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Exploring the Experiences of Racial Identity and Stereotype Threat in African American Male Medical Doctors

Christopher G. Beaumont

Dissertation Committee

John E. Smith, Ed.D., Advisor
Pamela F. Foley, Ph.D., ABPP, Chair
Lewis Z. Schlosser, Ph.D., ABPP
Cheryl Sard, Ph.D.
Margaret Brady-Amoon, Ph.D.

Submitted in partial fulfillment of the requirements
for the degree of Ph.D. in Counseling Psychology
Seton Hall University

2012

SETON HALL UNIVERSITY
COLLEGE OF EDUCATION AND HUMAN SERVICES
OFFICE OF GRADUATE STUDIES

APPROVAL FOR SUCCESSFUL DEFENSE

Doctoral Candidate, **Christopher Beaumont,** has successfully defended and made the required modifications to the text of the doctoral dissertation for the **Ph.D.** during this **Fall Semester 2012**.

DISSERTATION COMMITTEE
(please sign and date beside your name)

~~Mentor:~~ Committee:
Dr. John E. Smith 11/20/12

Committee Member:
Dr. Pamela F. Foley 11/20/12

~~Committee Member:~~ MENTOR
Dr. Lewis Z. Schlosser 11/20/12

Committee Member:
Dr. Cheryl Thompson-Sard 11-20-12

Committee Member:
Dr. Margaret Brady-Amoon 11/20/12

The mentor and any other committee members who wish to review revisions will sign and date this document only when revisions have been completed. Please return this form to the Office of Graduate Studies, where it will be placed in the candidate's file and submit a copy with your final dissertation to be bound as page number two.

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ABSTRACT

The purpose of this study was to explore the experiences of Racial Identity and Stereotype Threat among African American medical doctors, while also gaining an understanding about possible barriers and useful resources for negotiating the medical training process. There is very little research on African American male physicians, which made this study relevant in several areas (i.e., medical training programs, and the social constructs of racial identity and stereotype threat). In addition, this study served as a contribution toward research in this area since there continues to be not only a lack of diversity but also discriminatory treatment of minorities in the field of medicine. Interviews consisted of participants answering open-ended questions pertaining to their thoughts, feelings, experiences, and recommendations as African American male medical doctors who successfully completed medical training. In addition, this dissertation used Consensual Qualitative Research (CQR) in order to analyze the aforementioned data. This research produced a number of key findings: participants encountered various forms of racism (i.e., blatant, aversive, institutional) that contributed to their racial identity, career specialization and patient care; pride, obligation and sense of community were salient factors; participants displayed resiliency and were driven to overachieve despite encountering several barriers throughout the medical training process; participants appeared to be cognizant of race, however, it was not important to all of them; participants receive daily reminders of their race; participants have an awareness of differences unique to the experience of being African American, while they also focus on thoughts of perception and acceptance as a result of their race; racial socialization had an

impact on the racial identity for some participants, yet other participants reported that there was no impact; participants encountered stereotype threat and reported utilizing supportive resources (i.e., mentors, African American faculty, African American medical doctors, professional organizations, family, spirituality, community) in order to cope. The conclusion drawn from this research is that African American male medical doctors are aware of their race and may have encountered racism; however, they utilized resources (e.g., internal, external) to complete their training and secure their current career.

Chapter I
INTRODUCTION

African American males continue to be underrepresented in the field of medicine due to several multifaceted factors (e.g., historical, financial, social). In particular, recent statistics show that African American males account for only 2.4% of medical students; this is an 11% increase since 2006 (AAMC, 2010). However, the lack of African American male representation in the medical profession permeates as a significant social concern despite an increase in applications to medical school training programs by black men (AAMC, 2010) For this reason, past research (e.g., Cohen, Gabriel, & Terrell, 2002) in this area has focused on the historical implications of race and medical school education in the United States. Although there has been an increase in the number of African American male medical doctors throughout the past 30 years (Cohen et al., 2002), research conducted by Nunez-Smith, Curry, Berg, Krumholz, and Bradley (2008) found that race played a significant role in their professional experience (e.g., shaping their interpersonal interactions, determining their institutional environment). While programs such as Affirmative Action are aimed at increasing the admission rates of minorities in medical school, institutions continue to overlook the support that is needed by these individuals following the onset of their training.

According to the U.S. Census (2009), there are over 300 million people currently residing in the United States of America. As one of the largest minority groups of this country, there are approximately 40 million African Americans, 18 million of which are males. In comparison to the number of white males who practice medicine, the paucity of African American male doctors is evident. In addition to the disparity between the proportion of African Americans in the population and those in medical school, there

continue to be disparities in the number of African American males who are admitted to medical schools compared with those who graduate. In 1990, the federal government decided to enact initiatives such as the Project 3000 by 2000, in order to increase minority enrollment at medical schools. In addition, these programs provided minority students with community-focused partnerships through academic medical institutions and neighboring grammar schools (Cohen et al., 2002). While these programs were moderately successful at increasing the number of admissions of African Americans in medical schools, the graduation rates of these students have remained constant. The concern at the forefront of this issue, then, is to understand why some African American males are not successfully completing their training programs. Research conducted by Erwin, Henry-Tillman, and Thomas (2002) found that minority students perform better when they have interventional services (i.e., early career development, mentoring, professional training experiences, student/faculty development) that ultimately assist in negotiating racial barriers and obstacles in medical training programs.

Medical school training programs are not only defined by the competency of their students in the workforce but also through the instruction being provided by their faculty. Essentially, instructors serve in several capacities with the institution, students, and general public. For example, many faculty members are expected to participate and continue some form of research or initiative that will bring recognition to their assigned institution. These same faculty members also act as "gatekeepers" for their profession, while providing instruction for possible professionals in the medical field. Thus, faculty plays an integral role in professional identity and practice of medical doctors moving

forward. It is important to note here that most medical schools are predominantly white institutions with the faculty being predominantly white as well.

Interestingly, a recent report by the Institute of Medicine found that approximately 20% of minority faculty members are employed by the four historically black medical school programs in the nation and three in Puerto Rico (Hood, 2000). Also, the report highlights the lack of diversity in the field of medicine and how it can ultimately lead to isolation and disempowerment by medical staff of color. In addition to the lack of opportunities being provided by predominantly white institutions, African American faculty may choose to work at historically black medical schools as a form of benevolence in a process of providing education and mentoring for students of color. Essentially, African American faculty members serve as role models for future medical doctors due to the similarities in experiences and culture. Qualitative research conducted by Erwin et al. (2002) queried nine African American faculty members and one resident regarding their professional experiences and the factors that made them elect to work at a historically black medical school. Results show that both social class and economic concerns influenced participants' professional careers, in addition to consensus that faculty members and students are treated differently because of race.

A cause for concern may be attributed to a predominantly white institution's lack of initiative to diversify their faculty and administration. While the general understanding in most positions is that the most qualified individual will be hired, it is important to explore the diversity and broadness of the pool of candidates being considered for faculty posts. For example, the National Football League (NFL) has implemented a rule known as the Rooney Rule, which requires that all teams interested in hiring a new head coach

must interview at least one African American candidate (Thorton, 2009). The result of this initiative was the opportunity that allowed four African American coaches to lead their teams to the NFL's annual Super Bowl over the past five years.

A recent study conducted by Palepu et al. (2000) found that African American medical doctors who possess comparable credentials and experience to their white counterparts have been overlooked for promotions while working in hospitals or clinics. In addition, African American medical doctors also have a greater chance of remaining in the original position for which they were hired rather than being promoted (Fanh, Moy, Colburn & Hurley, 2000). For this reason, researchers have made several postulations regarding the reason for the lack of promotion of African American medical doctors in the field of medicine. A survey of physicians in Massachusetts found that non-white participants reported experiencing difficulty in achieving professional advancement. According to Betancourt and Reid (2007), the reason for disparity exists in the healthcare workplace, ultimately exacerbating the "minority" status and supplementary hindrances of African Americans. In addition, Cohen and colleagues (2002) argue that the expansion of medically trained administrators and policymakers in leadership positions will diversify in the healthcare workforce.

While medical school training programs provide education and experiences for future healthcare professionals, they also have a responsibility for producing competent medical doctors who are capable of working with a diverse population. According to Cohen et al. (2002), the curriculum of most medical school training programs does not focus on producing professionals who are culturally competent, but rather medical doctors who are capable of treating patients according to their disease or illness. On the

other hand, the 2012 standards for accrediting medical schools attempts to address this issues by requiring medical training programs to give basic principles for providing culturally competent healthcare (LCME, 2012). As a culturally competent professional, an individual would be capable of providing medical care to any patient, while being cognizant of cultural factors that may be a part of the patient's presentation. Due to this lack of cultural awareness and understanding, medical professionals may overlook relevant values and experiences while providing treatment and/or instruction. For instance, research shows that patients may adhere to idioms of distress or culturally bound syndromes (e.g., Dhat, Wacinko, Susto, Brain Fag), which can be misperceived and ultimately result in ineffective treatment (Paniagua, 2001). In addition, due to the lack of cultural training, they may not be as competent with culture among their colleagues.

