However, my positionality as a white woman studying issues related to race and culture has remained at the forefront of my mind and pushes me to ask the question: What makes me the right person to tell this story?

I believe that my chosen research study is suited to my transformative, or advocacy/participatory worldview (Creswell, 2009). This worldview posits that "research inquiry needs to be intertwined with politics and a political agenda" (Creswell, 2009 p.9). As such, this worldview informs my research inquiry which aims to address social issues such as inequality (Creswell, 2009). This worldview has been a large part of my educational and occupational experiences. I spent over a decade in the study and practice of psychology. As a student I worked to learn the theoretical underpinnings of human behavior and as a clinician I employed those paradigms in my practice as both a therapist and advocate. My training specifically focused on Cognitive Behavioral Therapy (CBT). In this paradigm, the therapist places emphasis on what is going on in the person's current life, rather than what has led up to their difficulties (White & Freeman, 2000). This does not mean that a history is not obtained, more so, that the focus

is primarily on moving forward in time to develop more effective ways of coping with life (White & Freeman, 2000). A component missing in my formative education with CBT, was the lack of specific training on mental health symptoms which are directly related to experiences of marginalization and oppression (Williams, 2013). This gap was problematic in supporting my worldview of advocacy and as a requirement of maintaining my licensure. I maintain that culturally competent practice depends on more than just sensitive rhetoric. There must be action and demonstrated change (Castro & Ruiz, 2009). Because of this, I made a conscious decision to improve my awareness of how marginalizing/oppressive experiences impact an individual's internal thoughts, feelings, and behaviors. I found my continued education within cultural competence courses to be exceptionally beneficial, not only to me, but to the diverse population of patients I treated.

Milner (2007) supports the need for cultural awareness and appreciation of differences, arguing that one of the most detrimental positions a researcher/practitioner can place themselves in is one in which all individuals are treated as neutral. The implication here is that in making no assumptions, the idea of differences in experiences remains unchallenged. In fact, Lopez (2003) and Tillman (2002) advocate that researchers take into account how history, politics and power shape their racialized and cultural systems of understanding as well as those of their participants. Therefore, continued reflection on these issues may bring to light “explicit, hidden, or unexpected matters, which can have a bearing on an entire research study” (Milner, 2007 p. 395). This practice aids in the development of “cultural humility” which is supported by

ongoing, intentional self- reflection, identification and exploration of values, beliefs and assumptions which influence relationships.

Essentially, my educational and occupational experiences have allowed me to spend my time with many different types of people, which has afforded me the opportunity to see the world differently. The ability to engage with different populations of individuals requires a level of skill and cultural competence to promote engagement (Milner, 2007). Where cultural knowledge is concerned, what matters in Tillman's (2002) assessment is "whether the researcher has the cultural knowledge to accurately interpret and validate the experiences" (p. 4) of others in a study.

My skill as a clinician has been my ability to employ empathetic reflexive practices. Cannon et al. (1991) supports this skill as beneficial, because it allows for a fluid transfer of experiential wisdom. In other words, it is possible for me to engage in a dialogue with participants to understand their experiences and identities in their own terms, while retaining my own identity (Hill Collins, 1993). Empathetic reflexive practice not only enriches the experience but demonstrates respect for agency the individual has in their own lives, which is essential to the work of dismantling systems of oppression (Kools et al., 2015).

Research, most notably qualitative research, is a shared space in which the identities of researcher and the participants shape and impact the research process (England, 1994). As such, identities become an important part of not only how we perceive others, but how others perceive us (Ellis, 2007; Gómez, et al., 2011; Suárez-Ortega, 2013). Just as my experiences are framed in a social- cultural context, so too are

those of the participants (Best, 2002). Once I enter the field to begin collecting data, I must be clear not only with myself, but with my participants about my motivations for engaging in this research and data collection (Edwards, 1990).

My positionality is entwined with my subjectivity, as I am dually positioned as both the researcher and the research instrument. As such, it is my expressed voice which will reflect the reporting of the research findings (Denzin, 2001). Through this voice, I leave my own imprint on the project. With this in mind, my previous educational and occupational experiences play a critical role in my subjectivity and subsequent reporting of findings (Bourke, 2014). As a member of the dominant culture in multiple categories, I must be mindful of the fact that conducting a study which may highlight issues of difference may contribute to the further marginalization of the participants of the study (Bourke, 2014).

While my experiences as a clinician are beneficial, I must also be aware that this familiar pattern of engagement does not impede my determinations of the meaning of the phenomenon being researched. While it is tempting to focus on the psychological states like personal feelings, personal perceptions and emotions, those foci are part of psychological analysis and not phenomenological in the truest sense (Adams & van Manen, 2017; van Manen, 2017; van Manen, 2018). I must continually monitor myself and utilize methodological rigor to work to look at the non-psychological ways to understand meaning and significance of the essence of human experiences (van Manen, 2018). Ultimately, simply accounting for my positionality is not enough. Reflection and strategies to counteract positionalities, biases and objectives must be addressed

throughout the research and data collection process (Bourke, 2014; Bradbury-Jones, 2007).

**Ethical Considerations**

This research is oriented using both intersectional and critical race theories and as such, uses the critical assumptions of each to challenge the conventional norms for considering the research and ethics by acknowledging 1) Research fundamentally involves issues of power 2)The research report is not transparent but rather it is authored by a raced, gendered, classed and politically oriented individual 3)Race, class, and gender are crucial for understanding experience and 4)Historic, traditional research has silenced members of oppressed or marginalized groups (Rossman and Rallis 1998,p. 66). Therefore, beyond the pro forma information needed for ethical research, culturally responsive relational reflexive ethics will also be used (Lahman et al., 2011b). Culturally responsive relational reflective ethics (CRRRE) acknowledges that researchers may not be able to fully understand the perspectives of the varied cultures with whom they interact and must be open to examining ethical issues from the perspective of the participants (2011). To engage in CRRRE researchers must address the "Three R's" in that they must be: responsive, relational and reflexive (2011).

CRRRE researchers are responsive. Noddings (2014) defines responsive behavior as a caring response which involves a deep consideration of others point of view. This method ensures that researchers remain open minded and continuously revise their understanding as they learn about cultural ways (Rogoff, 2003; Rothstein, 2013)

CRRRE researchers are relational. Ellis (2007) describes this construct as recognizing and valuing mutual respect, dignity, and connectedness between the researchers and researched, and between researchers and the communities they live and work in (p. 4). To do this, researchers balance their work with their obligations, care and connections with their participants (Etherington, 2016).

CRRRE researchers are reflexive. Reflexivity winds itself throughout all aspects of the research process. In doing so, it challenges us to improve our awareness of the ideological, cultural and political contexts of those we study as well as those we select as our audience (Etherington, 2016). Reflexivity requires continual and critical self-reflection that occurs at all points of the research process in such a way that it becomes a "continuing mode of self-analysis and political awareness" (Pringle & Thorpe, 2017 p 35). Reflexivity requires constant attention to power imbalances between the researcher and the participants (Etherington, 2016). Additionally, this attention requires action on the part of the researcher, as they must react and adapt within the research environment to ensure that participants' dignity, safety, privacy and autonomy are respected (Doran, 2019; Wilson, 2009).

The study was conducted using the ethical guidelines as described by the Institutional Review Board (IRB) of Rowan University. Research did not begin until IRB approval was obtained. A copy of this approval is placed in appendix (See Appendix D). When conducting research using a human subject's informed consent must be obtained (Munhall, 1988). Informed consent means that the participants not only have enough information about the research but are able to understand the information and can voluntarily exercise free choice in whether to accept or rescind permission to participate

(Walker, 2007). Even with a concerted effort to predict all the benefits and risks of the research, it cannot be known definitively what the researcher may uncover. As such, it will be clearly stated and written that participation within the research is completely voluntary and that this consent can be rescinded at any time. Participants will be informed that the interviews will be recorded but will remain confidential within the study. To further protect participant's anonymity, a pseudonym was provided to each, and only I knew the assignments. I only referred to participants by their pseudonym in the transcription and coding processes, and did not use any other personally identifying information.

### *Online Data Collection: Ethical Considerations*

Online data collection provides challenges related to cyber security. Because I am conducting online qualitative research I worked to ensure the security of my collected data to the fullest extent that I could. However, despite security measures, total anonymity or confidentiality could not be guaranteed. It is important to recognize that individuals with technical expertise in accessing computer data (commonly referred to as hackers) cannot be stopped completely (Eynon, et al., 2016, Im & Chee, 2006). Additionally, participants may be using their own computer to participate in this study, therefore, I would have less control over who has access to the data. Participants can save the data file from the online interview and share it to others without the knowledge of the researcher (Wilkerson et al., 2014).

## Summary

This chapter details the selection and rationale of the qualitative research design which includes an overview of the data sampling strategy, methods of data collection and analysis framed within a phenomenological methodology. In addition, positionality, ethical considerations and confidentiality are discussed.

# Chapter 4

## Findings

This chapter discusses the findings of data collected through the interviews of six Latinx osteopathic medical students. The research captured the participants' experiences and perceptions of their navigation of osteopathic medical school. The purpose of this research was to investigate the experiences of women who identify as Latinx and are completing their medical studies in an osteopathic medicine school in the Northeastern United States. The findings discussed in the chapter reflect responses to the guiding research question: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

The research study involved informant-rich narratives from six participants. Utilizing the model proposed in Bevan's (2014) method of phenomenological interviewing, the researcher used two semi structured interviews with each participant. Two interviews provided latitude to examine a wide breadth of experiences of the phenomenon of interest and included opportunities to dialogue further about interpretations regarding the participants' experiences. I use anecdotes from the narratives throughout this chapter to create shape and meaning of the phenomenon (Eilifsen, 2011). According to van Manen (1997), anecdotes are experiential examples of the phenomena that help the reader sense the world by simultaneous engagement and reflection. The theoretical framework of van Manen's (1997) lifeworld existential offers a lens through which to explore the experiences of the participants and offers one possible interpretation of the phenomena under investigation. This chapter begins with revisiting the purpose and guiding research question and an introduction to the study's

participants. The chapter describes the findings discovered upon interviewing the participants and concludes with a summary.

## Mini Portraits of Each Participant

In order to make this research more personal, I have included a mini-portrait of each participant to describe them in greater detail. The information in this section was informed by what the participants shared with me during interviews. As described in the preceding chapter, I assigned each participant a pseudonym by which they would be identified throughout this study. I offered each participant the opportunity to choose their own pseudonym, however none of the participants chose to do so. For the purposes of participant protection and de-identification, I will refer to each of the participants under the pseudonyms of Ava, Maria, Laureana, Tiffany, Julia and Miranda. All six participants identified with and responded to the following inclusion criteria: (a) 18 years or older, (b) currently enrolled in an osteopathic medical school in the northeastern United States (c) Identified as one or more of the following: Afro-Latina, Chicana, Boricua, Hispanic, Latina/x, Central American, South American. The following mini- portraits will introduce readers to Ava, Maria, Laureana, Tiffany, Julia and Miranda and provide background about their decision to become an osteopathic medicine physician.

### *Ava*

Ava is currently in the first half of her residency. She self identifies as Latina and Cuban. A dedicated dancer, her initial aspirations were to join a company and delay going to college. However, when an injury cut her dancing career short, her focus became academics. It was during her undergraduate experience that she fell “in love” with

neuroscience and decided to pursue a career in medicine. “I remember like when I started inclining and thinking about possible medical school, you know, my mom is an immigrant. So… to her it's like, yeah, great…be a doctor like perfect… And to me, I became a neuroscience major as I progressed in my classes… I really liked the physiology of the brain.”

