BLACK MEN'S CHOICE PROCESS IN ATTENDING

A HISTORICALLY BLACK COLLEGE AND UNIVERSITY MEDICAL SCHOOL

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ABSTRACT

This qualitative study examines Black men's graduate school choice process enrolled in a Doctor of Medicine (MD) degree program at a historically Black college or university (HBCU) medical school. While there is foundational literature regarding graduate school decision-making (Olson & King, 1985), the literature on graduate school choice is limited. Recent work of English and Umbach's (2016) four-layer graduate school choice conceptual model, adapted from Perna's (2006) college choice model, serves as a theoretical framework and a basis throughout the literature landscape of graduate school choice. Furthermore, when exploring the medical school choice, there is little current literature that examines the choice process for Black men in attending HBCU medical schools. The decreasing presence of Black men in medical school commands attention to graduate school choice for these students. Through this study, a critical gap in medical education scholarly work will be filled.

The purpose of this research is to ascertain the school choice process for Black men enrolled in an MD program at an HBCU medical school, using in-depth individual interviews with these students. Extracting from English and Umbach's (2016) four-layer graduate school choice conceptual model and McDonough et al. (1997) Black college choice model, this study expects for Black men's medical school choice to be determined by habitus, the context of school and community, the context of higher education, and context of social, economic, and policy. This research provides an essential perspective into Black male students' medical school choice process by investigating these influences. This study advances the knowledge of a budding body of research associated with graduate school choice and assists HBCU medical schools in

identifying the factors attributed to Black male enrollment in HBCU medical schools. Having this knowledge empowers HBCU medical schools to better prepare for Black male medical students' recruitment and retention.

DEDICATION

This work is dedicated to my grandparents, Henry L. Powers, Sr., Roberta Powers, Willie James Morris, Sr., and Sallie Mae Morris. Thank you for laying the foundation to make this all possible.

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To my Lord and Savior, thank you for keeping me on this journey. Mia, thank you for your unwavering support. Zaia and Xander, thank you for giving me the purpose to continue. To my parents and family, thank each of you for your support throughout the journey. I am so grateful for my committee, Drs. Bray, Katsinas, Laanan, Mobley, and Howse, for all of your guidance, wisdom, and support. A thank you to my cohort members. I could not have asked for a better group of individuals to take with me this journey. Dr. Miles-Richardson and Dr. Booker, thank you for planting the seed that all of this was possible. Dr. Gerbi and Dr. Waldrop, thank you for reminding me that all things are possible. To rest of my colleagues, thank you for your continued support throughout this journey. And to the twenty students that so graciously shared their stories with me, this would not have been possible without you. I am forever grateful.

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CHAPTER I: INTRODUCTION

In recent years, the number of Ph.D. degrees awarded to Black males has doubled. However, only about 35% of those are in science, technology, engineering, and math; most of them have been in psychology, social studies, and business (Patton, 2014). The field of medicine is an area of science from which fewer Black men are matriculating than their Black female and White counterparts. Only 1,061 Black males applied to medical school, with 371 entering a medical school of the 382 accepted (Jacob, 2015; Association of American Medical Colleges [AAMC], 2017). In the admission year of 2018-2019, there were 21,622 matriculants to medical schools in the U.S. Of these matriculants, 10,783 were White, while Blacks only accounted for 1,540 (AAMC, 2018). Of the 1,540 Black matriculants to medical schools in the U.S., 604 were black males with only 284 reporting as U.S. born (AAMC, 2018).

There are various possible reasons for the avoidance of young Black men from entering these fields, including negative stereotypes of Black men and low expectations from them, few Black mentors or friendship networks, poor academic advising, social support, debt, and lack of hands-on research or laboratory experiences. The void of African American males in science fields diminishes the benefits from diverse perspectives across academia and the populations they may serve (Patton, 2014). Gose (2014) also recognizes that many Black males are not succeeding in these demanding fields because of lack of preparation or ability but because of academic and cultural isolation.

Perceptions of Black men as not competent, and therefore unable to handle the rigors of medical school, have been held by both Blacks and Whites since slavery's past when the theory that Black people were not equal to Whites was put forth (Noguera, 2003). The idea of incompetence has been perpetuated so that many educators see young Black men as troubled and underperformers (Rao & Flores, 2007). Attempts are made to blame Black males for academic failure or even the lack of interest in higher education or advanced degrees for careers such as medicine (Gregory, Skiba, & Noguera, 2010; Noguera, 2003; Rao & Flores, 2007; Rowley et al., 2014). Programs have also focused on trying to force Black men to fit into the White academic model, instead of looking at ways to amend the academic system that has created barriers for them (Patton, 2014). The circumstances surrounding a young Black man's decision to go to college, much less enter medical school, are historically complex.

The declining number of Black men applying and enrolling in medical schools is a challenge that higher education faces. In 1978, the Association of American Medical Colleges (AAMC) reported that 541 Black men were newly enrolled in medical school compared to 515 in 2014 (Jacob, 2015). While that is only a 5% drop in enrollment, one would expect the number to increase over those 36 years. Prior to 1968, only 2.5% of all physicians were Black in the U.S. (Baker et al., 2008), with only 130 Black students matriculated from medical schools in the U.S. in 1968 (Steinecke & Terrell, 2010). Although enhancements have been made for diversity, including changes to admissions policies (Razack, Hodges, Steinert, & Maguire, 2015), focused recruitment of minority students (Achenjang & Elam, 2016), and the creation of two additional historically Black college and University (HBCU) medical schools in the late 1960s and early 1970s (Harley, 2006), the number of Black male applicants has not increased.

Research has shown that having people of color in medicine is essential and positively affects the areas of medical education, the healthcare workforce, patient health, and future students of color in the field on medicine (Ansell & McDonald, 2015; Bowman, Brandenberger, Hill, & Lapsley, 2011; Davis & Allison, 2013; Rice, 2015). A medical school with a diverse student population aids its students as it allows for interaction with individuals of different backgrounds and cultures that also prepares students for diversity in the workforce and better patient care (Bowman et al., 2011).

Having diversity in primary care fields has a profound impact on vulnerable populations (Rice, 2015). A shortage of Black physicians can seriously affect access and quality of service in low-income rural and urban communities because Black doctors are likely to practice in these locations due to their deep commitments to their neighborhoods and their wider cultural communities (American Medical News, 2013). An increase in the number of Black male physicians can alter patient health outcomes in dramatic and positive ways because patients are more apt to discuss health issues and follow through with care orders when those orders are given from health care professionals that most resemble them (Ansell & McDonald, 2015; Davis & Allison, 2013; Hamilton, 2006). This is particularly true for Black male patients, who have the lowest life expectancy of any population, living 4.5 fewer years than white men on average. (Alsan, Owen, & Graziani, 2018; Torres, 2018).

With the creation of pipeline programs (Capers & Way, 2015), students of color have the opportunity for exposure to medicine as a career option and the ability to see others in the profession that resemble them to reaffirm the possibility of medicine as a career (Jacobs, 2015). The University of Kentucky College of Medicine, for example, created a pipeline program that was led by a student initiative. It attempted to increase underrepresented applicants by spending

two days at the University of Kentucky College of Medicine to experience life as a medical student. This recruitment program is seen to be a successful method of recruiting minorities in medical schools (Achenjang & Elam, 2016). Another pipeline program, the Meyerhoff Scholars Program at the University of Maryland Baltimore County, has also attempted to increase Black men in science fields, encouraging them to pursue Ph.Ds or obtain medical credentials. This program focuses on strengths such as perseverance, resiliency, and determination and has been successful, but it is in limited use (Hrabowski, 2014).

On the other hand, Duke University has tried to reach students at very early ages to spark their interest in the medical profession and have found ways to support them along the way. They provide field trips to local elementary third graders to Duke's health care facility. To talented underrepresented minority and low-income fifth graders, they offer participation in the Duke's Building Opportunities and Overtures in Science and Technology (BOOST) program with a summer program, overnight field trips, and extra science and math enrichment (American Medical News, 2013).

Pipeline programs, unfortunately, are rare and attempt to deal with one aspect of the decline in enrollment in medical schools: recruitment. Having proper academic advising is also critical for success in recruiting young Black males and maintaining academic success in medical school (Barr, Gonzales, & Wanat, 2008). However, other factors, such as handling the enormous debt medical school education imposes and dealing with discrimination and stereotyping, are important considerations.

Some organizations strive to advocate for Black and other underrepresented minorities (URMs) in health care professions. White Coats for Black Lives is one such organization. Founded in 2015, it supports the aggressive recruitment of URMs into medical schools and

encourages hiring and retention of URMs in leadership, teaching, and medical research efforts. White Coats for Black Lives also attempts to set national medical school standards for curricula that recognize racism and develop ways to dismantle structural and institutional racism (White Coats for Black Lives, 2018). Like pipelines, organizations like these are only making small inroads into attracting Black males into the medical profession.

Davis and Allison (2013) emphasize the difficulty Black male medical students have found mentors in general and those of their same race, in particular, to help advise them about education and career goals. Applying homophily theory, which is the desire for people to form ties or belong to groups like them, becomes a significant barrier to medical school (Davis & Allison, 2013).

Thurmond and Cregler's (1999) longitudinal study looked at gifted high school students from underrepresented minority (URMs) and had expressed interest in health professions. They surveyed 123 students between 1984 and 1991 and found that slightly under half (49%) had entered health care fields. Some cited trouble with the coursework, but most said they pursued other careers due to persuasion from mentors who were not in the medical or health field (Thurman & Cregler, 1999). Their recommendation was an early introduction to mentors who could steer them to tutoring and extra help for difficult subjects and find career opportunities in health care fields (Thurman & Cregler, 1999).

Pentyala et al. (2016) found that mentors can be influential. However, their selection must include "appropriately matched, highly committed participants who attain deep connections" (p. 176). Herein is the crux of the mentoring issue. Both the student and the mentor must develop a relationship wherein they are focused on long-term career goals, and the

mentor must be knowledgeable about medical school and the profession (Pentyala et al., 2016). Finding such encouragers for young Black men is often difficult.

HBCUs may hold many young Black men's potential because they may provide supportive environments and Black mentoring they require (Gasman, Nguyen, & Commodore, 2017). Getting young Black men to apply to medical school in the first place and helping them succeed there, however, is the real challenge.

Problem Statement

In 1968 and 1969, the number of Black and Hispanic students combined accounted for less than 3% of first-year medical students in U.S. medical schools (Davis & Allison, 2013). Soon after, in the early 1970s, affirmative action was introduced to address several social goals for the country, with one goal being to increase the number of minority physicians to improve the health of individuals who experience with lack of access to adequate healthcare who are of lower economic status (Keith, Bell, Swanson, & Williams, 1985). Sadly, despite affirmative action in the early 1970s, in 2012, Black men and women comprised 7% of the total number of students enrolled in U.S. medical schools (Garces & Mickey-Pabello, 2015) even as the nation's Black population was 13% (Morris, 2014). In fact, medical schools have experienced a 5% decrease in Black males' enrollment in the past four decades (Jacob, 2015).

This creates a crisis of care for those seeking physicians of color and impacts the medical profession itself. Diversity broadens student learning, allowing various perspectives and fresh insights (Bowman et al., 2011). Black patients, especially men, benefit from having an African American physician. They are more open to discussing their medical concerns and follow medical advice when given by a Black doctor (Ansell & McDonald, 2015; Davis & Allison,

2013; Rice, 2015). Exploring the reasons why Black men are not opting to go to medical school, and if they do, what schools are they choosing to attend is critical.

Purpose of Study

This research endeavor aimed to understand better the factors and experiences that contributed to Black males choosing to attend an HBCU medical school and find reasons and meanings behind their experiences. Through the use of Perna's (2006) conceptual model of student college choice and McDonough et al.'s (1997) Black college choice model, this proposed study seeks to examine Black men's premedical experiences and their process for medical school selection as factors for graduate school choice in attending an HBCU medical school. This model explores four factors that shape college choice: 1) the individual's home environment, including family; 2) the present school and community environment; 3) the higher education environment of prospective colleges, their characteristics, social climate, and attendance requirements; and 4) the economic, social, and policy contexts (Perna, 2006). Though Perna (2006) focused her research on students choosing undergraduate four-year colleges, a modified version of her model for professional and graduate school choice (English & Umbach, 2016) will serve as a guide. For this research on medical school choice, it will be structured into four primary inquiry areas that will examine race and ethnicity factors, financial opportunities and barriers, medical school strengths and incentives, advising and mentoring, and social supports.

Due to the limited amount of research on Black males' graduate school choice, specifically for medical schools, this proposed research seeks to help fill that gap in the literature and provide insights into how Black men choose to attend an HBCU medical school. Understanding the factors of graduate school choice of a small group of Black men at a

particular school can assist HBCU medical schools in their recruitment efforts and retention of Black male students.

Significance of Study

The data collected from this study along with findings and conclusions can assist the 125 allopathic medical schools, including the four allopathic HBCU medical schools, to address the increasing need for their student bodies to reflect better the society in which they plan to serve. Many medical schools are seeking solutions for inclusion and diversity. There is a challenge in how medical schools achieve this goal, as many have decided to keep their same competitive student selection processes (Razack, Hodges, Steinert, & Maguire, 2015). This research provided valuable information that can increase diversity in medical schools and the healthcare workforce and facilitate more intense recruitment of Black male students. This study aids in these efforts by revealing Black males' decision-making processes who are considering entering medical school.

This study provided information to faculty and departments in medical schools with information concerning the importance of recruitment and retention of Black faculty at medical schools to increase Black men enrollment in medical schools. This has long been a long-standing issue, as just 3.5% of the 175,889 faculty members at U.S. medical schools being Black (AAMC, 2018). This is important because minority faculty members at medical school institutions are vital to minority student retention. Minority student success is increased in classrooms and campuses with greater same-race population ratios as the likelihood of racial discrimination and stereotyping is decreased (Boyd & Mitchell, 2018; Chapman, Contreras, & Martinez, 2018; Chavous, Rivas-Drake, Smalls, Griffin, & Cogbun, 2008; O'Hara, Gibbons, Weng, Gerrard, & Simons, 2012; Steele, 1997).

Regarding the healthcare workforce, this study sheds light on the efforts towards eliminating health disparities and what must be done to increase racial and ethnic diversity of the physician workforce (Marrast, Zallman, Woolhandler, Bor, & McCormick, 2013). This research can also catalyze administrators at medical schools, particularly HBCU medical schools, to launch pathway programs that focus on Black male students and increase black male enrollees in medical schools. Research has found that despite the lower MCAT scores, the Black students from PWI and HBCU institutions did not differ significantly from each other in graduating, matching into residency programs, or passing boards (Capers and Way, 2015). Diversity within medical schools themselves has been found to enhance learning for all students, creating an environment of more open inquiry (Whitla et al., 2003). The themes that have risen from this study will provide a deeper understanding of why young Black men choose to become physicians, and the importance of HBCU medical schools are to them.

Research Questions

Examining factors for Black males' graduate school choice in attending a historically Black college and university (HBCU) medical school, research questions include:

1. What is the graduate-school choice process for Black men who enroll in a MD degree program?
2. What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?
3. What factors for Black men led to the choice to attend a HBCU medical school?

Chapter Summary

Since diversity has a profound effect on delivering healthcare to a diverse population, there is a need to determine why Black males are not choosing to pursue a medical degree. This chapter identified this problem and proposed a qualitative study to explore why young Black males are not choosing medicine as a career path. It identified why this was important to research and what insights this study provides to address the need for universities to increase the enrollment of more diverse students to reflect better the society they plan to serve. The next chapter will discuss this problem's background and reveal the literature gaps that have not been pursued entirely to explore this problem.

CHAPTER II: LITERATURE REVIEW

This literature review presents a brief history of Black medical schools in the United States: how they came to be formed, what challenges they faced historically, and the emergence of new schools in the mid-twentieth century. It also discusses Black student enrollment past and present in medical schools, the hurdles young Black men face in education, and the student debt burden. In addition, a discussion is offered of diversity in healthcare: its composition, importance, and positive contributions. Finally, this literature review looks at medical school admissions successes for Black men and their specific medical school choices. This in-depth literature research lays a foundation for the questions this study will pursue concerning the factors surrounding Black male students' decisions to enroll in medical school in general and HBCUs specifically.

History of Black Medical Schools in the U.S.

After the Civil War and the official end of slavery in 1863, educational opportunities began to open for Black Americans. The American Baptist Home Mission Society, a philanthropic organization run by whites, sought to encourage all African Americans by establishing Black colleges in southern states to train Black teachers. This group coined the term, the Talented Tenth, that was later used by W. E. B. Dubois (1903) in a seminal essay about Black Americans. The Talented Tenth referred to the top 10% of African American men who showed promise and benefit through further education. The American Baptist Home Mission

Society thought these men would positively contribute to their communities and the wider society (Muhammad et al., 2019).

For African American families, access to education seemed to be the means to be equal in society finally and, therefore, succeed financially and socially. Self-sufficiency and the want to support and regulate schools for themselves and their children was the basis of Freedman's educational movement (Anderson, 1988). What free Blacks wanted to secure most in the movement was assistance without control (Urban & Wagoner, 2009). Free Blacks and slaves started their movement for the organized instruction of other free blacks and slaves who were illiterate before benevolent societies of the North entered the South in 1862, the Emancipation Proclamation in 1863, or the Freedman's Bureau in 1865 (Anderson, 1988). Early Black schools were created and sustained mostly through the efforts of Blacks (Urban & Wagoner, 2009). The first of the early Black schools started in Savanah, Georgia, existing from 1833 to 1865, unknown to the slave institution. The Pioneer School in New Orleans opened in 1860, followed by a school in Fortress Monroe, Virginia, in September of 1861(Anderson, 1988).

Ex-slaves found other notable means to initiate and sustain schools, whether northern aid was available or not. The Sabbath School system afforded a curriculum of educational activities carried out broadly due to the ex-slave community (Anderson, 1988). These schools ran mainly on the weekends, during evenings, and provided basic literacy instruction (Urban & Wagoner, 2009). While free Blacks created an educational self-improvement institution that supported most of their schools, they were also amongst the first of native southerners to fight for universal public education (Urban & Wagoner, 2009). From its creation in 1860 of just a few schools with the assistance of northern benevolent societies and the Freedman's Bureau, Black schools form their practically complete system in its official form by 1870. Fourteen Southern states had

founded 575 schools by 1865, employing 1,771 teachers for the 71,779 Black and white students that regularly attended (Anderson, 1988).

While ex-slaves benefited from these early Black schools, this did not come to pass for many. Though Black men began to have access to education with the construction of new schools and new teachers in the South because of the Reconstruction Act of 1867, they were restricted in what they could learn. The prevalent use of freedmen's texts that were profoundly racist and continued the construct that Black Americans were inferior and not worthy of education ran counter to any philanthropic ideas of bettering African Americans (Bronson, 2016).

After Reconstruction, White lawmakers in the South still had control of school funding, securing 30 times more for each student in White schools as students in Black schools (Butchart, 2010). This was a practice that also occurred in the North, through a funding means called redlining. Later, banks, insurance companies, and other businesses used redlining, drawing red lines on a map, to determine areas where they thought it would be risky to invest. These risky areas were usually in inner cities or other Black neighborhoods (Darling-Hammond, 2012). This also meant there was less investment in schools and medical facilities in these areas. Because most of these educational challenges occurred at the primary to the high school level, they resulted in fewer well-prepared students seeking college educations.

Before the Civil War, no colleges, common public common schools, or high schools existed for Blacks. Until after the Civil War, Black students were nearly excluded in U.S. higher education. From 1636, with the founding of Harvard College, to the 1830s, no U.S. institution of higher education allowed the entrance to Black students (Anderson, 2002). While Blacks were barred from attending White colleges in many states, Ohio and Pennsylvania created three

institutions for young Blacks. They were the Institute for Colored Youth in Cheney, PA, in 1837, Lincoln University in rural Pennsylvania in 1854, and Wilberforce University, Wilberforce, OH, in 1856. Though called institutions and universities, these schools began as educational centers to teach elementary and secondary subjects to Black students who had no previous education (U.S. Department of Education, 1991).

The Second Morrill Act of 1890 established land-grant colleges for Blacks. Sixteen Black colleges were built in southern and border states. However, though they were colleges, they only offered industrial, mechanical, and agricultural training, not higher education degrees. In response, more black secondary schools were built in response to the U.S. Supreme Court's decision in the *Plessy v. Ferguson* case in 1896 that established what was known as "separate but equal" schools (U.S. Department of Education, 1991). This helped better prepare Black students for college. Some of the privately funded Black colleges appeared, including some of the first Black medical schools. Among these were Hampton Institution, Howard University, Spelman College, Fisk University, Tuskegee Institute, Meharry Medical College, and Morehouse College (U.S. Department of Education, 1991).

Many of the privately funded Black colleges benefitted greatly from organizations such as the United Negro College Fund (UNCF). Not only did UNCF function as a fund-raising machine, but they also leverage the outcomes of court cases such as the 1954 decision of *Brown v. Board of Education* to bring into focus a new level of relevance for Black higher education (Gasman, 2007). After the federal courts mandated integration, black colleges' need was at the forefront of donors' minds, who were mostly white. While the *Brown v. Board* verdict was more impactful on the primary and secondary education levels, it directly affected higher education (Gasman, 2007). In the cases of *Sipuel v. Board of Regents* and *Sweatt v. Painter*, in which the

plaintiffs were both black students seeking admittance into law school in Oklahoma and Texas respectively, were denied based on race. UNCF used these cases as the foundation for their continued push for philanthropy in stating that black colleges were still needed as the road to colleges being fully integrated would be a long one (Gasman, 2007). This also allowed UNCF to reiterate the great work that black colleges had done in producing black scholars. In turn, the UNCF proclaimed that black colleges' work needed to continue and expand to the post-secondary level (Gasman, 2007).

Fourteen Black medical schools were between 1868 and 1900. This was an impressive feat since newly freed Blacks' education was a significant struggle even at the primary and secondary levels (Harley, 2006). During this time, medical education for Blacks was mainly due in part to The Freedman's Aid Society and American Baptist Home Missions Society (Savitt, 1992).

Some Blacks, freed during slavery, traveled north to train at eastern and midwestern universities at Northwestern University, Indiana University, Yale University, University of Pennsylvania, and Harvard University (Savitt, 2000). However, they were not always welcome even there. Isaac Snowden, Daniel Liang, and Martin Delaney enrolled at Harvard in 1850 but were ousted due to protests from White students (Baker et al., 2009). James McCune Smith, who later practiced medicine in Manhattan, New York, was forced to travel to the University of Glasgow in Scotland to receive a medical education, making him the first Black physician to receive a formal medical degree in 1837.

Even so, some bright students managed to succeed and practice medicine. James Durham is credited as being the first Black physician in the U.S. He learned medicine from two slave-owner physicians in 1788 in Philadelphia, Pennsylvania, and was taught,

apprentice-style, how to mix medications, and offer bedside care for patients (Curtis, 1971). David Jones Peck was awarded a medical degree from Rush Medical School in 1847, making him the first university-trained Black physician in America (Baker et al., 2009). In addition, Rebecca Lee Crumpler earned her medical degree from The New England Female Medical College in 1864, making her the first Black woman to do so (Curtis, 1971).

In the late 19th century, medical education for Blacks was considered disorganized, inconsistent, and of lesser quality. These Black medical schools were more often underfunded with an inadequate faculty, had poor facilities, and lacked patients needed for practice (Savitt, 1992). At this time, Black medical schools were missionary-church related or proprietary based, and tuition-based aimed solely to grant a degree and not to provide a more extensive, broad formal education. Many of the proprietary schools were established by graduates of the missionary-related schools and proved to be for-profit endeavors. Often they were no more than degree mills, which furthered the problem of medical education for Blacks (Savitt, 1992).

Between 1846 and 1910, medical societies were typically the only places physicians could confer with colleagues, obtain hospital privileges, and share breakthroughs in method and research. State licensing boards determined membership. Without a membership, physicians risked professional ostracism and possible loss of income. A non-member could not obtain a bank loan to start a practice or buy equipment and medicines and were often denied hospital privileges (Baker et al., 2008, 2009)

Unfortunately, even as prestigious a body as the American Medical Association (AMA) did not fully embrace Black physicians. This came in part from faulty science that implied that African American brains were smaller than Caucasians and therefore probably could not learn the medical arts (Baker et al., 2009). This egregious idea, along with blatant racism, impelled the

AMA to exclude Black physicians. In 1870, Alpheus W. Tucker, Alexander Thomas Augusta, and Charles Burleigh tried to gain recognition as delegates from the District of Columbia at the AMA's annual meeting. After their denial, they sought remedy from Congress who found the AMA in error but offered financial recourse to help these and other Black physicians. They formed an integrated medical society called the National Medical Society (NMS). Still, they could not be recognized by the AMA, even though they openly welcomed an all-White organization that had violated the AMA Code of Ethics by admitting "irregulars," Homeopathic and other fringe physicians. The reasoning was that the members of the NMS were not properly trained. This AMA edict extended to the NMS members' approved college, Howard University, barring all physicians from that institution, including White members (Baker et al., 2008, 2009).

Black or integrated organizations began to spring up, including the North Jersey National Medical Association (1895), the Old North State Medical Society of North Carolina (1887), the Medico-Chirurgical Society of the District of Columbia (1884), and the Lone Star State Medical, Dental, and Pharmaceutical Association of Texas (1886) soon after the National Medical Association formed to support Black physicians (Baker et al., 2008, 2009).

Early Black Medical Schools

These Black medical societies represent how dedicated Black physicians were to their professions. Their supporters, initially missionary groups, founded several Black medical schools. Below is a listing of those schools backed by missionary groups and grassroots efforts by founding date and includes a brief history.

Howard University College of Medicine (1868). Named after Union Major General Oliver Otis Howard, the Howard University College of Medicine was founded in 1868. Of the first five faculty members, only Dr. Alexander Thomas Augusta was Black (Cobb, 1967). It is

reported that he is the first Black to serve on a medical school faculty in the U.S. Refused entry by medical schools in the U.S., Augusta attended medical school in Toronto at Trinity Medical College. Howard College of Medicine not only offered a medical program, but they also offered one in pharmacy (Epps, Johnson, & Vaughn, 1994). Their dentistry program was introduced in the early 1880's (Cobb, 1967). Howard graduated its first class in 1870 with five student students, two of whom were Black (Cobb, 1967).