Many training programs in the helping field have incorporated into their curriculum the significance of being culturally competent while working with diverse patients. In doing so, helping professionals are capable of working with diverse demographics, while being considerate of race and culture as possible salient factors in the lives of their clients. Similarly to the experience of professionals in the helping field, medical schools attempt to prepare students for working with diverse populations through mandatory workshops and lectures. However, these institutions also have an obligation to educate students about treating patients from different cultures while processing their own biases in order to prevent inappropriate treatment of diverse patients. For example, past research shows that African American and Latino patients received less pain treatment than White patients while obtaining emergency room care for fractured bones (Hood, 2000; Tinsley-

Jones, 2003). In addition, ethnic minorities are less likely to be placed on a kidney transplant waiting list, or be screened for cholesterol levels (Van Ryn, 2002). One factor contributing to these disparities may be the unconscious factors that impact the judgment and behaviors of medical doctors who assume themselves to be free of racism (Tinsley-Jones, 2003).

As of 2009, African Americans accounted for approximately 6% of medical doctors in the United States, which is significantly higher when compared to the statistics of 30 years ago (AAMC, 2010). Despite an increase in enrollment and graduation rates of African Americans, they remain an underrepresented demographic in the field of medicine (Liebschutz et al., 2006). Conceivably, African American medical doctors will encounter experiences their white counterparts will not, such as "non-privilege" and microaggressions in the workplace. For example, an African American physician in the emergency room may encounter a patient who refuses to be examined by an African American doctor due to apprehensions about their professional competence and capability. In addition, African American male medical doctors may lack the opportunity to identify with other professionals who have had similar social experiences due to race. While research shows the advisement relationship having an important impact in a student's professional development because of the advisor's role (Schlosser, Knox, Moskovitz, & Hill, 2003), it is important for these advisors to be sensitive to the issues of racial identity and self-perception that may arise in African American medical advisees as a result of their low representation (Green-McKenzie, 2004).

Although race is salient and embraced in the lives of many minority medical doctors, the effects of racism and discrimination are realistic from an institutional perspective.

According to Tinsely-Jones (2003), racism has manifested in forms ranging from overt actions and socially accepted acts to aversive and institutionalized behaviors. Racialists, who are individuals that ascribe to racist ideology through the use of scientific and political knowledge, typically advocate for inequality through passive means (Richards, 1997). In doing so, African Americans can potentially encounter aversive forms of racism that are meant to promote inequality. Therefore, African American medical doctors work in a system that adheres to policies that were implemented without the consideration of race. Additionally, the issue of racial inequality and discrimination in the workplace is often met with apprehension and denial due to the social guilt "White" America has about its history. There has been a movement toward race relations and headway made through progressive initiatives and social networking programs (e.g., Title VII programs); however, discrimination still impacts the lives of African Americans, even those with high educational attainment (in this case, medical doctors).

Numerous constructs provide possible explanations for the function of race in the achievement and promotion of African Americans. In particular, the constructs of racial identity and stereotype threat assign a social cue to make a group association (i.e., negative, positive) or identity uniquely salient (Armenta, 2010). For example, Schmader (2002) found that women who were higher in gender identification were more susceptible to the effect of stereotype threat in mathematics.

The primary goal of this study is to gain a better understanding of the experiences of African American male medical doctors regarding race, racial identity, and stereotype threat. Although past research has focused on graduation/attrition rates (e.g., Liebschutz et al., 2006) and occupational barriers (e.g., Cohen et al., 2002), there continues to be a

lack of exploration into the social dynamics that have impacted the lives of this specific group. Given the stigma and negative stereotypes often associated with this selected group, it is important to investigate the factors that have contributed to successfully negotiating the medical training process. In doing so, researchers will gain knowledge about helpful techniques and interventions, while also being able to reinforce positive initiatives that were beneficial for the participants. On the other hand, this research also seeks to examine the social struggles and stressors experienced by African American males throughout medical school, residency, and the workforce.

Research conducted by Cohen et al. (2002) illustrates the benefits and significance of being culturally competent in treating patients/clients. More importantly, medical school training programs are responsible for educating future instructors in the field of medicine. Therefore, incorporation of cultural awareness, understanding, and empathy are ultimately the decision of the institution. Consequently, most medical doctors provide care to a diverse demographic, without the consideration of cultural factors that may affect their treatment. The need for instruction in cultural awareness and striving for cultural competence extends across gender, race, and ethnic groups. Interestingly, African American male medical doctors are more likely to work in underserved communities and provide care to larger numbers of minority patients regardless of race (Cohen et al., 2002).

Most students who matriculate to medical schools receive some form of advisement (e.g., academic) throughout their process. In some cases, the advisement relationship will manifest into a mentoring relationship. With African American males being underrepresented in the field of medicine and more likely to attend a predominantly white

institution, the need for a mentoring relationship may be integral during their professional process. Research conducted by Jones (2000) suggests that mentoring and "learning to work the system" are essential for African Americans when addressing the challenges of negotiating the medical field. In addition, a study of African American medical residents found that participants valued support and rapport; however, they valued their relationships with black colleagues and mentors as a better source of support (Liebschutz et al., 2006).

Research conducted by Odom, Roberts, Johnson, and Cooper (2007) found that African American medical doctors viewed discrimination and racial stereotyping as barriers to professional achievement. The implications of this study are important to improving race relations (e.g., perceptions, performance) in medical schools, while exposing an area for systemic growth and institutional development. Unfortunately, many medical schools may not be cognizant of the social and psychological stress that affects racial minorities, who are a part of a negatively stereotyped group. According to Steele and Aronson (1995), the self-assessed stress associated with confirming a negative *stereotype* about one's group as a conceivable self-characterization that may be viewed by others is known as *stereotype threat*. The task of an African American medical student seems cumbersome in addition to being twofold due to academic requirements that are accompanied with external factors (e.g., dealing with racism).

Literature by Palepu et. al (2000) reported that minority faculty members are less likely than White faculty members to hold higher ranking positions (e.g., school dean, departmental chair). Another qualitative study conducted by Erwin and colleagues (2002) found that African American medical school faculty experienced considerable social and

class concerns that ultimately influenced their professional livelihood. The researchers also reported that possible contributing factors to this disparity may lie in career development: early influences and challenges, working the system, professional training experiences, and student/faculty development. While this group continues to be underrepresented, their white colleagues have steadily made progress toward promotions in the field of medicine. Research shows that white males tend to be promoted toward positions of power more frequently than equally qualified candidates who are minority and/or female (Liebschutz et al., 2006).

Research Questions

Research Question #1: *What impact has race had on the careers of African American male medical doctors?*

Research Question #2: *What role has racial identity played in the academic and professional lives of African American male medical doctors?*

Research Question #3: *What role has stereotype threat played in the academic and professional lives of African American male medical doctors?*

Research Question #4: *How do African American male medical doctors perceive their treatment of patients?*

Operational Definitions

a. **African American:** Anyone who is a resident of the United States, ancestrally African, and is a descendent of African slaves brought to the United States.

b. **Stereotype threat:** Self-assessed stress associated with confirming a negative stereotype about one's group as a conceivable self-depiction that may be viewed by others (Steele & Aronson, 1995).

c. **Racial identity:** A sense of collective or group identity based on an individual's insight regarding racial heritage commonalities he or she may share with a particular racial group (Helms, 1990, 2007).

d. **Medical doctors (physicians):** Anyone who has completed the necessary requirements set forth by their governing body, (i.e., successfully completes medical school, possesses licensure) and is currently practicing medicine.

Chapter II
LITERATURE REVIEW

This chapter provides a comprehensive review of the literature regarding African American males, medical training programs, and the social constructs of racial identity and stereotype threat. There is very little research on African American males in medical training programs, which makes this study relevant in the aforementioned areas. Current medical literature (i.e., Carrasquillo & Lee-Rey, 2008, Cohen & Steinecke, 2006, Sasha, Guiton, Wimmers et al., 2008) highlights the need for research in this area due to the lack of diversity and the discriminatory treatment of minorities in the field of medicine. Across this literature review, this research will focus its critique of relevant research on issues related to racism, racial identity, and stereotype threat. The study concludes with a brief summary of the pertinent points that were covered throughout the chapter.

African American Males

To achieve a general understanding about the perceptions of African American males and the psychological distress they often experience, a historical context is important. Throughout the history of the United States of America, African Americans have experienced discrimination, oppression, prejudice, and racism. In the process of establishing the United States, Africans were brought as slaves against their will to serve as inexpensive labor; of course, serious psychological and social effects accompanied this experience (Robertson, 1988). For example, African males were typically separated from their families and sold to different plantations where the process of reunification was a near impossibility. In addition, African slaves would customarily be forced to adopt the surnames of their slave owners, therefore eventually losing a primary source of cultural

identification and connection to their country of origin. Further, slavery reinforced the belief that Africans were "savages," subhuman, lazy, and stupid (Thompson & Akbar, 2003). Thus, the acceptance of disparaging labels became the norm for not only the dominant culture but also equally acceptable by slaves of African descent.