***Maria***

Maria is currently in her third year of medical school. She self identifies as Peruvian. She describes growing up in a close knit “vibrant Latino” family in a predominantly white suburb. Maria credits her desire to pursue medicine as being directly influenced by an experience she had while traveling to Peru. While in Peru, she had the opportunity to shadow a family member who is a medical doctor there. It was on this trip that she had first-hand experience witnessing the disparity in medical access and care, indicating “I wanted to help the Latino community."

***Laureana***

Laureana is currently in her second year in medical school and refers to herself as Mexican American, though says if she had to choose between Hispanic and Latin American she would prefer Hispanic. Growing up, Laureana spent part of the year in Mexico and the remainder of the year in the United States. She credits her upbringing as the “reason I'm fluent in writing and also speaking and reading Spanish." Laureana discusses some of the hardships she faced obtaining medical care. Accessing a physician's services often required months of waiting and negotiation of scarce transportation resources. Medicine was not something that was of initial interest,

however, during her graduate studies, she decided to take part in a program which provided an opportunity to take classes at a medical school. At the root of her desire to heal is a “servant's heart". It was after this program that she felt as if she had found her “true calling" and she decided to become an osteopathic physician.

***Tiffany***

Tiffany is currently in her fourth year of medical school and self- identifies as Mexican. She articulates that medicine was always of interest, though she wasn’t confident in her ability to pursue it “if you would have asked, you know, five-year-old me, what I wanted, it was a doctor, but I never thought they could do it." Tiffany credited her experiences caring for an ill family member and exposure to a national organization which supports better health care to the Chicana/o/Latina/o communities as her primary motivators for becoming a physician, and offered “That that's really been my motivation for wanting to learn more and help others who were in my position and teach them."

***Julia***

Julia is a first-year student in medical school. She self -identifies as Salvadorian and Italian. She reported being the first person in her immediate family to pursue medicine, though she has male cousins in El Salvador who are doctors. When asked about her family's response to her decision to become a physician, she replied “they were like...well, no one's ever tried. And I'm like, well, I’ll try then.” Julia discussed how experiences in medicine serving remote areas in El Salvador illuminated the disparities in healthcare and fueled her desire to assist others.

### *Miranda*

Miranda is in her fourth year of medical school. She identifies as Dominican and Peruvian. She reported being the first person in her immediate family to pursue a college education as well as pursue medical school. On becoming a physician, she discussed how while she enjoyed many subjects in school, she was exceptionally fascinated by the inner workings of the human body. She also spoke about her desire to take her education to the highest level she could, saying “I'm the type of person where if I am going into something, I want to know everything there is to do with it. So I'm like a physician is the highest I can go…. So that's definitely what I want to do." Miranda credited her experiences with illness in her own family as well as experiences in Peru witnessing the health inequities as her motivation to pursue a career in medicine.

## Framing the Themes

The themes reflect van Manen’s (1997) “lifeworld existentials” as a framework. van Manen (1997) suggests that many experiences correspond to four lifeworld existentials: lived time, lived space, lived human relations and lived body. Lived time is synonymous to how one subjectively understands and experiences time. Within the lived time existential, feelings or emotions can influence how an individual experiences time as well as how the demands and freedoms placed by time can affect experience.

In the existential of lived space, an individual’s exploration of space can affect the way they feel and, conversely, the way they feel can affect the way they experience a particular space. Lived human relations refers to the relations individuals make and/or maintain with others in their lifeworld. The existential of human relations includes the

communications and relationships individuals experience with others through the shared and created spaces and interactions within them.

Lived body is the physical body or bodily presence in everyday life. Within this existential, an individual is always present in the world within their body. It is through this body that individuals communicate, feel, interact and experience the world. While each of the existential lifeworlds offer a different focus, they are not separate from one another, rather they are interwoven to create the complex construct of a lived experience. As such, these existentials provide a lens through which the findings of the phenomena under investigation are examined. (1997).

**Themes**

Four overarching themes emerged from this research:

- Negotiating Expectations (Lived Time)
- Navigating the Collective (Lived Space and Human Relations)
- Belonging in Osteopathic Medicine as A Latinx Woman (Lived Body)
- Utilizing Lived Experiences to Inform Practice (Intersecting Existentials)

Within the first theme of negotiating expectations (lived time), participants discussed preparation and the complex experience of educational, occupational and emotional reconciliation of personal identity as an emerging osteopathic medical student. Lived space and lived human relations had significant overlap as they related to the relational environments for participants. Both the existentials in this theme required the participants' adjustment and reorientation within their relational environments as well as within themselves. The idea of "community" as a space which is not constrained by

geography but is intertwined with the participants' daily lives is inherent to this theme. Therefore, findings from both existentials are presented as one theme: navigating the collective (lived space and human relations). The third theme of belonging in osteopathic medicine as a Latinx woman (lived body) incorporates the overlap of gender and culture within the existential of Lived Body. The fourth theme, utilizing lived experiences to inform practice (intersecting existentials)**,** presents findings related to participants' patient care experiences as they are related to the existentials framework. The following section presents further elucidation of themes and their respective subthemes.

### Negotiating Expectations (Lived Time)

Framed within the existential of lived time, I will discuss how participants aligned their expectations of osteopathic medical school with their lived experience. Findings of this theme are based on participants' description of their development of their “core beliefs" related to their desire to become a physician as well as solidifying their desire to pursue medicine. According to participants, the development and solidification of their “core beliefs" were influenced by experiences such as occupational, educational and social exposure to medicine and healthcare access. The subtheme of transitioning from student to student doctor was related to participants' reconciliation of their expectations regarding the assumption of their new identity as a student doctor. I have also identified the subthemes of reconciling expectations of self and reaffirming core beliefs in order to strengthen academic perseverance which are related to the participants’ discussion about the divergence and convergence of their thoughts and beliefs about these expectations.

### *Transitioning from Student to Student Doctor*

Participants had varied initial educational interests for exploration of osteopathic medicine. However, they all have similar foundational or "core" beliefs about their rationale for going into medicine. Each of the participants indicated that they wanted to help people, and specifically in their formative educational experiences were drawn to the sciences. All the participants described taking "time off" from school after the completion of their initial degrees. While the participants used the words "time off" as their description, it was not indicative of disengagement. Rather, participants spent this time engaged in direct healthcare practice, providing space for them to gain hands-on clinical experience but also to reflect on areas of interest which "grounded" their desire to pursue their medical education.

> I actually took four years off before going into medical school and I worked at a medical center…working interventional pain. And then I took a year off to be a caregiver for my step-grandmother, who was suffering from liver cancer. Um, and then after that, I went to work for a medical devices company in a hospital center (Julia)

> "I became an EMT and I became a medical assistant during my gap year" (Maria)

The time spent pursuing occupational experiences varied for each participant, from 1-7 years before they officially matriculated into their osteopathic medical school program. Julia discussed how she took time to work in the medical field both in the United States and abroad in several different capacities and noted that "my experiences have built me" and that she "needed those experiences to like… ground me." These

“grounding” experiences were noted across all participants, who had direct clinical experience in serving areas which had limited healthcare access and resources- from the Appalachia to remote volcanic villages in Peru. Julia offered: “if I didn't have that experience, first…I would be really confused right now." Ava’s response aligned with Julia’s in that her experiences helped her to frame her goal of becoming an osteopathic physician saying, “So when I start med school, I’ll know what I want.” For Laureana, her faith and her belief that her “calling” is to be a physician who serves the Hispanic community is what she utilized as a core belief when she is faced with challenges.

Similarly, Maria reflected on a profound occupational experience she had when she witnessed the challenges of healthcare access in other countries. Maria recalled walking with her grandmother to her first day volunteering in a hospital. Approaching the hospital, she saw a line of people forming. Reminiscent of lines at a supermarket deli counter- she realized with shock that this was the line of people waiting for the *possibility* to be seen. Her grandmother explained that often people would wait hours to even get into the door of the clinic, often missing a day's worth of wages just to be seen. Maria offered that after this experience it helped her “to understand... like... *why* I'm pursuing medicine.” These experiential opportunities within healthcare helped the participants begin to visualize what it may be like to inhabit the professional role of a physician. Additionally, Julia offered that her experiences helped solidify the decision to further her education within osteopathic medicine offering that it helped to “really *know* you're here for something”.

While life and occupational experiences were important components of the process of entering osteopathic medical school, being prepared emotionally was also

something discussed by some participants. Tiffany struggled with feelings of insecurity and doubt initially, saying: "if you would have asked, you know, five-year-old me, what I wanted, it was a doctor, but I never thought I could do it." She discussed a continued interest in medicine, but cycled to doubt saying, "I just thought, well, you know, I'm not that smart. I can't be a doctor." After a terminal diagnosis of a family member, Tiffany decided to continue with her medical education at the community college while being a caregiver. It was then she said she:

> Decided to go forth with my dream of pursuing medicine because of my grandpa, he got diagnosed with dementia and I was his caregiver. For those first few years. And it was really that not knowing what…*How* to care for someone like that…that's really been my motivation for wanting to learn more and help others who were in my position and teach them.

Julia provided insight into her decision-making, sharing her rationale for delaying going to medical school saying "do I regret coming to school a little later?... No... I got to enjoy my twenties. Um, yeah, I would never want to do this at 23...So much like sadness, not being able to go party and have fun with my friends while we were young... now everyone's settling down. So I'm like, I'm not missing anything." In this respect, Julia was able to reconcile her decision to pursue her medical career without feelings of resentment toward the time she would be spending on her education.

Transitioning into osteopathic medical school took on a different meaning for two of the participants as it related to coping with significantly distressing family issues. Ava discussed how she had made a previous attempt at navigating the first year of medical

school. In her first attempt, her sister's health issues derailed her progress. She shared that during her “second” first year, her sister passed away. It was after this event that she reported feeling that she “had such a different head on my shoulders, just a different perspective." Ava discussed her almost decade long process to matriculate and succeed as a medical student, and said “I had been trying to get in at every opportunity. But realizing now, in retrospect, it wasn’t the right time for me to go." For participants, development of their “grounding” or “core” beliefs about why they wanted to become a physician were essential in creating a path to enter medical school. Their preparedness encompassed a wide range of skills like resilience and maturity that enabled participants to handle the challenges they were faced with and still find ways to thrive as they matriculated.

***Reconciling Expectations of Self***

Each of the participants entered osteopathic medical school with pre-existing identities that had been shaped by a variety of prior experiences. Specific to these participants was the sense of self which was tied to their ability to rapidly master complex educational concepts and earn high academic distinction which set them apart from their peers. However, all the participants discussed challenges to their sense of identity once they matriculated into osteopathic medical school and attempted to master a large volume of new information within a peer group of equal motivation and intelligence. All the participants had the initial expectation that medical school was going to be “a lot of work”, but the reality was that there was a sense of disorientation related to their perceived sense of academic self. Laureana likened matriculating into osteopathic medical school to “being a fish out of her pond." The participants explained the

disorientation was connected to becoming aware of how their pre-existing identities may or may not effectively integrate with the medical school culture to which they were being introduced. Academically, each of the participants described being high achieving students prior to coming to medical school and several of the participants discussed how undergraduate course work only required some minor adjustments in how they studied, Maria explained:

> For the most part, for a lot of people, and once you get a hang of undergrad, undergrad becomes very easy. Like I remember my freshman year of undergrad, like I had to study so…so… much just to get like a, B or C in something. And then once you hit, junior, senior year, I don't know how it is for others, but for me it became like, I just, I was able to study so much more efficiently. I could do so much and understand huge topics in such a short amount of time that I was able to relax and get a 4.0, both semesters. Cause I was like, I *know* what I'm doing.