The Howard University College of Medicine is closely linked to the Freedman's Hospital of Washington, DC. In 1863, Dr. Alexander Augusta was placed in charge of the hospital (Cobb, 1967). Two years later, the hospital came under the direction of the Freedman's Bureau, and in 1869, it was moved to the campus of Howard University and occupied space in the Medical Department Building (Epps, Johnson, & Vaughn, 1994). The Howard University Hospital replaced the Freemen's Hospital in 1933 and continues to serve as the College of Medicine's principal teaching hospital. Freedmen's Hospital played an important role in training Howard University medical students and providing care to Blacks during the decades of segregation. This hospital also played a critical role in training Black residents who were turned away from other residency programs (Epps, Johnson, & Vaughn, 1994).

A high school diploma was not required until 1903 for admission to Howard College of Medicine, and only two years of college were required beginning in 1914 (Cobb, 1967). The Medical Department operated as an evening school from 1868 to 1908. From 1908 to 1910 the school offered a four-year day program and a five-year evening program (Cobb, 1967).

From its founding in the 1860s until the 1960s, Howard, along with Meharry, trained most of the nation's Black physicians (Epps, Johnson, & Vaughn, 1994). This was due in large part to the rigid segregation of medical schools, especially in the South. The University of

Arkansas was the first southern medical school to integrate in 1948 in due part to the Supreme court ruling of *Gaines v. Canada* in 1938 (Kilpatrick, 2009). Most southern medical schools did not graduate their first Black students until the late 1960s and early 1970s (Epps, Johnson, & Vaughn, 1994).

Meharry Medical College (1876). Meharry Medical College traces back to 16-year-old Samuel Meharry and his encounter with a Black family in 1826. While Meharry was driving a salt wagon by himself, his wagon became stuck in a ditch, in danger of losing all his goods (Riley, 2008a). He noticed a cabin nearby that was the home of former slaves. The Black family took Meharry into their home for the night, providing him with food and shelter (Riley, 2008a). Taking Meharry in was a risk during this time, even as freed Blacks because they could be recaptured and put back into bondage (Riley, 2008b). The next day, the Black family helped Meharry free his wagon, and he promised the family that when he was financially able, he would do something positive for the Black race (Riley, 2008a).

In 1876, 12 years after the end of the Civil War, Meharry and his brothers donated $30,000 and real estate to establish the Medical Department of Central Tennessee (Riley, 2008b). During the first year, the school had two faculty members and eleven students. Classes were held in the Clark United Methodist Church's basement in Nashville, Tennessee (Riley, 2008b). Meharry Medical College grew quickly with the establishment of courses for nurses in 1876. A Department of Dentistry was established in 1886. Meharry also made history by graduating the first female physician in 1893 (Riley, 2008a).

In 1915, funds were raised by the George W. Hubbard Hospital Association to build Hubbard Hospital. Dr. George Hubbard was one of the first two faculty members at the medical school, serving in 1901 as the President of Walden University, of which Meharry Medical

College was a part (Riley, 2008a). Meharry Medical College became the first medical school in the South to offer a 4-year training with the opening of Hubbard Hospital (Riley, 2008b).

As with most private Black colleges, Meharry's leadership did not reflect the student body. Dr. Harold West, who was appointed president in 1952, would become the first Black president of the school (Riley, 2008b). Under West's direction, the Department of Psychiatry and Social Work was established. Dr. West was also responsible for integrating the student body at Meharry Medical College in 1957, well before most of the majority-serving schools in the region attempted to do so (Riley, 2008b).

In 1972, Meharry Medical College became the first medical center in the nation to provide a comprehensive health care delivery system, which gave underserved patients access to physicians and dentists (Riley, 2008a). A decade later, Dr. David Satcher was appointed president and served a term from 1982 to 1994. Dr. Satcher left the position to serve as director for the Centers for Disease Control and Prevention and later as U.S. Surgeon General under President H.W. Bush and President Clinton (Riley, 2008b). Under Dr. Satcher's direction, Meharry Medical College merged Hubbard Hospital with Metro General, which led to the hospital becoming a part of the Metropolitan Nashville health system (Riley, 2008b). Dr. John Maupin, who served as president from 1994 to 2006, is credited for the financial turnaround of Meharry Medical College by erasing a $49 million deficit and providing a balanced budget with a $1 million surplus within his first two years as serving as president (Riley, 2008a).

Lincoln University Medical Department (1870-1876). Lincoln University's medical department started with three students and four faculty members. Though Lincoln was the only Black medical school in the North, it faced an uphill battle because of its extremely rural location and underfunded by the state legislative (Savitt, 1985). Though Lincoln matriculated students, it

never conferred any medical degrees thought its students received medical degrees from other institutions. Lincoln attempted a move to Philadelphia to revive the school, but it closed its doors in 1876 (Savitt, 1985).

Flint Medical College of New Orleans University (1873-1911). Founded by the Freedman's Aid Society of the Methodist Episcopal Church, this medical school graduated 116 students before closing in 1911. In 1930, Straight College and New Orleans University merged to form Dillard University (Savitt, 2000b).

Straight University Medical Department (1873-1874). Named after Seymour Straight, an early supporter of the university, it was founded in New Orleans, Louisiana, in 1869 by the Congregationalist Church with the medical department opening five years later (Savitt, 2000b). Due to issues surrounding Reconstruction Era politics, the school only stayed open one year before closing its doors in 1874 without having graduated a physician (Savitt, 2000b).

Knoxville College Medical Department (1895-1910). Established in Nashville by the Freedman's Bureau of the United Presbyterian Church, the college moved to Knoxville in 1875 and the Department of Medicine was created 20 years later (Savitt, 2001). The school closed in 1900 after graduating two doctors. It attempted to reorganized shortly after as Knoxville Medical College but closed again in 1910 (Savitt, 2001).

Louisville National Medical College (1888-1912). Louisville National Medical College was founded as a proprietary medical college by William Henry Fitzbutler. Fitzbutler was the first Black graduate of the University of Michigan College of Medicine (Savitt, 2001). Louisville National Medical College was one the more successful proprietary schools, graduating over 100 physicians, but suffered from financial stress brought on by requirements to update equipment.

Chattanooga National Medical College (1899-1904). A proprietary school located in Chattanooga, Tennessee, Chattanooga Medical College was started by Thomas William Haigler, a graduate of a proprietary Black medical school. Chattanooga Medical College school graduated approximately 16 students before it abruptly closed in its fifth year of operation (Savitt, 2000a).

Hannibal Medical College (1889-1993). Established in Memphis, Tennessee, by Tarleton C. Cottrell as a proprietary school, Hannibal Medical College never reached the same level of success as other proprietary schools. The school graduated five physicians and was only in operation for four years (Savitt, 2000b). Controversy surrounded the founder and school as Cottrell claimed to have graduated from Bethel Medical College of Southwestern University in Little Rock, Arkansas, which proved to be a nonexistence medical school. Also their degree-granting process of three of their five graduates was heavily questioned. Due to negligent entrance requirements, poorly qualified faculty, lack of academic rigor and dismal facilities, Hannibal Medical College was closed in 1896 (Savitt, 2000b).

Shaw University-Leonard Medical School (1880-1918). Named after the white benefactor and brother-in-law of Shaw's founder, Judson Wade Leonard, Shaw University-Leonard Medical School was the most successful of the now obsolete Black medical schools. Leonard Medical School conferred close to 400 medical degrees (Savitt, 1984). It closed in 1918.

University of West Tennessee College of Physicians and Surgeons (1900-1923). Established by Miles Vandahurst Lynk, a Meharry Medical College graduate who was also pivotal in founding the National Medical Association, the school eventually moved to Memphis. It began accepting advanced-standing students from Leonard Medical School when it closed in

1918 (Savitt, 2000a). Due to the school's low educational standards, 46 states, including Tennessee, would not recognize graduates with degrees from the University of West Tennessee. The school conferred 155 medical degrees before closing its doors in 1923 (Savitt, 2000a).

The Flexner Report

One of the foundations on which the American Medical Association (AMA) was based was medical education reform. The AMA and the Association of American Medical Colleges (AAMC) began to explore how to improve medical education with the AMA's creating the Council on Medical Education (CME) in 1904. During this era, there were three types of medical school education. One was through an apprenticeship with a physician as one would learn the culinary arts through a master chef. Proprietary schools that were set up to make money provided much of the training for physicians, and universities provided both lecture and clinical practicums (Halperin, Perman, & Wilson, 2010). These schools offered not just standard medical training but a variety of other types of medical philosophies including homeopathic, chiropractic, osteopathic, physiomedical, botanical, and even Tomsonian herbology (Halperin, Perman, & Wilson, 2010). These proprietary schools had their own curricula and practices with no standard of practice for them all. In this climate, the AMA and the CME wanted them investigated and reformed. The CME labeled proprietary schools as threats to medical education and proposed their unrecognition (Savitt, 1992).

By reforming medical education, the AMA and its CME looked to improve education requirements and create a standard medical education curriculum (Harley, 2006). Following the findings of the CME, The Carnegie Foundation commissioned Dr. Abraham Flexner to explore the landscape and provide recommendations on the future of medical education in the U.S. On the surface, this seemed a proactive move for the AMA and the CME that would improve the

quality of every medical school in the country. However, Flexner's investigation was not without bias, and neither were the application of rules and standards by the AMA, the Association of American Medical Colleges (AAMC), and state licensing boards (Miller & Weiss, 2008).

Flexner visited and reviewed the curriculum of 155 medical schools in the U.S. and made recommendations for improvement (Harley, 2006). He held John Hopkins as the gold standard for medical schools in the U.S. due to its endowment, university affiliation, laboratories, and its noted hospital (Harley, 2006). One of the goals of his investigation was to judge not only the quality of the medical education in the schools he reviewed, but also to determine how many new medical schools should be built. He applied a population formula to determine the number of physicians needed for a given state's population.

Flexner recommended coeducation of men and women but disapproved of racial integration in medical schools (Miller &Weiss, 2012). In his final report, Flexner provided a chapter entitled "The Medical Education of the Negro". In this section of his report, Flexner stated that Black physicians were gullible and should not believe that because they possessed a medical degree that it was a real one. He also proclaimed Black physicians should only treat their race and, even then, that Black doctors should not be surgeons or specialists but they should be "sanitarians" and teach African Americans proper hygiene, basically because they lived in large numbers in such close proximity to their White neighbors (Baker et al., 2009; Flexner, 1910).

Flexner also did not apply the population formula to the Black population, saying that African Americans did not need more schools but higher quality ones (Baker et al., 2009; Flexner, 1910). As a result, he suggested that five of the seven medical schools in existence at

that time for Blacks were not able to make a contribution of value to the medical education of their students (Miller &Weiss, 2012). Only Howard University College of Medicine and Meharry Medical College were said to be worth developing in his report (Miller & Weiss, 2012).

Many hold Flexner responsible for the decline of Black medical schools following the release of his findings. A total of 56 U.S. medical schools, three being Black medical schools, closed, merged or began to offer only a two-year non-clinical program after the report was issued (Miller & Weiss, 2012). In 1925, an additional 22 schools discontinued their degree program. Only Howard and Meharry, of the first Black medical schools, remained in operation (Miller & Weiss, 2012).

In all fairness, Flexner was callous in his assessment of White schools, too. He found that 90% of all of the schools he visited had inadequate admissions standards, with only 16 medical schools requiring an undergraduate degree (Baker et al., 2009; Flexner, 1910). He saw that most of them also had poor laboratory facilities, did not provide proper clinical experience, did not have adequately trained faculty, and did not provide sufficient course work (Baker et al., 2009; Flexner, 1910). Flexner stated that the U.S. had an overabundance of physicians and they were mostly ill-trained and not necessary to meet the needs of the population (Baker et al., 2009; Flexner, 1910). Nevertheless, the Black populations suffered from Flexner's draconian cuts to Black medical schools, even though he admitted at the time that two schools were inadequate to train enough physicians to serve 9.8 million Black Americans in the U.S. at that time (Baker et al., 2009; Flexner, 1910).

The schools that fell under Flexner's proposed cuts were many. Without being able to improve the financial outlook of Louisville National Medical College, the Flexner Report dealt the school its final death blow with its report of no campus and subpar facilities. Flexner deemed

the school of little value. After graduating over 100 doctors, the school closed in 1912 (Savitt, 2001).

Shaw University-Leonard Medical School found itself in trouble when it began receiving ratings of "C" in the periodic reviews giving by the Council on Medical Education (CME) around 1914. Another setback came in the disparaging statements of the Flexner Report. Soon after the release of the report, students began to transfer, which led to its closing in 1918 (Savitt, 1984).

Though Howard and Meharry survived the cuts, they were inadequately funded and struggled in the years following Flexner's report. When they did get funding, it was always after White schools received theirs. Ironically, Flexner became an avid supporter of Meharry and Howard a decade later and he served as Chairman of the Howard University Board of Trustees (Baker et al., 2009; Cobb, 1967).

The goal of the Flexner report was to increase the quality of medical school education. However, many hold Flexner responsible for the decline of Black medical schools. After the release of the report, between 7% and 22% of the 168 medical schools Flexner investigated either closed or merged, with most of the Black medical schools being shuttered, leaving only Howard and Meharry in operation (Hiatt & Stockton, 2003). Seven percent amounted to 56 U.S. medical schools, three of which were Black medical schools, closed, merged or began to offer only a two-year non-clinical program immediately after the report was issued (Miller &Weiss, 2012). Eventually five Black medical schools closed: Leonard Medical School of Shaw University, Flint Medical College at New Orleans University, Knoxville Medical College, Louisville National Medical College, and the Medical Department of the University of West Tennessee at Memphis (Hunt, 1993). In 1925, an additional 22 schools discontinued their

degreed program. Only Howard and Meharry, of these first Black medical schools, remained in operation (Miller &Weiss, 2012).

Though Flexner is considered the architect of the demise of Black medical schools, his report, which was scathing of nearly all of the facilities he visited, reflected the structural racism rampant among state licensing boards and the American Medical Association in particular (Miller & Weiss, 2011; Steinecke & Terrell, 2010). Flexner was a product of his time and his upbringing in Kentucky. However, in spite of his obvious racism, which was common in his era, Flexner was a forward thinker. His ideas of reform had a solid foundation. He advocated flexible learning strategies, including a mix of lecture, bedside teaching and observation, lab and clinical exercises, and casework. He strongly advocated for stricter admissions standards, insisting that students should complete at least two years of course work that encompassed biology, chemistry, physics, and even philosophy and literature. He also encouraged graduate education for physicians to specialize in a specific field, and he promoted lifelong learning. In addition, he insisted that philanthropists should endow medical schools so that the burden of tuition did not fall on medical students alone (Halperin et al., 2010; Hoover, 2006). In truth, he was a staunch medical school reformist.

The Post Flexner Era: Segregation and Black Colleges

In the years following the Flexner Report, in the segregated South, especially, where separate-but-equal schools were built, Black enrollment rose to 32,000 students by 1953 in private Black colleges and 43,000 in public Black schools of higher education. Graduate programs in Black colleges also boosted their enrollments to 3,200. These institutions of higher education trained not only doctors but also other professionals such as teachers, lawyers, and ministers. During this time, more Black students enrolled in White professional schools and

graduate programs, usually in Northern states. Ironically, higher education desegregated on the graduate school level first before segregation penetrated secondary schools and baccalaureate colleges (U.S. Department of Education, 1991).

Nevertheless, Black colleges struggled with inadequate funding, poor facilities and laboratories, and the continuing need for well-trained faculty. When the *Brown v Board of Education* case was heard by the Supreme Court in 1954, a legal means to overturn the separate but equal doctrine was found. However, change did not come quickly or easily as the nation endured the pangs of dissent and activism even after the Civil Rights Act of 1964 was passed (U.S. Department of Education, 1991).

The Civil Rights Era and Change

The Adams case in 1997 sought to desegregate public higher education through specific criteria. Seeing the contribution that historically Black colleges and universities (HBCUs) made to the Black population, funds were supposed to be allocated to update equipment, buildings, and libraries, while providing funds to increase faculty as these Black schools also were required to desegregate. Today's HBCUs have racially diverse faculties and student enrollments both in undergraduate programs and graduate programs, more so that White colleges and universities (U.S. Department of Education, 1991).

Black medical schools, however, have had to face an uphill battle for recognition, accreditation, and acceptance by their White peers. During its history, the American Medical Association (AMA) repeatedly failed to integrate within its august body even after the Civil Rights Act was signed. Black AMA delegates were denied admission and integrated medical societies such as the National Medical Association (NMA) were also barred, even though it had White members. Though the AMA claimed it did not discriminate in service to patients nor in

its inclusion of physicians, it circumvented over a dozen attempts to integrate the organization, as late as between 1944 and 1965. The invariably left the final decisions for inclusion to state licensing boards and other local bodies, well aware that those in the South would continue to bar Black physicians through state segregation and Jim Crow laws (Baker et al., 2008). It was only after the reach of the Civil Rights Act of 1965 impacted Medicare payments that hospitals became desegregated and the AMA finally became a supporter of inclusion (Washington et al., 2009).

Change came slowly. It was another 30 years before the AMA recognized Black physicians. Lonnie Bristow became the first Black AMA President in 1994. A year later, the AMA brought Regina Benjamin onboard as the first Black woman AMA board member. Finally, the NMA was seated as voting member in 1996. Later in 2004, the NMA, AMA, and the Hispanic Medical Association formed the Commission to End Heath Care Disparities, which comprises over 70 state and specialty groups.

Addition of Black Medical Schools Post-Flexner

Beck (2004) suggests that the stricter entrance requirements and longer period of study that Flexner recommended began to shape an elitist medical profession that barred many bright but financially-strapped students from entering medical school or completing it. This was especially true of many young Black students who wanted to become physicians. This fact combined with the lack of support for Black physicians and Black medical schools stalled the establishment of new medical schools for Black students.

After the release of the Flexner Report in 1910, 58 years would pass before another Black medical school would be established. The first two were the Charles Drew Medical School in 1966 and Morehouse School of Medicine in 1975 (Harley, 2006). The creation of these schools

during the late 1960s and early 1970s spoke directly to the goal of affirmative action to increase the number of minority physicians in an effort to improve the health of individuals with lack of access to adequate healthcare and of lower economic status (Keith, Bell, Swanson, & Williams, 1985).

Affirmative Action and Black Student Enrollment

The Civil Rights era created several remedies for segregation and other racial discrimination policies. One of the most helpful but controversial was affirmative action, a term first used by President Kennedy in 1961 when he signed an executive order establishing the Equal Employment Opportunity Commission in which employers were to take "affirmative action," meaning proactive measures to ensure equal treatment regardless of race, creed, color, or national origin (Eisaguirre, 1999). To many, affirmative action was a just means to remedy the discriminatory admission and hiring policies Blacks, in particular, had endured for decades (Johnson, 1967).

As affirmative action unfolded, companies and higher learning institutions began to recruit and accept more minorities and women. Because there were a finite number of opening available at any given time, universities in particular, began to set enrollment percentages or quotas for minority students (Garrison-Wade & Lewis, 2004). Initially, enrollments increased, even for medical schools, but still not proportional to minority populations and not equal to the numbers of White students (Garrison-Wade & Lewis, 2004).

During the early 1970s, however, many medical schools began to eliminate racially conscious admission policies that battled inequalities surrounding race and ethnicity at medical schools across the U.S. Such practices were created in part as a reaction to the verdict of the U.S. Supreme Court case of *Regents of the University of California v. Bakke* in 1978 (Cohen,

2003). Alan Bakke, a White applicant for the University of California, Davis School of Medicine, was denied admission twice to the institution. Bakke challenged the medical school's current policy of reserving admission slots for disadvantaged minority students. He claimed that the reserving of slots violated his 14th amendment rights under the Equal Protect Clause. While the Supreme Court did deem the school's quota practice unconstitutional, the Court did permit the school to use race as an admission factor during the selection process (Cohen, 2003). In addition, California, Florida, Texas, and Washington implemented affirmative action bans that negatively impacted enrollment of Black men and women in the medical field during this timeframe. These states experienced a 12.2% decline of minority students enrolled at public institutions (Garces, 2012).

Affirmative action bans have harmed minority student enrollment. Howell's (2010) predicted a 2% decline in minority admissions in 4-year colleges, white or HBCUs, and would decrease minority representation at these campuses by 10%. States that enacted affirmative action bans have seen decreased enrollments. Washington, Texas, California, and Florida felt the effects of decreases in minority participation in engineering, social sciences, business, natural sciences, humanities, and education, with engineering, natural sciences, and social sciences suffering the most significant losses. Science-based degrees provide specialized education that serve the American population and allow the country to compete globally (Garces, 2013).

California's affirmative action ban had a negative effect on medical school enrollments and completions, even 12 years later. While medical schools had no trouble filling classes, the number of minority residents accepted fell from 233 in 1993 to 156 in 2001, roughly a 30% drop in enrollment. The rate of medical student matriculation fell from 192 in 1993 to 129 in 2001.

Further, since the state enacted the affirmative action ban, 52.8% of minority California residents have graduated from out-of-state medical schools (Steinecke & Terrell, 2008).

Backes (2002) found that affirmative action bans did indeed affect Black and Hispanic student enrollment in 4-year public universities, not only in California but also in other states. The bans affected Hispanic students slightly more than Blacks, but all felt the repercussions. Also, Black and Hispanic students did not enroll in private or two-year institutions as a result (Backes, 2002).

Garces' 2012 study also found that affirmative action bans affected enrollment numbers of students of color in graduate programs. This study revealed a 12.2% reduction in graduate programs enrollments in states where affirmative action bans were in place. Further, Garces and Mickey-Pabello (2015) found that affirmative action bans seriously affected students of color in medical schools in states where these bans existed (California, Florida, Michigan, Nebraska, Texas, and Washington). This study found a 17% decline in matriculation rates of underrepresented students of color in these medical schools. This echoed other research findings in public undergraduate institutions, graduate schools, and law schools (Garces & Mickey-Pabello, 2015).

Black Student Enrollment in U.S. Medical Schools. Enrollment in U.S. Medical Schools has been historically in smaller numbers for Black Americans. Increases in the number of medical schools open to Black students increased from 77 in 1938 to 85 in 1961. Admissions also increased from 22 Black medical students to 57 in those same years. More Blacks students matriculated from medical schools in northern and western states than in southern and border states, regardless of the year. Black medical students graduate from private schools in the north

and west and more from public schools in the South and border states (Raup & Williams, 1964). These dismal enrollment statistics reveal evident barriers in southern and border states.

Before 1968, only 2.5% of all physicians were Black, and 0.2% were Puerto Rican, Mexican American, or Native American (Baker et al., 2008). A mere 130 Black students matriculated from medical schools in the U.S. in 1968 (Steinecke & Terrell, 2010). The Association of American Medical Colleges (AAMC) encouraged medical schools to increase enrollment to reflect the percentage of underrepresented minorities in the population, 12% at that time. Enrollment for these minorities peaked at 10% in 1974 before affirmative action bans affected enrollment numbers (Carlisle, Gardner, & Liu, 1998).

Lee and Franks (2009) reported that the 1960 U.S. Census count found Whites comprised 88.8% of the population, Blacks 10.6%, American Indians, Eskimos, Aleuts 0.3%, and Pacific Islander and Asians 0.3%. There was no information on Hispanics, nor were Alaska and Hawaii counted. Projections for the 2030 U.S. Census in 2009 foresaw the U.S. population to grow to 363.5 million, with ethnicity percentages as Whites (non-Hispanic) 57.5%, Hispanics 20.1%, Blacks 13.9%, Asians 6.2%, and other races 4.1% (Lee & Franks, 2009). Ironically, the current U.S. population is close to those projections at 325.7 million for estimates as of July 2017. The current race breakdown is White (non-Hispanic) 60.7%, Hispanic 18.1%, Black 13.4%, Asian 5.8 %, American Indian 1.3%, Native Hawaiian and other Pacific Island 0.2%, and mixed-race 2.7%. In addition, 30.3% of the population over 25 has a college degree (U.S. Census). This has implications for current and future college enrollment, indicating that underrepresented populations' growth has remained constant and still are underrepresented.

By 2006, though Black Americans comprised 12.3% of the population yet, only 2.2% were medical students or physicians. Ironically, this is a slightly smaller percentage than there

were in 1910 when Flexner released his report (2.5%) (Baker et al., 2008). Since 1968, while more Black Americans graduated from medical school (1,109 students), numerical increases have largely stalled with an average of 1,133 Black Americans who graduated each year between 2000 and 2010 even as America's Black population rises (Steinecke & Terrell, 2010).

With the racial and ethnic imbalances in medical school admission steadily increasing into the 1990s, the Association of American Medical Schools (AAMC) initiated Project 3000 by 2000. This project sought to enroll 3000 underrepresented minority students by the year 2000 (Nickens, Ready, & Petersdorf, 1994). While the goal of 3,000 students was not reached, the project did achieve some success by increasing the number of underrepresented minorities matriculating medical school from 1,500 in the beginning of the project to over 2,000 during its height in the mid-1990s (Terrell & Beaudreau, 2003).

Challenges on the Path to Medical School

For many young Black men, the path to higher education is often met with several challenges and steep hurdles. These challenges are significant to highlight as they can inform stakeholders and direct future efforts for increasing the number of Black men in medical school. Of equal importance are the factors for admission and graduate school choice for medical school.

Early Education of Black Men

Specifically, many Black male students are often disproportionately identified as requiring special education services and tend to attend underfunded schools that cannot correctly diagnose or give these students assistance. Typically, schools that are underfunded do not have the financial resources or human capital to provide a solid foundation for a quality education, especially one necessary for premed studies (Jacobs, 2015). Because of the disproportionate representation of Blacks in underperforming schools, Black students are behind in college

readiness in English, reading, and math in relation to their White counterparts (Center for Community College Student Engagement [CCSE], 2014). Early educational experiences coupled with poor performance or interest in science courses seriously affect the numbers of Black men entering the medical field (Rosenthal, 2014).