Following the Emancipation Proclamation, African Americans continued to be oppressed through the denial of human and political rights (Howard-Hamilton, 2003). Several initiatives (e.g., grandfather clauses, Jim Crow laws) were implemented and reinforced to suppress freed slaves' progression toward social equality. In addition to the systemic programs that maintained racial inequality, radical groups (e.g., Ku Klux Klan) utilized extreme strategies (e.g., lynching, cross burning) that were socially acceptable during certain time periods in U.S, history as a means of intimidation. As a result, feelings of helplessness and victimization manifested within the African American community due to depersonalization and are, therefore, associated with their history (Franklin & Boyd-Franklin, 2000). In particular, because of their incapability to execute masculine gender expectations, African American males developed opposition toward White males (Richards, 1997). For example, African American males during this time were commonly referred to as "boy" by White males, which exacerbated tension between the two racial groups.

Research shows that stereotyped assumptions strongly determine the salience of African American males' physical and psychological presence in many circumstances (Franklin & Boyd-Franklin, 2000). Thus, members belonging to this group are often associated with generalizations that are viewed as socially unacceptable. For example, African American males tend to be portrayed as either criminals, entertainers or athletes

through the media, which can be misleading for entertainment value. Franklin and Boyd-Franklin (2000) argue that the assumptive perspective of most individuals is manipulated by the attitudes of their racial group. Therefore, the aversive effects of oppression have followed African American males since the time of slavery.

The career development of African Americans is influenced by their perceptions of educational and career opportunity, as well as their perception of barriers (e.g., racism, classism) (Arbona, 1990; Astin, 1948). An examination of educational attainment among African American males shows a discrepancy in their academic training leading up to their high school years. As a result, this group becomes a significant risk for high school failure and dropout (Oyserman, Gant, & Ager, 1995; Solorzano, 1992), is less likely to be "college ready" upon graduation, and tends to be suspended more frequently than other gender/racial groups (Cokley, 2001). Additionally, African American males are more susceptible to placing an emphasis on competing in sports rather than negotiating school curriculum (Martin & Harris, 2006). In doing so, unless they are exceptionally talented athletes, these students are at a disadvantage when competing against other prospective students during the admissions process. Research conducted by Cokley (2001) found that African American male students tended to be less motivated about school than African American female students. A possible explanation for this disparity could be the high value and visibility of male athletes that is not shared by female athletes. In addition, past research shows that African American women tend to be more confident in their academic abilities (Allen, 1992), while African American males have higher levels of achievement orientation and psychosocial wellness (Berger & Milem, 2000). According to Garibaldi (2007), African American males continue to underachieve academically,

which has eventually led to significantly expanding the gender gap between African American females and themselves. In addition, African American males have significantly high rates of school suspension, expulsions, non-promotions, drop-outs, and special education placements. Current research asserts that African American males are socially reinforced toward salience and significance of sports (Beamon & Bell, 2006). In particular, the socialization toward athletic (aspiration) of this group occurs through multiple outlets (e.g., role models, current athletes, media, family) (Harris, 1994). African American males also tend to experience a significant separation from the educational process (Lee, 1991), as they may struggle to identify with tangible role models who value education.

Research shows that the African American racial category functions as the archetypal connection for numerous seemingly race-neutral concepts (e.g., crime, basketball, ghetto). (Eberhardt, Goff, Purdie, & Davies, 2004). In addition to negative stereotypes, African Americans are associated with certain terms regardless of their life experiences or social class. In particular, the concept of "crime" has become synonymous with African American males due to media exposure and negative generalizations. However, African Americans comprised 39.2% of inmates in the correctional system as of 2009 and they continue to be the minority in correctional facilities in the United States (U. S. Department of Justice, 2010). For this reason, current research has postulated possible causes for the "criminal" stigma attached to African American males (Rollock, 2002). For instance, African American males may encounter corrupt and racist police officers who indirectly reinforce turmoil between the two groups (i.e., African American males, White police officers). In addition, public officials often capitalize on

opportunities to criticize criminal figureheads and their activities. Coincidently, many of these individuals are African American males (e.g., Willie Horton), which reinforces the criminal stigma even further.

Although African Americans have endured continuous adversity and hardship since their origins in this country, African American males have suffered excessively during this period. In addition to the apparent effects of racial inequality, the psychological impact of slavery and segregation has impacted this particular group in several ways (e.g., occupational, academic, environmental). Moreover, African Americans males have become socially synonymous with negative stereotypes and perceptions that potentially impact daily living (e.g., learned helplessness).

Medical School

Although the need for African American physicians persists in the United States, their numbers continue to increase at an extremely slow rate (JBHE, 2007). According to Girotti (1999), there are several obstacles that impede the admission and enrollment of African American candidates to medical school training programs (e.g., inadequate pre-college preparation in the sciences, low scores on the Medical College Admission Test (MCAT), financial disadvantages, Henry, 2006). The number of African American applicants to medical school has increased slightly since 2003, but is eclipsed by the greater numbers of the mid to late 1990s. During this time, the federal government implemented initiatives such as the Association of American Medical Colleges' (AAMC's) Project 3000 by 2000 and other Title VII programs that focused on diversifying the medical field. Research conducted by Taylor, Hunt and Temple (1990)

found that the negative institutional perceptions held by the African American community was a primary barrier to the enrollment of minorities into medical schools in the South. While low enrollment rates among African Americans persist as an issue, the concern of successfully negotiating the medical training process is an equally important problem to address. The graduation rate of African Americans from medical school reached its peak during 1998 with 1,192 graduates. Consequently, this number has decreased since then with only 1,122 African Americans graduating from medical schools in 2006 (JBHE, 2009). A recent study (JBHE, 2007) shows some progression with 46 U.S medical schools graduating at least 10 African American students.

Research shows that African American medical students experience higher levels of stress when compared to White medical students as a result of their minority status and discrimination encountered during training (Liebschutz et al., 2006). These students are likely to experience social, academic, and financial concerns that are less common for White students. For example, financial concerns can be more severe for African American students who are more likely to be financially disadvantaged than their white classmates (Liebschutz et al., 2006). In addition to financial strain, African American medical students may encounter inequitable treatment from administrators and staff. Gartland, Hojat, Christian, Callahan, and Nasca (2002) found that African American medical doctors endorsed greater dissatisfaction with their communication and interactions with medical administrators, faculty, and staff when compared to white students. Additionally, these authors also reported that African Americans were less likely than white students to recommend medical school to other minority applicants.

African Americans continue to slowly increase their applications to medical training programs; however, their acceptance rates have been steady. Current enrollment is lower than the mid 1990s when initiatives were implemented that focused on diversifying the national pool of medical doctors. Regardless of these programs, African Americans continue to experience discrimination and unequal treatment.

Training Experience

According to Schlosser and colleagues (2003), the advisement relationship is an essential component to the professional development of graduate students because of the advisor's role. In addition to providing guidance and support for their advisees, advisors also act as gatekeepers for their discipline, while offering instruction for professional development. Hence, the advisory alliance has the potential to develop into a mentoring relationship, where the connection between student and mentor is perceived as more meaningful and transcends beyond being strictly professional into a more personal relationship. Schlosser and Foley (2008) assert that constructive and healthy advisement relationships potentially have several common attributes similar to mentoring relationships. These authors also argue for the presence of multicultural competence in establishing effective mentoring relationships with students of color. Similar to this assertion, Nunez-Smith and colleagues (2008) maintain that medical school students of color who receive culturally competent education and advisement will perform better academically and have an understanding of working with diverse populations. As a result, there will be an increase in the number of medical doctors who are capable of providing optimal treatment to diverse populations (e.g., minorities, SES, ability). Current research suggests that professionals who receive multicultural training have an increased ability to

conceptualize the presentation of culturally diverse patients (Constantine & Ladany, 2000). Comparable to counseling, cultural competence training and education in both nursing and medicine leads to an increase in information, ability, and attentiveness in professional practice (Beach et al., 2005).

African American medical doctors are essential for working with minorities and also for serving as mentors/role models for current students (Green-McKenzie, 2004). Jones (2000) argues that African American medical school students should receive mentoring and guidance from African American medical doctors in order to assist with negotiating negative academic influences. Through this relationship, African American medical students are provided with opportunities to learn how to "work the system" (e.g., course selection, networking) through encouragement and guidance from professionals who have already completed the process. These students may also be provided with opportunities for professional training experiences that are less likely to perpetuate covert and deliberate discrimination. Taylor and Rust (1999) argue that for African American students to successfully negotiate the medical training process, they must be fostered through diverse supportive methods (e.g., providing a supportive learning environment, teaching what is successful with all learning styles, valuing students' diverse cultural identities). In addition, qualitative research conducted by Erwin and colleagues (2002) found that medical doctors viewed preparation and the negotiation of medical training programs as a difficulty during their process. Furthermore, these respondents made disclosures about the importance of receiving support and guidance from their mentors while achieving their academic/career goals.