However, the confidence with which they once approached their coursework waivered once they began their medical school studies. Maria discussed how she felt about returning to her education, “Once you learn it, you've got the flow. Right….? And then once you get the flow, it's hard to go back to the beginning where you're like, gosh, darn it."

> Where like, I used to think an 89 was an F like getting an 89.9 was like the worst thing I could ever get. Like, I'd be like, why even bother studying? I just think.... And I think a lot of pre-meds do that because they're just, you need to get an A, because it's this whole, like, you *need* to get an A to get into med school, like

> people with Bs, *don't* get into med school, but it's crazy. And then there you are... your first med school exam. You go there, you get a C….. And you're just like, I DON'T get Cs?! (Maria)

Participants needed to reconcile the fact that while they were high achievers in their former institutions, within medical school they were “average." The challenges of academic adjustment were frequently discussed by participants as being coupled with their own understanding of their sense of academic self.

For example, during undergraduate coursework many of the participants discussed their having good grades and academic performance. Jokingly, Maria said “my friends think I am a genius." However, once matriculated in osteopathic medical school, she identified her cohort as “the people who like got all the A's just like you did, who did all the work, who did everything to be where they’re at." Participants frequently discussed that they had formerly been in the “top” percentage of high achieving students. Which set them apart from their peers, however, in medical school, peers are all those high achieving students as well. Laureana articulated that while academics had always been challenging for her, she had always been able to maintain above average grades. She described how her expectation regarding her academic abilities was tempered with the idea that her intense preparation and struggle with the MCAT would somehow make the transition into medical studies “smoother." She offered: “The reality of that expectation was number one, *NO*….it was not *smoother*." She described “struggling” within her first year of medical school dealing with the heavy amount of course content. She likened how fast and intense the course work is to “trying to take a sip of water from a firehose." She

elaborated further “you're just falling behind… and the materials are just piling up." As each of the participants progressed through their training, they all reflected on diminished feelings of mastery and self-efficacy which were intertwined with the uncertainty and unpredictability that accompanied new learning.

However, it was the divergence of their expectations from the reality of their experience of being an osteopathic medical student that negatively impacted their physical and psychological comfort. Participants shared their fear and anxiety as drivers of this discomfort, specifically related to the intense educational pressures inherent in medical school coursework. Maria offered that she was aware that “it’s going to be hard”, however, once she was matriculated and immersed in the rigors of the curriculum, the reality of the challenge was overwhelming. She emphasized this sentiment by saying “Like… it starts… like...*hitting* you." Tiffany shared her impression that “I don’t think you truly know until you're going through it." Laureana, in response to her attempts to reconcile her educational struggles with her decision to pursue medicine offered, “I mean it tested my faith. Sure. No doubt about it. It really tested, you know, the foundations of what I believe….. Am I really cut out to be here? and is this really my true calling?” The sheer volume and intensity of the coursework was only fully appreciated once participants were in the throes of their coursework.

Additionally, the experience of matriculating into medical school was one that participants articulated required a significant commitment of time. For Julia, this meant recognizing and coming to terms with “10 plus years of schooling and *everything*." However, the development of their emerging professional identity around a new educational timeline created points of conflict. These conflicts were often related to the

negotiation of the multiple roles and identities they have in their lives- such as student, sister, daughter, friend, wife and mother. The idea of "everything" is further elaborated on as the consequences of the decision to place education as a priority. The decision was one that many of the participants struggled with, at times 'second guessing' themselves and their decision to pursue medicine. To this, Julia said:

> Was this the right decision for me? Because as much as I want to help out and stuff, I also would be really upset if my educational goals... like kind of blocked me from having also... like…social goals too, of like having a family and all that.

Further, Miranda articulated that prior to medical school, she was better able to negotiate her multiple roles. Miranda said that a large part of her sense of self was reflected in activities which she placed her energy and personal resources. These activities were related to her physical, emotional, and spiritual wellbeing. Miranda identified that "working out" at the gym allowed her to maintain her health physically and emotionally. In addition, participating in church related activities assisted her in maintaining her spiritual connection which she identified as being very important. However once in medical school she said, "I put academics first, like way too much. Like…. I kind of let *myself* go." Miranda described feeling almost "unrecognizable", having gained weight and lost connection with her church. In this respect, there is a continuous restructuring of medical students' subjective sense of self, as they attempt to reconcile their multiple roles and identities into the singular identity of an osteopathic medical student.

### *Reaffirming Core Beliefs in Order to Strengthen Academic Perseverance*

Participants were able to remain resolute in their clearly established ambition to become a physician, because their ambition was reinforced by their "grounding" or "core" beliefs. For participants, these beliefs were developed early in their transition into osteopathic medical school and were continually reaffirmed as they moved through critical milestones within the program.

> I just knew in my being… like what I wanted to do. And I kind of didn't like somebody telling me that I couldn't. And like when I realized that it was like, look at the circumstances under which I'm doing these things, like, you know, I could say I'm like, no…*I'm* amazing (Ava)

Many of the participants describe their aspirational goals and beliefs as being entwined with aspects of self- efficacy.

> There's always going to be someone whose parents, you know, are a doctor… so it makes, it makes things easier for them or, you know, they have a sibling or a husband or whatever that has been through it… so they could put them into contact with another doctor…or somehow...a lot of these roads have already been paved for a lot of these students. And I think that that can be intimidating for someone in my situation because you're... you're literally *digging* that path for yourself and it's hard…. and they have it already. And I, at least... my mom always tells me what I have to tell myself is...be proud that you're digging it... because that takes more dedication and hard work that you're digging that path because it's so much easier for them. And I think even back in high school… SAT

> prep, so many people have private tutors...How's it that I still got to the same spot everyone else did? So it shows, I guess…the moral of the story is... you're always faced with seeing people that may appear to…. not necessarily that they do, but it may appear that they have things easier, but you can't let it get to you. (Tiffany)

Participants' persistence and resilience behaviors were rooted in the strength of participants' personal agency and reliance on their "core" beliefs established early on in their medical educational pathway. Their noted self-efficacious beliefs provided the underpinning for motivation, well-being, and achievement. Throughout the noted challenges, each participant made a conscious effort to "ignore the outside stuff" and deeply invested in developing themselves as emerging osteopathic medical practitioners.

## Navigating the Collective (Lived Space and Lived Human Relationships)

The second theme captures the interpersonal, social, and familial spaces and relationships within which participants lived their daily lives. The notions of space and relationships were explored not just in terms of physical proximity or location, but specifically as they relate to the conflicts and reconciliations participants encountered as they worked to integrate the role of osteopathic medical student into their identity.

### *Externalizing Success*

For many of the participants, a subtheme interwoven into their narratives was the element of externalizing success. These women did not attribute their success to their own skill or abilities, rather something external to them. This externalization was often noted by participants as a feeling of being an "imposter" or that somehow "luck" or easy materials was the rationale for their success. Tiffany shared:

> I feel that one of the things that was really intimidating for me was, yeah, kind of just not that I felt out of place, but I always felt down here in comparison to others. That's what I felt. I just felt like, did I get lucky that I got here….. that I got in it? Was it luck? You know, how did this happen? And, and yeah, I think that has been the, you know, and especially that first year, that first semester where it was really challenging.

The externalization of success was present even when there was direct evidence that contradicted this belief. For example, during our second interview, Tiffany showed me the whiteboard in her home. Turning the camera away from her, she walked me through a small area of her apartment. The most vivid and decorated space was that around the whiteboard on her wall. She moved to a photograph, which appeared to be from the cover of a school publication. She responded that she was specifically chosen as a representative for the cover of an academic success guide from her college. Though she was literally the face of "success", she continued to have moments in which she depreciated the quality of her own academic ability.

> And then there are times not all the time, but there are times where like, success, Oh, I did well. But then I was like, Oh, I did well, because you know, like there's an easier, like it was an easier concept or it was, I don't know, something was easier. And that's the only reason why I did well, you know? So that's annoying, that's annoying. (Tiffany)

This experience was not unique to Tiffany, other participants, like Maria, often attributed success to "luck" or other external reasons and not to their abilities. However,

participants' attribution of success to external sources and forces was not discussed as being equated with them struggling with low-self-esteem or lack of self- confidence. Rather, it was discussed in the narratives of the participants as connected to feelings of self-doubt related to perfectionism and high achievement. Miranda further elaborates that her academic endeavors were heavily focused on “scores" and what she could demonstrate academically, saying, “we have to do all *this*… and we have to do it *perfectly* for it to work out." While all the participants placed exceptionally high standards for success on themselves, the externalizing of success noted among several of the participants, seemed to serve as a mechanism of self-protection within the highly competitive culture of academic medicine.

### *Comparing and Competing with Other Osteopathic Medical Students for Academic Standing*

Throughout much of their higher education experience, participants have cultivated the ambition and enthusiasm to become osteopathic medical practitioners. However, within the culture of academic medicine, these qualities also feed into a sense of urgency and competition. Competition and comparisons to others was a behavior that was common among all participants. A significant adjustment for many of the participants was the issues of competition and comparisons within the culture of academic medicine. Julia affirmed that competition and comparison are just “the way it is" in medical school and that academic medicine and the practice of medicine is a “competitive discipline." Miranda articulated that academic medicine is created to support the culture of competition offering “I need this score to get into this because all of these other people got it. So I think from the start, like the school kind of makes you

compare yourself." The competitive nature of the discipline was a challenge for Tiffany who discussed how her academics were "influenced" negatively because she felt "very intimidated by people," specifically her peers. Interestingly, Miranda shared that without having any other support on "how to accomplish things", the comparisons with peers became necessary to assist her in the navigation of medical school.

> If I had like a physician in my family, maybe I wouldn't have to compare myself to others and I could just lean on them for like a hundred percent of like advice on how to get through medical school. But because I only have my peers that I think that's why I lean so much on like, what are they doing? How am I supposed to do this? You know? (Miranda)

Tiffany echoed a similar sentiment to Miranda as she discussed how the comparisons to peers caused her to be "intimidated" in determining how to best approach her studies. For Tiffany, after an initial struggle, the realization came that she saw the most academic growth when she began "ignoring all the outside stuff." For Ava, this meant developing confidence in her study habits, offering: "It's like almost going back to basics, for me…. like *how* to be a student… right?... And like honoring that...that process." While many of the participants spoke about these ideas in relation to "learning" how to learn once they got into medical school, after further discussion, it seemed that what participants were articulating was more reminiscent of trusting *how* they learn. In many instances, this was achieved by ignoring the external comparisons between themselves and peers and focusing on what made the most sense to them.