For many young Black students, a diagnosis that places them in special education classes is often an erroneous diagnosis based on a misunderstanding of culture or direct racism. Black males have been disproportionately placed in special education classes (Foster, 1984). This became so flagrant that schools in California, Arizona, Idaho, Montana, Nevada, Oregon, and Washington were banned from even testing Black male students for anything related to special education, including learning disabilities and ADHD by the courts. Fortunately, that ruling was overturned later in order that those who really needed services could be assessed (Foster, 1984, Muhammad, et al., 2019).

Cultural misunderstanding and blatant bias has resulted in disproportionate numbers of Black male students being misdiagnosed since the first assessment for mild retardation and slowness to learn come from classroom teachers. Often placement into special education classes became a simple and legal means to remove specific children from the classroom. Sometimes this was because the selected students were disruptive or did not quite fit with the classroom atmosphere (Lewin, 2012).

Harry and Anderson (1994) found that multiple biases occurred in those early casual assessments: gender, race, culture, and language (dialect or usage). Further, that study found that even formal assessment tools were culturally biased toward the majority (White) population.

Not only did these young Black male students suffer the stigma of misdiagnosis, but they also were isolated from their peers, thereby producing an academic segregation that was based

on race (Harry & Anderson, 1994). This segregation of Black students, especially Black males, produces overt and implicit messages about race, gender, and achievement (Noguera, 2003). This affected young boys' self-esteem and their desire to succeed. It became a self-fulfilling prophecy since these young men continued to be low-achievers and to view school in negative terms (Harry & Anderson, 1994; Davis & Jordan, 1994).

Further, Donner & Shockley (2010) indict the curricula and the test instruments of the federal No Child Left Behind legislation as being culturally slanted in favor of the majority culture, and therefore skewed toward students of color. Again, these measures do not accurately assess Black achievement. In addition, Bargarin, Chinn, & Wright (2014) identified nine specific challenges for African American boys in the school environment. They were harsh school discipline by either teachers or principals, poor relationships between teachers and students (especially Black males), poor quality teaching materials and teacher skills, anti-school attitudes by peers, the absence of fathers in the home or other male role models, the trauma of poverty, socioeconomic adjustment difficulties, and cultural stereotypes.

Howard (2008) posits ingrained racism at the heart of the difficulties of that some African American boys have in elementary and high school. He uses Critical Race Theory as a means to explore this phenomenon in a qualitative study of young Black students. Critical Race Theory recognized that racism is prevalent and considered normal and permanent in American society as is another form of oppression, including sexism and classism, in the classroom. Critical Race Theorist use knowledge and techniques of women's studies and ethnic studies to understand discrimination more fully. They seek to uncover the motivations behind seemingly inclusive doctrines such as race neutrality that mask the interests of the dominant culture. Counter storytelling is a critical tool used by Critical Race Theorists to acknowledge and uplift stories of

the Black experience. Howard's (2008) study uncovered how Black male students felt they were viewed by their teachers and saw counter storytelling as a vital tool within the school environment.

Perception of Black Men

Other confounding variables contribute to the challenging journey to higher education for young Black men. The negative perceptions of schoolteachers and administrators can negatively impact trajectory of these young Black men; this causes challenges as some teachers and administrators see young Black men as troubled and underperformers (Rao & Flores, 2007).

In general, Black male students have been suspended and disciplined at a greater rate than White males (Lewin, 2012). Overall, Black males in inner-city schools with teachers who overly stressed discipline and were unable or unwilling to motivate students showed poor academic performance and poor attitudes toward school (Davis & Jordan, 1994). In addition, structural factors and school contexts influence negative school outcomes for Black males. Often, these are the result of the lack of male role models, especially Black male teachers, and misperceptions within their own culture that the academic realm is more feminine and does not bolter the strong male image some young Black males seek (Davis & Jordan, 1994). Therefore, some cultural peer pressure comes to bear on how young Black male students view school.

Complicating that are teachers' perceptions of some young Black male student as lazy, disinterested, disruptive, and unable to achieve academically (Rowley et al, 2014). In schools where teachers and students displayed open or inferred discrimination, Black students suffered, regardless of gender (Greene, Way, & Pahl, 2006). When teachers and other school personnel displayed racism toward Black students, those students had poor academic achievement. When fellow students displayed racism, Black students displayed more depression and lower self-

esteem (Benner & Grahman, 2013; Davis & Jordan, 1994). For Black males already expected to not to like school and to do poorly there, this was another push toward those outcomes.

Black male students' perception of who they are and what they are capable of achieving is a profound factor in the reasoning why some Black males do poorly in school in general. These perceptions are further fueled by engrained theories held by certain Blacks and Whites that because of slavery's past, no Black person will ever be equal to Whites (Noguera, 2003). In addition, the lack of Black male role models, other than sports figures and entertainers, hampers some Black males from pursuing college or entering into academic professions such as medicine or law (Muhammad et al, 2019; Noguera, 2003). Finally, Black developmental theory suggests that the embryonic identity of Black males may perceive academic achievement as acting White (Cross, 1971, 1991; Noguera, 2003). Noguera (2003) insists, however, that until Black male students and their families engage in changing these perceptions, no amount of new programs, new opportunities, or even altering policies will make a difference in academic outcomes.

Gregory et al. (2010) found that disciplinary actions were a contributor to poor school performance, especially if the student was suspended for any length of time. This effect they found was cumulative and contributed to students falling farther behind. These researchers also referenced that in general, White and Black students were disciplined at equal rates in a particular school district, it was for very different types of violations. White students were disciplined for observable and very objectionable acts: vandalism, swearing, leaving campus without permission, or smoking. Black students, mainly males, were disciplined for subjective offenses: being disrespectful, loitering, being noisy, or appearing to be a threat. These are clear indicators that a negative perception of Black male students was present.

Nevertheless, when Black males move out of these misconceptions and move beyond the racial and cultural discrimination to enter academia, they are often faced with being a Black man in historically White institutions. This invariably generates a new level of misperceptions, institutional racism, higher hurdles for opportunities for Black men, microaggressions, and increased environmental stress (Smith, Hung, & Franklin, 2011). This results in what the authors call racial battle fatigue.

Stereotyping. Black males in college face stereotyping from some of their White peers who think Black students know where to buy drugs, can teach them to dance, come from disadvantaged neighborhoods, always use street slang, or will need remedial classes to keep up in school. Further some may see all African American males as angry Black men and may view Blackness as a threat in some form (Boyd & Mitchell, 2018). For Black male students, in particular, this presents a stereotype threat that creates more stress than the rigors of college life in general (Steele, 1997).

Stereotype threat coupled with daily perceived microagressions (subtle, unconscious racism) can lead to what McGee and Martin (2011) called racial battle fatigue. Daily dealing with this can lead to emotional exhaustion, lower self-esteem, loneliness, and failing grades (Boyd & Mitchell, 2018). Racial battle fatigue is particularly marked in students who feel they are capable and belong in college more so than those who are not as engaged with school.

Stereotype threat can affect students who are prepared for college, feel capable and confident, and are expected to do well. Ramist, Lewis, & McCamley-Jenkins (1994) found that though SAT scores were good predictors for preparation for college and ultimate college success and were equal for both White and underrepresented minorities (URMs), when URMs entered college, their performance dropped, some dramatically. Some of these students, including young

Black males, may have developed a positive academic identification, meaning they have a perception that they belong in the college environment and can succeed there (Steele, 1997). However, when Black males enter college, they find a number of structural and cultural threats and stereotyping. Some internalize the stereotype and become what they are perceived as being (Steele, 1997).

For some Black male students, they may feel pressured to become or be reduced to whatever is considered bad about the stereotype (angry Black man, possible violence, being incapable of completing college, etc.). This constant assault can affect the confident, high-achieving student the most because this may be the first time, he is confronted with the possibility he cannot succeed. He does not have to believe the stereotype or believe it applies to him, but he is affected by it nonetheless (Steele, 1997).

Overcoming stereotype threat is exhausting; especially when a student keeps trying to prove the stereotype is wrong. Often one way that Black males cope with this is by trying to outperform peers in a specific course where he is confronted by the stereotype threat. He may do well and score at the top of his class in that course, but he cannot generalize that performance from one setting to another. In other words, he will have to prove himself in every course or even in a different college (Steele, 1997).

Brodish et al. (2011) found that when perceived racial discrimination was higher in male adolescents, these individuals developed more unhealthy behaviors such as drug use and overeating as adults. This has implications for college performance, since developing unhealthy behaviors in response to perceived racial threats could translate into drug use or poor academic performance in college or other unhealthy coping strategies. This was echoed in Dubois, Burk-Braxton, Swenson, Tevendale, & Hardesty's (2002) study of adolescent adjustment. They

concluded that daily race-related stress contributed to increased emotional and behavioral problems in Black males.

Brody et al. (2006) concluded in their longitudinal study of African American youths in communities other than densely populated urban areas that perceived discrimination contributed to an increase in conduct problems for African American boys, but not girls. They also posited that more incidents of perceived discrimination would be found in boys from families with higher social economic status due to their living integrated neighborhoods and having more contact with other racial and cultural groups. The authors also noted regardless of urban or rural location, racial discrimination experienced by African American children and adolescents, increased their challenges to their mental health. This reveals the origins and progression of negative behaviors for Black youth that can extend into early adulthood in the college setting.

This was also the finding in Wong, Eccles, & Sameroff's (2003) longitudinal study of middle school adolescents. Perceived discrimination not only from teachers and administrators, but peers as well, influenced lower academic self-efficacy, poor attitudes about the value of school tasks, lower grades, and negative impacts to mental health (depression, anger, poor self-esteem, and lower resiliency. These students also sought out peers who had little interest in school achievement and participated in more problem behaviors.

Felix and You (2011) recognized that peer victimization or bullying based on race was also a factor in African American students being able to have a successful school experience. They found that, in general, Native American and Black students of both genders experienced more peer bullying than other ethnicities. Female students experienced more sexual harassment than males as has been noted in other studies. However, males were subjected to physical victimization more than females. Native American and Black students experienced more

physical bullying (shoving, fighting, etc.) and were more likely to have their belongings stolen or be threatened or injured by a weapon of some kind. Felix and You (2011) felt that this type of racial bullying was more prevalent when African Americans and native students were a minority in school populations. When there were more students of their same ethnicity in a school, they were less likely to be bullied. Felix and You (2011) suggested there was protection in groups, either because lone students were easier to isolate and victimize and a lone student might be reluctant to report such incidents.

Chavous, Rivas-Drake, Smalls, Griffin, and Cogburn (2008), on the other hand, found that having a strong identification with being Black (racial centrality) could help boys maintain academic values even in discriminatory settings at school. Wong et al. (2004) also found that a strong identification with racial and cultural identity for African American students mitigated the influences of discrimination. This could affect Black male college students positively by becoming involved with Black student unions or Black professional groups, etc.

Compounding bias. O'Hara, Gibbons, Weng, Gerrard, and Simons (2012) found that as early as 5th grade, discrimination can affect African American students so much it has become a predictor of their not attending college. In making a distinction between a student's aspirations (dream or desire) to attend college with his expectation to do so, the researchers felt that aspirations are independent of external influences, whereas expectations are dependent of external influences. Future orientation or a focus on goals and plans mitigated the effects of discrimination, however.

Discrimination and negative stereotyping that has been accumulating throughout a Black male's life from his earliest experiences in school to how he is perceived in the workplace and community will have a negative effect on his motivation, perseverance, self-concept, and social

and financial success (Brodish, Fuller-Roswell, & Malanchuk, 2011; Davis & Jordan, 1994; Wong, Eccles, & Sameroff's, 2003). When the lack of support and encouragement is also found within the home, this also negatively impacts his personal and professional life. Racial battle fatigue becomes a reality as bias mounts year by year (McGee & Martin, 2011).

Bias may also be a contributing factor to failing to increase inclusion of Black students in medical education either through the institution's process or the students' lack of interest in applying. Although the recruitment process has been revamped and there has been an increase in the recruitment of minority students for medical school, the number of Black men in medical school has decreased over the past 20 years. Even HBCU medical schools are graduating disproportionately fewer numbers of Black medical students (Ansell & McDonald, 2015).

Cost of Attendance for Black Men

Another factor to consider when discussing key points that have directly affected Black men enrolling and matriculating through medical school is the cost. The financial burden of attending medical school is discouraging for some Black students as they are more likely come from families that are not able to provide financial support and are reported to anticipate medical school debt more than $150,000 (Dugger et al., 2013). Medical school costs fall on medical students who are often loan-dependent. Though debt at graduation can amount to between $120,000 and $200,000, many will pay triple that amount over the 25-30 years it usually takes to pay off medical school debt (Greyson, Chen, & Mullan, 2011). Often medical residents will moonlight to jump-start payments, which can be not only taxing for already stressed and overworked students who are working long hours or are on call. This is dangerous not only for these young physicians but puts their patients at risk.

Greyson et al. (2011) saw difficulties with the current medical school debt dilemma. They reported that there was no standard for costs, with even schools in the same city charging differing fees. There was no consensus of what the true costs of training a physician really were, and that increased debt often limited the diversity the medical workforce could have if students of color applied but were deterred by the potential financial burden. As costs of higher education have risen for any student, lenders may become reluctant to extend credit for increasing loans for medical school and those requests may exceed federal borrowing caps.

For Black students, in particular, the burden of educational debt is higher even for undergraduate degrees than for other ethnicities, especially Asians. More debt for medical school is piled on top of undergraduate costs, compounding the debt burden. Watson (2013) suggests that Black students may not have the financial support that many Asian students have from immediate and extended family. Asian families may expect their sons and daughters to attend college and even medical school and save for it as soon as their children are born and may require their children to work and put money aside for school. Many Black families often do not have these incentives because they may come from disadvantaged households or ones where no one has attended college (Watson, 2013).

Grinstein-Weiss, Perantie, Taylor, Guo, and Raghavan (2016) found that Black students from families with low to moderate incomes have twice as much student loan indebtedness as White students from the same circumstance. Black students also have the highest amount of federal student loan debt. These researchers speculate that part of the reason is many Black students choose to attend for-profit schools that have higher tuition costs. A more pertinent reason may be Black students and their families have diminished access to formal credit options

and therefore either go to high-interest private lenders or their lack of credit history may cause banks to offer higher interest rates (Grinstein-Weiss et al., 2016).

Steinbrook (2008) points out that medical schools are usually need-blind, meaning they do not consider need a factor in costs or tuition assistance. In 2006-7, of the $1.5 billion dollars in federal financial assistance, only 20% comprised grants and scholarships. The rest was in loans. Currently, half of the students in U.S. medical schools come from the tip quintile for family income, echoing the composition of historical medical school attendance, moving the medical school population once more into an elite status (Steinbrook, 2008).

This sentiment was also expressed by Joly and Chase (2005). They stated that since 1970, income for physicians rose 34.6%. However medical school indebtedness has increased more since then. Currently, interest rates for medical school loans are very low. If they rise, the educational debt burden could deepen.

Tran, Mintert, Llamas, and Lam (2018) also found that student educational indebtedness contributed to stress and thus affected their physical and emotional health. This was especially true for Black students and Latinos. Tran et al. (2018) found that overall, Black students express regret or buyers' remorse for their educational debt. Adding to this stress is the fact that some Black students may not finish their degrees and therefore have the burden of paying off school loans while never reaping the benefits of their education. Tran et al. (2018) called for the need for better education about tuition assistance and credit for Black families

Even if students, White or Black, decide to take on this financial burden, they may choose to go into a specialized field, often increasing their indebtedness, because the pay is higher for specialists than for primary care physicians. Davis & Allison (2013) found that more Black male medical school graduates chose high-prestige specialties such as surgery than

Whites. Private schools tended to graduate more students, Black or White, going into specialties than primary care because more of these students were more affluent. However, carrying a higher amount of debt almost always predicted medical school students' choice of a high-prestige specialty. Underrepresented students reportedly have higher medical school debt than their White counterparts (Davis & Allison, 2013).

Again, this limits diversity in primary care where doctors of various ethnicities could serve their communities (Greyson et al., 2011). Steinbrook (2008) stressed that diversity, including ethnic and economic diversity, is not only just but benefits the educational process and patient care.

Diversity in Healthcare

Diversity has many shades of meaning, often just used as a blanket term to mean race. It is more complex than that and brings more to the table than the color of one's skin. Diversity rather consists of many things, including race, that comprise an individual's worldview. This involves culture, traditions, language, values, beliefs, philosophies, modes of thinking, and personal experiences (Lee & Franks, 2009; Smedley, Butler, & Breston, 2004). Having more diversity in education, the workplace, and in one's healthcare providers offers different perceptions, different ideas, and perhaps different treatment approaches because of a broadening of experience and knowledge.

The Association of American Medical Colleges (AAMC) recognized the need for more diversity in the profession and furthered fledgling affirmative action in 1969 when it received funding to open the Office of Minority Affairs. This office sought to ensure equal opportunity for URM students by removing barriers to access to the medical professions. Their efforts and those of others effectively increased the enrollment of URM students from 3% to 10% in the

following five years (Strelnick, Lee-Rey, Nivert, & Soto-Greene, 2008). Challenges to affirmative action soon began to appear as early at 1974, however, with the *Funis v Odegaard* case that was heard by the U.S. Supreme Court. At issue was a student's challenge to the University of Washington School of Law's admission policies (Strelnick et al., 2008). Soon numerous other cases were heard in other states. Some cases found affirmative action in error; others did not, even for the same university. One ruling, *Grutter v. Bollinger*, is compelling for the discussion at hand. It found that the use of race as an admissions criterion supported the benefits of having a diverse student body (Strelnick et al., 2008).

Though great strides were made since 1960 to increase the number of minorities in healthcare, there is still a distinct gap between Whites and minorities. Currently only about 37% of the graduates from medical schools are minorities, with underrepresented in medicine (URMs) populations only accounting for 16% and Blacks totaling 7% of medical school graduates (Lee & Franks, 2009). URMs consist American Indians and Alaska First Nations people, Native Hawaiians, other Pacific Islanders, Blacks, and Hispanics. Asian students, also a minority, are making great strides in increasing their numbers in medical schools and in the healthcare profession (Lee & Franks, 2009).

Education. Educational disparities, especially in medical research, can affect the competitiveness of the U. S. in the global marketplace. The lack of diversity is at the heart of educational disparity and not only has an impact on the standing of American education and medical inquiry, it directly has an impact on the quality of healthcare for all (Steinecke & Terrell, 2010). Providing young adults with exposure to racial diversity is critical in preparation for working in today's modern society. Enrolling in higher education institutions highlights the importance of preparing students to work in diverse settings (Bowman, Brandenberger, Hill, &

Lapsley, 2011). College provides the setting for students to have interactions with their peers of diverse backgrounds. Literature suggests that student interactions with diverse (racial/cultural) peer groups while in college positively affected their personal growth, purpose in life, and recognition of racism (Bowman, Brandenberger, Hill, & Lapsley, 2011).

Having more diversity within academia has been proved to improve the learning environment for all students. Butler and Breston (2004) posit that various points of view stimulate a more dynamic learning environment where students and faculty can challenge assumptions and engage in intense dialogue and freer inquiry. This has impact not only on medical school training for physicians but also for researchers in the medical field.

Nivet and Berlin (2014) emphasize the importance of diversity, stating that by integrating it "into formal and informal learning environments—while creating and fostering cultures of inclusion—benefits the intellectual development, service orientation, critical thinking, and cultural competence of all involved" (p. 16). They see diversity's impact on medicine as a critical factor, encouraging pipeline programs to bring in URMs and the development of holistic reviews for admission policies instead of relying entirely on test scores and other sterile criteria.

Patient care. Diversity impacts patient care in many ways. LaVeist and Pierre (2014) found that minority patients when matched with White physicians report lower quality of interactions with their doctors due to shorter time spent in the office visit, less trust of their doctors, poor communication, and felt diminished respect from physicians and other healthcare providers. Communication disparities were not because of language or idiom but by a lack of cultural understanding. When minority patients were matched with physicians of their own race, they reported having longer doctor visits and better compliance with physicians' orders (LaViest & Pierre, 2014).

This is echoed by Smedley et al. (2004) who reported that diversity in healthcare professionals improved access to care, increased patient choice and satisfaction, and improved provider-patient communication. Moy & Bartman (1995) also reported that minority patients were 4 times likely to have a minority physician than White patients. They also stated that minority doctors often treated more minority patients who were not only financially disadvantaged but also sicker. In addition, Sullivan (2004) reported more minority healthcare professionals were more likely to serve minority and underserved populations.

Though research, as stated above, indicates that minority physicians are a good fit for treating minority patients, Saha, Guiton, Wimmers, and Wilkerson's (2008) study had an interesting finding. They surveyed 20,112 graduating White and URM students from 118 medical schools found that White students, especially in schools with racially diverse populations, reported overwhelmingly that they felt they were prepared to serve minority and underserved populations more so that URM students. However, HBCUs were omitted from this this self-reported survey, and the responses may be a reflection of the hopeful outlook of young White doctors, who may feel ready to take on the world.

There are real benefits for increasing diversity in the physician workforce. Diversity can improve quality of care through higher levels of trust. It can enhance cultural competency in healthcare in general, but also in patient-physician interaction where patients feel they have been heard and their concerns have been respectfully addressed (LaViest & Pierre, 2014). Diversity can broaden access to care for minorities and open up access for geographically underserved regardless of race. Diversity can enhance research opportunities and the depth and scope of medical inquiry. In addition, diversity may encourage more minority physicians to open their own practices, many of which may be in underserved or minority communities, thereby bringing

health care to neighborhoods where access might be limited (LaViest & Pierre, 2014).

Physician workforce. Providing diversity in medical schools will likely affect diversity in the healthcare workforce. Having students that are underrepresented in medicine can meet the growing need of having healthcare providers that represent underserved communities (Achenjang & Elam, 2016). Black medical schools are important to the diversity in healthcare in the U.S. HBCUs in general produce 85% of all Black physicians (Minxon et. al, 1995). Xavier University and Prairie View A&M University are two HBCUs that rank at the top as producers of Black physicians.

Xavier University is the top producer of Black STEM graduates and applicants and graduates of medical school in the U.S. (Jones, 2015). Xavier credits its success to its peer-led student tutoring centers and peer- and instructor- led drill system. Peer-led tutoring is accessible at centers on campus led by peer tutors who have been selected by faculty. The peer- and instructor-led drill system provides two-hour drill classes once a week that reinforce the skills and concepts covered in courses. These programs have become institutionalized practices at Xavier (Gasman, Smith, Ye, & Nguyen, 2017).

Prairie View A&M University has created two programs that has attributed to their success as one of the top HBCU producers of Black STEM graduates and Black physicians. The Premedical Concepts Institute, created by the Biology Department, is a summer program for incoming freshman interested in careers in STEM. The second program, offered through their Cardiovascular and Microbial Research Center, supports independent problem solving through research projects and mentoring. Prairie View also includes the approach of inviting alumni that serve as physicians back to campus throughout the year to speak with students to ensure students see success on a prominent and regular basis (Gasman, Smith, Ye, & Nguyen, 2017).

In response to this growing need for diversity in healthcare, the American College of Emergency Physicians issued a statement in 2018 that encouraged more diversity in staffing across all hospital departments, and supported enlisted more qualified diversity in hiring emergency physicians. They stressed this reflected the multicultural society of the U. S. and thus needed to be better addressed (Workforce Diversity in Healthcare Settings, 2018).

Access to health care for that diverse base, however, is often difficult. Mensah and Sommers (2016) emphasize the shortage of primary care physicians in general and a declining number of them who will serve minority or underserved populations. There are over 60 million people living in primary care health professional shortage areas in the U.S. They also state the AAMC predicts a shortage of 31,000 primary care physicians by 2025 (Mensah & Sommers, 2016). Having fewer diverse doctors in the healthcare workforce has an impact not only on research and education but on direct patient care. This impacts access to healthcare, the quality of care patients receive, and whether or not outcomes of care are positive (Lee & Franks, 2009).

Ansell and McDonald (2015) addressed how biases in academic medical centers can affect the lives of Black patients. Through their research, Ansell and McDonald found that doctors that hold racially based stereotypes tend to change their course of care and treatment for their patients. Despite healthcare providers' best intentions of being ethical and providing equitable care, Black patients continue to be disadvantaged when considering patient outcomes, medical education to patients, and faculty recruitment (Ansell & McDonald, 2015).

One contributing factor to such negative outcomes is the shortage of physicians who practice in underserved areas. This is a compounding issue as the minority and non-English speaking populations in the United States are growing significantly (Marrast, Zallman, Woolhandler, Bor, & McCormick, 2013). Research found that Black physicians are more likely

to care for underserved populations than white physicians; however, Black physicians remain underrepresented in medical field (Capers &Way, 2015). To combat this issue, HBCUs accept and matriculate students with lower entrance test scores, while predominantly White institutions (PWI), mainly medical schools, are hesitant to partner with HBCUs to create pipeline programs (Capers & Way, 2015).

Success in Medical School Admission for Black Men

Previous research, as mentioned above, has focused on obstacles for Black men with aspirations to attend medical school. Research is minimal that identifies contributors to the success in admission to medical school for Black men. However, recent qualitative research suggests factors such as motivation, social support and guidance, and more creative and innovative admissions screening might not only attract more Black male applicants to medical schools but also identify factors that would make them better fit for the healthcare profession.

Hadinger (2016) sought to find out why barriers in the admission process impede Black male students from making the cut or even getting an interview and undertook a qualitative study that explored the perceptions of Black/African American and Hispanic/Latino medical students regarding the medical school admissions process. Using a grounded theory approach, one-on-one telephone and in-person small group interviews were conducted with Black/African American and Hispanic/Latino medical students (Hadinger, 2016). Two growing themes where found among the 33 student participants: 1) barriers and support, and 2) motivations for a career in medicine. Participants emphasized prior knowledge or experience, role models, interested in science, and perceived benefits among their motivations for a career in medicine. Regarding the theme of barriers and supports, participants included academic and financial factors, social

support and guidance, and persistence (Hadinger, 2016). These have been reported before by others (Steele, 1997; Chapman, Contreras, & Martinez, 2018).