African American medical students tend to feel isolated due to their encounters facing significant social barriers in medical school (Taylor & Rust, 1999). Research shows that this group is more likely to view and experience racism as a barrier to its professional future (Henry, 2006). Past research has found that African Americans are significantly influenced by their perceptions of barriers (e.g., social, racial) and educational/professional opportunities (Arbona, 1990; Astin, 1984; Betz & Fitzgerald, 1987; Hurtado, 1989, Lent, Brown, & Hackett, 1994;). For this reason, Black medical schools have adopted the mission to be more than institutions that train future African American medical doctors. Moreover, in addition to providing instruction on the core curriculum, students' racial pride is encouraged, while also promoting upward social mobility (Smithers, 2009).

The advisement relationship plays a significant role in the professional development of students who have needs that surpass the academic requirements. More specifically, African American medical students benefit from an advisement alliance that provides support and guidance from mentors who are knowledgeable and experienced with negotiating the training process. Therefore, these students are better prepared to navigate their training in spite of encountering barriers and obstacles.

Healthcare

A study conducted by the Association of American Medical Colleges found that African American medical school graduates and doctors are more likely to work with the impoverished and uninsured (Association of American Colleges, 2002). These medical doctors are also more likely to service other minorities and those that have

Medicaid (Cohen et al., 2002). The number of African American medical doctors is relevant to the treatment of underserved communities and eventually contributes to the improvement of overall healthcare. Thus, there is an urgent need in the United States for educating and training African Americans in the medical field (JBHE, 2007). As a result, discrepancies in the quality of care being provided to minorities and underserved populations will be addressed and ultimately resolved.

Research shows that the mortality rate among African American infants is 130% higher than that of whites, which is indicative of the discrepancy in healthcare within the Black community (Mechanic, 2002). Moreover, literature shows that African Americans tend to receive lower quality of care than whites, even when insurance availability, income, and severity of illness is controlled as a variable. Researchers in the field of medicine (e.g., Cohen & Steinecke, 2006) have postulated that diversifying the face of healthcare will ultimately lead to the production of culturally competent professionals who can improve accessibility to high quality care for minorities. In addition to the improvement in patient care, attention will be focused on broadening medical research, and increasing the opportunities for leadership at the medical executive level.

Cultural competence is defined as the skills, attitudes, knowledge, and behavior required of professionals to provide appropriate and beneficial healthcare to culturally and ethnically diverse populations (Brown & Lent, 2008). Given the constant changing demographics of the United States, the possibility of medical doctors and healthcare professionals working with minorities is highly likely. Furthermore, it is important that medical doctors are attentive to diverse belief systems, cultural biases, ethnic origins, familial dyads, observance of medical/clinical opinions, and reaction to treatment. When

medical doctors and other healthcare professionals disregard the importance of diversity during treatment (e.g., discount the significance of language, ignore cultural bound syndromes, avoid religious practices/taboos, overlook alternative forms of medication), they are ineffective in providing the best course of treatment (Cohen et al., 2002). Therefore, cultural competence is an active and ongoing process of professional development that ensures optimal treatment for all patients through constant workable goals (Sue & Sue, 2003). There are, however, examples of institutions committed to the value of diversity and the incorporation of cultural awareness in the curriculum. For instance, the Albert Einstein College of Medicine, which is New York State's only federal designated Hispanic Center for Excellence, incorporates a curriculum that emphasizes cross-cultural medical education and supports minority faculty development and outreach to the local minority community (Carrasquillo & Lee-Rey, 2008). Consequently, the presence of discrimination and prejudice continue to be a concern for minority medical doctors.

A survey of physicians practicing medicine in Massachusetts found that more than half of the non-White respondents reported encountering some form of discrimination (e.g., disrespect of co-workers, difficulty in professional advancement) during their work (Liebschutz et al., 2006). Another study conducted by Erwin and colleagues (2002) explored the experiences of African American medical doctors in academia and found that each participant encountered some form of discrimination or racism throughout their professional careers. As healthcare professionals in a field where they are disproportionately represented, African American male medical doctors experience racism and prejudice in several ways. For instance, an African American male medical

doctor who wears hospital scrubs could be mistaken for a technician, patient escort, or custodian if he decides to take off his lab coat and stethoscope before entering into the staff cafeteria for lunch. Jones (2000) postulates that race-associated differences in the recruitment, development, and retention of African American medical doctors are directly impacted by racism. Therefore, the entire process, from training to practice, can potentially be plagued by experiences of racial inequality and unfairness due to ethnicity. Although these forms of racism may be subtle, less blatant, or even unconsciously occurring, they remain psychologically distressing to the recipient.

Healthcare disparities persist in underserved communities, despite advancements in medical technology, medication, and treatment. In order to reconcile this issue, the field of medicine is attempting to diversify the pool of medical doctors in an effort to increase the quality of care being provided to the financially disadvantaged and underserved. Accordingly, African Americans medical doctors are more likely than other medical doctors to work with the aforementioned population.

Racism

In the text *Race, Racism and Psychology*, Richards (1997) asserts that racism in the United States was incarnated following the acknowledgment from the dominant culture that Africans belonged to a race. Prior to this, Africans, American Indians, and other indigenous cultures were considered to be inhuman. This author explored the phenomenon of "racialism" in the United States, which was extremely prevalent throughout the nineteenth and twentieth centuries, and continues to be presently common in doctrine that provides justification for racism. In doing so, Richards made a distinction

between the identification of a racist (e.g., S.D. Porteus) and a "racialist" (e.g., T.R. Garth). It is important to note many "racialists" are also racist; however, most racists wouldn't be considered "racialist" because their racism lacks theoretical and belief systems. The reason for this is due to the intellectual justification that is essential for the "racialist" ideology, which submits to an ideological belief that justifies the analysis of racial differences and human behavior through scientific validity.

Racist acts against African Americans were not only socially acceptable in specific regions of the United States prior the Civil Rights Movement of 1960s they were also understood to be the norm by the dominant culture (i.e., White Americans). In addition, radical racial groups such as the Ku Klux Klan terrorized African Americans while continuing to reinforce the beliefs of segregation and the inferiority of African Americans. Consequently, the history of the United States demonstrates how racism evolved from overt and discriminatory acts (e.g., sitting in the back of the bus, racially segregated rest rooms) to covert and aversive behaviors (e.g., being ignored at a store); events that are now referred to as microagressions (Sue, 2010). Aversive racism tends to be recognized as the present-day form of prejudice that characterizes the racial outlook of many White Americans who identify themselves as non-prejudiced, but subtly discriminate against others (Dovidio, Gaetner, & Bachman, 2001). Interestingly, regardless of the type of racism experienced by African Americans, they are psychologically and emotionally affected by racist acts. Consequently, even the perception of a racist act is psychologically distressing (Harrell, 2000) and can have a detrimental impact on functioning.

Current research has provided significant information about the relevance of institutional racism and the widespread significance of this construct. It has the capacity to affect the behavior of individuals to the extent that racism occurs from ideology that is consistent with rationalized thinking in current culture (Wade, 1993). This form of racism tends to be multidimensional because of its broadness across the social and cultural norms. For example, institutionalized racism can appear in the form of personal threats and unfair treatment or the denial of access to opportunities. Although some individuals perceive themselves as being racism-free, their social judgment and behavior may be unconsciously impacted (Tinsley- Jones, 2003). African Americans may be systematically denied access to services and opportunities, treated with less respect and courtesy, or ignored because of their cultural group membership (i.e., institutional racism). African Americans experience negative representations of their cultural group and infrequently encounter positive portrayals (Utsey & Ponterotto, 1996). Conversely, this construct exists as accepted and normalized policies, attitudes, and behaviors in the dominant culture. A study of African Americans conducted by Klonoff, Landrine, and Ullman (1999) found that 98% of the African American participants experienced some form of racial discrimination during the course of that year. As a result, racism-related stress tends to be a reaction to the experiences of cultural, institutional, and individual racism (Lewis-Coles & Constantine, 2006). Institutionalized racism has been associated with the sub-optimal physical health of elderly African Americans, in addition to the lack of precautionary health services in the African American community (Utsey, Payne, Jackson, & Jones, 2002). Moreover, these communities continue to lack the reception of direct quality healthcare, receive compromised services, and lack the financial means for

sufficient medical treatment. In addition to the lack of effective and available resources for African Americans, they may rely on coping techniques that were inspired through their history and tradition.

Culture-specific coping refers to the techniques utilized by members of a specific social group, who rely on traditional knowledge to provide insight and resources for dealing with stressful events (Slavin, Ranier, McCreary, & Gowda, 1991). Current literature states that although African Americans encounter significant amounts of racism, they, more than any other ethnic group, have utilized culture-specific religious orienting systems as their coping mechanism (Pargament, 1997). Another form of culture-specific coping is Africultural coping, which has been utilized in research conducted by Utsey and colleagues (2000). This construct is described as consisting of four elements (i.e., cognitive/emotional debriefing, spiritual-centered coping, collective coping, ritual-centered coping). Constantine, Donnelly, and Myers (2002) found that African American adolescents who utilized Africultural coping at high rates were more likely to view their cultural association as important, in addition to possessing a positive perception of their cultural group.