The challenge for participants in dealing with comparisons, was to find the balance between the "toxic" comparisons and the healthier interactions. To do this, participants worked to articulate boundaries which assisted them in disengaging from the "toxic" competition and actively focused on themselves and more healthy forms of engagement with their peers. For example, Maria discussed how she needed to remove herself from peers who were "high stress" prior to exams. Discussing how she found it beneficial to remain in her car until right before she needed to enter the class to take her exams. Miranda shared that she found it difficult to study in the library, as she would often begin to compare her learning processes to those of her peers. Participants also discussed how they would work to reframe the "toxic" comparison to ones which were more relevant to their personal experiences.

> I stepped back and I'm like, well, hold on…. there's not many Latino medical students, much less Latino women in this field. So… it'd be like comparing yourself to the whole generation. You're not like… *average*, you're pretty high up. But like, I give myself pep talks like that. (Maria)

> I would remind myself, there are too many people, you know... there's too many Mexican migrant farm workers or whatever. Latinos, Mexicanas you name it, who are not getting the care they deserve…. And if all I do is just *woe is me* and I give up, then I will never have the opportunity to reach them now, will I? (Laureana)

Participants all discussed a similar strategy of reframing the initial negative reaction to comparison, to one of positivity. Insight regarding the "toxic" nature of comparisons was

expressed by many of the participants as well as strategies to mitigate the negative effects comparisons had on their own self efficacy.

### *Negotiating Conflicting Roles within the Family*

Familial relationships were frequently discussed within the participants' narratives as being largely contributory to perceived feelings about support and strength as they pursued their medical education. Paradoxically, these relationships were also noted as sources of conflict. The following subthemes explore these relational interactions as well as strategies participants used to mitigate conflict. Participants articulated that their families were exceptionally supportive of their decision to pursue osteopathic medicine. Frequently, participants indicated that their family wanted them to have "more" in regard to educational and occupational opportunities. Julia talks about her "hardworking" mother, who immigrated to the United States and began her own business. Julia says her mother has always been supportive of her dreams to become a physician saying she "wanted more for me than what her culture and her country afforded her." Laureana had a similar experience when talking about her educational goals with her father, sharing that he had said to her:

> I don't want you to have to know what it's like to have no career and no dreams or aspirations and staying at home, basically…like being your mother. It was kinda like a little bit of, put down at times. But I saw that ….and I... it just meant the world to me that my mom would sacrifice so much. And both of them... so much... so... that I could be where they weren't able to be themselves.

The strength derived from participants' families was an important mechanism to navigate osteopathic medical school.

Collective power was something that each participant discussed as a means of negotiating their life inside and outside of medical school. For many, this initial collective consisted of family members. Laureana described the values and importance of a collective power as “the power behind the engine”. This collective power was a source of support, encouragement and comfort for the participants. However, once matriculated into osteopathic medical school, a significant adjustment was the physical absence of this network.

Each participant talked about struggling with the idea of a more solitary and independent experience. Tiffany recounted her initial experiences, sharing that even mundane tasks like going to the grocery store required an adjustment “How many stairs…?! WAIT…why did I buy this much food? I'm here alone. I am making multiple rounds….like the negotiation of that, like, you know, putting yourself into that perspective of doing these things without your…. the person right there." The idea of having “the person right there” was also discussed by many of the participants. Julia articulated this as a significant “adjustment” as she has always lived very geographically close to her family and going to medical school placed her further away from her family.

As such, many of the participants discussed feeling uncomfortable and out of place within academic medicine. As Laureana said, the experience of matriculation into osteopathic medical school made her feel as if she were a “fish out of her pond." To mitigate this discomfort, participants worked to cultivate and replicate “collective” support of their families through groups of peers within their new environment. For Ava,

this group consisted of select cohort members and faculty, while several other participants discussed their engagement with Latino Medical Student Association (LMSA). Maria described a feeling of “community” and familial connection within the LMSA group. Julia explained that the sense of community was important to her sense of belonging and the feeling that she had a “place” within the school offering, “it's nice to have that community. Cause it kinda, it doesn't make you feel that out of place…. when you do feel out of place." Through the cultivation of support networks, the participants appeared to recreate the supportive elements of their “family” within their new environment. The strength derived from the security, support and encouragement within the cultivated networks facilitated academic and social development of the participants.

Family relationships were simultaneously sources of support and opposition. Participants described that the support they received from their families was often tempered with the continued expectation that they would still behave in culturally prescribed ways. This was most often noted when familial roles, often related to gender and culture, were being negotiated with their role as a student doctor. For instance, Ava says “I think academics in my home... that aspect was always supported, you know… but expectations to find a good husband were also there." All of the participants spoke about their “culture” as one in which women are largely seen as caregivers- responsible for taking care of the home and family but not necessarily seen as excelling outside of those areas. Maria articulates, “They expect the excellence to come from the man and not the woman." As participants discussed their backgrounds and familial systems, they were the only woman in their families working toward a degree in medicine. Participants

discussed that as a result of this unique educational and occupational trajectory, it necessitated an increased need to explain or justify their decisions in delaying or dismissing traditionally assumed roles within their families such as marriage or having children.

> Your job in life is to take care of the other people in this world right. So yeah... It's just hard. It's like you're already being criticized for things that haven't even happened yet. They already know the lifestyle and they're like, it's wrong (Julia)

> And maybe some women don't even want kids. And then that may even look negative on them…. just because they're like, well, you can't say you *don't* want kids. Like you're too young. But like, what if they're like set in stone? They don't want it. We just can't win (Maria)

Most often the increase in explanations were related to their deviation from typical roles within their family such as marriage and caregiving. For Laureana, caregiving was her parentified role within the family, especially about her younger siblings' education, because she served as a translator between her parents and the school systems. All participants spoke of the increased conflict between their need to be present for their families as well as their need to be present within their academics. Miranda shared:

> I'm the oldest in my family...it's me and my younger brother. And I feel like they [parents] depend a lot on me…. like resolving issues in the house, I guess, because I'm so ….I guess...I'm at this age where they kind of feel like I have a good sense of what's going on and I can give them advice

Ava speaks about her role of "caretaker" and "protector" of her younger siblings, as being difficult to disengage from. Similarly, Laureana faced conflict in caring for the needs of her family members. A taxing family emergency contributed to the repeat of her first year and necessitated her to become a healthcare advocate for a family member. However, this decision also alienated members of the family for a time. Laureana said: "So now I'm having conflict. Conflict is with whom I least expected to have it with... It was with my two main, like, these are my...these are my...*these* people support me." Many of the participants discussed how they were affected by their parent's overreliance on them to handle issues within the home. Miranda says "The first month in, they would just call me all the time" and I'm like, I can't do this... that kind of affected me in the beginning… my mind was just somewhere else when I was trying to study." It is in this space where all the participants discussed the most contention within their families. Conflict was most often centered on the adjustments the whole family had to make as a result of participants' matriculation into osteopathic medical school. Frequently these adjustments were about diminished presence within family decision making.

***Mitigating Familial Conflict***

To alleviate the challenges brought on by conflicting familial roles, all the participants described how they needed to create a new set of personal boundaries. Miranda described how she was aware of the adjustments she needed to make regarding her roles within her family and her academics, however, she indicated that she did not feel as if her parents were as aware of their own need to reorient and adjust to her new role. She asserted her boundaries with them by saying:

> I told them ….you have to stop putting me into whatever's going on at home because it really takes away from my focus during school. Like if I have an exam, I can't stop thinking about what's going on at home and I can't go home.

This was similar to what Ava encountered, as she worked to assert her boundaries within her family. Of this Ava says, "it was like learning how to make those boundaries and learning that it was okay...and I wasn't going to save anybody or it wasn't my responsibility. You know... it was *my* time." The awareness of the need to create boundaries and make themselves a priority in their educational and occupational journey was also shared by several of the participants. For instance, Julia and Maria spoke about obtaining space for their studies. Julia got her own apartment so that she could have time to study, and reduced some of the visits she had with her parents. She discussed how this time apart something the whole family was had to negotiate. Maria discussed how she created a boundary within her home that when her bedroom door was closed, she was not to be disturbed.

Emotionally, learning and accepting that it was "okay", to create these protected spaces for themselves, was an important concept that many of the participants found aided in reducing the guilt they felt they asserted their independence from their families. Laureana discussed that the conflict with her family caused her, at times, to doubt her decision to pursue medicine, and at some level tarnish the experience. She consciously chose to assert a personal boundary related to the negative comments her family was making about her decision to continue osteopathic medical school- saying, "I'm not going to let that rob me of my joy anymore". Even though personal boundaries were

challenging to navigate, setting and communicating them was essential for creating a sense of agency over participants' physical space, body, and feelings.

## Belonging in Osteopathic Medicine as a Latinx Woman (Lived Body)

Using the existential lived body as the frame, belonging in osteopathic medicine as a Latinx woman, immerged as an overarching theme. Belonging was described as a sense of connectedness and acceptance to the academic and professional environment. Representation and microaggressions surfaced as subthemes that related to how participants communicate, feel, interact and experience the world of academic medicine. Representation addressed the concept of visibility and microaggressions were related to participants' gender and racial experiences with others within academic medicine.

### *Wanting to be Represented within the Academic Context*

Participants describe a network of representation within academic medicine. This network is composed of faces and spaces, such as the cohorts of students and the physical spaces within the academic medicine buildings. However, the participants do not see themselves as being represented within these networks. Julia shared “when I look at my class, I'm the only one." Laureana shared a similar experience saying “I'm the only Mexican female in a class of 200 students.  There's nobody I can talk about with this…. as to how I'm feeling." She goes on to describe what it felt like to sit in a large lecture hall and look around at the other people in her class, offering “I still get a little bit emotional... but every time that I sat in the classroom in the conference hall here in medical school and looked around me and all I could see was how small and insignificant I felt." These feelings of being “the only one”, were made more pronounced by the fact that many of

the participants utilized pipeline programs as their introduction to osteopathic medical school.

These programs were often composed of ethnically and racially diverse pre-matriculants, who participants identified as being more “similar” to their own backgrounds and experiences. These programs, as noted by participants, were highly structured and offered a lot of support related to day-to-day academic activities. However, a limitation of these programs noted by participants was the adjustment from a highly structured, diverse, and guided “pipeline” program into the “ocean” of matriculated status with less structure, an abundance of resources and lack of diversity. Once in medical school, many of the participants discussed feeling “overwhelmed” and having limited guidance on how to utilize and navigate the myriad of resources available to them. Additionally, they felt underprepared for the socially experienced feelings of isolation within their cohort which was not present within their former pipeline programs. Maria reports similar feelings of limited representation, though she acknowledges “I also knew before going into med school, no matter where I was going, the diversity was going to be very minimal to what I was used to." Similarly, Tiffany shares that she was surprised and saddened “that there wasn't a lot of Hispanics, in my year. I'm the only full Mexican, and coming from where I come from that is so out of the norm." She goes on to say:

> I guess that was like the biggest unexpected thing that I didn't really think of when I was like applying, I was kind of just like, this is a great school. I want to come here. This is great. And then I realized, I was like, wow, there's really not a lot of

> what I'm used to just, there's not a lot. And so that was, I think something that I wasn't expecting.

The experiences of limited representation were also described in the spaces in which the participants found themselves. Tiffany shared:

> In our hallway there's all the pictures of the graduates of previous years. And there was…. I remember a time... where there were classmates pointing out their uncle and their dad and their this.... and their...that... in the hallway. And I'm just like, omigosh... are you kidding me?!"

Participants discussed how they did not feel represented within the spaces and narratives of academic medicine, and further indicated what they saw reflected within the composition of their cohorts and the displays on the walls of the school was a visual reminder of what the institution values as well as, who is welcome and who fits in.