Research specifically addressing Black men and medical school admission examined what individual experiences and characteristics contributed to the successful admission and graduation from medical school for black men (Thomas, Manusov, Wang, & Livingston, 2011). Through the interviews, this qualitative research was able to identify six contributors to successful admission to and completion of medical school which included faith, education, social support, group identity, social responsibility, and exposure to the field of medicine (Thomas, Manusov, Wang, & Livingston, 2011). These contributors were assembled into four major themes of psychosocial– cultural experiences, educational experiences, personal attributes and individual perceptions, and exposure to medicine. The authors created the metaphor of a table, which represents success with four legs, each leg representing one of the four major themes to illustrate the multifaceted dynamics that contribute to success (Thomas, Manusov, Wang, & Livingston, 2011).

Innovative admissions programs have been suggested. Nivet and Berlin (2014) encouraged less stress on MCAT scores and fostered holistic interviews for medical school applicants. Lumsden, Bore, Miller, Jack, and Powis (2005) suggested using the Personal Qualities Assessment instrument that measures not only cognitive ability, but looks at personal traits and moral/ethical reasoning. It also measures empathy to a degree. Their findings suggest that when cognitive ability is equal, a deeper look into a candidate will reveal more than intelligence and desire.

Lievens (2003) found situational judgment tests gave a deeper look into medical school candidates. This was felt to better predict interpersonal skills throughout the student's medical career and how he or she might perform at the bedside of patients.

Koenig et al. (2013) argued that there is validity in personal competencies assessments for medical school applicants, but until recently there is no consistency as to what those core competencies are. The Association of American Medical College's Innovation Lab Working Group (ILWG) and the Admissions Initiative identified nine core competencies that medical school applicants should have not only in order to succeed in school, but to be competent physicians. Those are reliability and dependability, ethical responsibility, dedication to service, capacity for improvement, interpersonal skills, oral competence, teamwork, and cultural competence (Kenig et al., 2013). The problem, however, is finding the proper tools that can assess these personal competencies. The MCAT and a CV are clearly not enough.

With these successes comes a disturbing insight. White, Brownell, Lemay, and Lockyer (2013) analyzed 210 medical school admissions essays. They found that often medical school applicants write what they think they are expected to say about themselves and their aspirations. This skews the selection process in favor of those who may have an insight into the whole application process or have had relatives or mentors who coached them with their essays. This points to the extreme competitiveness of the medical school admissions process and how it may be slanted toward those with insider information, of which many Black male students may not be aware. This may be another reason why Black men are not applying to medical school.

There have been improvements to prepare, recruit, and select Black men for careers in the healthcare profession, but they are still doing so in lower numbers. When they do decide they want to pursue a medical career, many factors are involved in that choice.

Student College Choice

Choosing to go to college is a major decision for African American families. There are several studies that explore undergraduate college choice (Litten, 1982; Manski & Wise, 1983; Hossler & Gallagher, 1987; McDonough, 1997; Perna, 2006). College choice is the term used to define the two-step process that leads to a student, first, reaching a decision to resume formal education after high school and, secondly, determining which college or university to attend (Hossler, et al., 1989). For additional context, Hossler, et al. (1989) describe the student college choice as a "complex, multistage process during which an individual develops aspirations to continue formal education beyond high school, followed later by a decision to attend a specific college university or institution of advanced vocational training" (p.234).

Adapted from Hossler and Gallagher (1987), Cabrera and La Nasa (2000) proposed a three-stage process in which students choose whether or not to pursue college. These stages begin in middle school and run through high school and are salient references for making this kind of decisions. Those three stages are the Predisposition Stage in grades 7-9, the Search Stage in grades 10-12, and the Choice Stage in grades 11 and 12. The Predisposition stage requires parental support and financial planning, the use of high school academic advising for information about colleges, and the student's abilities and career and educational aspirations. This is also when the student enrolls in college prep courses. The Search Stage also relies on parental support, and the student's abilities, and career and educational interests, but it also relies heavily on academic advising and collecting information about types of schools and specific coursework, amenities, and campus climate. The Choice Stage involves delving into financial aid, admission requirements, attainment of college attitude and entrance test scores, support from family and

friends, submission of application, and final selection of school as well as preregistration and applications for financial aid.

Sociological and Economic Perceptions for College Choice

Over the years in studies regarding college choice, sociological and economic perceptions have been the main focuses of this research (Bourdieu, 1977; Coleman, 1988; Paulsen, 1990; St. John, Paulsen, & Starky, 1996; Lyn, 1998; Perna, 2000; Perna, 2006; Vrontis et al, 2007; Winkle-Wagner, 2010). The perception of sociological factors in college choice explore the predisposition of students seeking and attaining higher education based off their academic preparation and socioeconomic status (Cabrera & La Nasa, 2000). Formative research in this area by Sewell and Shah (1968) broadened the idea of college choice by including the aspects of a student's life situation and experience. Sewell and Shah's (1968) seminal seven-year research work with high school students found that intelligence, parental encouragement, and socioeconomic status were important parts of the process in college choice.

Perna (2006) also notes the correlation between students with educational accomplishments and preparation at advanced levels receiving higher levels of encouragement to attend college, which resulted in increased aims for attain higher education for students. One of Perna's (2000) earlier works considered the social capital and cultural effects of college choice by observing the relationship between academic preparation and access to capital among different ethnic and racial groups. The research found that cultural and social capital played an important role in the possibility of academic achievement in Hispanic and African American students attending college while both Hispanic and African American students possess less access to capital than White students (Perna, 2000).

In the perceptions of economics factors in college choice, personal investment in higher education leads the discussion (Becker, 1962; Becker 1993; Cabrera & La Nasa, 2000; Avery & Kane, 2004; Baum, S., & Payea, K., 2004; English & Umbach, 2016). Economic models and theories have been beneficial in examining the financial structure of higher education. But when considering college choice, its economic perspective is based on a cost-benefit analysis (Hossler, Schmit, & Vesper, 1999; Paulsen, 1998, 2001). Paulsen (2001) concludes that the belief behind the economic perspective college choice is that students hypothesize if a college education is valuable, that determination is based on the projected benefits and costs related to investing in a college education. Economic models and theories adopt the thought of students' college choice decision making as itemizing the advantages and disadvantages of each school, giving each a value, and then selecting the less or more rational of the choices in order to capitalize on benefits relative to costs (Hossler, Braxton, & Coopersmith, 1989).

In exploring the economic perspective and college choice, Paulsen and St. Johns (1997) studied students college choice decision making in selecting public and private institutions. They found high financial aid packages to be significant to students attending private colleges while living and tuition costs were less important in their college choice decision making. In contrast, students choosing public colleges found low tuition and living costs the most significant factors in their college choice decision making process. Also imperative in college choice was location as students choosing public colleges found proximity to home (lowering living costs) and ability to work while in school important (Paulsen & St. Johns, 1997). St. John, Paulsen, and Starky, (1996) offered a key point in that students have very different contexts within their choices, which affect the stages and sequences in their decision making. Some students' college choice is dependent upon the cost of tuition, which is seen in research regarding traditional age

college students; while others choose colleges to maximize their living costs by living at home and working through school, which are habits seen in non-traditional students who may have limited choices for college due to restricted finances (Jackson, 1978; Manski & Wise, 1983).

Parental Involvement

Parents have a positive influence on college choice. If parents attended a university or college, they have a higher influence and engagement in their child's school choice. Lack of college experience can lead to under-matching students with less prestigious schools or schools that may not quite fit their child's needs (Chapman, Contreras, & Martinez, 2018).

Chapman, Contreras, and Martinez (2018) emphasize that if African American parents have a K-16 education plan, their children are more likely to succeed in college and in the workforce. These researchers also stress parental involvement to encourage their sons and daughters to take college prep classes and advanced placement classes for college credit. They also argue parents should also initiate discussions about college costs and the pros and cons of different types of schools, as well as specific schools. Though these parents are usually very involved in their child's college decision-making, they must negotiate between their interests and desires for their child and the student's own aspirations and interests. Students of parents who are not just supportive but who also help them find resources about schools, financial aid and scholarship, arrange for college visits, and who reach out to their own professional and family networks for college resources seem to make better school choices and have a more favorable opportunity to succeed in college.

In addition, many Black parents see their child not only as an individual but as part of a minority culture. They offer solid reasons for getting a degree for personal success, but they also see the whole higher education process as a means of combating racism and stereotypes about

Blacks in academia, especially their sons. These Black parents worry about their children becoming token Blacks in PWIs and are aware of how limited diversity has a negative influence on their child's emotional and social wellbeing, as well as their success in college and having a positive school experience. Often these Black parents will encourage their child to not accept an offer from a prestigious school if the racial climate was not as positive as that at a less prestigious college (Chapman, Contreras, & Martinez, 2018).

Racial stereotypes can affect the engagement of college faculty with students, even very bright and promising ones. They are often considered "intelligent thugs" who are anomalies within their culture (Wood & Newman, 20017, p. 1072). When students have parents who have attended college before or they themselves have been in school longer, they become aware of these racial academic stereotypes and have a better sense on how to deal with them. Ironically, those students who have greater perception of these stereotypes actually have better engagement with faculty (Wood & Newman, 2017). Hilton and Bonner (2017) also see the lack of parental experience with college negatively affects a student's ability to select the right school for him or her. Attending an HBCUs is often a positive decision for many Black students. At these schools, students find a supportive environment where they not only see minority students who look like themselves on campus, but minority faculty as well (Hilton & Bonner, 2017). This may be critical for young Black male students, who benefit from solid academic advising and student support services. However, Hilton and Bonner (2017) theorize that with ability, goals, and motivation, students of color can succeed in any college environment.

Black College Choice Model

Research regarding Black students' attainment, participation, and access to higher education have been widely studied (Gurin & Epps, 1975; Braddock & Dawkins, 1981; Astin,

1982; Smith, & Allen, 1984; Allen, 1985;1986; Allen & Hanif, 1991; Allen1992; Thomas,1992; Allen & Jewell, 2002;). While research has been completed on Black students in higher education, studies addressing ethnicity and its influence on college choice is limited (Hossler, et al., 1989; Paulsen, 1990; McDonough & Antonio, 1996). Although it has become the theme of more recent studies, HBCU college choice has an even smaller footprint in academic research (McDonough, Antonio, & Trent, 1997; Freeman, 1999; Freeman & Thomas, 2002; Johnson, 2018).

Grounded in the theories of Bourdieu (1977), The Black College Choice Model (McDonough, Antonio & Trent, 1997) is framed by cultural dimension, college choice, and traditional status attainment models. In the development of the model through a quantitative study, the authors considered the characteristics of students' background, including college choice behaviors, self-concept, and goals, along with high school activities. Employing regression analyses, these points were used to examine their influence on a student's choice to attend an HBCU. McDonough, et al. (1997) found that educational experiences, financial concerns, aspirations, and background characteristics to be factors in the decision to attend an HBCU. Mainly the reputation of the college, desires of the parents, and the student's religious affiliation (Baptist) were the top reasons that study participants chose to attend HBCUs.

Additionally, a qualitative study conducted by Freeman (1999) sought to decipher if the type of high school attended would influence a student's choice to attend an HBCU or PWI. The author led group interviews in five cities with large Black populations. The research indicated that students from private high schools that were predominantly White, who were considering PWls, were more likely to give thought to attending an HBCU than students from predominantly Black high schools. While the predominantly Black high school students were soundly

considering PWIs, the study did find that having a connection to an HBCU significantly swayed their consideration of choosing HBCUs. The research of McDonough, et al. (1997) and Freeman (1999) share a focus with this proposed study to examine a single racial group, Black males, in their choice processing to attend HBCU and PWI colleges. While the McDonough, et al.'s (1997) work was restricted to high school students, that model's constructs for choice are suitable for the use in this proposed research as the key variable, HBCU choice, is the same.

Graduate School Choice

While there is literature available on the complexities of undergraduate school decision-making (Olson & King, 1985), the literature on graduate school choice is limited. The early 1980's saw the first studies exploring the choice process for graduate school, based on the same theoretical framework, became a thoughtful topic of research (Mullen, Goyette, and Soares, 2003). Prior graduate school choice studies were limited in their complexity and range due to the availability of datasets with only a small number having a sample that were representative of the nation. As well as there being numerous theoretical and conceptual frameworks that were utilized to perform a variety of analyses (Perna, 2004). Graduate school choice process research started with many points consisting of enrollment of professional programs in specific disciplines, enrollment of underrepresented populations on the graduate level, and the outlook on the pipeline of college faculty (Zhang, 2005). Literature regarding college student persistence and college choice has served as the foundation for graduate school choice research (Kallio, 1995).

In quantitative research, the federal Baccalaureate and Beyond studies of 1993, 1997, and 2003 served as the launching pad for new studies concerning the knowledge and understanding of choice processes for graduate school (Heller, 2001; Millett, 2003; Mullen et al., 2003; Perna,

2004; Zhang, 2005). Through these early studies, shared themes were born in exploring the process of graduate school choice, that encompasses the student's type of undergraduate institution, academic performance, undergraduate major, the characteristics of the student's family, demographical and biological factors, and the debt incurred while obtaining the undergraduate degree.

There are few studies available, mostly in Europe, which address graduate school choice regarding medical school decision-making (Foster, 2014; Adams & Garden, 2006). One study examined the factors that make an established and newly formed medical school attractive or otherwise to potential students in the United Kingdom as it was believed this to be important to study since there is little empirical evidence that explores this issue (Brown, 2007). It was determined that three categories of medical school qualities were prominent as positive elements of choice. These elements were academic strengths, location, and other intangibles. For academic strengths, reputation was considered the most important. Location was centered around specific cities. The intangibles, included recommendations from others, personal contact with the school or faculty and gut feelings (Brown, 2007).

Gasman et al. (2017) postulate that HBCUs in urban areas often expose Black male students to a larger population of Black students and role models of men like them who foster solid academic habits and attitudes for success. Often urban HBUCs act as community centers for many Black male students (Gasman et al., 2017).

Brown and Evans (2008) echoed the need for Black male role models. Their study found that ethnic socialization by Black mothers was associated with higher grades in their grade school sons and higher grades in adolescents if that ethnic socialization was done by fathers. Ethnic socialization is the teaching of Black heritage, culture, and values. In this case, having a

male caregiver offer guidance and a sense of pride in Black heritage and values impacted teens as they looked toward completing high school and pursing college.

Perna's Model of Student School Choice as Modified

Perna's (2006) model of school choice provides an approach that is multi-layered and consists of social, economic, and other societal contexts. In researching the choice process at the professional and graduate education level, having a framework that can explore the complexities of the decision making of Black males attending an HBCU medical school improves the understanding of the professional and graduate school student choice. The landscape of literature on school choice is heavily skewed on the exploration of high school students with rare appearances that include professional or graduate education. Due to the limiting nature of the student college choice stages of predisposition, search, and choice (Hossler & Gallagher, 1987), student college choice has not been conducive in examining professional and graduate student populations.

English and Umbach (2016), however, provided an initial modification of Perna's (2006) model when they explored graduate school choice through habitus, cultural capital, and social capital. A significant finding for this proposed study is English and Umbach (2016) discovered that African American and Hispanic/Latino undergrad students were more likely to decide to continue their education through graduate school in major professions (law, medicine, hard sciences) that their White peers. They also found a need to improve these students' undergraduate matriculation rates since smaller numbers than their White counterparts reached that level (English & Umbach, 2016).

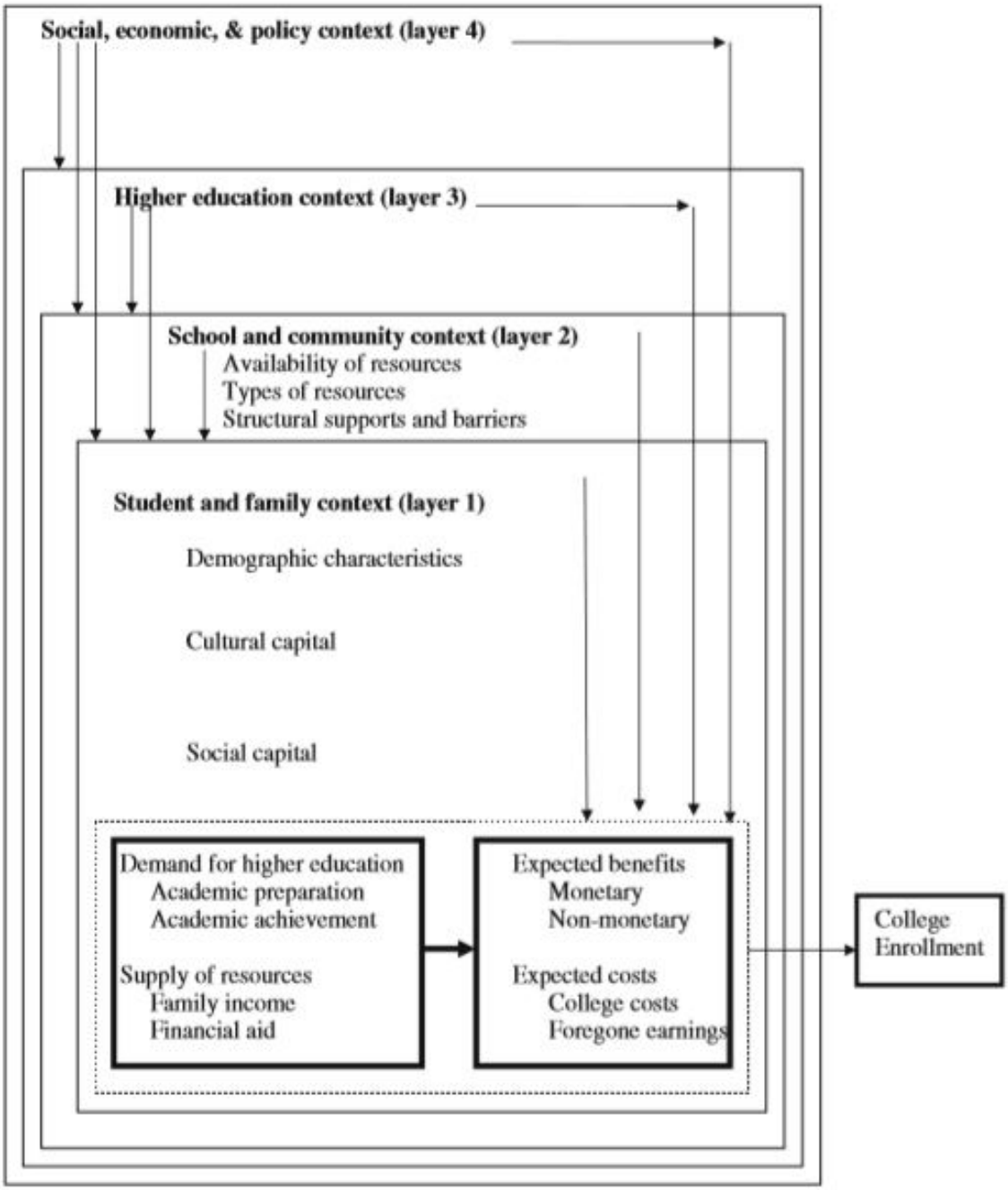
The current study will examine the choice processing of Black males enrolled in an HBCU medical school utilizing Perna's (2006) conceptual model of college choice. That model

of college choice has parallels for students going from undergraduate to professional or graduate school (Perna, 2006). Though this model surveys students as they move from high school to college, Perna's model can serve as a valuable basis for a template in examining the choice process of students who progress from undergraduate to professional or graduate school.

Perna's conceptual model (see Figure 1) views the decision formed of college choice through four contextual layers: (1) habitus; (2) school and community contexts; (3) higher education context; and (4) social, economic, and policy contexts (2006). The first layer, habitus, refers the internalized system of beliefs, attitudes, values, experiences, and actions that an individual attains from family, school, and community environments (Bourdieu, 1977; McDonough, 1997; Perna 2006). Habitus also includes demographic characteristics such as race and gender, as well as social and cultural capital (Paulsen & St. John, 2002; Perna, 2006). The second layer, school and community contexts, discusses the type and accessibility of resources, as well as obstacles and supports present within the institution and its surrounding community. The school and community contexts understand that resources and social structures can aid students in the choice process (Perna, 2006). The third layer, higher education context, realizes the influence institutions have in a student's college choice through its characteristics along with recruitment and marketing efforts. The final layer, social, economic, and policy contexts, recognizes that college choice for a student is also formed by public policies and societal changes (Perna, 2006). Literature in relation to graduate school choice stems from English and Umbach's (2016) four-layer graduate school choice conceptual model (see Figure 2) as a theoretical framework adapted from Perna's (2006) college choice model.

Figure 1.

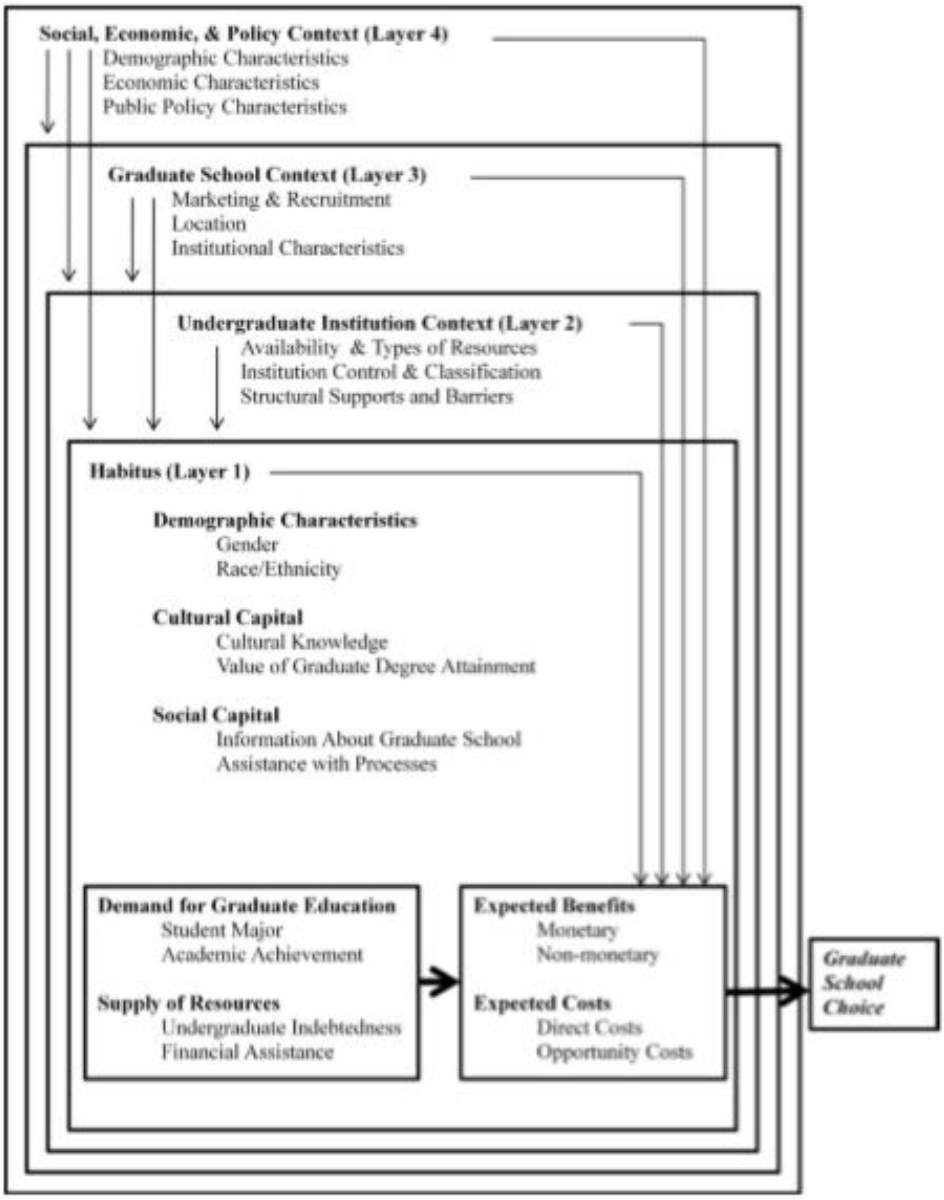
Perna's Model of Student College Choice



Note. Adapted from "Understanding High School Students' Willingness to Borrow to Pay College Prices", by L.W. Perna (2008), *Research in Higher Education, 49*(7), 589–606. Copyright 2008 by Springer Science & Business Media, LLC.

Figure 2.

English and Umbach's Four-Layer Graduate School Choice Conceptual Model



Note. Adapted from "Graduate School Choice: An Examination of Individual and Institutional Effects", by D. English and P.D. Umbach (2016), *The Review of Higher Education,39*(2),173–211. Copyright 2015 by the Association for the Study of Higher Education.

To be inclusive of the specific characteristics of the institution type for the current research study and professional and graduate education, the adaptation of Perna's model for graduate school choice in Figure 2 served as the framework for analysis of the study. As an addition, constructs from the Black College Choice model (e.g. reputation of the college, desires of the parents, and the student's religious affiliation) were utilized in the habitus layer of the graduate school choice model as they were found to be significant in the choice of attending a HBCU. Both Perna's adapted model for graduate school and the Black College Choice Model and choice informed the proposed study of Black males' choice process in attending an HBCU medical school. Both models offered a fitting setting for exploring the choice processing of Black male medical students deciding to attend an HBCU medical school.

Due to the limited research on graduate school choice in regard to medical schools, research on the graduate school choice of Black men and medical school is nearly non-existent. To explore the reasoning behind medical school choice for young Black men, this qualitative study was proposed.

CHAPTER III: METHODOLOGY

The purpose of this qualitative study is to better understand the factors that contribute to Black males' graduate school choice in attending an HBCU medical school. The research design proposed for this study is a qualitative approach. This was chosen because quantitative methods will not provide the richness of the qualitative design of phenomenology as it captures lived experiences (Moustakas, 1994). Phenomenology is credit to Edmund Husserl as he is seen as the forefather in defining it purpose in research in the early 20th century (Kafle, 2011). Husserl's thought was that no norms should advise phenomenology's inquiry. The emphasis should be on what is given from an individual's intuition (Moran, 2000). Phenomenology for Husserl was a concept where any phenomenon that has been lived has the opportunity to be studied thereby driving analysis past the simple perceptions of sensory to the experiences of memory, thought, imagination, and emotion (Reiners, 2012).