Past research has examined the impact of race-related stress on minorities following their experiences with racism. African Americans tend to have higher rates of race-related stress than Whites (Elligan & Utsey, 1999). Recipients of race-related stress are, as a result, susceptible to several physical symptoms and compromised health. These indicators include a lower quality of life, higher chance of hypertension, increased rates of coronary heart disease and cancer (McCord & Freeman, 1990). In addition to the physiological effects of race-related stress, research (Simpson & Yinger, 1985) has

shown that it also contributes to psychological distress (e.g., high levels of depression, helplessness). Krieger and Sidney (1996) found that chronic stress as a result of racism is associated with life-threatening events such as stroke, high blood pressure, and cardiovascular disease. Additionally, African American males have shorter life expectancies than males of other races (Pearson, 1994), which may be attributed to their encounters with race-related stress. According to Tinsely-Jones (2003), racial minorities who encounter racism have a tendency to experience depression, anxiety, and feelings of helplessness at higher levels than Whites due to their minority status.

Significant attention has been focused on the healthcare disparities that exist between minorities and Whites, which may be attributed to the systemic policies that were established for and essentially cater to accommodation of the privileged. A study conducted by Hood (2000) found that African Americans and Latinos who received emergency care were less likely to receive pain treatment when compared to White participants. Another study found that African Americans and Latinos are also less likely to be placed on kidney transplant lists or receive cholesterol screening (Van Ryn, 2002). Interestingly, literature shows that African American males continue to have one of the lowest life expectancies when compared to the general population due to homicide (Hammond & Yung, 1993), cardiovascular disorders, hypertension, diabetes, and substance abuse (Anderson, 1990).

Similar to the experiences of other races, the attributions of behavior for African Americans tend to be both positive and negative. Positive aspects typically surface in the form of tokenism or being perceived as the exception. For example, an African American female from the inner city who does not fit the criteria of a negative group stereotype

may be told, "You're different and not like others in your race." Although this assertion may have had intentions of being affirmative, the implications indicate negativity that accompanies this person's association to African Americans. Consequently, the negative aspects work to confirm stereotypes, while reinforcing generalizations about group behavior. Literature shows that the marginality of African Americans is primarily caused by racism, which is a significant concern in the Black community (Franklin & Boyd-Franklin, 2000). Therefore, the exceedingly high social risk of their community coupled with experiences of racism (e.g., perceived, actual), contribute to the perceptions and expectations of African Americans (Gordon, Gordon, & Nembhard, 1994). As a result, the relevance of racism for African Americans has generated different means of socialization, a degree of vigilance, and a range of coping techniques (Franklin et. al, 2000).

According to McIntosh (1990), African Americans tend to suppress attributes of behavior that are perceived as being unacceptable to whites in an effort to gain access to their privileges. Although African Americans cannot be afforded the same opportunities that come along with White privilege, they have the prospect of being accepted as "exceptional" or as a "token." For example, research conducted by Kelly (2007) found that "token" African American teachers experienced occupational stress and social concerns due to visibility. According to Kanter (1977), the theory of proportional representation postulates that individuals who are considered to be tokens experience higher levels of occupational, social, and psychological stress than those who are not. Kanter's theory also suggests that "tokens" are more susceptible to decreased levels of emotional well-being as a direct result of three distinct stressful sources (i.e.,

performance pressure, boundary heightening, role entrapment). Collectively, these stressors contribute to psychological strain along with the coping responses that accompany them (Jackson, Thoits, & Taylor, 1995). Moreover, performance pressure is exhibited when "tokens" feel attacked and scrutinized due to being the representative for their group, which may ultimately lead to opportunities for others. In response to performance pressure, literature shows that "tokens" tend to either overachieve or avoid drawing attention to their performance and undertakings (Jackson et al., 1995). Accordingly, boundary heightening tends to be a constant reminder to "tokens" about their differences with the dominant group through the use of aversive behaviors (e.g., humor, exclusion, false interpretations). As a result of boundary heightening, "tokens" will attempt to be accepted by presenting themselves as exceptional for their group. Role entrapment occurs when "tokens" are classified into cultural stereotypical roles by the dominant group. Therefore, "tokens" who oppose being stereotyped may be perceived as confrontational and/or aggressive due to their coping strategy in an effort to resolve feeling marginalized.

According to Rogers, Hoffman, and Wade (1998), the establishment of critical mass of racial minorities is important in creating an educational or training environment that is hospitable and encouraging. In essence, critical mass provides a resolution for tokenism because of the effort to include a substantial sample, rather than a single representative. A study conducted by Rogers and Molina (2006) found that graduate departments that included critical mass of students of color, were able to retain these students at higher rates than departments that did not include critical mass of students of color.

Stereotype Threat

Research conducted by Steele and Aronson (1995) postulates that people tend to experience a self-evaluative threat as a result of social-psychological concerns that occur when commonly known stereotypes about one's own group are known. African Americans in particular have been associated with the stereotype of being intellectually inferior, thereby producing a stereotype threat with only the mention of intelligence (von Hippel et al., 2005). For example, African American students may experience a significant disruption with intellectual functioning as a result of stereotype threat during a standardized examination. This construct focuses on the direct contextual threat that emerges from the extensive aspect of stereotypes about one's group. The risk of possibly being judged contributes to anxiety and stress that eventually affects performance. Stone (2002) asserts that stereotype threat can potentially lead to behavioral self-handicapping (e.g., negligence in performance preparation). Although this construct is salient to both age and gender, it is extremely relevant to race. Steele and Aronson (1995) conducted a study that examined the intellectual ability of both Black and White undergraduate students, when prompting Black participants about their performance and establishing a clear threat. Results show that Black participants who anticipated taking a difficult diagnostic test about ability, exhibited higher cognitive establishment of stereotypes about Blacks. In addition, these participants experienced higher concern about their ability, tended to elude racially stereotypic behaviors, and avoided having their racial identity associated with their performance.

A study conducted by von Hippel and colleagues (2005) examined impression management and claims of intelligence in 339 participants (207 non-Hispanic Whites, 12

African Americans). Researchers tested participants individually in a computer equipped laboratory in order to focus on denial as a coping strategy. Results show that African Americans who were more concerned about impression management were more likely to claim to be intelligent. Interestingly, this connection was likely to appear when the experimenter was White and when the participant attended a predominately Black high school. Furthermore, these findings were congruent with the researchers' predictions that impression management and claims of intelligence would emerge as responses to the coping strategy of denial in Black participants, and that Black participants from predominantly Black high schools should be less experienced with coping with stereotype threat. This study relied on median split to test hypotheses, which accentuates the need for replicating the study. Although von Hippel and colleagues (2005) were able to able to confirm their predictions regarding stereotype threat and denial as a self-presentational mechanism, their results lack qualitative information about participants' experiences with the construct.

There appears to be a lack of research about the strategies individuals employ in order to cope with stereotype threat. Regardless of this information, there continues to be several ways for coping with stereotype threat that are implemented by individuals (Major, Quinton, McCoy, & Schmader, 2000). Literature shows that stereotype threat is an aversive state that prompts a coping reaction from the individual being stereotyped (von Hippel et al., 2005). These authors also argue that effective coping with stereotype threat requires the reestablishment of self-integrity (i.e., intrapersonal in nature, self-presentational purposes). Conversely, denial of the stereotype is the straightforward method for managing self-integrity; however, the aforementioned technique is not used

by these individuals. In addition, Miller and Kaiser (2001) state that explicit denial tends to be the most efficient technique for coping with this construct and it can be conveyed through endeavors (e.g., avoidance) as opposed to words. Hence, impression management seems to be relevant to individuals who attempt to resolve issues of competence and being associated with negative stereotypes through management approaches (e.g., denial) (Lakin & Akin, 2005).

Stereotype threat has the potential to be debilitating to any group that is associated with a negative stereotype (i.e., age, race, gender). In particular, this construct is salient to African Americans and intelligence, therefore potentially compromising their performance on tasks that prompt the identification of their race. In the process, this threat can eventually lead to anxiety and self-defeating behavior for the individual.

Racial Identity

Research states that African American males continue to experience significant stressors (e.g., economic, social) that have contributed to their lack of efficacy in several personal domains (Anderson, 1990). In particular, the role of African American males has been compromised within their families, communities, workforce, and social institutions (Hutchinson, 1994; Kunjufu, 1985; Madhubti, 1990; Pierre & Mahalik, 2005). In the process, this group has developed associations and labels that remain consistent with how they are perceived. In order to cope with negative stigma, African Americans have devoted energy toward salient characteristics, which have gradually become synonymous with their group identification. Thus, the development of their racial identity is directly impacted by being a minority (Helms, 1990). Although racial

group memberships and categorizations are important for racial identity, they are not considered to be psychological constructs because they are not indicative of behaviors, personalities, values, or biological situations. (Helms, Jernigan, & Masher, 2005). Moreover, these constructs are deemed as sociopolitical and used for grouping individuals who possess apparent biological traits (Helms, 1990). Literature states that the racial identity of immigrants and other nations differ from the encounters of Americans if they have not experienced similar racial enculturation (Helms, 2007). Therefore the premise of racial identity is to provide an explanation for explicit group progression in a sociopolitical context.