### *Dealing with Racial and Gender Microaggressions within the Academic Context*

Microaggressions are interactions or behaviors which communicate bias toward historically marginalized populations (Young, et al., 2020). In this subtheme, racial and gendered microaggressions were noted as common occurrences within the academic context, most often unnoticed by the aggressor but which had an emotional impact on the participant. These experiences were prevalent throughout participants' narratives and began in discussions about their transition into osteopathic medical school.

**Racial Microaggressions.** Laureana describes an incident in which she interviewed with a group of minoritized peers for osteopathic medical school in her home

state “Several of us sat in an interview, but basically got, well, what I got was we don't have enough seats for *your kind* ...like for your ethnicity.” This incident was pivotal for Laureana as she described how several of the others who interviewed with her changed their mind about pursuing a career in medicine, “They said, *forget it*. We're not going after this...that ruined us…for what we expect any other medical school to do to us.” To this, Laureana responds “I don't care how many other med schools I apply to, but I… *I* wanna practice osteopathic medicine.” Continuation of microaggressive experiences were noted after matriculation by many of the participants. Maria describes how she feels an undercurrent of negative sentiment within her peers “that they'll just discredit your hard work and your effort” regarding admission to medical school:

> They say this to some people, like, if they're minorities, like you only got in because you're a minority. They’ll be like... I'm better than you. And you only got in because you’re a minority and they play *that* card. (Maria)

Julia affirms Maria’s beliefs, and offered that “The whole aspect... kind of irritates me” and further says “we have the same credentials...it's just harder to get in.” In response to the microaggressive behaviors, participants discussed their acknowledgment that such incidents were often invisible to those who were in positions of privilege or power. Laureana recounted an incident in which she felt as if there was an instance of microaggressive behavior, “I go as far as to mention it to a professor and they're like, Oh, you know, you just, you might've been imagining it.” Thus, bias and microaggressive behaviors were more readily apparent to those who experience them. For participants, these instances are often met with limited support for remediation.

**Gendered Microaggressions.** Gendered microaggressions were also discussed by participants. For example, instances of incredulity from others were noted with participants sharing experiences related to patients not "realizing" they are student doctors. Many of the participants shared that they are first assumed to be nurses or other health support staff. For example, Maria shares a story about being in her hometown getting a coffee at a local shop. She encounters a former classmate who asks what she is currently doing. Maria offers that she is in medical school, and her classmate's first response is to question what she is studying, asking if it's nursing. Maria said:

> And then I give them a look…. I don't mean to, but it probably just... I'm just like, *NO*. And they're like…medical school?... like… *what* do you study? I'm like... *MEDICINE* to be a *DOCTOR."*

Differences in how participants perceived the experience within the academic environment were noted as being related to gender. Laureana spoke about noticing the difference in treatment between herself and male peers. She discussed that they are often given more positive feedback over her "the men are still the ones that get rated. Um, you know... still get the compliment from across the room... that's noticed. And usually, you know, they're sitting next to me or they're my partner." Miranda spoke about her participation in class as being diminished or talked over by her male peers, saying "even if I knew the right answer, they wouldn't listen. They would just listen to each other just because they have louder voices or. . . whatever it may be."

Ava, having advanced into residency, is working more independently within medical settings, and discussed that while she has encountered microaggressive issues

noted by the other participants, she has also encountered some increases in intensity of those experiences. She shares about a situation in which the intersections of being a doctor, a woman and a mother, was met with aggressive resistance. Ava offers “This one like really hurt me for like a few days” recounting how during an on-call rotation within the Intensive Care Unit (ICU) a postpartum woman who had been breastfeeding, was highly stressed after coming out from emergency surgery. She had become engorged with breastmilk and was crying because she thought she was starving her child. Ava noting “This woman was. . . *IN DISTRESS*. . . She kept screaming ‘*my God, my milk, my milk, my baby, my baby, my baby’."* Ava offered to assist the male surgical resident and indicated that she could get a breast pump to at least “pump and dump” the breast milk in an effort to calm the patient. However, Ava was met with significant aggression in response “And he just... like went into a rage... and it was just…horrible." A witness to the incident, Ava recalled, tells her she should never have said anything. Despite the negative interaction, she believes that it was an “an opportunity” for the team she was part of “ to learn how to take care of a woman… who's just had a baby." Later, Ava reflected that she sought out additional feedback from another surgeon who agreed with her initial plan to assist the distressed patient. Ava reports, “He was just like, no, I think actually it sounds like a pretty good idea and would have helped her. It would've helped her blood pressure... it would have helped her." While the shock of the incident carried with Ava for days, it served to further her belief that caring for patients requires a holistic appreciation of patients, that they are more than just their presenting diagnosis. Ava’s story lends itself to the idea that many participants discussed, in that they feel

“discredited” and that they “have to work harder”, to be recognized for their contributions and success.

Many of the participants had difficulty articulating an answer to the question related to the expectations for women as Latinx within osteopathic medical school. Maria says “I don't think there's many expectations placed on us. I don't think that necessarily means they expect us to fail or anything”, she further elaborates by offering: “Like they don't expect you to know things, or they don't expect to be impressed by you." Interestingly, many of the expectations that were placed on participants were related to their negotiation of family and motherhood with career trajectory or specialty. Julia offers that she feels that there is an “expectation of caregiving or putting aside, career aspirations for family. So, Oh, well you should freeze your eggs. Like you should put all these things aside so that you can go ahead and *procreate* versus *educate*.” Several of the participants discussed how they were told “family medicine” would be an ideal choice because they would not have to worry about “late nights” away from their families. While Miranda shared about researching the idea of becoming a physician assistant rather than a doctor, as it would potentially give her more “time” to plan a family.

> So is it realistic to be a female, have a family or get pregnant and still be able to do everything else?... Some people were like, PA school is the best because it'll give you time. But then I thought about myself and it's like, I *WANT* to become a physician. I shouldn't let my gender affect the decision of me wanting to go into medical school (Miranda)

Miranda shared how when discussing her interests in “pediatrics and psychiatry” a male physician indicated that while he could see her in pediatrics, he would not consider something like “surgery or orthopedics” to be a good fit for her. Miranda said:

> And now I look at it….I feel like that…. that culture... is like very male dominated. So is that what he's *trying* to say? Like, am I too friendly? Or like, too, like….. I don't know. Why does he….why am I with kids? *Because* I'm a female that I'm going to be *with* kids?

The gendered microaggressions noted in participants’ narratives point to the concept of gender being deeply ingrained in societal and cultural beliefs about the appropriate roles and activities of men and women. Of significance, is the frustration all of the participants described related to their reproductive choices, specifically expectations that participants must make decisions and behave in ways that supported being a “mother” over being a doctor.

**Utilizing Lived Experiences to Inform Practice (Intersecting Existentials)**

In this theme strengths across the existentials of lived time, lived space/lived human relationships and lived body are discussed as being factors in the development of participants’ professional attitudes toward their practice and their patients. Beginning with lived time, the development and continued utilization of “core” beliefs about participants' purpose and rationale for becoming osteopathic physicians were noted as important mechanisms to develop foundations of relationships with patients. Ava describes how she believes “healing and health isn't just the symptoms- it's getting a

holistic appreciation of the patient and the world they live in." The same appreciation for a holistic understanding of patient care is present within all the participants' narratives.

The foundational belief of a holistic appreciation and treatment of patients underscores many of the participants' "core" beliefs as to why they have decided to become a physician. As the narratives shift toward discussions about clinical interactions with patients, participants articulated a strong preference to join with patients to create a shared sense of purpose within their clinical relationships. Laureana described how her experience doing medical outreach work sometimes going "out into the actual farms or the Apple orchards where our Spanish speaking patients were because they didn't have vehicles, or they didn't have transportation to come and get a blood pressure reading or insulin." improved upon her "capacity as a healthcare provider... I got to live that through… kind of... the patient's world." In this way, the cultivated collective power participants developed within their familial, social, and academic environment was then recreated in their emerging occupational environment as a means for further developing a relationship of mutual understanding between themselves and their patients.

All the participants discussed their belief in having good communication including the ability to "listen" as a way to better serve their patients, especially those who may be more apt to be underserved in medicine. Within the frame of lived body, ideas about representation centered around clinical experiences aimed at making "the invisible-visible" and what that means for patient connection. Ava shared that often without the foundational belief of holistic appreciation, nuances about comprehensively caring for patients may be missed.

> I evaluated him head to toe and his sacrum, his butt bone was just like completely flipped back. And if you know the anatomy, it's all connected. Especially right here..to... there. All I did was treat his butt bone. He's like laying on his belly and you just readjust real quickly or whatever. And he got up off the table and he was like, thanks so much, doc. You know, like the value of taking and listening….I, would've never known he was a truck driver. If I hadn't asked... I would've just been at his neck. (Ava)

> I want to really be that person, you know, you know, I understand them, I understand the culture. I understand, you know...the culture and... a lot of their beliefs and I really want to be that doctor of osteopathic medicine...who considers all the factors...looking at a patient as a whole. And I feel like in order to do that… is by truly understanding the patient and where they're coming from. (Tiffany)

Maria shared an example of an interaction she had when caring for a blind and deaf patient, who was presenting for treatment, "And so *he* let me know what his issue was. The resident was like, how'd you even get him to talk? I'm like... to be honest, I don't even know. I think I was just patient enough to listen."

Reflected in several of the participants' narratives, they share that they perceive themselves to be more aware of the elements of empathy, compassion, and patience especially as it relates to caring for others. All participants believe these are important skills which improve their effectiveness in practicing medicine. As each of the participants shared about their development and growth in their knowledge, skills and

abilities as osteopathic physicians, their noted experiences have aided and enhanced their practice. Specifically, their "core" beliefs, collective power, and awareness of the implications of culture and gender to inform patient care activities. Notably, with patients who are underserved in medicine.

## Summary

For this chapter, I addressed findings from the data to respond to the guiding research question: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture? Consequently, findings correspond to the purpose of this research study to understand the experiences of women who identify as Latinx and are completing their medical studies in Osteopathic Medicine in the Northeastern United States. Using rich, thick data to exemplify components of the themes, I have supplemented excerpts from participant narratives to demonstrate and examine the convergence across the experiences of the participants. The findings described in this chapter begin to explore and understand the experiences of women as Latinx osteopathic medical students.

Highlighted in the participants narratives were instances in which they were able to overcome challenges both academically and socially to move past cultural and gender expectations. Cultivated construction of collective power, personal agency and boundaries were cited as a source of empowerment and support commonly among the participants and continue to remain as a vital component in the development of their practice. The next chapter will focus on interpretations and discussion of the findings, especially in relation to future directions for research, practice, and education.

# Chapter 5

# Discussion

This chapter presents a discussion of the findings of the study. To provide a context for the discussion, a review of the problem and its significance and the purpose of study, as well as a summary of the findings, is presented. The results are discussed in the context of the research on the experience of women as Latinx osteopathic medical students. Following the discussion are implications for practice, policy, future research and a concluding statement.

## Review of Problem

Inadequacies in the number of physicians, especially from underrepresented minoritized groups, have hindered efforts to provide extended healthcare access to underserved communities (Caldwell, 2015; Raymond-Flesch, et al., 2014; Smedley et al., 2003). As populations increase in their diversity, it is critical that healthcare practitioners are prepared to care for patients with varied belief systems, customs, language barriers, social structures, and other cultural differences (Cohen et al., 2002).