In Husserlian phenomenology, a lived experience of a phenomenon includes features known as essences. These features usually are perceived by individuals who experienced the phenomenon and can be identified to create a generalizable description. According to Husserl, essences of a phenomenon signify the true nature of that phenomenon (Moustakas, 1994). In Husserlian phenomenology the goal for the researcher is to reach transcendental subjectivity. In transcendental subjectivity, the researcher's influence on the inquiry is evaluated frequently and preconceptions and biases are defused, so the object of the study is not influenced (Lopez & Willis, 2004). To reach this state, the researcher has to achieve three phases of reduction:

bracketing, transcendental-phenomenological reduction, and imaginative variation. To achieve the first phase, bracketing, researchers must set aside or bracket, like a mathematical equation, their past knowledge, assumptions, previous understandings about the phenomenon of concern (Ashworth, 1996). For the second phase, transcendental-phenomenological reduction, researchers view each participant's experience as an individual experience. Researchers also create a description of essences and meanings of the phenomenon (Moustakas, 1994). The third phase, imaginative variation, relies on instinct and involves picturing several variations of the phenomenon to arrive at the essences of the phenomenon. The essences from these phases develop the groundwork for all the knowledge about the phenomenon (Gill, 2014). This qualitative method will offer the needed depth for this proposed study. The Husserlian phenomenological design is recommended for this research because participants will able to fully express their experiences that contribute to graduate school choice in attending an HBCU medical school (Moustakas, 1994).

Qualitative research was most suitable for this research as it provides the best opportunity to uncover the factors that influence school choice among Black male students who choose to attend an HBCU medical school. There is a need for qualitative studies as there is a dominance of college choice research in the quantitative realm (Perna, 2006). Through the use of individual interviews, the proposed study looks to examine the graduate school choice process for attending a HBCU medical school. Thus, this study sought to focus on understanding the narratives of Black male medical students enrolled at one particular HBCU.

Research Questions

To examine factors for Black males' graduate school choice in attending an historically Black college and university (HBCU) medical school, there were three research questions drafted. Those were:

1. What is the graduate-school choice process for Black men who enroll in a MD degree program?
2. What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?
3. What factors for Black men led to the choice to attend a HBCU medical school?

Site Selection

The study was proposed as a single-site study with the Black male medical students at a medical school in the South. Along with the lack of Black medical colleges, racism was prevalent and continued to stifle the aspiration of Blacks within the medical profession. In the 1960s, five southern medical schools still had policies to prohibit the admission of Blacks (Gasman, 2012).

From 1975 to 1980, the site medical school served as a two-year medical education program. Students completed their first two years of medical education there and their third and fourth years of clinical education at other four-year medical schools. In 1981, the site medical school became a four-year medical institution and become independent of its original host university (Gasman, 2012).

At the time of study, the host medical school had 453 students across eight degree programs, including the doctorate of medicine. Ninety-five percent of the medical student population is full-time with 66% women and 34% men. In the Doctor of Medicine program,

from academic years 2014-2015 to 2018-2019, Black men make up 23% of the student population. Black women account for 44.4% of the student population while White men and women comprise 5.7% and 3.8% respectively. Asian Indians, Hispanics, East Asians, and students that identify as other represent the reminder of the student population at 8.4%, 5.7%, 4.9%, 4.1% respectively. The site for this research was selected due to its population's cultural background, accessibility to the proposed study population, and the willingness of the administration of the institution to participate in the study.

Table 1

Host Medical School Demographics by Academic Year (AY)

Race/Ethnicity & Sex (Self-report)	AY 2014 N (%)	AY 2015 N (%)	AY 2016 N (%)	AY 2017 N (%)	AY 2018 N (%)	Total N (%)
Black Men	12 (15.4)	21 (25.0)	20 (22.2)	25 (25.0)	26 (25.7)	104 (23.0)
Black Women	38 (48.7)	41 (48.8)	45 (50.0)	42 (42.0)	35 (34.7)	201 (44.4)
White Men	3 (3.9)	3 (3.6)	6 (6.7)	5 (5.0)	9 (8.9)	26 (5.7)
White Women	3 (3.9)	4 (4.8)	2 (2.2)	5 (5.0)	3 (3.0)	17 (3.8)
South Asian/ Indian Men	6 (7.7)	1 (1.2)	6 (6.7)	4 (4.0)	4(4.0)	21 (4.6)
South Asian/ Indian Women	1 (1.3)	1 (1.2)	5 (5.7)	7 (7.0)	3 (3.0)	17 (3.8)
Hispanic Men	5 (6.4)	2 (2.4)	1 (1.1)	2 (2.0)	5 (5.0)	15 (3.3)
Hispanic Women	3 (3.9)	4 (4.8)	1 (1.1)	2 (2.0)	1 (1.0)	11 (2.4)
East Asian Men	1 (1.3)	2 (2.4)	2 (2.2)	4 (4.0)	5 (5.0)	14 (3.1)
East Asian Women	1 (1.3)	1 (1.2)	2 (2.2)	1 (1.0)	3 (3.0)	8 (1.8)
Other Men	3 (3.9)	3 (3.6)	0 (0.0)	2 (2.0)	4 (4.0)	12 (2.6)
Other Women	2 (2.6)	1 (1.2)	0 (0.0)	1 (1.0)	3 (3.0)	7 (1.5)

Participant Selection

Participants for this research study consisted of Black male medical students enrolled at the site medical school. Working with the institution's Senior Associate Dean for Medical Education and Student Affairs, Black males that enrolled in their first through third year at the school were identified. This pool of participants was chosen due to accessibility of the researcher and participants for interviews. In addition, the site is representative of HBCU medical schools' demographic characteristics in terms of race, sex, and student body size. An email describing the study and requirements for participants was sent from the researcher to students via their campus email accounts in the hopes of having 15 to 30 Black male students to participate (See Appendix A). The final number of participants interviewed for the research was 20. All twenty students self-identified as male and as Black, a cultural identity that included African American, African, Caribbean American, and other Black racial, cultural, and geographic designations.

Data Collection

"First-person reports of life experiences" are produced through phenomenological research (Moustakas, 1994, p. 84). The proposed focus of this study is to gain a better understanding of the experiences of Black males that lead to choosing to attend a HBCU medical school and to find reasons and meanings behind their experiences. To gain a better understanding of the meaning of these life experiences, scientific research must be valid (Moustakas, 1994). The tape-recorded interview method that is one-on-one will be effective in obtaining information from participants in this study (Creswell, 2002). In the qualitative interview process, "researchers ask one or more participants in a study mostly general, open-ended questions and record their answers" (Creswell, 2002, p. 203). Interviews and collected data support the

firsthand exploration of the phenomenon related to Black males' graduate school choice in attending a HBCU medical school.

Prior to conducting the study, an Institutional Review Board application for permission to interview Black male medical students at MSM will be submitted through MSM's Human Research Protection Program (Appendix B). The Senior Associate Dean for Educational Affairs at MSM was contacted to discuss the objectives and timeline of the study and to obtain permission to pursue this study.

Interview Protocol

Participants signed a consent form before each interview began (See Appendix C). The researcher asked a series of open-ended questions during each interview (See Appendix D), that were modified as necessary to continue the flow of conversation about the topics review involved. All of the interviews were recorded and carefully transcribed for analysis by a transcription service. Every recording and transcription was assigned a number to maintain the anonymity of every participant, such as P1 for Participant 1. All recordings and transcriptions were stored securely until the data were analyzed and written. Then they were destroyed.

Data Analysis Procedures

Qualitative data must be analyzed differently than quantitative data, due to the nature of oral/written interviews. Ellingson (2011) stressed that qualitative data should be broken down into more manageable segments in order to study and interpret the data. Since this study's data were derived from twenty participants, the amount of transcribed material from the interviews was extensive, resulting in nearly 300 pages of data. Though daunting, the researcher made a strategic change in data analysis.

Initially, NVivo software was first considered for this study. However, a more thorough, hands-on approach was decided that would provide a much deeper insight into the participant's responses. Though NVivo is useful for the search for key words and phrases, it can miss nuances when dealing with clusters of phrases of similar meaning but not specifically worded. Therefore, Graneheim and Lundman's (2004) manifest content analysis was used. This is a six-step process. The initial step was to read all of the interviews several times, first to make sure the transcriptions were correct, then to read for clarity and content, and finally to look for repeated ideas and themes. During this process the interviews were cleaned, meaning duplicate words, typos, and extraneous interjections such as "like" or "you know" were removed so that the participants' thoughts could be clearly understood.

The next step was to look for similar units of meaning within the interviews. To do this, responses to specific interview questions were extracted from each interview and put into a working file for that question. Then the content of these responses was searched for important units of meaning and repeated themes. These were further grouped together by question. This process diverts from simple marking and coding data but was chosen because of the large amount of data collected by this research. By computer highlighting and lifting data to appropriate files, the integrity of each interview was preserved, meaning what was collected was identified as coming from a specific participant. It also condensed the amount of data to be analyzed. During this process, several overarching themes were identified that ran through most of the interviews.

Positionality Statement

Research can have a shared viewpoint that is shaped by both the researcher and participants. The identities of the researcher and participants can impact on the research process

(Bourke, 2014). For this reason, the researcher, as the interviewer, must share the context of his positionality.

The researcher was graduate of the selected site. He completed his Master of Public Health (MPH) degree within the academic program of Graduate Education in Public Health. Three years post-graduation, the researcher returned to host medical school to serve as the Program Manager for Graduate Education in Public Health. As an administrator at the institution of the proposed study, the researcher does have a professional interest in the academic achievement of students attending the institution. The researcher hoped that the findings of the proposed research will assist in advising the institution of enhanced methods in the cultivation, recruitment, and retainment of Black male medical students in the future. The students who participated in this study are not involved in any program for which the researcher is responsible and thus does not have any personal relationships that may have affected the participants' ability to be open or honest concerning their experiences.

The researcher does hold a professional interest in this population because of his place of employment and aspirations of professional promotion within the institution. However, the researcher was not a medical student and in his current role has only limited interaction with medical students. The researcher understands that he is the data collection tool and one of the conductors of the date analysis in this qualitative research study; therefore, he recognizes that his personal experiences and opinions should be clear and on the forefront as he practices self-awareness through the process in order to accept when data begin to represent personal views rather than those of the participants.

Delimitations

There are delimitations, assumptions, and potential bias inherent to any study. This proposed study is no exception. While the proposed study will analyze the accounts of Black males, there will not be a comparative group of another gender or race. Through the review of literature and what is identified in the space of professional and graduate school choice, the proposed research gives license to the accounts of the Black male students in a manner that will not require a comparison group of another gender or race. In addition, the medical school chosen for the proposed research could have an influence on the data. For example, choosing an HBCU medical school connected to a university system could generate different findings than a freestanding HBCU medical school. The research was also confined to an HBCU medical school in the Southeast so that all interviews could be conducted face-to-face.

Delimitations in a research study are features that define boundaries of the study and define its scope (Simon, 2011). These can prevent the findings of the study from being generalizable to all populations (Bryant, 2004). While generalizations at the population-level may not develop from a single quantitative interview, interviews together can produce conclusions that are pertinent or consistent to the participant group and portray generalizations within the study (Simon, 2011). Additionally, findings from the proposed study can provide alternative explanations to existing research findings or new directions for research that would alter the present knowledge of the professional and graduate school choice process (Simon, 2011). Seeing as the proposed study is qualitative by design, the purpose of this research is not to yield generalizability that is all encompassing, but to offer an assessment of student accounts at one medical school to enhance the existing knowledge of the choice process for Black males attending an HBCU medical school. The delimitation that the study will be conducted at a single

HBCU medical school does not allow for generalization for all HBCU medical schools. Another delimitation is the population as the study is proposed for Black male medical students of one particular medical school. Another delimitation is that participation is voluntary, making the proposed research dependent on the participants' willingness to complete the interviews.

Assumptions

Every study also has assumptions built into its design. In most cases, assumptions are facts or concepts that are thought to be true but are not verifiable. Often these are in regard to participant participation or the strength of the research design. One of the first issues to consider is whether the topic under study is relevant and worthy of investigation. It is assumed that researching what factors affect Black males' decisions to attend an HBCU medical school is important and will yield findings that will benefit the participants and others who are shaping medical school recruitment and application processes.

It is also assumed that the research design was crafted to be the best fit for this particular type of investigation. Another assumption is that the population being sampled is appropriate for this research topic and design and that their responses will yield the necessary data to explore the study questions presented (re: individual processes of Black male college choice) (Simon & Goes, 2013). Also, it is assumed that a level of trust will be established between the interviewer and the participants and that participants will answer the interview questions truthfully and will offer insights into their decision-making processes. Another assumption is that the Black male students at the selected HBCU are the most qualified to use to answer the research questions of this study. In addition, it is assumed that the participants have a genuine process for making the decision to study at this particular HBCU medical school. Finally, it is assumed that the

researcher will use best practices in collecting and analyzing the data and that apparent bias will be eliminated or well managed during the entire study.

Bias

Bias is another type of limitation. In this study, bias may exist because the researcher may know some of the participants due to working at the institution. A biased study will jade the findings, rendering them inaccurate and unreliable (Mullan & Williams, 2013). Roulston and Shelton (2015) recognize individual researcher bias, but this can be mitigated if the researcher/interviewer recognizes it and manages it. Asking open-ended questions is one way to minimize researcher bias and being vigilant to sources of personal bias to ensure that the qualitative standards are met is another (Sarniak, 2016). Though all sources of bias may not be eliminated, every effort will be made to minimize it (Roulston & Shelton, 2015).

Trustworthiness

Trustworthiness in qualitative research is often more difficult to ensure than in statistical quantitative research. However, there are some specific procedures that can be used to do this.

In order to determine trustworthiness, Lub (2015) analyzed the work of seminal researchers Lincoln and Guba (1985) who tried to set standards for the qualitative research community. Credibility, transferability, and dependability were critical criteria that soon became more complex with their introduction of more prolonged engagement and observation in the field, member checks, peer debriefing, meticulous audit trails, and even adverse case selection where outliers in data were critically analyzed. All of this was an attempt to create a detailed paper trail and evaluations to document what was done and how it was done and for further researchers to duplicate if they chose and ensure the research's validity. However, though still valid and used today, these methods came under fire by various researchers who did not feel

there was a single standard due to different perspectives or paradigms researchers held (Hammersley, 2007; Rolfe, 2006; Sandelowski & Barroso, 2002).

Creswell and Miller (2000) later tried to reconcile these different paradigms into a framework. Those paradigms were: The Paradigm Assumption/Lens, Postpostive Paradigm, Constructivist Paradigm, and Critical Paradigm. Each paradigm had three specific procedures for assuring validity in qualitative research. Lub (2015) used the same 12 procedures but renamed the paradigms: Purpose Evaluation/Perspective, Instrumental Effectiveness Policy/Program, Meaning Policy/Program for Target Group and Practitioners, and Empowerment Clients/Target Group/Practitioners. He based his new model on the inner purpose of the research being done. These were three areas: Was the policy or framework the research was investigating working, and what were its components? (Postpositive Paradigm) What was the meaning of the target group? (Constructivist Paradigm) Moreover, did it empower or educate the participants? (Critical Paradigm) (Lub, 2015). However, over it all was Creswell and Miller's (2000) overarching reasoning for any qualitative research: the researcher's perspective, the participants' perspective, and the external or reader's/reviewer's perspective.

In this research, all three perspectives were observed. Since this research will deal with the purpose of finding meaning and specific processes of Black male students deciding to attend an HBCU medical school, it will deal with the Constructivist Paradigm. However, this research will use the validity methods of all three paradigms. It will contain a meticulous audit trail and will use member checking of the Postpositive Paradigm. Member checking here will involve conducting interviews in such a way that responses are periodically checked for clarification and accuracy during the process and may even involve follow-up questions. This is a two-way exchange to make sure the participant's responses are clear and precise (Stake, 1995). This will

minimize misinterpretation during analysis.

This research will also use thick description as a Constructivist Paradigm validity procedure. This means that the researcher will spend as much time with the participants during the interviews is necessary in order to obtain depth of the individual's responses. In addition, this research may use peer debriefing, a Critical Paradigm validity procedure, in order to make sure that data collection and analysis is thorough and accurate. Using all of these procedures should ensure validity.

Generalizability

Again, in qualitative research, it is often more difficult to engender generalizability than quantitative research. Often, the reason for lack of generalizability is that the researcher is dealing with a much smaller sample size and particular parameters for a specific study. Since qualitative research deals with interactions with participants through interviews, written surveys, or, in some cases, impersonal data (books, newspaper articles, documents, etc.), it is often more challenging to apply the resulting data to a broader population because the researcher is dealing with the perceived experiences of a specific sample (Creswell, 2007). Generalizability often cannot be formed from an anticipated outcome through a specific research hypothesis because data are most often not black and white, either and or, and therefore not quantifiable (Leung, 2015). This makes it difficult to extend the results to a broader population. Selection parameters resulting from the research design in this study may create an internal bias specific to the selected participants; however, their responses may represent other Black male students and their medical school college choice and, therefore, valid (Kukull & Ganguli, 2012).

Other factors, such as how skilled the interviewer is (Patton, 2002) and how forthcoming the participants are, may also curb generalizability. If the participants do not generate lengthy,

detailed responses, data may be further limited and may not be generalizable. Since the reason to conduct qualitative research is to examine a topic with depth of detail, the desired outcome is to accumulate a robust understanding of the factors individuals experience in regard to the topic at hand (here, Black male student choice of HBCU medical schools) (Patton, 2002). This is one reason qualitative research has an advantage, sometimes, over quantitative methods (Ramm & Kane, 2010).

Siedman's (2013) themes indicate the subjective and specific nature of qualitative research. The human experience is temporal and transitory, and all human experience is subjective, lived experiences are studied, and experiences are grounded not only in specific meaning but also in the context in which they are perceived. Because this guides all qualitative research, data generated is personal and specific to those interviewed and may not be generalizable to a larger population. However, data may be generalizable to a similar population.

Chapter Summary

This chapter discussed the methodology proposed for this qualitative study. Its purpose was to understand better the factors that contribute to Black males' graduate school choice in attending an HBCU medical school. The research design proposed for this study was to interview a small number of Black male medical students enrolled at medical school in the South to examine the graduate school choice process for attending an HBCU medical school.

CHAPTER IV: RESULTS

This chapter provides the evidence for the themes arising from transcription and analysis of the data for this study. This qualitative research examined the decision making of African American men who decided to attend a historically Black college or university (HBCU) medical school. This study used three research questions:

1. What is the graduate-school choice process for Black men who enroll in a MD degree program?
2. What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?
3. What factors for Black men led to the choice to attend a HBCU medical school?

As qualitative research, this study presented an opportunity to reveal life experiences and influences that impacted decisions to illuminate what was previously misunderstood, unknown, or discounted (Bogdan & Biklen, 1993). Examples are presented to understand the research participants' circumstances and their strategies in deciding to eventually attend a medical school. Quotations are utilized to permit the participants to speak for themselves, offering multiple perspectives. Knowing and appreciating the choice process in decision making from undergraduate to graduate school is essential in the needed examination of these processes and narratives of Black men who decide to attend an HBCU medical school.

This chapter begins with a description of the participants, how data were collected, and how it was analyzed. The findings section will be presented as key segments based on the layers

of English and Umbach's (2016) graduate school choice conceptual model: habitus, undergraduate institution context, and graduate school context. First, the research participants, including their demographics will be discussed in the habitus layer to provide beneficial descriptors of the participants and their backgrounds to give insight into their cultural and social capital, including the demand, supply resources, and benefits/costs of a medical education. Secondly, how participants engaged the undergraduate college choice process is explored, as well as how they view institutional control and classification, availability and types of resources, and the structural supports and barriers experienced at their respective undergraduate institutions. This assists in fully understanding their medical school choice process. Thirdly, the results of the graduate school's context of marketing and recruitment, location, and institutional characteristics will be discussed. The closing segment of the chapter offers a conclusion, emphasizing how the participants' narratives reflect their influences and individual habitus as it relates to their graduate school choice.

Demographics of Participants

All participants identified as male (100%, n=20) and as Black (100%, n=20). The Black category was further divided into African American (n=16), African (n=2), and Afro-Caribe (n=2). One was an African national and one of the Afro-Caribe participants held dual American/Canadian citizenship. The participants ranged in age from 22 to 32. The mean age was 25.7 years. The median consisted of two ages: 24 and 25. The mode also consisted of two ages: 24 and 26; five participants were 24 and five were 26.

Participants were a mix of first-year, second-year, and third-year medical students. There were seven first-year students, 11 second-year students, and two third-year students. The range of ages within those medical school levels revealed differences in the timing of when these

students entered medical school. The two third-year students were 25 and 26, indicating that they began as first-year students within the normal age range of 22 and 23, which would indicate they entered medical school directly from their undergraduate programs.

The first- and second- year students showed a wider range of age. Among the seven first-year students, there was an age range from 22 to 27. Only one was 22; three were 24 and three were 27. Second-year students showed a wider age range (23-32), with the mode being 26 (five participants). There was one student each at the age of 23, 24, 25, and 32. Two students were 29 and five were 26. Many of the participants in the older age range of 26 to 32 had a delay in staring medical school. This could be due to going to graduate school to obtain a master's degree or taking a gap year or two; this was borne out through statements by the participants.

The participants, though they are currently living in the state in which their medical school in located, were not all from that state. Ten participants were state residents, nine were out-of-state residents, and one is a foreign national. One out-of-state participant also had dual US/Canadian citizenship.

In addition, eight students attended an HBCU either for their undergraduate education or for their graduate programs. Five students attended an HBCU for their undergraduate work and three earned their master's degree from an HBCU.

Finally, data looked at the participants' undergraduate GPAs and their current GPA in medical school. The undergrad GPA range was 2.7 to 3.94 (only one was under 3.0). The current medical school GPA range was 2.7 to 4.0 (two just listed As and Bs or an A because it was early in their first-year experience). There were three students who were currently below 3.0 GPA, (2.7, 2.8, 2.95), and six students had a current GPA of 4.0. This data is interesting because it suggests the difficulty of medical school but also reflects the determination of the

students. None of the participants had a 4.0, but nine had a GPA of over 3.5. What is significant in the data is that one student went from a 2.7 in his undergrad studies to a 4.0 in medical school.

Table 2

Summary of Study Participants

Participant	Year	Age	Hometown Region	Undergrad Institution Type	Undergrad Major	Undergrad GPA	Current GPA	First Gen.
Dwaine	MD 1	27	Northeast	PWI	Biology	3.7	4.0	No
Franklin	MD 1	24	Southeast	PWI	Exercise Sports Science	3.5	3.5	No
Remy	MD 3	25	Southeast	HBCU	Biology	3.2	2.8	No
Justin	MD 1	24	Northwest	PWI	Chemistry and Physics	3.9	3.8	No
Antwan	MD 2	26	Midwest	HBCU	Biology	3.4	3.8	Yes
Robert	MD 2	24	Southeast	HBCU	Biology	3.1	3.2	No
Terrell	MD 1	22	Northeast	PWI	Biology	3.9	4.0	No
Aaron	MD 2	26	Southeast	PWI	Exercise Sports Science	3.1	3.2	No
Richard	MD 2	32	Southeast	PWI	Biology	2.7	4.0	No
William	MD 2	26	Southeast	HBCU	Biology	3.5	3.0	No
Marques	MD 1	27	Southeast	HBCU	Biology	3.4	3.8	Yes
Rashad	MD 1	26	Northeast	PWI	Biochemistry	3.9	3.5	Yes
Arlen	MD 1	24	Southeast	HBCU	Biology	3.3	4.0	No
Leon	MD 2	24	Southeast	HBCU	Biology	3.6	3.4	No
Kennard	MD 2	25	Southeast	PWI	Biology	3.4	3.0	No
Bobby	MD 2	26	Southeast	PWI	Biology	3.2	4.0	No
Corey	MD 3	26	Southeast	HBCU	Biology	3.8	3.6	Yes
Alfred	MD 2	29	West	PWI	Anatomy and Physiology	3.2	3.0	Yes
Carlos	MD 2	23	Southwest	PWI	Biology	3.7	3.3	No

Brian	MD 2	29	Midwest	PWI	Psychology	3.1	2.9	No

As the demographic data clearly indicated, all of the participants identified as male and Black. However, not all of them identified as African American (n=16). Two identified as African and two as Afro-Caribbean. One of them was an African national, two were naturalized citizens (one African and one Afro-Caribbean), and one of the Afro-Caribbean participants held dual American/Canadian citizenship. For all of these students, their Black identity was important, though experienced and expressed differently because of their cultural identities.

This forms the basis of the habitus layer that participants used to make their decisions about college choice for undergraduate school and medical school. Their decisions for graduate school, however, were based strongly on cultural factors, moderately on social factors, and very loosely on policy factors.

Presentation of Findings

The emergence of three themes were seen through the data collected from the participants' in-depth interviews. The design of the research questions intended to elicit more insight into the graduate school choice process for Black men attending a HBCU medical school. Participants in the study revealed family impact & support, institutional environment, and institutional reputation influenced their decision-making process in attending a HBCU medical school.

Family Impact & Support

Each participant disclosed how their parents, mostly mothers, were instrumental in their decision making to attend college and selection medicine as career aspiration. Students shared how expectations were set by parents as they provided encouragement and supported them through their decision-making process for undergraduate and graduate school. Some participants

mentioned people who influenced their decisions to go to college or a specific school. Robert mentioned his dad pointing out an HBCU. Aaron attended three different undergrad schools. His high school coach had influenced his decision for the first one, a friend who played football influenced his second choice, and his future wife influenced his third where he graduated. Though Marques entered a bridge program in engineering and had a HOPE scholarship, it was his immigrant parent who fostered a strong work and study ethic. Kennard's mother was an alum of [Dunbar University] so that influenced his decision to go there. Corey wanted to move away to be independent. He chose a place closer to his girlfriend who eventually became his wife and they ultimately went to the same college. Many of the participants expressed they had the belief from their parents that attending college was not a choice but an expectation. This expectation and support appeared to be a driving force for many of the students in this research to pursue medical school.