Cross (1978) initially developed a stage focused model for racial identity recognition and development that centered on Blacks' perceptions and approaches toward White culture. Helms (1990) modified Cross's racial identity model in order to distinguish each stage as a "world view" in which individuals use cognitive patterns to manage information about themselves, others, and organizations. Helm's (1995) model for Black racial identity consists of four components that classify cultural awareness and attribution attentiveness. The "preencounter" status is typified through racial identity attitudes that disparage Black culture, and admire White culture/values. Literature shows that this status tends to be the least affirming among African Americans in the United States (Pierre & Mahalik, 2005). The "encounter" status occurs following individuals questioning their "Blackness" as a result of an experience with society. The "immersion" status consists of individuals eventually learning and developing an appreciation for the distinctiveness of their culture. Research shows that individuals may not experience a genuine sense of "Blackness" during this status, which can be attributed

to a reaction toward racial oppression by the privileged, White culture (Parham & Helms, 1985). Internalization transpires following individuals experiencing their Black identity as important and self-affirming. In addition, individuals are able to employ a healthy and practical sense of their self-affirming experience being Black. (Pierre & Mahalik, 2005).

For the sake of this study, it is important to distinguish the difference between racial identity and ethnic identity because of their past interchangeable use. According to Helms (1996) racial identity explains responses to social oppression due to race, while ethnic identity explains the acquirement and sustainment of attributes salient to one's culture. For example, an individual who has a salient ethnic identity may be committed to her or his specific cultural group and actively participate in its practices (Helms, 2007). Although there has been debate regarding the relevance of racial identity in the field of psychology due to its phenotypical reliance (Parham, 2002), conceptual differences between racial identity and ethnic identity still remain ambiguous (Cokley, 2005). Moreover, Helms and Cook (1999) assert that racial identity development is utilized by individuals in order to accomplish self-affirming characteristics that negotiate racism associated with their group membership.

Racism and discrimination are considered obstacles toward achieving expectations, and ultimately shape racial group values (Majors & Billson, 1992). Conversely, research shows that racial identity can act as a defense against the negative effects of racism through the instillation of racial pride and self-affirming behaviors in spite of unconstructive stigma, discrimination, and prejudice (Cross & Strauss, 1998; Miller, 1999). On the other hand, African Americans may develop an internal vigilance

for identifying racist attacks (e.g., microaggresions), which is commonly referred to as the sixth sense in the Black community (Franklin, 1993). Thus, it is appropriate to presume that African Americans who possess a greater understanding and appreciation of their own racial identity will be able to recognize and negotiate racial harassment. Although many African Americans reside in environments where they are deprived of recognition and other critical resources necessary for a positive identity (Franklin, 2000), the development of racial identity is central in negotiating stressful racist experiences (Franklin, 1999). Thus, racial identity may concretize cultural self-perception following encounters of racism, while also developing into a defense mechanism against the negative effects (Franklin, 2000).

A study conducted by Thomas (2009), examined the role of racial identity as a buffer for perceived teacher discrimination on academic achievement among African Americans and Caribbean students. The researcher hypothesized that racial identity would augment academic achievement regardless of participants' ethnicity once demographic variables and perceived teacher discrimination were controlled. Results failed to support this hypothesis, which is inconsistent with past research (Smith, Atkins, & Connell, 2003) that discovered a relationship between increased levels of racial/ethnic satisfaction and elevated standardized test scores in Black children. Moreover, the research utilized self-reports for this study, which is potentially susceptible to response bias. In addition, a cross-sectional design was used, which makes it difficult to make generalizations and contributory inferences about the findings.

Summary

In summary, the literature provides evidence for the relevance of research with African American males in the field of medicine, who continue to be underrepresented and experience unfair treatment as a result of race. Past research has focused on the existence and impact of racial identity and stereotype threat in African Americans; however, there is a lack of qualitative research into the experiences of African American male medical doctors. Furthermore, in this study I will seek to explore commonalities and themes in the experiences of this population throughout their professional development (i.e., medical school, residency, workplace). In addition to race and racism existing as salient factors in the lives of African Americans, social constructs such as stereotype threat and racial identity play a significant role throughout their development (i.e., social, academic, occupational). This study is restricting its scope by examining only African American male medical doctors, however, this group is unique because even while being a stigmatized group facing social barriers and obstacles it has been successful in negotiating the medical training process.

Chapter III
METHOD

Participants

Current research on the social constructs of racial identity and stereotype threat has focused primarily on their existence (Yip, Seaton, & Sellars, 2006) and impact (Pearson, 2006) in African Americans. In particular, the majority of the extant research has utilized quantitative methods. Although this research is extremely relevant and applicable to the experiences of most African Americans, there is a lack of empirical studies that focus on the encounters of African American male medical doctors throughout their professional development and training. Given the research that suggests this population is associated with negative stereotypes about crime (Rollock, 2002), laziness (Thompson & Akbar, 2003), and education (Cokley, 2001), in this study, I will explore the subgroup of this demographic that has successfully negotiated medical training despite these social barriers and obstacles.

African American male medical doctors

According to Hill, Thompson, and Williams (1997), it is recommended that researchers conducting Consensual Qualitative Research (CQR), select a homogenous sample of 8-15 participants who are knowledgeable about the phenomenon being investigated. For this particular study, the participants were African Americans males who were raised in the United States of America, have completed their medical school training, and are currently either completing their residencies or working in the field of medicine as a professional. In this study, I sought to examine the experiences of this population during the medical training process. In addition, I explored the participants'

exposure and experiences with the constructs of racial identity and stereotype threat. For the purpose of this study, participants were selected from individuals practicing medicine in the Northeastern region of the United States. I ruled out medical doctors who received their medical training at historical black college and university medical schools since their experiences with race would be different in comparison to those who attended a predominantly White institution.

Interviewer and judges

While conducting this research, the primary interviewer, who was the only person conducting the interviews for this study, was a counseling psychology doctoral student and a 31 year-old Jamaican American male who has received instruction in CQR, in addition to researching as a judge during a previous study. The second judge was a 25 year-old African American female, who is also a third year counseling psychology doctoral student. The third judge was a 40 year-old Jewish White male who is currently working as the Psychological Service Unit Director for the New York City Department of Correction. In addition, the third judge serves as an advisor for the first judge. He has conducted several studies in CQR and has received instruction from the method's designer. The auditor was a licensed psychologist and 33 year-old White female. The auditor has received instruction in CQR, in addition to researching as a judge in previous studies.

Prior to conducting the interviews, the primary interviewer and the other two judges convened to process their experiences, views, and biases regarding African Americans, negative stereotypes, and medical doctors. Following this discussion, the

relevant information processed included thoughts about African Americans experiencing racism throughout their training, being impacted by stereotype threat, utilizing other African American doctors as a resource, and being proud of their accomplishments.

Methods

Current research asserts the importance of using qualitative inquiry due to the several advantages provided to researches with this methodology (Hoyt & Bhati, 2007). For example, qualitative research is appropriate for exploring aspects of the human experience (e.g., personal meaning of daily encounters). In addition, qualitative inquiry is utilized with small samples and provides descriptive information about the participants' experience. Lastly, qualitative research may be significant to studying uncommon populations (e.g., African American male medical doctors). Therefore, the goal is to achieve a substantial understanding of the experiences of participants who are considered unique. This study examined the experiences of African American male medical doctors throughout their training, while also exploring the impact of racial identity and stereotype threat.

Synopsis of Consensual Qualitative Research (CQR)

This study utilized Consensual Qualitative Research (CQR) for acquiring data, analyzing results, and interpreting findings. Hill and colleagues (1997) developed this exhaustive and comprehensive form of qualitative methodology to integrate the valuable features of several qualitative approaches. Previous to its inception, the descriptions of qualitative methodology were considered to be unclear and difficult to use.

CQR involves interviewing and investigating of eight to fifteen participants. Interviewers utilize open-ended questions through a semi-structured information collection procedure. By so doing, researchers are able to reliably collect data across participants and comprehensively examine their encounters. Hill and colleagues (1997, 2005) assert that interview questions be restricted between eight and ten queries in order to assure continuity during interviewing, and that several judges be on the research team to conduct data analysis to promote various perceptions. In addition, there should be a consensus regarding the meaning of the data. Once the research team reviews the transcripts, domains are developed from the data. Research team members are responsible for working separately on creating domains, and eventually collaborate as a whole in order to come to a consensus about the domain lists.

Eventually, the research team will construct core ideas for the data, which ideas should remain as consistent to the data as possible, refrain from making assumptions and explanations, decrease repetition, adhere to the exact wording of the case, and processed in order to reach a consensus. During this step of analysis, researchers "edit" the participant's words into a layout that is succinct, understandable, and analogous to the other cases (Hill et al., 1997, 2005). Pronouns are altered for the purpose of consistency, redundancy is removed, and irrelevant information is extracted. Thus, the primary researcher is responsible for acting as an internal auditor who is involved in each case and helps edit the core ideas in order to guarantee accuracy, clarity, and relativity.