This is of critical importance as population growth estimates project that while the Latinx population is quickly increasing, the number of physicians from these groups remains disproportionately small (Current Trends in Medical Education, n.d.; US Census Bureau, 2016).

Current research on minoritized students pursuing a career in medicine has been primarily deficit focused (Barr et al., 2008; Hadinger, 2017; Levinson, et al., 2013; Miller-Matero et al., 2018; Rao & Flores, 2007; Thomas et al., 2011) and has typically

combined historically marginalized students into one large group or failed to capture the experiences of women as Latinx medical students (Babaria, et. al., 2012; Chapman, et al., 2019; Miller-Matero, et al., 2018; Xu, et al., 1998). This is problematic because it places the burden on the students who are left behind for their predicament, rather than on the practices and policies which perpetuate inequitable systems. Additionally, combining marginalized groups presents a limited focus which assumes all marginalized students have the same racial, gendered, and cultural experiences regarding their education.

**Significance and Purpose**

This examination is important to medical educational research and practice and policy for multiple reasons. This research can assist in creating a strength focused narrative about women as Latinx osteopathic medical students. The first objective was to provide a platform for women as Latinx osteopathic medical students to narrate their story, in their way, from their perspective. The next objective was to provide a lens to view the experience of female Latinx medical students. The third objective was to provide information that may be useful in understanding the experience of female Latinx osteopathic medical students as they move through medical school. The purpose of this research is to contribute to the appreciation of multidimensional aspects of identity as well as how multiple identity experiences impact individuals, from students to patients. As a result, the findings operate in response to the guiding research question: How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?

## Summary of Findings

Findings were gathered across twelve interviews from six participants (i.e., two interviews per participant) identifying as women as Latinx osteopathic medical students, provided rich, thick qualitative data stemming from narrative experiences. The findings, which were analyzed and framed using van Manen's (1997) lifeworld existentials converged into the following themes,

- Negotiating Expectations (Lived Time)
- Navigating the Collective (Lived Space and Human Relationships)
- Belonging in Osteopathic Medicine as A Latinx Woman (Lived Body)
- Utilizing Lived Experiences to Inform Practice (Intersecting Existentials)

vanManen (1997) defines the existential of lived time as the subjective understanding of time rather than a more factual sense of time, such as what is measured on a clock. The first theme, negotiation of expectations, is framed by lived time and captured the feelings or emotions which influence how participants experience the time transitioning from student to student doctor within osteopathic medical school. These experiences were discussed by participants as a complex experience, often occurring during significant periods of transition or experience of educational, occupational, and emotional reconciliation of personal identity as an emerging osteopathic medical student. Additionally, findings were described as participants initial educational interests and exploration as they fostered and solidified development of "core beliefs" related to their desire to pursue a career in medicine by becoming an osteopathic physician. Further, findings in this theme were related to participants' descriptions of their expectations

regarding assuming the new identity of student doctor, and the the convergences and divergences of their expectations regarding the experience.

The second theme, navigating the collective, is framed with the combined existentials of lived space and lived human relationships. As defined by van Manen (1997), lived space is the reciprocal interaction of the way a space affects how one feels and those feelings affect how one experiences a particular space. Lived human relations refers to the relationships with others within shared interpersonal space (1997).

Within this second theme, the profound internal shifts around self-efficacy and competency related to being a medical student were discussed. For participants, this was the reality of their expectations. For some, these adjustments meant reorganizing their sense of self regarding their academic standing. All the participants spoke of being good students and high academic achievers, which had previously set them apart from many of their peers during their undergraduate education. However, within medical school, the reality was they were now among only the high achievers. This led to an adjustment of self-perception regarding their place within the academic community.

Further, findings within this theme, connect to the values and importance of a collective power. This initial collective was described by participants as their families, but matriculation into osteopathic medical school challenged this system and created conflict within their relationships. However, participants maintained that their families support was central to their perseverance and determination. In turn, this led to the cultivation of support systems which mirrored the support they gleaned from their familial networks. These groups provided opportunities to embrace their culture, share stories and develop “community”. Therefore, the idea of community is not one merely

suggestive of location or group- but as a blurred space characterized by everyday relationships and co-existence.

The third theme was framed by the existential of lived body, which refers to the physical bodily presence in the world. Within this frame, the theme of belonging in osteopathic medicine as a Latinx woman was related to how participants communicate, feel, interact, and experience being in osteopathic medicine. Participants describe a network of visible representation within academic medicine composed of faces and spaces, such as the cohorts of students and the physical spaces with the academic medicine buildings. Noted in the narratives for participants was the idea that what they saw reflected within the composition of their cohorts and the displays on the walls of the school was a visual reminder of what the institution values as well as, who is welcome and who fits in. Microaggressions were noted as being related to race and gender. As noted by participants, these experiences most often were unnoticed by the aggressor but had an emotional impact on the participant. Both racial and gendered microaggressions were often met with limited support for remediation.

The fourth theme, utilizing lived experiences to inform practice, strengths across the existentials of lived time, lived space/lived human relationships and lived body are discussed as being factors in the development of participants' professional attitudes toward their practice. Findings in this theme were related to ideas about participants "core" beliefs, collective power, and awareness of the implications of culture and gender to inform patient care activities, notably with individuals who are underserved in medicine.

## Discussion

While educational research has sought to affirm its commitment to social justice, it has been prone to engage in deficit-based research (Nicholson & Cleland, 2017). Existing research often offers perspectives that do not appropriately capture and address the strength of Latinx communities. The use of an intersectional framework enables identity to be viewed as a whole, recognizing that one is neither minoritized or a woman, nor is one minoritized plus woman, but rather a minoritized woman (Walton, 2017). Therefore, life experiences are both racialized and gendered (Bernal, 2001. Latino Critical Race Theory (LatCrit) provides a necessary orienting lens for this research, as it seeks to explore experiences and structures of oppression specifically focused on Latinx concerns (Solorzano & Bernal, 2001). Using these two epistemological paradigms allows for the experiential knowledge of this community to elucidate and orient the content and meaning of their multidimensional identities "by situating it among groups of people traditionally unheard and spaces continually unexplored" (Galvan, 2001 p. 607).

To mitigate the limitations, present within deficit centered research, the ideas presented in the Community Cultural Wealth (CCW) model (Yosso, 2005) help shape the following discussion about the experiences of women as Latinx osteopathic medical students using a strength-based perspective. The strengths based CCW model is informed by a range of theories pertaining to minoritized groups, including women (De Graca& Dougherty, 2015). Introduced within the model, Yosso (2005) identifies six forms of capital: aspirational, linguistic, familial, social, navigational and resistance.

### *Aspirational Capital*

Within the CCW framework aspirational capital refers to ability to maintain hopes and dreams even when faced with challenges (Yosso, 2005). Some sources of aspirational capital were present from pre-matriculation while others developed during the program. All of the participants had worked in health and caring roles prior to osteopathic medical school. These experiences were instrumental in participants' informed understandings of medicine and healthcare, and they also ignited profound interest and fostered the early development of their physician identity. This lends itself to the existing literature noted in chapter 2 that exposure to healthcare careers and medicine facilitates the exploration and matriculation into medical school for minoritized students (Rao & Flores, 2008).

While experience is an important component in a student's matriculation into medical school, it is only one part of the equation. Research described in chapter 2 have shown that minoritized students were more likely than non-minoritized students to experience lower scores on the MCAT and graduation delays (Davis et al., 2013; Orom, 2013; Soto-Green, et al., 2005). Findings from the current study confirmed previous research as two participants repeated a year of course work, while others made repeated attempts at taking and securing a passing score on the MCAT.

Many of the participants acknowledged that they experienced and overcame academic hardships. Each participant also articulated a clearly established ambition to become a physician, often described as a ‘passion’ or a “core”. Two participants, Ava and Laureana, described how a family crisis had threatened their continuation. However, their aspirations to become physicians were the reason they each stayed. Several of the participants, like Ava, describe their aspirational goals and beliefs as being entwined with

aspects of self- efficacy. Self-efficacy is “rooted in the core belief that one has the power to effect changes by one’s actions” (Bandura, 2004 p. 622). For the participants, their noted self-efficacious beliefs provided the underpinning for motivation, well-being, and achievement. This is particularly critical in intense learning environments such as osteopathic medical school, where learning is dependent on overcoming a range of doubt-inducing intellectual, social, and motivational challenges (Klassen &Klassen 2018).

### *Linguistic Capital*

Linguistic capital refers to strength of communication, derived from various experiences such as, acting as an interpreter or listening and sharing cultural based stories which enhances "memorization, attention to detail, dramatic pauses, comedic timing, facial affect, vocal tone, volume, rhythm and rhyme.” (Yosso, 2005 p. 79). Linguistic capital becomes exceptionally important when looking at cultural resources and skills within clinical interactions (Shim, 2010). These cultural resources, skills, dispositions and interactional styles impact patients and providers alike in their ability to obtain and deliver patient-centered care (Dubbin et al., 2013).

For one participant, this strength was developed early in her life, as she often acted as an interpreter for her parents. Yosso (2005) claims that this type of experience enhances the ability to be attentive to the verbal and nonverbal details of communication. This attentiveness is not just about speaking, but actively listening as well (Marte,2019). Fishman (2012) discussed the idea that to be an effective physician, requires the ability to “heal what hurts, on both a physical and emotional level. The key to making this therapeutic connection with your patient, in a word, communication” (p.4). All the

participants discussed their belief in having good communication including the ability to "listen" to better serve their patients.

As the participants' experiences demonstrate, linguistic capital becomes exceptionally critical when looking at the importance of cultural resources and skills within clinical interactions (Shim, 2010). These cultural resources, skills, dispositions and interactional styles impact patients and providers alike in their ability to obtain and deliver patient-centered care (Dubbin et al., 2013).

### *Familial Capital and Social Capital*

Familial capital and Social capital refer to the social and personal human resources students have, which are drawn from their extended familial and community networks. As Gofen (2009) explains, "a family can overcome adverse circumstances by using its behavioral, emotional, and relational assets [and] emerge from difficulties feeling strengthened and more confident" (p. 106). The assets derived from this capital are then invested into educational attainment. For participants, strength comes from a sense of "communal goals" which is supported with increasing evidence that having a higher level of a prosocial and communal goal orientation aids in retention within biomedical sciences (Allen et al., 2015).

For many of the participants familial capital was leveraged from their involvement in Latino Medical Student Association (LMSA) which was described as "family". The advantage of having a sound educational and occupational network should not be underestimated (Toretsky et al., 2018). Based on existing literature, exposure to supportive networks within the medical education field is a powerful tool to ensure the matriculation and completion of medical school for minoritized students (Alfred, et al.,

2011; Guerrero, et al., 2015; Smith, et al., 2009). This was true for all the participants in this study, many of whom shared their experiences and professional development they found with LMSA. These networks, particularly with LMSA, allowed participants to develop a secure base from which strength was derived.

Research has shown that students often find themselves isolated as they study for exceptionally long periods of time while they prepare to take examinations (Reddy & Sindhu, 2019). The culture of academic medicine is a competitive and academically intimidating environment which has often led to a lack of supportive peer networks (Hurtado, et al., 2009). Research has demonstrated how social support is an important means through which the negative effects of stress can be mitigated. Within academic medicine, minoritized students arguably have an increased need for comprehensive social support due to noted feelings of isolation and microaggressions they experience during their studies (Syed et al., 2011). Therefore, it is of critical importance to medical student success that they have access to and receive adequate support from their peers and mentors.