Decision to attend medical school. Though all the participants had an intention to attend an undergraduate college, not all of them did so with the intention of immediately moving on to choosing a medical school. Many participants had made an early decision to become a physician. Some did not choose that career path until they were in their undergraduate programs. These early decisions were based on a variety of factors that included exposure to the medical field, an interest in science, or suggestions or influence from teachers or family. The timing and circumstances for those early decisions were not based on any of the factors in college choice. The age that participants first decided to become a physician varied greatly, ranging from age 6 or 7 to the second year of undergrad college (around 19 or 20). Age when participants made a conscious decision to go to medical school ranged from before high school to early undergraduate college years.

Participants who decided before high school often did not make a full commitment until they were older. Four participants (Dwaine, Remy, Corey, and Carlos) decided to go to medical school before high school. Dwaine and Corey both knew when they were very young, around age 6 or 7, but they both did not commit until the first year of undergraduate school. Remy decided at age 12 after observing people in his family with illnesses. It was as he entered high school, however, when he took steps toward this career. Carlos was also young (sixth grade) when he decided because a teacher saw his potential after he had done well on a science test. Nine participants (Justin, Antwan, Terrell, Richard, Rashad, Arlen, Leon, Kennard, and Bobby) decided during high school or just after. Rashad, being an African national, had the unique opportunity to make a career decision during his high school in Ghana. He to choose a major to finish his secondary education. Terrell, Justin, and Arlen were encouraged by family members. Terrell decided in his senior year in high school to become a doctor because a family member wanted him to, but he chose this career path as a junior in college. Justin's family said that he expressed an interest as a child, but he didn't remember that. He did choose medicine early on in high school and was influenced by his sister who was in the medical field. Likewise, Arlen grew up being around the medical field because his mother was a nurse. However, he was in eleventh grade when he decided to go to medical school himself.

> **Arlen:** While my parents got divorced when I was in the 5th grade, so she didn't think I was old enough to go home by myself. I used to go to doctors' offices after I got off the bus from school and just kind of hang around doing my homework there… The doctor that my mom works for, he's a genuinely good guy…. He's one of my role models in life.

Leon and Kennard were influenced by special programs in school. Leon decided in high school after he did a summer medical program. Similarly, Kennard did a dual program as a biology major where students in high school took courses both in high school and college. While participants received family support in their decision-making process, they expressed their desire to support their families and community. Participants indicated the economic impact of working in the field of medicine. Students shared narratives of the wanting financial security for them and their family. Students also stated their beliefs that their future career field would offer a position of power that would allow for them to help and serve their community in a meaningful way. Students detailed the desire to be role models for Black youth in their communities. The impact of these factors often drove them to a deeper commitment seen within their morals and faith driven by parents and other family members. Students revealed the pursuit of medicine as their calling as it allowed for the development of their individual passions while allowing the fulfilment to help others while being an inspiration. Brian had multiple reasons for his decision to go into medicine, especially since he was reluctant to go into this career. He also expressed that it was his calling.

> **Brian:** I was resistant to go into medicine… I was four years into psychology… after I took that first biology course, things really started to open up. And I realized what my calling… But I had to do some real deep searching… Recognizing I have an interest in being a team leader. Being a creative thinker. A critical thinker. Wanting to leave a mark in society. Wanting to help demographics that don't feel like they have a voice or help demographics that don't feel like… they're really being helped.

Six participants (Franklin, Robert, Aaron, Marques, Alfred, and Brian) did not decide

until they were undergraduates. Alfred and Robert decided while in college because of influences by specific medical programming. Alfred decided when he was a member of Health Careers Opportunity Program, an organization for students interested in health. Robert decided in his freshman year but did not really act on his career decision until his junior year after many students and alum from an HBCU medical school came to discuss medical careers.

Franklin and Aaron chose to be in the medical field, but as physical therapists (PT) first. Aaron said he decided, "About my, I guess, junior year in terms of credits in college. I was like, this is what I want to do. Because I was kind of in the physical therapy rut." Franklin thought that being a doctor was very daunting, but he changed his mind as a junior in college. Brian also changed his major, but he was ready to graduate in psychology. However, his psychology professor suggested he might be more suited to medicine than pure psychology. He had to play catch-up, staying an extra three years because he had to take extra classes to be pre-med.

Marques changed his major because of a physics course he was in. He was an engineering major and was in the wrong course, and it would cost him money to change. He reported that a trip to the Dean's office, prayer, and a powerful dream set him on a new path. The Dean, however, was not encouraging.

> **Marques:** And I remember praying about it. And one night I had this dream, and in my dream, I was in a hospital and a doctor had walked up to me and…he was like, come, come with me… I went with him, and we entered the patient's room… "teach me about medicine." …. there's no reason that I should have had that dream right around this time anyways… I think that's my calling. I think I'm going to do medicine….
>
> But in order to change a major, you had to go speak with the dean of the department to allow you to change. And so, she pulled up my grades… She looked at me. She said,

"You want to do medicine?... you really want to do this?" I was like, "yeah… Put me in…" She was like, "I don't know. Your grades don't look like … you will do well with this"… "I will; just put me in." The next semester when I started, I had never taken anything before. I got the highest grade in the class.

Reasons for choosing medicine. All the participants answered this question, but many spoke at length about their reasons for making this choice. Only Remy offered a vague answer, explaining that undergrad was "a gateway to becoming a physician." There were also several participants who offered multiple reasons for deciding to become a doctor including personal interest, money and prestige, personal health reasons, desire to give back, faith and morals, and chosen vocation. The responses of all participants can be gathered into the areas of habitus, cultural capital, and social capital. Habitus includes a variety of influences and resources that are part of cultural and social capital (Paulsen & St. John, 2002; Perna, 2006). For this analysis of participant responses, habitus has included elements of the environment that include basic needs, such as money. The area of money, however, does have a cultural component in prestige and power. For this presentation of findings, both money and prestige will be listed in habitus.

Four participants (Dwaine, Justin, Bobby, Corey, and Brian) based their decision on personal scientific interest. Corey stated, "I love science. I've always been good at it and seeing my mom do the healthcare, just helping people through help care. I'm a very… giving person… I felt like it was something attainable for me." Dwaine said, "I've always been interested by the human body. …when I was younger, I wanted to be a veterinarian. But when I realized that you got to put animals down and that they don't make as much money." Justin and Bobby expressed their skill and interest in science, but both stated that there was a more altruistic reason behind being in a profession that you are good at. Bobby stated, "I love the human body. I'm very

inquisitive… My love of learning. And then my just passion to help other people and to give back to those that are less fortunate than I am."

Seven participants (Dwaine, Justin, Antwan, Marques, Arlen, Bobby, and Corey) based their decision on money. Some were honest, such as Justin who said, "I want to provide a life for me and others." Marques confessed that a career in medicine would ease his mind about basic needs. "I don't have to worry about taking care of myself. I won't have to worry about how I will pay my bills." Antwan, Arlen, Bobby, and Corey also offered honest answers about financial security, but they also added a social, ethical outreach element. Bobby chose medicine because it was something he loved and was good at it, but it also had good financial rewards. Corey stated, "I can help people, serve at a higher standard, and also make good money while doing it,…That's the biggest thing, helping...just elevating myself all around." This was also reflected in Arlen who saw becoming a doctor as financial security but also as having the power of the position.

Participants stated reasons for choosing medical school that were based on their values and a willingness to help the wider community. Those were divided into family/personal health reasons, a desire to give back, personal values, and faith, and feeling this was a chosen vocation. Five participants (Dwaine, Robert, Terrell, Corey, and Carlos) based their decision on the influence of family, usually because of illness in the family or a death. Dwaine stated, "my freshman year of college, my grandfather died of liver cancer and he didn't have like a primary care physician. So, he really didn't get care until it was too late." Robert and Carlos both had family members who were ill whose treatment by the medical profession heavily influenced their decision to go to medical school. Robert was upset with how his uncle has been treated by a doctor. This had a strong influence on his decision to become a physician himself. Corey and

Carlos had family members who were in the medical field who influenced their decisions to go to medical school. Richard, however, also had a relative with a condition that required a lot of medical visits. Both of those things heavily shaped his decision to go to medical school. Terrell had a medical condition himself that heightened his awareness of the healthcare profession and influenced his decision to go to medical school.

Since this study focused on medical school students, it was not surprising that many of the participants expressed philanthropic reasons for being in medicine. Thirteen participants (Dwaine, Franklin, Justin, Aaron, Richard, William, Rashad, Leon, Kennard, Bobby, Corey, Alfred, Brian) expressed their main reason for deciding to go to medical school was because of an avid desire to give back. Leon, Justin, William, Kennard, and Bobby had strong interests in science, but their decisions to become physicians was deeper than that. Corey and Alfred also saw medicine as an avenue not only help others but to grow as a human being. Kennard had decided to become a physician's assistant but decided to skip that step and become a physician. He expressed needing to have a purpose, a reason to get up in the morning and do a job. This made medicine more of a vocation than just to make money. William had an interest in science and strong family encouragement. He told a life-changing story of the influence his Black male pediatrician had on his life and that became his own desire to help others.

> **William:** the biggest thing was being able to meet my first Black doctor… I had… a Black male pediatrician… Because that was something rare… being able to see like how much power he had… as far as…helping people…. The rapport… just to see how he was able to help change people's lives… this man comes from the same background as me, and he's able to actually get his platform and use his voice, being able to help enact change in the community. And that was something I… always… knew I want to do… I

> want this opportunity to go ahead and be a voice in my community, make sure I'm being a voice for voiceless, because growing up was just like an underserved area... Being able to help my community… Just want to be that agent of change…. I want to be in a place where I can make a huge difference.

Five participants (Dwaine, Franklin, Robert, Aaron, and Richard) expressed a desire to be role models not only for their communities, but also for Black youth. Franklin had begun wanting to be a physical therapy student, even shadowing a physical therapist during high school. That changed and so did his vision of helping others. Richard's story, though, shows that he could not only overcome his own issues with education but also become more of a role model. He taught eighth grade in an all-boys, predominately Black school and found that often these students were dismissed because standardized tests were the norm and many students didn't do well on them. He did more for them to help them learn and then felt this same concern for hospital patients.

Rashad and Terrell had very different experiences because they were born in Africa, and one is still an African national. Yet, their desire to give back was just as strong as their American cohorts. Terrell offered deep insight into what he learned from a gap year project that had impact on how he plans to practice medicine. He recognized his own privilege, coming from a two-parent home in a middle-class family from Nigeria. He understood that his future patients would not have his advantages. This was a surprising insight because the concept of privilege has been associated with White individuals. It is also a result of socioeconomics.

Cultural capital often includes one's religious and spiritual foundations. Marques felt his decision to go to medical school also revolved about personal fulfillment. He reported he persisted because of his faith. He also recognized he could help others and be an inspiration.

Plus, he felt this path allowed him ownership of his own life. Two participants (Alfred and Brian) felt as if medicine was their calling or that they were chosen, making it a vocation. Alfred not only wanted to help people, but he felt chosen. He had tried other careers but kept coming back to medicine. Brian had multiple reasons for his decision to go into medicine, especially since he was reluctant to go into this career. He also expressed that it was his calling. Aaron's medical school choice removed his active decision-making, leaving it entirely up to God.

Institutional Environment

Participants attended both HBCUs and PWIs for their undergraduate studies. Some students shared their undergraduate experiences of being supported and encouraged and wanting to find that environment again in their medical school choice. Students also expressed being in an environment with other students that understood their culture and plight provided a peaceful environment and a place where they are comfortable was important. Students articulated their decision in choice of their current medical school included the opportunity for mentorship and the forming of meaningful relationships with professors, administrators, and alumni of similar background that resemble them. Data attained from the in-depth interviews revealed some of the students experience negative moments within their undergraduate environment and voiced wanting to avoid a similar environment for medical school contributing to their choice of their current medical school.

Undergraduate school choice. The participants in this study based their choice of undergraduate school mostly on habitus, cultural capital, with some social capital for a few. There were several factors under each of those areas. Participants chose their undergraduate school because of convenience and a sense of feeling at home at the college or university. It was important for six participants (Dwaine, Remy, Terrell, Richard, William, Brian) to be able to live

at home and go to school or just be close to family. This reason often had financial factors at the root, but some participants acknowledged a level of social immaturity or unwillingness to go out on their own at that stage in their lives. Brian had to weigh being very far away from his family and the higher cost of the school he had first planned to go to. He decided that being able to live at home and getting a full scholarship were important, so he chose a school in his home state. In undergraduate college choice, social capital manifested in the university's ability to offer scholarships and other money incentives. Five participants cited social capital as a strong reason to choose the undergraduate school they did. Six participants (Franklin, Terrell, Richard, William, Kennard, and Bobby) cited money (scholarships) as influencing their decisions. Franklin wanted to go to a prestigious school, but his grades and his HOPE Scholarship kept him in his home state. Rashad chose a small school with a full scholarship that allowed him to enter into a biochemistry program without having to become a general biology major first and then prove himself. He went to HHH and then to SSS for his master's degree. Bobby was recruited to play football, but it was the academics side of the school that made him decide.

Five participants (Antwan, Robert, Arlen, Corey, and Carlos) commented on feeling "at home." Robert did not have an HBCU on his radar. He had intended to follow his mother and aunt's lead by attending a local state school. However, with his dad's influence, he checked out an HBCU campus and "fell in love" with it. Arlen reported, "The campus reminded me of home. The surrounding cities reminded me of home. I get that feeling when, you know, something's all right." Carlos spoke of how he felt about a college visit: "the way they presented a tour and how I like the atmosphere, felt like I was at home there. I just felt like that was a place for me to be."

Participants expressed cultural capital in terms of Black presence and the influence of others. This layer is often an extension of the habitus layer because some of the family influences

grow out of the environmental aspects of home and location. Remy's response clearly illustrates how habitus and cultural capital influence one another. He noted convenience first, but felt that being around other educated Black men, who were career driven, was impressive. Antwan and Corey both said they felt at home when seeing Black students like them when visiting an undergraduate HBCU. Antwan's response was articulate as he pointed out the personal education, he felt he received just being around people who looked like him but were also very diverse with different lived experiences. This was a powerful first impression he received on a tour of the campus as a high school student.

As a corollary to Black presence, Franklin's response was a surprising finding. When asked if he ever considered an HBCU, he stammered around a very incoherent reply and only when he was pressed for details was the reasoning more apparent but not upfront. He stated he may have given HBCUs a brief consideration when he was younger but dismissed the idea. The deeper reason was because he did not feel he understood Black culture enough or presented it personally enough to fit in at an HBCU. Mostly, this was through surface, outward presentation such as clothing or shoes. He mentioned that people have said that he talks like a White person. He felt this is an issue with many young Black educated men.

Graduate school decision: Difference in decision making. All but two participants (Franklin and Remy) felt it was a very different process choosing a medical school than it was an undergraduate college or university. Remy felt that there was no difference in choice, but he knew he wanted a school with diversity as was his experience at another HBCU. For those who found this decision process was indeed different, there were levels of what made it so complex. Those can be grouped into the areas of habitus, cultural capital, and social capital.

Participants looked at practical things like finances and location. Dwaine felt any medical school would be more expensive and farther from home. Antwan chose his school because of location because of his wife's educational choices. Justin had personal constraints, such as required courses and finances, that impacted his decision-making. Two participants (Bobby and Carlos) just wanted to be accepted by any medical school. This is not exactly a habitus issue, but it is one of basic need, which is related to habitus as described by Maslow's (1964) Hierarchy of Needs. Carlos found his medical school because he just looked out of state after getting no response from medical schools in his home state. He came to an HBCU medical school because it was the first to accept him. Like Carlos, Bobby just found his HBCU medical school because it was the only one to accept him. He did not seek out an HBCU medical school but was grateful to be accepted by one and that became beneficial to him.

Participants also looked at the differences in the decision process through the view of cultural aspects. Some participants targeted specific schools, aligning them with their personal values or mission; some spread their search more broadly, just wanting to be accepted somewhere. Robert said the process was similar but different from choosing an undergrad school. It was similar in that he applied a targeted approach to both searches. He sought schools where he would have the best odds of being accepted. For his undergraduate process, he had a high GPA and applied to schools where he could get the most scholarship money. For medical school, he had mid-range grades, good but not outstanding. He targeted schools where he felt that as a Black male it would be easier to be accepted because of his being Black. Robert felt that would be HBCU medical schools. Also hearing the experiences of other Black men in PWI medical schools shaped his graduate school decision making process.

Robert: with this school being an HBCU, you also know that at least with like me being a Black man, an African-American… they're going to look out for me. I'd heard some other stories about people who went to like other schools, like PWI for medical school and how it's just like they feel like they're just like in a world all alone and how they're just… mistreated… micro aggressions, racism, overt and covert… I need to be somewhere that I feel supported. And then having gone to an HBCU for undergrad and then just seeing… the support that I got there as a Black man, seeing that people were there, people around me who were gonna help me become more, helped me to grow as a Black man, helped me to grow as a man, period.

Arlen realized that his grades would be a big factor in his being accepted to medical school but were not so much a factor in going to an undergrad institution where he felt he could be accepted anywhere. Medical school, however, was much more discerning. Two participants (Dwaine and Franklin) wanted a school to align with their own mission. Dwaine stated that it was important to him to pick a school whose social mission aligned with the reason why he wanted to become a doctor.

The layer of social capital deals with what an institution can do for its students. Five participants (Aaron, William, Kennard, Alfred, and Brian) reported wanting support and additional help from medical school. Like Robert, Aaron did chase the money in his undergrad choice, but he sought a medical school that would offer more to help him. Aaron said, "I want to know who is going to nurture my growth academically. And then I saw my sister-in-law who is here and saw her growth… this is where I want to be." Alfred echoed that need for support. William chose an undergrad college close to home to help his family, especially his younger siblings. Choosing a medical school, however, involved placing his needs first and finding a

comfortable environment with support. Brian talked about his final medical school choice was a school that nurtured him and offered opportunities.

Seven participants (Dwaine, Franklin, Antwan, Terrell, Richard, Marques, and Rashad) said they wanted a school with more ethnic diversity. This was the most significant theme in the question about differences between the process of choosing an undergraduate college and choosing a medical school. As the participants began to more deeply explore their past reasoning in medical school choice, significant revelations about their own ethnic and cultural identity was revealed. Diversity is not just an element of an institution but speaks to various identity constructs Black men, in particular, must acquire when navigating a predominately White environment and the relief and growth they experience when those constructs are removed. Dwaine stated "there're only three HBCUs. Rest of them are primarily like White and Asian. So, I wanted to go to schools that had a semi-decent, you know, Black, Hispanic population." Franklin stated, "It was definitely more of finding a school that had … classmates that look like me as well as faculty." This was significant for him since he reported that fellow classmates at other schools found themselves one of four or five Black students in a classroom of 90. He spoke of the onus that placed on him.

Antwan and Terrell both had habitus considerations in mind (an environment that felt comfortable and the location), but it was the cultural context that was a stronger factor. Antwan stressed being in an environment, not just on the school's campus, where he could interact with professionals of color. He said, "being able to be in 'this city' and to see so many… professional Black people… see so many different faces of success that again look like me... I hadn't seen that before." Terrell's explanation about the cultural element is most telling. He had an

awakening about HBCUs and how much that Black identity was important to him, both academically and professionally.

> **Terrell:** So, the metric that I was using initially to select a med school was climat**e.**.. And then I discover while I'm in that climate that I'm not looking for a climate. I'm looking for culture… I really gravitated towards YYY. Very strong online presence that I listened to a lot of podcasts… And then as I started listing more, I started … prescribing to the idea of a HBCU … This is their president… He's Black. This is another faculty member. Black… that's basically how I got started…. looking …med school in terms of how many Black [people] are there… how I will feel in that place. Would I feel at home? … would I not have to do the things I had to do in undergrad in terms of like dealing with a lot of imposter syndrome, dealing with a lot of code switching, dealing with a lot of fake smiles… because you're not 100 percent comfortable in that environment… And I didn't want to do that in med school.

Richard echoed this sense of being comfortable in a more diverse environment, echoing the feeling of being just one of a few Black people in undergraduate classes. Marques told in detail what going to an HBCU as an undergrad was for him and how that influenced his decision to attend another HBCU for a master's program and eventually to attend a medical school that was also an HBCU. His response describes what an impact one class he took at an HBCU had on him and his potential. He goes on to reveal a deeper understanding of what impact attending an HBCU had on him internally. Therefore, he sought out an HBCU medical school. Rashad also explained that his feeling comfortable was a big factor in his medical school choice. Though he did not say explicitly it was because of the ethnicity of the medical school, he did say that it was because the culture was different from his undergraduate school.

Graduate school decision: Reasons to attend current medical school. From the responses given in the question about differences in the choice process between undergraduate choice and graduate school choice, it was not surprising that these responses in regard to attending their current medical school fell within the habitus, cultural capital, and social capital arenas. Within each focus area were different aspects that the participants found significant.

The habitus layer for these responses dealt with location and feeling comfortable, or as the participants said "feeling at home." As these responses reveal, however, participants valued different qualities of each of these areas. Eight (Dwaine, Antwan, Robert, Terrell, Arlen, Leon, Bobby, and Corey) participants chose their current medical school because of location of the institution. Location, though, varied throughout the responses. It was more than just the physical location, but the fact that the institution was close to family or other aspects. Two participants (Dwaine and Robert) chose the school purely because of location. Dwaine reported a simple climate change: "I'm from the North. I wanted to go somewhere where winter doesn't exist. Atlanta seemed like a good place." Robert also chose his current medical school because it was in the South and not cold in the North. But he also had other factors that he considered.

Six other participants chose their current medical school because the location offered connection with family and friends. Corey stated, "Being closer to family because most of my family is in Albany and a sister stays in Atlanta. So, I have more of a family support here." Leon said, "it has in-state tuition, which is a big factor… My best friend… also went to [Lawrence College]; we were roommates. He's a third year, so he was already here.… my best friend and some of my classmates were already here." Arlen and Bobby felt that they needed the support of family near their current medical school was important. Antwan had location as a reason to come to his current medical school, but it was sweetened by having the school feel like family and

having great support from Black faculty and alumni. Terrell chose his current medical school because of the airport first but recognized some other factors once he was enrolled.

Eight participants (Franklin, Justin, Antwan, Robert, William, Rashad, Arlen, and Brian) chose their current medical school because of the welcoming atmosphere on the campus. Franklin and Brian reported that their experiences on the campus of their current medical school during their matriculation in the master's program informed their decision to go to medical school at that location. Franklin said, "And when I did that program… I think I was really moved by … how welcoming, how inclusive everybody was, how encouraging everybody was." Brian explained that recommendations from others informed him intellectually about his current medical school, but it was his own experience on the campus during the master's program that cemented his decision to go to medical school here.

The rest of the participants (Justin, Antwan, Robert, William, Rashad, and Arlen) specifically stated it was the atmosphere or welcoming feeling of the institution that solidified their decision to enroll at their current medical school. Antwan expressed the feel of his current medical school as "that family feeling" and stated that the faculty and recruitment team understood his needs. William echoed that feeling of comfortability due to his matriculation in the Master of Science in Medical Sciences program as well. Alfred chose his current medical school because he had already done a master's program in the city of his medical school. Also, his wife was a licensed nurse in the same state. Justin commented on his visit to another HBCU medical school and how it contrasted to the visit to his current medical school. Rashad, like a few others above, expressed how essential interviewing and school visits were in the decision-making process, even though he understood that everyone involved in recruitment always presented their best selves during those visits.

The layer of cultural capital includes Black presence in the graduate school choice process of the students selecting their current medical school. The most common response and the most significant was that the school had a Black presence. Another student spoke about his faith being a factor in his school choice. Two participants had participated in a summer program (Remy and Leon) where they cited that it was the environment where they saw Black men on campus and in positions of authority that made a difference for them in college choice. Richard cited having a Black presence was important, even as an undergraduate. Those relationships aided in his being admitted into medical school. Alfred talked more about HCOP (Health Career Opportunities Program), a pipeline program for minorities in medicine and sciences, at his undergraduate school. Though it was very helpful in giving him practical tips to prepare him for medical school, he said that mainly there were more Latino students in HCOP and only a couple of Black students. Robert stressed that it was important for him to not only being around Black men but also around those who had similar goals. Richard said it was his interviews and the lack of a Black presence at other medical schools that tipped his choice toward his current HBCU medical school.

Three participants (Dwaine, Leon, and Corey) chose their current medical school because of the desire to go to an HBCU medical school with a large Black population. Leon, as an alumnus of a HBCU, stated, "an HBCU, would obviously be the best environment." Corey lamented the lack of diversity in his previous education and sought that in a medical school. Remy chose his current medical school because of the diversity in the student and faculty populations, not just in its Black presence, and the support of that environment. He also stressed that minority populations are vulnerable with poor healthcare outcomes. Therefore, it was

important for him to be in an environment that would educate him toward serving those populations.

The responses of the participants revealed that many found social capital a valuable commodity in their graduate school choice process. Social capital often involves what an institution can provide for the student. Four participants (Antwan, Robert, Marques, and Carlos) chose their current medical school because of the support the medical school offered to them. Richard and Franklin reported that the primary reason they chose their current medical school was the support they received from the faulty and even the students.

Institutional Reputation

Research participants shared that among the characteristics of a medical school, institutional reputation is one of the most significant factors to influence their graduate school choice decision. Students expressed the importance of the school's statistics regarding exam pass rates, retention, and residency placement rates. Corey's remarks were the most telling as he was torn between two schools, but his final choice was because of the current medical school's graduation statistics. He said, "that's when I looked at the numbers...what school is better for me? Is it going to prepare me to get to where I need to go? … that's what made me choose [The Medical School of the South] due to… the step-one pass rates." Corey looked at statistics such as USMLE step pass rates and residency match rates rather than whether the school would give him a full-ride sports scholarship as he had done in his undergrad search. Roberts's choice, like the others, was based not only on Black presence but also how that factored in the admissions process and how that manifested in support for persistence to graduation and success. These student success factors proved to be significant in the students' graduate school choice process in regard to institutional reputation as many experienced not being prepared for medical school

once leaving their undergraduate institution producing other obstacles in their path to medical school.