Finally, the cross-analysis can either be completed with the primary research team collectively creating categories, or with the individual members working alone and eventually coming together to discuss their work. According to Hill and colleagues

(1997, 2005), regardless of the approach selected, it is important that the research team comes to a consensus about wording, categories, and distribution into categories. The aforementioned authors provide characterization for the rate of categorization occurrences. Results are considered to be "general" if they are applicable to all or all with the exception of one case, "typical" if they apply to at least more than half of the cases above the cutoff for "general," and "variant" if they apply to at least two or three cases or to the cutoff of "typical," but fewer than half. Samples that are larger than 15 are recommended to include an additional category of "rare," which applies to 2-3 cases.

It is recommended that researchers continuously reference the raw data for accuracy in the placement of core ideas into appropriate categories, in addition to reexamining the possibility of revisions. Lastly, feedback from impartial and unbiased people can be helpful in assuring that the cross-analysis is understandable and apparent.

An auditor works with the research team to check whether the raw data is correctly domained, all important information has been represented in the core ideas, the wording of the core ideas accurately encapsulate the quintessence of the raw data, and cross-analysis dependably epitomizes the information. The auditor is responsible for providing feedback during each phase of the data analysis. In addition the assigned auditor will question and critique the analytical work of the research team, while attending to editorial work and extensive thinking.

Procedures

Recruitment of participants

Currently, the primary researcher works in a psychiatric emergency room at a metropolitan hospital, where I have made several contacts with African American male medical doctors. In the process, the researcher provided these candidates with an overview of his study and informed them about their possible participation. Many of these doctors also offered to contact other possible candidates within their professional network. The researcher also had access to African American medical doctors through the professional networks of his personal contacts. I included a brief purpose about the study in the overview, in addition to his contact information. I contacted each potential candidate and asked him a few questions to determine whether they fit the criteria for the study. Once the candidates were determined to be appropriate for the study, they were provided with a consent form and demographic questionnaire via regular mail. Participants were asked to provide their names and contact information in order to assist in the scheduling of interviews.

Demographic Questionnaire

The demographic questionnaire was mailed to the homes of each qualifying participant. It asked basic information, including age, medical school, residency program, current employment, and amount of years practicing.

Interview Protocol

The interview was formatted in a semi-structured manner with participants being asked open-ended questions meant to elicit responses about their experiences with racial identity and stereotype threat during their medical training programs and development (i.e., medical school, residency, workplace). The interviewer asked each participant the same collection of questions; however, due to the potential for probes, some queries elicited more information.

Protection of participants

Participants were informed about their freedom to leave the study at any time if they experienced discomfort during their disclosures, without the possibility of penalization. Participants were persuaded to acknowledge and share any concerns or apprehensions they may have had about the current study. The identity of participants remained confidential and protected by the primary interviewer, who assigned code numbers to interviewees, which were displayed on the demographic questionnaire and interview tapes. In addition, the transcripts did not provide any identifying information connecting the participant to his interview. I kept all participants' information (i.e., informed consent, demographic questionnaire, interview tapes) securely locked in a file cabinet in the researcher's office, and also destroyed all interview tapes following the completion of the data analysis.

Interviewing

Interviews were conducted via the telephone. I conducted two pilot interviews in order to practice utilizing the interview protocol. All interviews were recorded via

audiotape with the permission of the participant, in addition to notes were taken about completion time and participant/interviewer rapport. Participants were given an opportunity to provide additional information pertaining to the initial interview during the optional follow-up session. Participants were also given a chance to include any additional information or amend previous disclosures made during the initial interview; however, none of the participants chose to participate in the follow-up visit.

Transcripts

The interviews were audiotaped and transcribed verbatim. Identifying information of the participants was removed and they were assigned a unique code number.

Draft for final results

Participants were given the opportunity to request a copy of the draft of the final results of the study regarding their disclosures; three participants did so.

Analysis of Data

The data analysis was completed using consensual qualitative research (CQR). Following the completion of the data collection, research team members had an initial meeting in order to discuss any preliminary biases prior to the data analysis. According to Hill and colleagues (2005) researcher bias is unavoidable and should therefore be thoroughly processed to circumvent improper influence of the results. The primary research team reached a consensus following the process.

As suggested by Hill et al. (2005) the data analysis process started with each judge putting responses from each interview into separate domains. The next stage

involved each judge creating core ideas for data contained in the domain of each individual case. A cross-analysis was then completed in order to identify categories that describe the consistency in the core ideas with the domains across this study.

After each of the judges completed their data analysis, an outside auditor reviewed the results. The auditor was responsible for reviewing the data to guarantee that the cross-analysis completed by the primary research team was thoroughly and accurately done. The auditor also provided important and constructive feedback regarding the data.

The last stage of the cross-analysis involved the primary research team characterizing the frequency of occurrences of the categories (Hill et al., 2005). According to Hill, "general" results pertain to all where either all or all but one are present, "typical" results pertain to at least half of the cases, and "variant" results pertain to at least two to four cases, but fewer than half. This study had 8 participants interviewed, so "general" applied to 7-8 cases, "typical" conveyed 5-6 cases, and "variant" consisted of 2-4 cases.

Chapter IV
RESULTS

The data collected and analyzed for this study provided information regarding race, medical training, stereotype threat, and racial identity in African American male medical doctors. In particular, the data analysis generated 10 domains: perception of African American male identity, salience of race in their lives, experiences with race and racism, obstacles and barriers to success in medical profession, impact of racial socialization on professional life, resources used for negotiating medical training, impact of stereotype threat in training and professional life, advice for African American male doctors, possible reasons for participating in research, and experience of participating in research. Refer to Table 1 (Appendix E) for a list of domains/categories, subcategories, and frequencies for each domain. To maintain anonymity, all identifying information for participants of this study was replaced by pseudonyms.

Perception of African American male identity

Three variant subcategories emerged as a result of participants' disclosures about their views on African American male identity. One variant subcategory reflected African American males making professional accomplishments despite social barriers and obstacles. For instance, Dr. Michael provided the following response:

> Well, I was the first person in my family to become a physician and I certainly guess that I was part of a generation where for the first time we had a large number of men and women in our race becoming physicians and lawyers and that. So I felt that it meant that we were making strides and that we were able to

> accomplish the things in our lives that we wanted to accomplish if we put our minds to it.

Another example came from Dr. Jonathan, who disclosed:

> A sense of feeling that we as a people have come very far to make it despite different things that society has done to try to keep us from learning, going to school, and being educated. The ones that have come from the middle class and upper class have come a long way and there's a great sense of pride and I am proud to be African American.

Another variant subcategory that materialized was the participants' sense of obligation and pride that came along with being African American. Dr. Phillip, reported:

> First of all, it's a very honorable position to be in because I realize that a lot of other men my age in my profession did not have to overcome the same things that I had to overcome. And even on a generational level, their parents did not have to overcome what my parents had to get me to where I am today. So in a way I do wear it as a badge of honor for starters.

In addition, Dr. Edward disclosed

> So you have a sense of obligation to carry out something or finish the goal with the opportunity you've been given the skills set and genes of your parents to open up the door and follow through what other people have gone through. You have the obligation and then also we as academic people and spiritual people we have

> duty to our parents and duty to our community. So, we also have a sense of wanting to serve others.

Another variant subcategory that emerged was participants' perception that pressure was assigned to African Americans to achieve while remaining resilient despite past experiences. Dr. Phillip reported:

> I know that because a lot of African American males in this country don't have the same opportunities I have, it sort of puts an extra challenge on me to make sure that I make the most out of what God has given me. So, I guess to summarize, in a way it puts a challenge on me and in a way it's kind of a badge of honor to be an African American male in this country especially.

In addition, Dr. Edward disclosed:

> It's a great sense of obligation without question. Because if we understand history it tells us I'm not supposed to be in this position. So you have a sense of obligation to carry out something or finish the goal with the opportunity you've been given, the skills set and genes of your parents to open up the door and follow through what other people have gone through.

Salience of race in life

Typically, participants reported race being important because it determined how they were treated in society and gave them an identity. For instance, Dr. Edward shared:

> It's important because then I have an identity. I think again, being a person who believes and being a person who understands in the environment race is very

> important. I need to understand how the environment in which I would interact with me and how I am able to interact in the environment. So, there's just an understanding that black men have been profiled and criminalized. So, race is important because I can interact with the people in the community who have been marginalized to some degree and be able to help them better themselves.

Another example can be seen in Dr. Michael's disclosure:

> I guess it has to be very important because in this country a lot of, much of this country treats you based on your race. So, even if it wasn't important to me intrinsically, I find that it's a big factor in how I'm treated by people in this country. I don't think that it's that important whether another person is white or black or red; although, you are always more comfortable with your own and so culturally you're more at ease and you have more in common with members of your own race. And perhaps it shouldn't be that way but for me that's a reality. I wouldn't say that I judge people based on their race. I hope I don't. But, I suppose it is quite important in terms of people who are surrounding you and it's important to people who are around me, where you work and where you go to school.