### *Navigational Capital*

Navigational capital refers to the set of skills that help students maneuver through the dominant cultural norms present within many educational institutions (Kouyoumdjian et al., 2017). Some examples of challenges faced by participants were feelings of isolation, perceptions of racism, and gendered expectations from faculty or peers (Youmans et al., 2020; Marte,2019). The literature revealed studies in which minoritized students expressed experiencing discriminatory and microaggressive interactions within medical education (Odom et al., 2007; Rao & Flores, 2007). Congruent with literature in

Chapter 2, participants in the study cited instances when racial and gendered microaggressive comments or discriminatory behavior was observed. They described instances in which discrimination and microaggressive instances happened during their interactions within osteopathic medical school. However, some of the gendered microaggressive comments came from participants own support network, aligning with existing research that conflict may arise from families wanting them to succeed but also not understanding the rigors and personal sacrifice involved in the educational and training process (Barr et al., 2008; Freeman, et al., 2016). The most frequently cited area of conflict was regarding the gendered experiences of child rearing and familial responsibilities.

Thus, it becomes apparent that the process of becoming a physician includes many subtle practices related to racial and gender inclusion and exclusion, both within academic medicine and support systems, which have important implications for medical students' study and working conditions (Soliman et al, 2019). The importance of individual agency is also recognized within navigational capital (Huber, 2009). Individual agency is "understood as a relational construct that emerges through interaction with a wider socio-cultural context" (Schoon &Heckhausen, 2019 p.148). Bronfenbenner (1989), asserts that in addition to the wider social context, the ways in which individuals interact with this context should also be considered. For example, participants' reliance on their "core" beliefs enabled them to remain resolute in their clearly established ambition to become a physician. Additionally, within institutions social connections and networks such as participants membership within LMSA serve as factors that assist their successful navigation of osteopathic medical school (Huber, 2009; Yosso, 2005).

### *Resistance Capital*

Resistance capital "refers to those knowledges and skills fostered through oppositional behavior that challenges inequality" (Yosso, 2005, p.80). Of importance is the idea that resistance capital acknowledges the power of human agency like confidence and assertiveness in standing up on one's behalf (Solorzano & Solorzano, 1995). The strength in resistance is that it positions students to leverage their education and training to enter society as osteopathic physicians, prepared to solve challenging problems regarding healthcare access, equitable healthcare practices and other social outcomes (Cooper, 2021;Revelo & Baber, 2018; Rincón, 2020).

Resistance also serves as motivation to continue and succeed within osteopathic medical school. For example, participation in LMSA not only functioned as a mechanism for navigational capital, but also as means of resistance and support in the participants' persistence in their medical education. Such organizations provide a network of students who support one another while also working together to develop additional tools for increased persistence as well working to dismantle institutional barriers to persistence (Huber, 2009).

## Orienting Theories Revisited

Acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of experiences of people from historically marginalized populations. Attempting to understand experiences related to the navigation of academic medicine for women as Latinx osteopathic medical students through a single lens (e.g., gender or race) fails to capture the complex ways in which multiple social categories intersect with social discrimination based on those multiple intersecting categories

(Bauer, 2014; Bowleg, 2012). Intersectional feminist theory and Latino critical race theory examines the experiences of women as Latinx osteopathic medical students in their own context and from their vantage point rather than their deviation from the norms of the hegemony (Cooper et al., 2018; Huber,2010).

In this research, women as a Latinx osteopathic medical students narrated experiences within academic medicine that were connected to multiple and interlocking issues of sexism and racism on both a large social level as well as an interpersonal level. Their experiences at the intersection of their race/ethnicity, and gender correspond with empirically documented evidence of the racism/sexism that women often encounter as they pursue careers in medicine (Hill et al, 2020). Therefore, the combination of Intersectional Feminist theory and Latino Critical race theory aids in the elucidation of how systems of privilege and oppression result in multiple social inequalities (e.g., sexism, racism) and how those intersections at the both the social-structural and interpersonal level maintain disparities.

**Implications: Practice, Policy and Research**

The findings of this study are significant in that they expand the scope of existing literature on women as Latinx osteopathic medical students. In reviewing scholarly literature, numerous studies highlighting the issues surrounding the low number of minoritized students pursuing careers in medicine are limited in their focus regard minoritized students as a monolithic group (Babaria, et. al., 2012; Chapman, et al., 2019; Miller-Matero, et al., 2018; Xu, et al., 1998).

This research provides empirical data which addresses the gap in literature specifically regarding the experiences of women as Latinx osteopathic medical students

in the northeastern United States. In the following section, implications for practice, policy and research will be addressed- not as problems or limitations, but as opportunities to learn skills and tools to support women as Latinx osteopathic medical students.

***Practice***

The findings of this study reveal information about the experiences of women as Latinx osteopathic medical students that will provide medical education leaders, such as medical school deans, medical school recruitment professionals, and diversity affairs officers, with a new awareness of the factors that impact student academic experience. The findings underscore the importance of personal and collective agency as a means for medical schools to create and sustain supportive networks for students.

While support networks are important, this level of support must also extend to the idea of allyship to address racial, cultural, and gendered microaggressions in the clinical and learning environments. Further, the findings point to “leaks" in the pipeline once students are matriculated into medical school. An increase in attention could be placed on the structural determinants of academic success along with provisions for clear processes by which students can report challenges and seek assistance. Research on the self-efficacy beliefs of medical students builds understanding of students’ choices, level of effort, and persistence, and has the potential to inform instructional practices.

In addition, knowledge from the findings can ultimately assist medical education leaders, healthcare officials, and governmental agencies in addressing the issues of inequitable healthcare access and minority physician shortages within academic medicine as well as within the healthcare system.

***Policy***

The literature is replete with challenges faced by minoritized medical students (Crisp, et al., 2015; Franklin, 2013). As previously identified, commonly utilized deficit-based approaches tend to overlook institutional barriers such as discriminatory and microaggressive practices in academic medicine settings, and a lack of faculty representation (Samuelson &Litzler, 2016). As a result, developing policies which are informed by deficit-based approaches tend to fail to generate effective institutional changes necessary to address the challenges faced by minoritized students (Heinbach, et al., 2019). While institutions may not intend for their culture or policies to inhibit the academic and professional development of minoritized students, unexamined biases may be influencing practices (Thompson-Burdine, 2019). To mitigate this, policy makers should seek out assets-based approaches, such as community cultural wealth, which can bolster factors that support the perseverance of women as Latinx osteopathic medical students (Samuelson &Litzler, 2016; Yosso, 2005).

The findings from the narratives provided by participants, reflect their reliance on "community" as a source of strengths, thus providing them with increased success and effectiveness in their experiences. This finding recognizes the importance of continuously enlisting the input of the individuals directly affected by the programming and policies being developed within academic medicine as it promotes solutions which are rooted in the expertise of the community.

Rios-Aguilar and associates (2011) advocate for institutions and policy makers to "make explicit the instances and mechanisms utilized by educational institutions and institutional agents to deliberately misrecognize the forms of capital and funds of

knowledge of under-represented students" (p. 176). In garnering support and participation from the community and the individuals directly affected by policies, institutions may be able to better examine how their policies necessitate resistance.

### *Research*

There is a need for more research on the experiences of women as Latinx osteopathic medicine students. More specifically, there is a need to create a more robust body of knowledge regarding the experiences of these women within academic medicine as well as in direct practice to deepen points of interest found in the data.

Since this study was inclusive to the research site, one area of further research would be to study the experiences of women as Latinx osteopathic medical students at other institutions. This would allow the themes of this study to be further explored with potentials to discover new areas of convergence and divergence. This, in turn, could highlight more specific institutional practices and policies that are connected to the osteopathic medical school experiences. Studies examining curriculum development as well as the knowledge, skills and attitudes of medical school faculty, admissions officers and administration regarding minoritized osteopathic medical students. Further consideration to the ideas present within the Community Cultural Wealth model (CCW) as well as the structure and culture of academic medicine institutions may aid in the disruption of deficit focused narratives and practices warrant further research.

## Conclusion

Existing research has had a limiting focus on the experiences specific to women as Latinx medical students, a gap has been created, which restricts knowledge about experiences of perceived support and barriers within osteopathic medical school. This

research provided an opportunity to think more deeply and critically about the experiences for women as Latinx osteopathic medical students. The data collected was gathered from participants as they narrated their story, in their way, from their perspective. In existing literature, researchers have predominantly examined issues related to minoritized groups by juxtaposing differences and outcomes among groups without attention to the diversity of experiences, challenges and strengths.

Additionally, the scope of knowledge is further impeded by the utilization of deficit-based frameworks which fail to honor and recognize marginalized communities (Bernal, 2002). I specifically chose to capitalize on Yosso's (2005) Community Cultural Wealth model to provide a counterpoint to deficit discourse and highlight the contributions and strengths of these groups and communities. This study examines the complete and complex experiences of women as Latinx osteopathic medical students – drawing from the influences of gender, ethnicity, and other intersecting components. This study is offered as evidence of how strength-based frameworks can make visible the power of women as Latinx osteopathic medical students in their advocacy for well-being and health equity of the patients they serve.

Rooted in the participants narratives are anecdotes in which they demonstrate abilities to leverage their power and resources in ways that are often unaccounted for in research and academic medicine. It is through these narratives that everyday resistance and agency were made visible. It is my fervent hope that this research will help further engage and guide the work that is still necessary in addressing the experiences of women as Latinx osteopathic medical students.

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## Appendix A

## Recruitment Letter

Dear [Student]

My name is Dana Weiss and I am doctoral candidate in the School of Education at Rowan University. I am conducting a research study as a part of my dissertation, focusing on the experiences of first and second year Latina osteopathic medical students. You are invited to participate in the study. If you agree, your participation will consist of an online interview of approximately 1 hour in duration and a follow up interview of approximately 30 minutes.

Participation in this study is voluntary and will have no impact on your relationship with Rowan University. Your identity as a participant will remain anonymous at all times- during and after the interview.

If you have any questions or would like to participate, please contact me at weissdl@rowan.edu or 856-566-7173.

Thank you for your participation,

Dana Weiss

Rowan University

## Appendix B

## Informed Consent


**TITLE OF STUDY:** The Experiences of Women as Latinx Osteopathic Medical Students **Principal Investigator:** Dr. Cecile Sam

You are being asked to take part in a research study. This consent form is part of an informed consent process for a research study and it will provide key information that will help you decide whether you wish to volunteer for this research study.

Please carefully read the key information provided in questions 1-9 and 14 below. The purpose behind those questions is to provide clear information about the purpose of the study, study specific information about what will happen in the course of the study, what are the anticipated risks and benefits, and what alternatives are available to you if you do not wish to participate in this research study.

The study team will explain the study to you and they will answer any question you might have before volunteering to take part in this study. It is important that you take your time to make your decision. You may take this consent form with you to ask a family member or anyone else before agreeing to participate in the study.

If you have questions at any time during the research study, you should feel free to ask the study team and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

The Principal Investigator, Dr. Cecile Sam or another member of the study team will also be asked to sign this informed consent.

**1.** W**hat is the purpose of the study?**

I am a student within the Department of Education working on my dissertation. I am seeking to understand the experiences of women as Latinx osteopathic medical students.