Preparation for medical school. Eleven participants (Dwaine, Franklin, Justin, Antwan, Robert, Aaron, Marques, Leon, Kennard, Corey, and Carlos) reported that their undergraduate schools had prepared them well for medical school and attended medical school directly after completing their undergraduate studies. This preparation was due to having good course work and developing good study habits. Dwaine and Justin reported that undergraduate coursework prepared them, as well as taking a graduate course and working during undergraduate years. Leon had a strong foundation in biology as an undergrad. Also, he appreciated having Black male professors and even Black alumni teaching. He also recognized that his undergraduate school had state-of-the art resources for students, as well as printed class handouts, etc., whereas some other colleges did not. Corey felt that the classes were geared for lower level students. He, however, worked harder and aimed for a deeper understanding because his goal was to enter medical school. Carlos, on the other hand, felt his undergraduate college had a strong curriculum. He also had a lot of support through excellent advisement and preparation for the MCAT. Five participants (Remy, Aaron, Richard, William, Alfred, and Brian) said that they did find proper preparation through programs after graduation for post baccalaureate or master's programs. Remy and Richard both received additional training after receiving their undergraduate degrees. While Remy valued learning how to study and prepare for tests in his master's program, Aaron felt that he needed to understand the foundations of his studies in his accelerated, year-long post-baccalaureate program instead of learning test-taking skills.

Nine participants (Remy, Terrell, Richard, William, Rashad, Arlen, Bobby, Alfred, and Brian) stated they did feel prepared for medical school after completing their undergraduate

studies but did not start medical school directly after completing their undergraduate studies. Bobby reported, "That's why I took two years off because I took the MCAT my senior year of college. Did not do well just because it was senior year of college and I wasn't really focused on MCAT." Terrell said he learned to study "for the test" to boost his GPA but felt he had not really mastered the material. Though Alfred said he was not prepared after undergrad to go on to medical school, he noted that his major, however, did help him while at medical school. Arlen put conditions around his academic preparation, revealing that preparation for medical school or any strong profession requires more than just academic preparation. He admitted that his undergraduate school had a strong curriculum and offered opportunities, even getting a publishing credit. However, that was not enough for him to feel prepared for medical school. He said, "Academically, yes. Mentally, probably not…. Straight out of college going to medical school, I needed a break. So, I did take a year off and worked at Orthopedic Surgery Center." Aaron expressed mixed feelings because he felt his undergraduate major of exercise science helped prepare him for taking anatomy, but he did not take biochemistry, which is a necessary course, until graduate school.

Six participants (Justin, Terrell, Aaron, William, Rashad, and Corey) felt that they had not been prepared well enough in their undergraduate schools to pass the MCAT with a high enough score for medical school admission. Frustration with the MCAT was prevalent throughout the responses by the participants. Rashad, like many other participants, was sort of blindsided by the test results of their first MCAT. Justin said that the MCAT was one of the first multiple choice tests he had taken, and therefore had little preparation for it. However, his strong science background was helpful. Corey felt he had been prepared but needed more to pass the MCAT. He did an intensive, one-year post baccalaureate program at an HBCU, where he had

special help for the MCAT. His response revealed that he learned more intrinsic factors about graduate studies but also about himself. William felt that the pre-med curriculum at his undergraduate school missed some classes necessary to pass the MCAT. Those were electives. He took them but did not give them the dedication he should have because he kept telling himself they were just electives.

Seven participants (Justin, Terrell, Richard, William, Marques, Rashad, Corey) said that there was insufficient advisement and/or a pre-med or pre-health program. Marques had taken the proper courses but felt he didn't have proper post-graduate advisement not only about preparing for the MCAT but also all of the intendent information needed to move forward, particularly about financial needs and career support.

> **Marques:** I knew I wasn't prepared because I had not been equipped or equipped with the right tools to be successful in medical school. And the reason why I say that is, yes, I had the pre-medical courses…. I had the information. I had the baseline… So, I graduated from [Whitehurst] with poor advisement… I didn't know anything about taking the MCAT. It wasn't built into our curriculum… I didn't know about after you apply to medical school, you've got to have money to go visit those medical schools… I didn't have the background on knowing they cost money to submit your application. Now, all your other secondary applications are extra money, and some people actually end up spending two, three, four thousand dollars on the application cycle. And I can't even afford to put gas in my car… So, it wasn't until after I graduated that I really saw all the barriers to medical school…

Richard and Rashad also had poor advisement. Richard said that advisors were not helpful and favored some students with their time more than others. Rashad expressed a need for a pre-health professional advisor and had to hire one after he graduated.

Obstacles on the path to medical school. It was reasonable to assume that there would be obstacles that these Black men experienced on their path to medical school. It was no surprise that finances would be an issue. What was unexpected however, was the overwhelming number of participants who said that taking the MCAT was the biggest hurdle they had to face. Part of that issue was financial, and part was lack of proper preparation during undergraduate school. Other issues mentioned were no support and time. Only two participants (Terrell and Arlen) reported no obstacles. Terrell mentioned a personal issue, what he called a "relationship blunder," where he based his academic career on who he was dating at the time.

The MCAT was the biggest hurdle for these participants. Eight participants (Franklin, Remy, Aaron, Richard, Rashad, Kennard, Corey, and Carlos) reported having difficulties passing the MCAT. Franklin and Remy had problems with the MCAT, but they were able to overcome that by a critical thinking class and other graduate classes. Franklin said that finances were not a problem due to parental help and scholarships. "The main problem for me was the MCAT," he admitted. When asked what helped him, he said a critical thinking course provided test-taking skills necessary for him to pass the MCAT. Remy said that completing a semester of an Master of Science in Medical Sciences program helped him increase his MCAT score.

Eight participants (Aaron, Richard, Marques, Rashad, Kennard, Corey, Alfred, and Carlos) detailed their struggles with the MCAT and what actually worked for them. Aaron felt that his not taking some classes as an undergraduate impacted his MCAT scores, but his master's program really helped. Richard had issues with the reading section of the MCAT though he did

well on the other sections of the test. Rashad pointed out what many participants said directly or inferred about the MCAT. He said, "It's a different exam. I don't think it tests knowledge… just tests how well you know the exam... How fast can answer the question…How you can think?... It does not test content." Alfred took the MCAT four times because he was dealing with slow comprehensive reading. He discovered strategies to work with this issue and succeed. However, the reading section of the MCAT was a huge obstacle for him. Three participants (William, Marques, Corey) mentioned that the MCAT was slanted toward the majority population, which has been a criticism of many standardized tests. Marques articulated this thought well.

> **Marques:** One thing that minorities don't really have a good handle of is test taking strategies… I think that's going to continue to be an obstacle for us and it really eliminates a good bulk of us. I think that's one of the reasons for the shortage of doctors, because we can't even get past the SAT. We're intelligent. We're smart…We just haven't been given those skills… your teachers expect that because they're teaching you Algebra that it will just translate into that algebra that's on the SAT or the ACT. It doesn't, you know… It's like the difference between night and day… It is the exact same for the MCAT… I was a chemistry tutor and I had problems in the chemistry section on the MCAT. And the reason for that is because what your teachers want you to know in class is different from what a standardized test writer wants you to know… that's one of the major differences.

Eight participants (Dwaine, Justin, William, Marques, Rashad, Kennard, Alfred, and Carlos) stated that finances were a major obstacle. Though they cited that the MCAT was the main obstacle to entering medical school, Kennard and Dwaine both mentioned money as an obstacle. The issue of money centered around the costs for the MCAT, especially when a

student had to take it more than one time. Kennard stated that costs for MCAT preparation courses like the Kaplan course are expensive and sometimes students, like him, have to buy the course more than one time. Dwaine and Carlos also stated that not only was there the financial burden of paying for MCAT preparation supplies, there were also the expenses needed to pay for medical school applications and travel for interviews and school visits. Justin noted the burden of loans throughout undergraduate school and then the added loans for medical school. Both Justin and Rashad had worked full-time while in school but trying to do that in medical school would be difficult. William added a comment about the cost of books as well as tuition. Alfred had some financial hurdles such as taking the MCAT four times and limiting the number of medical schools he could apply to. However, due to his own determination and ingenuity, he found out about programs that helped him financially. Marques reported in the feeling prepared question that he had poor advisement, especially about the amount of money it takes to prepare for the MCAT, to take the MCAT probably more than once, to pay for medical school applications, to pay for secondaries, and to go to visit schools and do interviews. He felt that the financial costs of the MCAT had racial and socioeconomic overtones. Marques also explained that medical schools are wondering why they cannot attract more Black men. He felt that the talent is there but preparation for standardized tests and the costs involved were hurdles too difficult for many to surmount.

Nine students (Justin, Antwan, Robert, William, Rashad, Leon, Bobby, Carlos, and Brian) revealed how the obstacles of non-support, lack of time, personal challenges, and just being a black male nearly derailed their road to medical school. Three participants (Justin, Antwan, and Rashad) felt that they did not have enough support, emotionally and financially. Antwan had financial concerns but not having someone offer solid guidance and support was the

biggest obstacle. Rashad felt that having strong support in a role model or someone who could lead you through the paces of applying to medical school was vitally important. William felt that time was a commodity in short supply as an undergraduate, while applying to medical school, and being in medical school. He had to work throughout school and found that time to study was limited. Libraries were often closed when he got off work and he also had no privacy because of others in his living situation. Personal challenges that ranged from lack of focus and planning, a need for more maturity, being told or feeling not capable of success, family losses, and even getting in one's own way where shared by students. Carlos had problems with the MCAT but felt that it was his own lack of proper planning earlier on to study hindered his preparation. Bobby cited personal challenges as a major obstacle. For him, it was maturing and focusing on college academically. Robert was accepted into medical school but was told that he was a long shot. His grades and his MCAT were lower and he had no research experience, but he did have other factors, especially his volunteering, that helped him when his current HBCU medical school looked at the whole person. He also had experienced two deaths in his family when he was an undergraduate and then had to apply to medical school with grades and an MCAT score that were not stellar. Brian offered mature insights into his own life. Though he understood the heavy financial hit applying medical school costs students, he felt that that was not a real deterrent for him. What was his biggest obstacle was himself, getting in his own way. Leon recognized that money was a definite obstacle but a stronger barrier was being a Black male. His lengthy response recounts how he felt being not only a Black male in school but an academically gifted one. With both come attitude—both his and his teachers—revealing open discrimination and microaggressions.

Leon: Looking to even being a Black male who is academically gifted, which I could say that I was from a long time and being put into academically gifted pipelines…. being a Black male and still facing the type of discrimination that we're shown that Black males face all the way within the educational pipeline. I was put into the gifted program here… and because of my behavior--which is a lot of Black males also get knocked for more than other races, other genders-- I was kicked out

of that program… I was kicked out of school in elementary school in sixth grade because of my behavior although I was if not one of the top students…This is at an all-Black school… I had to go to school across town… about twenty-five miles away from my house just to stay within an academic program that was keeping up with me, even if I'm not in the advanced pipeline... So that was one of the biggest hurdles that I faced. And then being gone from all Black environment my whole life in the educational system to be taken to … a mostly White environment. And then even with my academic prowess being still seen in a different look of how people perceived my intelligence, my potential… By the time my senior year had come, I had taken 13 AP classes and I'm getting A's in all of them. And never did anybody asked me, until like two months before the end of school, "You going to college?" Me and my friend both laugh because they asked us both the question… "we're going to college and we have scholarships" … nobody who is an administrator really helped us with this situation… So, I think that was a hurdle, obviously.

Due to aforementioned impediments, some of the participants felt that they were not prepared academically, emotionally, or financially to go directly to medical school right after graduating with a baccalaureate degree. Seven participants (Remy, Aaron, Richard, William,

Corey, Alfred, and Brian) delayed medical school to attend graduate school. Corey stated that he took a short, one-year program in a related field. Three participants (Justin, Arlen, and Bobby) felt that by taking a gap year and working in the medical field would not only give them experience but maturity. Arlen stated, "Straight out of college going to medical school, I needed a break. So, I did take a year off and worked at Orthopedic Surgery Center." Bobby felt that working in the medical field would not only help his Vita but also give him a better feel of what doctors really do. Justin, Dwaine, and Brian just needed an emotional break. Justin said, "I did take a year off to kind of relax," and Dwaine stated, "I did work as a medical scribe for about five months. So that gave me a lot of good experience." Brian was in no rush to get into medical school and felt it was important to have good preparation and the proper mindset for it first.

Students also stated the medical school's mission, curriculum, opportunities for financial aid, and marketing presence, as factors in their decision-making process. Six participants (Dwaine, Franklin, Justin, William, Bobby, and Carlos) chose their current medical school because the mission of the school (social equity, health equity, underserved populations, eliminating health disparities, etc.). Justin considered the mission of the medical school he chose targeted medical ethics more than other school did. William felt his current medical school was the right choice because the mission spoke to the community, advocating for those who are underserved. Franklin made a profound statement about how Black patients feel about healthcare and how they are treated. The medical school he chose had a mission statement that addressed that.

> **Franklin:** I think that sometimes, especially… as Black patients… when you look at health… and you look at certain mortality rates… we can be at the bottom or we may not see the best care or we don't get the most attention because unfortunately some people think we tolerate pain… the best. Or they think that we were different, or our skin is thicker. The history that goes within life… the racism and the marginalization and the healthcare system that has unfortunately impacted us since we came here in slave ships.

> And I think that I wanted to be someone that could… be the change I want to see. And obviously, one of the ways to conclude that change is… representation. And this medical school I think… the mission statement is to serve the underserved, but also include representation.

Two participants (Leon, Bobby, and Carlos) were impressed with the structure of their current medical school. Bobby mentioned that his current medical school is attached to a teaching hospital where students get further training. This was a factor in his medical school choice because being able to work at that hospital would give him an opportunity to see how the school's mission aligned with his own personal values. Leon chose his medical school for financial reasons and the actual structure of the school, as well as location and being an HBCU. Terrell, Marques, and Brian were intrigued with their current medical school due to their marketing presence which influenced their graduate school process. Terrell had an unusual comment about his process. He likened his initial choice to online dating, seeing a web presence. The actual reality of being on the campus, however, solidified his decision.

Chapter Summary

This chapter looked at the findings of this study that examined the decision making of Black men who decided to attend an Historically Black College or University (HBCU) medical school. The findings revealed insights into three research questions:

1. What is the graduate-school choice process for Black men who enroll in a MD degree program?
2. What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?
3. What factors for Black men led to the choice to attend a HBCU medical school?

The findings broke down the undergraduate school choice process and the medical school choice process into three areas: family impact &support, institutional environment, and

institutional reputation. Each of these areas had focus on habitus, cultural capital, and social capital. The findings did not reveal the fourth area that dealt with institutional and policy capital. Also, discussed were demographics of the 20 participants and explored their early interest in becoming a physician and when the participants made a conscious decision to attend medical school. The findings also looked at the participants' feelings of adequate preparation for medical school and reasons many chose to take a gap year or go on to graduate school before applying to medical schools. Obstacles that these participants encountered on their way toward the goal of becoming a physician were presented. Finally, the participants commentary on the importance of institutional reputation was presented. The responses were varied, due to the demographics of the participants, but they held deep insights into what these Black men experienced on their higher education journeys.

In the next chapter, a discussion of these findings and their correlation to the research questions will be presented. Implications for practice and future research recommendations will also be suggested.

CHAPTER V: DISCUSSION

As the United States develops into a more diverse nation, it is essential that the implications of diversity within medical higher education are considered. It is predicted that there will no longer be a "majority" ethnic group in the United States by the year 2043 (Taylor, 2016). The growing diversity of the nation is not at the same pace for minorities in medicine, specifically Black men. For medical school admissions for academic year 2018-2019, Black matriculants accounted for 7% of the entering class with 3% identifying as Black men and only 1% as U.S. born. The enrollment numbers for Black men in medical school have not improved since 1978 when the U.S. saw its largest increased in black men in medical school enrollment at 3% (Jacob, 2015). While improvements have been made for diversity, including in the late1960s and 1970s the establishment of two additional Historically Black College and University (HBCU) medical schools (Harley, 2006), focused recruitment of minority students (Achenjang & Elam, 2016), and modifications to admissions policies (Razack, Hodges, Steinert, & Maguire, 2015), the number of Black male matriculants has not increased.

The current state of affairs gives a convincing case for the need to understand the factors of Black men's school choice process at a HBCU medical school. This qualitative study explores the graduate school process of Black men choosing to attend a HBCU medical school. As a theoretical framework, this study used English and Umbach's (2016) four-layer graduate school choice conceptual model, that was adapted from Perna's (2006) college choice model. Supplementing that was McDonough et al.'s (1997) Black College Choice model. As noted

previously, Perna's (2006) model of school choice was originally targeting high school students deciding on an undergraduate college. English and Umbach's (2016) modification of Perna's (2006) theory, however, concentrated on graduate school choice, which explored the contexts or layers of habitus, cultural capital, social capital, and economic, social, and policy contexts.

The habitus layer consists of influences and experiences within the student's environment that contributed to attitudes, values, beliefs, and actions (Bourdieu, 1977; McDonough, 1997; Perna 2006). This layer is far richer than simple demographic characteristics such as race and gender, but also includes a variety of influences and resources that are part of cultural and social capital (Paulsen & St. John, 2002; Perna, 2006).

Cultural capital, which comprises the second layer, delves more closely into community and therefore school influences and the accessibility to resources and support (Perna, 2006). The third layer, social capital in the context of higher education, involves the resources or influences the college or university uses in marketing and recruitment. Finally, the fourth layer of policy (social and economic) involves public policies and societal changes (Perna, 2006).

For this study, McDonough's key elements were used in the habitus layer of the graduate school choice model as they were found to be significant in the choice of attending a HBCU. Those included reputation of the college, desires and influence of the parents, and the student's religious affiliation).

Through the use of Perna's (2006) conceptual model of student college choice and a modified version of her model for professional and graduate school choice (English & Umbach, 2016), the research examines four factors that shape college choice: 1) the individual's home environment, including family; 2) the present school and community environment; 3) the higher education environment of prospective colleges, their characteristics, social climate, and

attendance requirements; and 4) the economic, social, and policy contexts. In this dissertation, focus is given to the habitus to provide beneficial descriptors of the students and their backgrounds as their narratives give insight into their cultural and social capital, including the demand, supply resources, and benefits/costs of a medical education. Attention is also given to the students' undergraduate college choice process as well as how their narratives on the availability and types of resources, and the structural supports and barriers experienced at their respective undergraduate institutions. The student's views on graduate school's context of marketing and recruitment, location, and institutional characteristics is provided as it assists in fully understanding and emphasizing how the students' narratives reflect their influences and individual habitus as it relates to their graduate school choice.

The emergence of three major themes were seen through data collected from the participants' in-depth interviews. The design of the research questions intended to elicit more insight into the graduate school choice process for Black men attending a HBCU medical school. Participants in the study revealed family support, institutional environment, and institutional reputation influenced their decision-making process in attending a HBCU medical school. Each theme and its components will be presented in relation to previous research conducted and to illustrate its correlation to this study.

Family Impact & Support

Each participant disclosed how their parents, mostly mothers, were instrumental in their decision making to attend college and selection medicine as career aspiration. Students shared how expectations were set by parents as they provided encouragement and supported them through their decision-making process for undergraduate and graduate school. These parental behaviors are consistent with prior research concerning school choice process (Hossler et al,

1999; Cabrera & LaNasa, 2000; Palmer et al, 2004; Smith & Fleming, 2006). Many of the participants expressed they had the belief from their parents that attending college was not a choice but an expectation. Freeman (2006) who offered a revision of the Hossler and Gallagher (1987) model, termed these students as "knowers" in her model of college choice. This expectation and support appeared to be a driving force for many of the students in this research to pursue medical school.

While participants receive family support in their decision-making process, they expressed their desire to support their families and community. Participants indicated the economic impact of working in the field of medicine. Students shared narratives of the wanting financial security for them and their family. Students also stated their beliefs that their future career field would offer a position of power that would allow for them to help and serve their community in a meaningful way. Students detailed the desire to be role models for Black youth in their communities. The impact of these factors often drove them to a deeper commitment seen within their morals and faith driven by parents and other family members. Students revealed the pursuit of medicine as their calling as it allowed for the development of their individual passions while allowing the fulfilment to help others while being an inspiration. Black parents are set apart when they have high-achieving students with this caliber of ambitions that are undergirded by their expectations (Chapman, Contreras, & Matinez, 2018).

Institutional Environment

Participants attended both HBCUs and PWIs for their undergraduate studies. Students that previously attended a HBCU shared their experiences of being supported and encouraged and wanting to find that environment again in their medical school choice. Participants' sentiments align with research that found HBCUs provide a familial environment for Black male

students (Palmer, Wood, & McGowan, 2014) and support their attainment of their future goals (Shorette & Palmer, 2015). Students also expressed being in an environment with other students that understood their culture and plight provided a peaceful environment and a place where they are comfortable. Research has shown how HBCUs provide environments for Black students where they feel a part of a family (Fries-Britt & Turner, 2002; Outcalt & Skewes-Cox, 2002; Palmer & Gasman, 2008). Brown and Davis (2001) share in their work how HBCUs serve the role as purveyors of social capital. The resources and networks that HBCU provide are important defenses for the existence, maintenance, and continuation of these institutions. Students articulated their decision in choice of their current medical school included the opportunity for mentorship and the forming of meaningful relationships with professors, administrators, and alumni of similar background that resemble them. Squire and Mobley (2005) and Van Camp (2010) have found that environments that are free from stereotypes of past and traditional are most often sought after by Black students when to comes to education. For many years, the decision-making process of Black male students has been positively affected by the cultural affirming attributes of HBCUs (Freeman& Thomas, 2002; Awokoya & Mann, 2011).

For many of the participants that attended PWIs for undergraduate shared their experience of how they found themselves in a racialized environment. Due to these experiences, students voiced wanting to avoid a similar environment for medical school. These remarks are parallel with the research of Black students whose decisions were influenced to attend a HBCU due to experiences of low expectations, isolation, alienation, and discrimination (Allen, Epps, & Haniff, 1991; Feagin, 1992; Hamilton, 2006; Booker, 2007; Guiffrida & Douthit, 2010; Robertson, 2012; Brooms, 2016; Robertson & Chaney, 2017). Data attained from the in-depth

interviews revealed that some of the participants experienced negative environments which contributed to their choice of their current medical school.

Institutional Reputation

Research participants shared that among the characteristics of a medical school, institutional reputation is one of the most significant factors to influence their graduate school choice decision (Volkwein & Grunig 2005; Volkwein & Sweitzer 2006). Institutional reputation in the form of the medical school's student success statistics showed to be important in the students' graduate school choice process. Students shared their experience of not being prepared for medical school leaving their undergraduate institution which produced other obstacles in their path to medical school. While several participants shared that they were prepared for medical school leaving their undergraduate institution, for many of the students, they did not feel prepared for medical school after completing college. Students stated the MCAT was their main obstacle. Researchers, Girotti et. al (2020), states, "Although MCAT scores provide useful information about students' academic readiness for medical school, the average scores of applicants from lower socioeconomic status (SES) backgrounds and races/ethnicities underrepresented in medicine (URM) are lower than those of applicants from higher SES backgrounds and races/ethnicities not underrepresented in medicine."

Participants revealed a lack of preparation for the MCAT in their undergraduate studies which was a result of insufficient advisement and/or the lack of a pre-med or pre-health program. Lucey and Saguil (2020) echoed this point through their research which shown minority students from undergraduate institutions with low resources have less access to prerequisites courses needed for medical school, exposure to and opportunities to participate in research projects, and availability of career advisors in health professions. The MCAT proved to produce several layers

of obstacles for the participants. Students provided details on these layers to include preparation, support, time while completing undergraduate studies, and the finances in preparing for and sitting for the MCAT. Gándara (2001) found that for minority students, the absence of family wealth leads to the need for students to work throughout their undergraduate matriculation. This need presents obstacles including less time for studying, shadowing, unpaid internships and other experiences. Participants also revealed the financial burden of the application process for medical school including sending MCAT scores, secondary applications, and interview process. This is consistent with research that states advisors in the health professions are vital in undergraduate students' preparation in becoming solid medical school applicants. Unfortunately, advisors are not dispersed impartially across institutions of higher education. For those students who attend institutions that are under-resourced, they are less likely to receive premedical advising or financial support (Carnevale & Strohl, 2013).

A stronger barrier of being a Black male and navigating through primary and secondary schooling was also explored. Thoughts of this topic aligned with Rosenthal's (2014) research on early educational experiences and its effects on the number of Black men going in the medical field. In Foster's (1984) seminal work, the researcher found that Black males where being placed in special education classes at the disproportionate rate often based on a flawed diagnosis founded on misunderstanding of culture or direct racism. Lewin's (2012) research found that since certain students were disruptive or did not quite fit with the classroom atmosphere. Due to these hurdles, many participants delayed medical school to take a gap year to attend graduate school or to work within the healthcare field. Research has shown that the negative perceptions of schoolteachers and administrators seeing young Black men as troubled and underperformers can negatively impact their trajectory (Rao & Flores, 2007).

Students stated the medical school's curriculum, opportunities for financial aid, marketing presence, and student success statistics as factors in their decision-making process. Participants communicated how having a level-one trauma center as a teaching center along with the layout of the courses influenced their choice. Students were also impelled by the available financial aid that met and, in some cases, surpassed other medical schools. Students also expressed the importance of the school's exam pass rates, retention, and residency placement rates. These institutional reputation factors proved to be important to the graduate school choice process (Volkwein & Grunig 2005; Volkwein & Sweitzer 2006). Historically, HBCUs have offered a market for Black men to acquire an education and have success as professionals (Goings & Gasman, 2014) due to comprehensive academic support and career services along with opportunity for students and faculty to form personal relationships (Tobolowsky, Outcalt, &McDonough, 2005; Perna et al, 2009; Albritton, 2012).

Revisiting Research Questions

Through the collection of data through in-depth individual interviews, more insight was gained regarding the graduate school choice process for Black men attending a HBCU medical school. Led by a modified version of Perna's (2006) conceptual model for professional and graduate school choice (English & Umbach, 2016), this study addresses the three research questions underscored throughout the dissertation:

1. What is the graduate-school choice process for Black men who enroll in a MD degree program?
2. What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?
3. What factors for Black men led to the choice to attend a HBCU medical school?

What is the graduate-school choice process for Black men who enroll in a MD degree program?

While the graduate-school process was special and distinctive for each study participant, there were similarities that occurred in the data that showed how the graduate-school process took form. For example, all the participants knew they were going to attend a college of their choice but not all of them made the decision to attend medical school directly after completing their undergraduate studies. As research has shown, the college choice process has stages in which students choose whether to pursue college. These stages begin in middle school and run through high school and are salient references for making this kind of decisions. (Cabrera & La Nasa, 2000). For graduate school choice, studies have shown themes that are integral to the decision-making process including type of undergraduate institution, academic performance, undergraduate major, the characteristics of the student's family, demographical and biological factors, and the debt incurred while obtaining the undergraduate degree (Heller, 2001; Millett, 2003; Mullen et al., 2003; Perna, 2004; Zhang, 2005).

Many participants made early decisions to become a medical doctor as early as age six or seven due to influence from family and teachers. Other participants made more a cognizant decision in high school and their early college years due to exposure to the medical field. Researchers, Hadinger (2016) and Thomas, Manusov, Wang, and Livingston (2011) found in their studies the prior knowledge and experience to medicine were found to be contributors for successful admission and graduation from medical school for black men. Interestingly, for the participants that made early decisions and had an introduction to medical field, these experiences did not have any factor in their college choice.

Students expressed how finances and location affected their college decision-making in wanting to lower costs by staying close to home. Paulsen and St. Johns' (1997) research found location imperative in college choice as students choosing colleges found proximity to home (lowering living costs) and ability to work while in school important. For medical school decision-making, finances meant constraints on the schools in which participants could apply, influencing location. Some of the participants shared how location means close to their spouse who was also in graduate school in their decision-making. This notion was dealt with in Cabrera and La Nasa's (2000) research which showed in college choice, the perception of sociological factors explored the predisposition of students seeking and attaining higher education based off their academic preparation and socioeconomic status.

Race and gender were significant influences among the students interviewed. Many of the participants expressed they sought out medical schools that they felt as a Black male, it would be easier to be accepted because of being Black. Supporting this thought, Goings and Gasman (2014) presented how HBCUs have offered a market for Black men to acquire an education and have success as professionals. A number of students reported the importance of support and additional help from the medical school as part of the decision-making process. For most, the support was described in a sense of a community where their growth would be natured academically in a comfortable supportive environment. The views of these students align with research that found HBCUs provide a familial environment for Black male students (Palmer, Wood, & McGowan, 2014) and support their attainment of their future goals (Shorette & Palmer, 2015). Majority of the students described their need for this type of environment from their undergraduate experience. Some students had negative undergraduate experiences centered around social and cultural context. Others experienced very positive involvements and wanted to

recreate that experience in medical school. In this research question, the first layer of Perna's (2006) conceptual model, habitus, was revealed in the students' responses as we heard their beliefs, attitudes, values, experiences, and actions that were attained from family, school, and community environments (Bourdieu, 1977; McDonough, 1997). While participants did share their narratives on social aspects that influences their decision choice making, the fourth layer of Perna's (2006) conceptual model, social, economic, and policy contexts, which recognizes college choice for a student is also formed by public policies and societal changes, was not fully realized through the students' accounts.

What are the influences for Black men to choose to pursue a MD degree program and a career in healthcare?

The habitus, cultural capital, and social capital of each individual showed to be significant in the decision-making process for Black men pursing medicine. The first layer, habitus, and second layer, undergraduate institution context, of Perna's (2006) modified conceptual model are discovered in this research question. The second layer, undergraduate institution context, is discussed through the participants narratives as they share the type and accessibility of resources, as well as obstacles and supports present within the institution and its surrounding community (Perna, 2006). Students presented a range within the three areas to include personal interest which reflected a parent's work within the healthcare field coupled with their interest in science and perceived and potential skills and value in medicine. While research has shown the importance of parent's college attendance on college choice (Chapman, Contreras, & Martinez, 2018), research on the influence of parent's profession on college and/or graduate school choice is non-existent. In not only recognizing their value to the field of medicine, students also gave their thoughts on the value medicine can have in their lives. A number of

participants indicated the economic capital impact of working in the field of medicine. In the assessments of economics factors in college choice, personal investment in higher education leads the conversation (Becker, 1962; Becker 1993; Cabrera & La Nasa, 2000; Avery & Kane, 2004; Baum, S., & Payea, K., 2004; English & Umbach, 2016). Students shared narratives of the wanting for financial security for them and their family. Students also stated their beliefs that their future career field would offer a position of power that would allow for them to help and serve their community in a meaningful way. These narratives are in correlation to Paulsen (2001) who found that students' determination of the value of a college education is centered on the anticipated benefits and costs related to investing in a college education.

Various forms of cultural and social capital were identified through family/personal health reasons, a desire to give back, personal values and faith, and feeling this was a chosen vocation. Students explained how the illness or death of a family member was a part of their decision-making process to choose medicine. They share narratives of how they witness what they considered to be subpar medical treatment of their family member and the lack of cultural competence and sensitivity of the attending physician. Numerous participants confirmed their desire to give back and saw medicine as an avenue to do so as it couples their personal interest and desire to learn more in science while utilizing their knowledge to improve lives. Students also detailed the desire to be role models in their communities, specifically for Black youth. The impact of these factors often drove them to a deeper commitment seen within their faith and morals. Students revealed their decision to pursue medicine was their calling as it centered around their developing insights of their individual passions and the need for fulfilment to help others while being an inspiration. The Black College Choice Model construct of religious affiliation (McDonough, Antonio & Trent, 1997) does not translate to graduate school choice as

students' decision choice making here is due more to a spiritual reasoning then a religious affiliation. The forementioned accounts align with the thoughts of Cabrera and La Nasa's (2000) work where sociological factors influence college choice. This also includes aspects of a student's life experiences and situation (Sewell & Shah, 1968).

What factors for Black men led to the choice to attend a HBCU medical school?

For Black men, capital is vital in their graduate school choice process when deciding where to attend medical school. These forms of capital range from cultural, social, and economic and all are influential in the students' decision to attend a HBCU medical school. The second layer along with the third layer, graduate school context, of Perna's (2006) modified conceptual model is seen in this research question as participants realized the influence institutions had in their graduate school choice through its characteristics along with recruitment and marketing efforts. We also see Many factors that went into the decision making of the students' undergraduate school choice, where also seen in their graduate school choice process. Participants explained how they chose their undergraduate school because of a sense of feeling at home at their undergraduate institution and location being convenient to family. Research has shown how college location and proximity to home are imperative factors in the college choice process for students (Paulsen & St. Johns, 1997). Other students shared how the cultural capital of having a black presence on campus and in the classroom was significant. Research has shown how HBCUs provide environments for Black students where they feel a part of a family (Fries-Britt & Turner, 2002; Outcalt & Skewes-Cox, 2002; Palmer & Gasman, 2008). And while there were students that looked like them, there was diversity within their lived experiences which made their undergraduate experience even more meaningful. Students also shared how the social capital of teachers and family members, mostly parents, influenced their decisions. Many

explained how parents pointed out HBCUs for undergraduate which left an impression for the consideration for medical school. Consistent with research (Hossler et al, 1999; Cabrera & LaNasa, 2000; Palmer et al, 2004; Smith & Fleming, 2006) parents involved in the college choice process have an influence of the college choice. Economic capital seen in undergraduate decision making was seen again in their medical school choice process. In their undergraduate college choice, economic capital was revealed in scholarship funds that an institution was able to offer. Scholarships and other financial aid incentives were important in the student's decision to attend a HBCU medical school. Paulson and St. Johns (1997) found important high financial aid packages to significant in college choice decision making. Experiences in the social, cultural, and economic capital spaces within their undergraduate matriculation influenced the participants' decision making in attending a HBCU medical school.

While students shared their perspectives on the influences of social, cultural, and economic capital as factors for them attending a HBCU medical school, their narratives on their undergraduate institution's preparation for medical school was also an important factor. Participants were mixed on how well their institution prepared them for medical school. Some students shared that they were well prepared as other did not. Students that felt prepared for medical school attributed their preparation to their undergraduate curriculum, ability to take graduated level courses, supportive faculty, and advisement for the MCAT and medical school application process. Echoed through Lucey and Saguil (2020), low resources at undergraduate institutions translates into less access to prerequisites courses needed for medical school, exposure and opportunities to participate in research projects, and availability of career advisors in health professions for minority students. Participants that did not feel prepared shared narratives that their undergraduate curriculum along with inadequate advisement did not prepare

them for the MCAT or the medical school directly after their undergraduate studies. Those students that did not feel prepared after their undergraduate matriculation expressed how they felt better prepared after taking a gap year to work within the healthcare field and/or completing a post-baccalaureate or a master's program. Unfortunately, students are less likely to receive premedical advising or financial support if they attend institutions that are under-resourced (Carnevale & Strohl, 2013).

Some of the students experienced differences in their graduate school decision making from their undergraduate decision making that created factors for them attending a HBCU medical school. Some students who now have their own families had to consider factors such as finances and location. Students also considered their cultural capital in their decision to attend a HBCU medical school. For undergraduate, many students shared how they considered institutions based on scholarship awards whereas for medical school they targeted medical schools where being a Black man would be just as an important factor to their application as their GPA and MCAT score. Participants also indicated the they wanted a medical school where the mission aligned with their own mission of pursuing medicine. For many students, in the alignment of the mission with their beliefs, they also wanted to experience a medical school that would offer support and opportunities to its students in a comfortable and ethnically diverse environment. Goings and Gasman (2014) found that for Black men, HBCUs have been a viable and attractive option to obtain an education and have success as professionals. This is attributed to opportunity that HBCUs provide for students to form personal relationships with faculty, and academic support and career services (Tobolowsky, Outcalt, &McDonough, 2005; Perna et al, 2009; Albritton, 2012). HBCUs are able to turn the networks and relationships that students build

while in school into meaningful and tangible resources known as social capital (Brown & Davis, 2001).

All participants shared narratives on how the factors previously stated were experienced during their visit or time at the current medical school for a master's program. Most of the students shared how they had a feeling of being at home due to location as it offered a connection to family, and friends, and other support systems. Also, the medical school and alumni providing support gives a true feeling of family. Students expressed the Black presence on campus, specifically Black men, and their positions of authority made a difference in their choice to attend this HBCU medical school. Participants also indicated the structure of the medical school as a factor including its curriculum, opportunities for financial aid, marketing presence, and student success statistics. Students shared how they felt the curriculum along with having a level-one trauma center as a teaching center influenced their choice. Students were also persuaded by the financial aid made available that rivaled other medical schools. Students also expressed the importance of the school's exam pass rates, retention, and residency placement rates. These institutional reputation factors proved to be important to the graduate school choice process (Volkwein & Grunig 2005; Volkwein & Sweitzer 2006). These sentiments are also aligned with Black College Model (McDonough, Antonio & Trent, 1997) construct of reputation of the college.

Implications for Future Research

This dissertation has exposed that more research in the areas specific to Black men at HBCU medical schools can provide greater insight in their decision choice making process. While this study, at its completion, provides a foundation for future research of the decision-making process of Black men and HBCU medical schools, it also provides insight into the

possibilities of future study construction of the same topic. There is an opportunity for future research of the same topic to include additional institutions. The addition of more HBCU medical schools will create a more representative sample population of the Black men that are enrolled at HBCU medical schools. This will allow for added insight and exploration into the decision-making process of Black men. This supplement will also provide the information of further variations of Black men with diverse backgrounds and locations in choosing to attend a HBCU medical school. While this research included Black men across the three years of the four-year MD program, there was no 4th year MD students in the research or division in the research of students by their year in the MD program. More insight into the graduate school choice process at different years in the MD program can provide additional understanding of the decision-making process of Black men who attend HBCU medical schools.

The findings of this dissertation provide a pathway for future studies to explore non-U.S. born Black men along with comparative studies to examine HBCU medical school choice. This research study included non-U.S. born Black men that shared experiences that were like those of U.S. born Black men. As with U.S. born Black men, their experiences in all four layers of English and Umbach's (2016) four-layer graduate school choice conceptual model shaped their decision-making process for attending a HBCU medical school. While there is research that speaks to the disparities in the achievement between non-U.S. born and U.S. born Black men in undergraduate (Bennett &Lutz, 2009; Gallagher, Charles, Torres, & Brunn, 2008), exploring the these two groups for graduate school choice, specifically medical school, can add to the literary landscape and dearth of knowledge of Black men and their decision-making process for attending graduate school, in particular a HBCU medical school.

There are also research opportunities for comparative studies investigating HBCU medical school choice. This includes comparative analysis between Black male students and Black female students and Black students compared to White students. Research emphasizing the similarities and differences among undergraduate student groups has been studied (Perna, 2000; Perna & Titus, 2005). However, this manner of research for HBCU medical school choice has not been conducted. This type of research can enrich the understanding of graduate school choice and provide vital insight for HBCU medical schools.

Implications for Practice

This research has complemented the body of literature associated with graduate school choice in many ways. These ways have shown to be profound and distinctive as it has shed light on the graduate school process for Black men choosing to attend a HBCU medical school. This study has also facilitated in exposing areas for implication of practice. As we see the United States become more diverse, the implication of diversity within medical higher education is vital. While the nation is shifting, the number of minorities in medicine is not keeping pace, specifically for Black men. Since the enrollment of the Black men in medical school has declined, the decision-making processes of these students must be understood by HBCU medical schools. Recommendations for HBCU medical school leadership including Presidents, Deans, and Institutional Advancement/Alumni Affairs will be presented.

Articulation Agreements for Accelerated BS/MD Programs

Strategies for the long-term will be needed for HBCU medical schools to recruit Black men to improve the medical higher education landscape. In improving this effort, HBCU medical school presidents and deans should include in their strategy the formulation of articulation agreements with neighboring HBCU universities to create accelerated BS/MD programs. These

programs will offer several benefits for black male students and HBCU undergraduate and medical institutions. For the student, the time to degree completion for the medical degree will decreased by one year; seven years instead of the customary eight years. The decrease of one year will provide thousands in savings for black male students. In the accelerated program, students will complete three years of pre-med studies at that undergraduate institution and begin their fourth year at the HBCU medical school.

As research participants shared the importance of institutional environment, this program will give black male students an opportunity to experience and become a part of the HBCU medical school environment. HBCU medical school and undergraduate deans can ensure students that are part of the accelerated program have the tools necessary to be successful throughout their seven years including tutoring, career counseling, and mentoring. This experience can have a positive effect in black male students' performance and play a role in the successful completion of medical school. The accelerated programs will also give the deans at each institution an opportunity to align curriculum to ensure students coming through the pipeline are best prepared for the undertaking of their fourth year at the HBCU medical school. Benefits for the HBCU medical school and undergraduate institutions entering into articulation agreements include increasing each school's institutional reputation as it relates to student success statistics, financial aid, and marketing presence.

To assist in providing funding for these accelerated BS/MD programs, HBCU medial school and undergraduate institution presidents can petition their state congress for additional state funding for their institutions to provide the infrastructure needed to make these programs successful. As the Association of American Medical Colleges predicts a shortage of 31,000 primary care physicians by 2025 (Mensah & Sommers, 2016), included in the request for state

funds could contain grant funding for Black males to work in the state in which they have completed medical school. For these graduates, grant funding can be made available for them to give seven years of service in urban or rural areas of the state in repayment of their seven years of schooling. This funding can relieve the financial burden that many black men experience when choosing and entering their undergraduate institutions. This funding can also reduce the brain drain that many states experience when graduates leave to work and live in other states after completing school.

Focused Efforts for Mentoring for Black Men

The most noteworthy findings in study displayed how critical institutional environment is during the medical school choice process. Students expressed that drivers for their decision to attend their current medical school included the opportunity for mentorship and the forming of meaningful relationships with professors, administrators, and alumni of similar background that resemble them. For deans of HBCU medical schools, this may require a shift in the planning of long-term strategies regarding faculty and staff recruitment to include approaches to ensure their faculty and administration represents the Black men they wish to recruit, enroll, and retain.

A shift in the direction of intentional recruitment of Black men in faculty and administrator roles at HBCU medical schools also affords the opportunity to address the meaningful relationships through mentorship. While finding a mentor can be challenging regardless of race, for Black men, it can prove to be a herculean undertaking. Due to the few number of Black physicians, Black men find themselves in a unique position in attempting to locate a mentor of similar background and racial makeup (AAMC, 2015). The easiest and most convenient cohort for HBCU medical schools to tap into is that of their Black male alumni.

With the leadership of Institutional Advancement/Alumni Affairs, HBCU medical schools can engage their Black male alumni to give back to their institutions in an unconventional method; by giving their time to serve as a mentor. Mentorship has been shown to impact personal development, productivity, and career choice positively (Sambunjak, Straus, & Marusić, 2006). Lack of mentorship has revealed to be the most critical factor impeding progress in medicine (Jackson et al, 2003). And for Black men, they represent a cohort in medicine that receives the least mentorship across their counterparts (Beech et al, 2013).

Conclusion

The accounts offered by the research participants have provided invaluable insight into the decision-making process for Black men attending HBCU medical schools. The intended purpose of this study was to advance the knowledge associated with graduate school choice and assists HBCU medical schools in identifying the factors attributed to Black men enrolling in a HBCU medical school. This study provides themes that validate the importance of Black men's demographic characteristics as well as their social and cultural capital (habitus) that are influential in their graduate school choice process. Additionally, family support, the importance institutional environment with a sense of community and institutional reputation are all factors that are important to the graduate school choice process for Black men attending a HBCU medical school. This research has also shed light on the importance for Black men to accumulate the capital within to be able to navigate the path to medical school before arriving at the point of choice. Those insights shared regarding social, cultural, and economic capital can be harnessed to assist students during undergraduate to prepare for next steps towards medical school. Accumulating this capital within can assists students in knowing what is of value when preparing for and accessing medical school. As students share narratives, they provide awareness of how

significant family members' work in the healthcare field and economic capital of being able to provide for their family in their decision process to pursue medicine. Furthermore, family/personal health reasons, a desire to give back, personal values and faith gave the feeling that medicine was their chosen vocation. Having this knowledge empowers HBCU medical schools to better prepare for Black male medical students' recruitment and retention.

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APPENDIX A

RECRUITMENT EMAIL TO POTENTIAL PARTICIPANTS

October 14, 2019

Good Morning Students,

I hope all is well! I am Brenton Powers, Program Manager for Graduate Education in Public Health at Morehouse School of Medicine and a doctoral student at The University of Alabama. For my dissertation, I am focusing on Black men's choice process for attending a Historically Black College and University Medical School.

I am conducting research this semester (Fall 2019) with medical students who identify as Black males. Participation will require an estimated one-hour interview with me on campus in the next two months at a day and time that is convenient for you. All of responses will be kept confidential and findings it will only be reported in aggregate form (e.g. "All of the participants shared a sentiment of…") or with a pseudonym that will not allow individual participants to be identified.

Participation in the study is completely voluntary and will not affect relations with Morehouse School of Medicine or any of its faculty or staff.

Only 30 participants are needed for this study and everyone who is selected to complete the in-person interview and does so will be compensated with a $10 gift certificate to Slim &Husky's Pizzeria.

If you are interested in participating, please respond to this email. Please feel free to contact me with any questions and I hope to hear from you soon!

Sincerely,

Brenton Powers
Doctoral Student
Department of Educational Leadership, Policy, and Technology Studies
The University of Alabama
bpowers1@crimson.ua.edu

APPENDIX B

HUMAN SUBJECTS APPROVAL

THE UNIVERSITY OF ALABAMA | *Office of the Vice President for* Research & Economic Development
Office for Research Compliance

September 25, 2019

Brenton Powers, MPH
College of Education
Department of ELPTS
Box 870302

Re: IRB # EX-19-CM-211: "Black Men's Choice Process in Attending a Historically Black College and University Medical School"

Dear Mr. Powers,

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given exempt approval according to 45 CFR part 46. Approval has been given under exempt review category 2 as outlined below:

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if: (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

The approval for your application will lapse on September 24, 2020. If your research will continue beyond this date, please submit the annual report to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the IRB-approved informed consent form to obtain consent from your participants.

Sincerely,

[redacted]

Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer

Cc: Dr. Nathaniel Bray

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

APPENDIX C

INFORMED CONSENT

Title of Study: Black Men's Choice Process in Attending A Historically Black College and University Medical School

Principal Investigator: Brenton Powers (Doctoral Candidate, Higher Education Administration)

Consent Form Key Information:

- Participate in a one-hour face-to-face interview regarding your choice to attend an HBCU medical school.
- No information collected will connect identity with responses.
- All interviewees will receive a $10 gift certificate.

<u>You are being asked to be in a research study</u>

The study is being conducted by Brenton Powers. He is Program Manager for Graduate Education in Public Health at Morehouse School of Medicine (MSM). He is also a student in the Executive Higher Education Administration doctoral program at the University of Alabama.

What is the purpose of this study? What is it trying to learn?
The goal of the study is to understand the school choice process for Black men who choose to enroll in an MD program at an HBCU medical school. Through individual interviews this study hopes to investigate the influences of the choice process and provide an important perspective into the medical school choice process of Black male students. This study looks to advance the knowledge of an up-and-coming body of research associated with graduate school choice and assists HBCU medical schools in identifying the factors that attribute to Black male enrollment in HBCU medical schools. Having this knowledge can empower HBCU medical schools to better prepare in the recruitment and retention of Black male medical students.

The research questions that will guide this analysis include: 1) What is the graduate-school choice process for Black men who enroll in a MD degree program? 2) What influences a Black man's choice to pursue a MD degree program and a career in healthcare? 3)What factors for Black men led to the choice to attend a HBCU medical school?

Why have I been asked to be in this study?
You have asked to be in this study because you are enrolled in the Doctor of Medicine degree program at Morehouse School of Medicine. This study is seeking medical students at MSM who identify as African American/Black and male.

How many other people will be in this study?
A total of 30 Black male medical students at MSM will be asked to participate.

What will I be asked to do in this study?
Participants will be asked to complete a one-on-one interview with the principal investigator. The interview will last approximately one hour and will be audio recorded.

How much time will I spend being in this study?
Participants will complete a one-time interview that will last approximately one hour.

Will being in this study cost me anything?
This study will not cost anything other than the time required to complete the interview.

Will there be any compensation for participating in the study?
All interviewees will receive a $10 gift certificate.

What are the risks (dangers or harms) to me if I am in this study?
There are no risks involved in this study. Your identity will remain confidential, and you may decide to discontinue your participation at any time.

How will my privacy be protected?
The principal investigator will not tell anyone you are in the study. You do not have to answer any questions or give us any information that you do not want to.

How will my confidentiality be protected?
We cannot guarantee absolute confidentiality of information about you. We will not give out information about you to anyone without your written consent unless the law says that we must. We respect your privacy. We will not tell anyone facts about you that might reveal you are in this study. We will do that in the following way. Names will only be known to the principal investigator. The names will not be used as identifiers in the research to ensure confidentiality of the participants. Information from the consent forms will be kept in a locked filing cabinet. Electronic data (interviews and transcriptions) will be maintained with UA Box provides a secure cloud-based system for file and data storage, sharing, and collaboration. All data are encrypted both in transit and storage and are maintained on domestic servers.

The Morehouse School of Medicine's Institutional Review Board -- the committee that approved this research project -- may have access to these research records. We will not identify you in any way as being in this research in any papers in scientific or other journals. We will not identify you in any reports made on this research at scientific meetings.

Do I have to be in the study?
No. You can refuse to participate in the study. You can also start the study and decide to stop at any time.

What if I have questions, suggestions, concerns, or complaints?
If you have any questions about the study now, please ask them. If you have any questions or concerns later, you can reach Brenton Powers at bpowers@msm.edu or 205-914-2134. You may also contact my UA faculty advisor, Dr. Nathaniel Bray at (205) 348-1169 if you have any questions.

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at http://ovpred.ua.edu/research-compliance/prco/. You may email us at rscompliance@research.ua.edu.

AUDIO/VIDEO RECORDING CONSENT:

I understand that part of my participation in this research study will be audio/video recorded and I give my permission to the research team to record the interview.

____ **Yes,** my participation in interviews can be audio recorded.

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. I will receive a copy of this consent form to keep.

_____
Signature of Research Participant Date

_____
Signature of Investigator Date

APPENDIX D

INTERVIEW PROTOCOL

Student Interview Protocol

1) Do you identify as male?

2) Do you identify as Black and/or African American?

3)What is your age?

4) What year are in the MD program?

5) Where do you consider is your hometown?

6) Tell me about yourself.

7) Where did you attend for undergraduate? What influenced you to enroll in that school?

8) Did your family and/or support system encourage you to attend college?

9) How did you perform academically in undergraduate? What was your grade point average leaving college? Currently, what is your grade point average?

10) What made you decide to go to medical school? When did you first think about

going to medical school?

11) Describe the primary influences for you deciding to enroll in medical

school?

12) Did you have individuals or mentors in your life that influenced you to choose medicine? If so, who were they, how were they apart of your life, and why?

13) After leaving college, did you feel prepared academically for medical school?

14) How different was it in your decision making from choosing between what medical school to attend compared to choosing what college to attend?

15) Were there any significant obstacles or challenges that you had to overcome to reach your goal of attending medical school?

16) Why and how did you decide to attend this medical school? What other medical schools did you apply to attend?

17) Were you accepted to other medical schools? If so, why did you choose this medical school over the other medical schools?

18) What about your background and demographics (gender, race/ethnicity, socioeconomic status, etc.) played a role in your choice to attend medical school?

19) What about your background and demographics (gender, race/ethnicity, socioeconomic status, etc.) played a role in your choice to attend this medical school?

20) What was the main reason for you attending medical school?

21) What are your family and/or support network thoughts on you pursing medicine? Have they been supportive?

22) How are you paying for your medical education?

23) How did the cost of medical school effect your decision to attend and where to attend?

24) What do you hope to do after you finish your degree? What are your long-term career goals in medicine and why?

25) Is there anything important that I did not ask that would help to understand how you came to make the decision to attend medical school?