## Informed Consent Continued

**2. Why have you been asked to take part in this study?**

You are being asked to participate in this study because you meet all of the following criteria: 1) be enrolled as an osteopathic medical student 2) Identify as a woman 3) Identify with one or more of the following categories: Afro-Latina, Chicana, Boricua, Hispanic, Latina/x, Central American, South American 4) Be willing to participate and have read and signed the informed consent document.

**3. What will you be asked to do if you take part in this research study?**

You will be asked to participate in two 90 minute online interviews using a videoconference application (either Zoom or Webex) on a date and time of your choosing.

**4. Who may take part in this research study? And who may not?**

We wish to have anyone who meets the criteria outlined above. The nature of this study is extremely specific to this targeted population. If students are not part of the targeted population, they will be excluded from the study.

**5. How long will the study take and where will the research study be conducted?**

The research will take place entirely online and will last approximately 3 months in duration.

**6. How many visits may take to complete the study?**

You will need to need to participate in two 90 minute interviews

**7. What are the risks and/or discomforts you might experience if you take part in this study?**

There is little to no risk of harm, however participants may feel some discomfort when discussing educational experiences which they found upsetting, however this is not the focus of the study.

**8. Are there any benefits for you if you choose to take part in this research study?**

There may not be any direct benefit. Results of our study may help enhance our ability to develop some guidelines with respect to cultural competency within osteopathic medicine that would in general, benefit students and society.

**9. What are the alternatives if you do not wish to participate in the study?** Your alternative is not to participate in the study.

**10. How many subjects will be enrolled in the study?** A maximum of 20 participants will be enrolled in this study

**11. How will you know if new information is learned that may affect whether you are willing to stay in this research study?**

During the course of the study, you will be updated about any new information that may affect whether you are willing to continue taking part in the study. If new information is learned that may affect you, you will be contacted.

**12. Will there be any cost to you to take part in this study?** There is no cost to you to participate.

## Informed Consent Continued

**13. Will you be paid to take part in this study?**

You will not be paid for your participation in this research study.

**14. Are you providing any identifiable private information as part of this research study?** We are collecting identifiable private information in this research study. Your identifiable information will not be used in any of the future research projects or disclosed to anyone outside of the research team.

**15. How will information about you be kept private or confidential?**

All efforts will be made to keep your personal information in your research record confidential, but total confidentiality cannot be guaranteed. Your personal information may be given out, if required by law. Presentations and publications to the public and at scientific conferences and meetings will not use your name and other personal information. Data will be collected electronically, using audio-recording software within the online video conferencing application (either Zoom or Webex), upon which participants will be fully briefed. Data will be kept in password protected and dually authenticated files on the university's Google Drive, to which only the PI's will have access. Data will be stripped of identifiers (participant names) and aliases assigned. The participants' informed consent will be kept in a separate, password protected file and will not be linked to participant data. Data will be analyzed using qualitative procedures consistent with the phenomenological approach, using password protected files to which only the PI's will have access. Data will be destroyed upon the completion of the project.

**16. What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?**

Participation in this study is voluntary. You may choose not to participate or you may change your mind at any time.

If you do not want to enter the study or decide to stop participating, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing to Dr. Cecile Sam, sam@rowan.edu or to Rowan University, 201 Mullica Hill Rd., Glassboro, New Jersey 08028

If you decide to withdraw from the study for any reason, you may be asked to participate in one meeting with the Principal Investigator.

**17. Who can you call if you have any questions?**

If you have any questions about taking part in this study or if you feel you may have suffered a research related injury, you can call the Principal Investigator:

Dr. Cecile Sam sam@rowan.edu

856-256-4500 x 53827

If you have any questions about your rights as a research subject, you can call:

Office of Research Compliance
(856) 256-4058– Glassboro/CMSRU

## Informed Consent Continued

**18. What are your rights if you decide to take part in this research study?**
You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

**AGREEMENT TO PARTICIPATE**
I have read the entire information about the research study, research risks, benefits and the alternatives, or it has been read to me, and I believe that I understand what has been discussed.

All of my questions about this form or this study have been answered and I agree to volunteer to participate in the study.

Subject Name:_____

Subject Signature: _____ _____
Date:

**Signature of Investigator/Individual Obtaining Consent:**
To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent:_____

Signature: _____ Date_____

# Informed Consent Continued

Title: The Experiences of Women as Latinx Osteopathic Medical Students
Principal Investigator: Dr. Cecile Sam

**ROWAN UNIVERSITY INSTITUTIONAL REVIEW BOARD**
**AUDIO/VIDEOTAPE ADDENDUM TO CONSENT FORM**


You have already agreed to participate in a research study conducted by Dr. Cecile Sam and researcher Dana Weiss. We are asking for your permission to allow us to record the Zoom/Webex interview as part of that research study.

The recording(s) will be used for analysis by the research team;

The recording(s) will include recording will include full facial pictures.

The recording(s) will be stored in a secure, encrypted and password protected environment with access limited to the study team.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

**AGREEMENT TO PARTICIPATE**

I have read the entire information about the research study, research risks, benefits and the alternatives, or it has been read to me, and I believe that I understand what has been discussed.

All of my questions about this form or this study have been answered and I agree to volunteer to participate in the study.

Subject Name:_____

Subject Signature: _____
Date:_____

**Signature of Investigator/Individual Obtaining Consent:** To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent:_____

Signature: _____ Date_____

# Appendix C

## Interview Protocol

RQ:

'How do the participants describe their osteopathic medical school experience with regard to their identified gender and culture?'

*The following protocol is a modified version of the protocol as described in Johnson (2014)*

**Interview Protocol**

I may not ask every specific question below, but I will make sure to cover all of the topics.

1. How do you describe your gender identity at this time?

2. How do you describe your cultural identity?

**Lived Time**

1. Describe your educational progression from college up to your current standing as an osteopathic medical school student.

    a. How did you prepare for your role as an osteopathic medical student?

2. Prior to your entrance into osteopathic medical school, what were your expectations?

    a. Now that you are in the program, describe how your experiences are the same, or how they differ, from your initial expectations.

4. How do you prioritize time for your academics?

**Lived Space/Lived Human Relation**

1. Describe your life outside of school.

2. How are your academic pursuits impacted by your non-academic pursuits?

a. How do you negotiate your various commitments?

b. Tell me about your family life in relation to your academics.

3. Describe the roles you have within your academic environment.

a. How do you negotiate these roles?

b. Tell me about your peer relationships in relation to your academic environment.

4. Describe the roles you have outside the academic environment?

a. How do you negotiate these roles?

## Interview Protocol Continued

**Lived Body**

**(The participant's preference for identity will be used as descriptors)**

1. Describe what being a woman in academic medicine is like for you.

2. How do you believe gender has shaped your academic path and development?

3. How do you believe culture has shaped your academic path and development?

3. What are the expectations of "XXX" women in your world?

   a. Outside of osteopathic medical school?

   b. Within osteopathic medical school?

4. How do you negotiate those expectations with your own beliefs and values?

I will close the interview with the following question: "Are there any additional personal life experiences that have contributed to your knowledge, ideas or beliefs about being an osteopathic medical student"?

# Appendix D

# IRB Approval

**DHHS Federal Wide Assurance Identifier**: FWA00007111
**IRB Chair Person**: Dr. Ane Johnson
**IRB Director**:
**Effective Date:** February 4, 2021

**Notice of Approval - Modification**

**Study ID**: PRO-2020-84
**Title**: The Experiences of Women as Latinx Osteopathic Medical Students: A Phenomenological Study
**Principal Investigator**: Cecile Sam
**Study Coordinator:** Dana Weiss
**Study Expiration Date:** December 20, 2021
**Submission Type:** Modification
**Submission Status:** Approved
**Submission Approval Date:** February 4, 2021
**Review Type:** Expedited
**Expedited Category:** 6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
**Description/Summary of Modification:**
Changed enrollment criteria, all medical students, regardless of 1st or 2nd year.
ALL APPROVED INVESTIGATOR(S) MUST COMPLY WITH THE FOLLOWING:

1. Conduct the research in accordance with the protocol, applicable laws and regulations, and the principles of research ethics as set forth in the Belmont Report.
2a. Continuing Review: Approval is valid until the protocol expiration date shown above. To avoid lapses in approval, submit a continuation application at least eight weeks before the study expiration date.
2b. Progress Report: Approval is valid until the protocol expiration date shown above. To avoid lapses, an annual progress report is required at least 21 days prior to the expiration date.
3a. Expiration of IRB Approval: If IRB approval expires, effective the date of expiration and until the continuing review approval is issued: All research activities must stop unless the IRB finds that it is in the best interest of individual subjects to continue. (This determination shall be based on a separate written request from the PI to the IRB.) No new subjects may be enrolled and no samples/charts/surveys may be collected, reviewed, and/or analyzed.
3b. Human Subjects Research Training: Proper training in the conduct of human subjects research must be current and not expired. It is the responsibility of the Principal Investigator and the investigator to complete training when expired. Any modifications and renewals will not be approved until training is not expired and current.
4. Amendments/Modifications/Revisions: If you wish to change any aspect of this study after the approval date mentioned in this letter, including but not limited to, study procedures, consent form(s), investigators, advertisements, the protocol document, investigator drug brochure, or accrual goals, you are required to

obtain IRB review and approval prior to implementation of these changes unless necessary to eliminate apparent immediate hazards to subjects. This policy is also applicable to progress reports.
5. Unanticipated Problems: Unanticipated problems involving risk to subjects or others must be reported to the IRB Office
(45 CFR 46, 21 CFR 312, 812) as required, in the appropriate time as specified in the attachment online at: https://research.rowan.edu/officeofresearch/compliance/irb/index.html
6. Protocol Deviations and Violations: Deviations from/violations of the approved study protocol must be reported to the IRB Office (45 CFR 46, 21 CFR 312, 812) as required, in the appropriate time as specified in the attachment online at: https://research.rowan.edu/officeofresearch/compliance/irb/index.html
7. Consent/Assent: The IRB has reviewed and approved the consent and/or assent process, waiver and/or alteration described in this protocol as required by 45 CFR 46 and 21 CFR 50, 56, (if FDA regulated research). Only the versions of the documents included in the approved process may be used to document informed consent and/or assent of study subjects; each subject must receive a copy of the approved form(s); and a copy of each signed form must be filed in a secure place in the subject's medical/patient/research record.
8. Completion of Study: Notify the IRB when your study has been completed or stopped for any reason. Neither study closure by the sponsor nor the investigator removes the obligation for submission of timely continuing review application, progress report or final report.
9. The Investigator(s) did not participate in the review, discussion, or vote of this protocol.
10. Letter Comments: There are no additional comments.

## Appendix E

## Document Protocol

The collected documents for analysis may include excerpts of personal communications and selected images. Examples of personal communication include journal entries, emails and social media communications. Examples of images include family pictures.

Experiences:

1. Who created the document?

2. When was the document created?

3. How does the document illustrate the important educational experiences identified by women as Latinx osteopathic medical students?

4. How does the document illustrate support systems identified by female Latinx osteopathic medical students?

5. How does the document illustrate the application process identified by women as Latinx osteopathic medical students?

6. How does the document illustrate the barriers and challenges identified by women as Latinx osteopathic medical students?

7. How does the document illustrate successes identified by women as Latinx osteopathic medical students?