A variant subcategory emerged in which some participants felt race was not important. For example, Dr. Jonathan stated:

> It's not. I wouldn't say it's important. I'd say that I am aware of it and I am always reminded that I am a black male. I wouldn't say it's important just that I am consciously aware of it.

Dr. Phillip, also revealed:

> I would say that it's very important but at the same time it's not important. It doesn't put food on my table, it doesn't keep my kids warm. The important things are that I can feed my family, keep them warm, keep them safe.

Another variant subcategory was the awareness of race and receiving daily reminders about it. Dr. Charles divulged:

> Well, I think it's always there. You will always wonder how people, as opposed to being a Caucasian person, when you meet people you always wonder how they will perceive you or how you will be accepted or things like that.

Similarly, Dr. Phillip shared:

> I think about it every single day. Somehow race comes up every day and that's the unique thing about being an African American in this country is that we think about it on a daily basis, the other races, especially the dominant race in this country, they don't have to think about it quite as much, do they?

An additional variant subcategory was the awareness of differences that are unique to the experience of being African American. This was evident when Dr. Phillip said:

> I can give you a plain example. If my kid comes home from school and tells me what a professor said to him within two minutes of that opening statement we're talking about race because race plays a factor in the comment in that was made to him or how we interpreted the comment. Whereas if I am of European descent within this country and the kid comes home and says the professor said this to me

> his response is going to be different. The conversation is going to be totally devoid of race. Whereas my conversation with my kid is going to be totally saturated with race.

Also Dr. Richard disclosed:

> I think that for me, the importance is that I recognize that I carry a certain legacy because of my race. So therefore I try to keep in perspective that that opportunity that I've had might have been the result of a lot of hard work and a lot sacrifice by many other people.

The last variant subcategory for this domain was participants' thoughts about perception and acceptance of others due to race. For example, Dr. Patrick noted, "You always kind of wonder or second guess what I am saying or how the other person is perceiving you.

Likewise, Dr. Edward revealed:

> While I was in medical school I was coming home from the medical school library, and I was stopped by three police officers. I'm getting out of the car and I had my book bag and so I need to understand that even though I have the chance and opportunity to be in a higher up education, the environment that I look at still sees me as a black man, I am still a threat.

Experiences with race and racism

Typically, participants discussed experiences of racism while in medical school and residency. For example Dr. Richard articulated:

> I can't say there was any tremendous overt racism necessarily in medical school or even in training, but I think there were certainly people who approached me like they didn't expect a lot out of me. And I certainly got challenged for frivolous things that maybe other white students wouldn't have been challenged on.

Additionally, Dr. Patrick reported:

> On the contrary going through classes, you always kind of wonder about perception of the teachers. Afterwards when you are on the wards as a black student, you still get the nurses looking at you like are you supposed to be the orderly, are you the nurse or are you really the medical student? Through medical training, you of course get occasionally the patient who doesn't believe you because you are black…

Conversely, some participants reported not experiencing racism in medical school and residency, as evidenced by Dr. Edward's response, in which he stated:

> In residency, I don't have any hard evidence. Of course you deal with the day to day or is he being hard on me because I am black. So we ourselves are racialized so to speak and we begin to say is that because I'm black or is that because I'm black. Is he being hard on me because I am black?

Also Dr. Charles, disclosed, "I think during residency I really didn't really experience much in the way of overt racism that I can recall during my residency."

Participants typically reported not encountering unfair treatment or racism at their current job. For instance Dr. Edward stated,

> I can't really pinpoint anything particular. If anything I think that there have been many individuals who have been in my corner because I am of African American descent. There were diversity programs that said who do not have enough black faculty members.

Dr. Michael acknowledged:

> I really just tried to come here and do my work the best I could. And I haven't encountered any tremendous problems here. I've always felt that top management here was always there for me when I needed help and when I was having difficulty on the job. And I never felt really that I was unfairly treated. If anything, there were times when they were trying to honor me too much, which I was very uncomfortable with and I fought against that.

On the other hand, participants also typically reported experiencing racism at their current job. For example, Dr. Edward said:

> We already know there are health disparities so when there is conversations happened about how we allocate resources to black communities you can't implicit bias. And it makes you cringe because are you talking about black people in that manner and then they look at you and make sure it was okay for you to say that. I'm sure that you know and you've seen the same thing at the level that you're at. I think that's mostly what I encounter is that interest bias which we're talking and trying to delegate tasks. Of course there are others things

> like since you're a black physician you can deal with cultural competency with the medical students.

Participants experienced the awareness of racial differences while growing up in a variety of ways. For instance Dr. Michael stated:

> I went to a special school in (metropolitan area) for advanced students, and I brought two of them to my home after school once day. Two white young boys and when my mother found out she hit the ceiling and just wanted to kill me. She was so angry but I had no idea why. And the next day, apparently most of the kids in the school had learned that I lived in a very tiny, I had a very small home. But I grew up in the projects and I was around my kind in the projects, mostly African American people. Although in school I was mostly around white children but there was no difference to me. I was just very naïve to the whole thing.

Dr. Jonathan disclosed,

> So I grew up in (metropolitan area) and I lived in a predominately African American community in (metropolitan area). However, I went to school in a predominately Caucasian school in (metropolitan area) so at a young age I was very aware that somehow or another I was a little bit different then all of the other children. So I would say about by age of four years old, something about me was a little bit different when I went to school and that was my first encounter with race, and differences in race and so forth.

Participants also provided variant responses about experiencing racism while growing up. This can been seen in Dr. Phillip's response, in which he shared:

> I encountered a lot of racism from kids, the name calling to name calling even from teachers. When I was in sixth grade, my teacher told me that blacks were better off as slaves. And then, I think what probably hurt me the most was that I noticed growing up that a lot of my white teachers had lower expectations, not all of them but quite a few of them, had lower expectations for me. And I think that's what motivated [me] the most to work hard in school and kind of overcome that. You know what they call the subtle racism of expectations is what I've heard somebody coin the phrase and I can actually apply to that growing up.

Additionally, Dr. Samuel said:

> I mean going to a predominately white high school, there are stereotypes. And obviously I did well in that situation. I played football and did well academically; however, it was a constant battle. You have Jewish and Italian kids and they have these perceptions about how we speak, our intellectual levels, our athletic prowess and so on; and make these preconceived notions and so at that age it can be difficult because you are fighting these stereotypes but you also want to try to make it through school. So it can get [to] you.

Dr. Patrick disclosed, "And finally, you do hear now that I am in practice, I heard it at least twice maybe three times [at] most, the patient who is like yeah I am not sure I want a black doctor."

Another variant subcategory that emerged was participants' negative interactions with law enforcement. Dr. Edward stated:

> I just think of one incident that impacted. I was a young adult and I am already over 21 and having to still interact with law enforcement, I understand that it doesn't matter where I am at. The most recent incident is that I was at (supermarket) in (metropolitan area) and I was turning into a parking spot and a police officer stopped me and said I needed to get out of the car and was asked to come to the back of the car. Two police officers began to engage me and I said to them listen, I mean no harm. They said the reason that they stopped me was because the light was out. I said that was fine and I'll take the ticket. But, I began to question why was I stopped in the manner that I was stopped because he was very rude to me. Get out the car this that and the third. I continued to tell him that I was a physician and I work at (hospital), I don't mean any harm. I don't give an (expletive) if you are a doctor this ain't the OR (operating room). So, the way in which law enforcement continues to interact with our community tells me I am still not supposed to be in this position. That was within the last year too.

While Dr. Richard shared:

> I was on my high school baseball team and after practice I used to have to walk a mile to the bus stop to get home. I was going home on a Friday catching a # 31 bus route because we were going to be going away to a spring baseball trip to Florida, and out of nowhere plain clothes police car pulled over to the side of the road and jumped out. [One] turns his safety off and starts pointing [the gun] in my face, puts us on the ground and we're surrounded by the cops. He said "oh yeah, so sorry." I said "oh, if this is what turns you on then you can have it." He said,

> "I'm very sorry, we were told there was a robbery and somebody stole some jewelry." I'm sure you did.

Obstacles and barriers to success in the medical profession

The emergence of a variant response regarding experiencing difficulty in medical school developed from this domain. Dr. Phillip noted, "I think there were just regular barriers that any medical student had that it's just a lot, a lot to learn, a lot to memorize in a short period of time."

In addition, Dr. Michael stated,

> I suppose that at some point in medical school I did have difficulty. It's really tough and it's really hard. I didn't always study the way I should have.

Impact of racial socialization on professional life

Several variant subcategories materialized from this domain. Participants reported that racial socialization has not impacted their racial identity. Dr. Samuel revealed:

> I don't think me going through medical school impacted my racial identity. I knew who I was prior to medical school. So that did influence me growing up and my parents installed a sense of pride and connotation this is who I am regardless. I'm black and in this society I'm going to be black and you're going to deal with the issues associated with being a black male in this society.

Correspondingly, Dr. Richard imparted:

> I don't think that necessarily my racial identity has been terribly affected by that. Again, I've certainly have had interacted with a person here and person there that's said something dumb and there's certainly been plenty of people who naturally assume because I'm black I must not be any good.

In contrast, other participants acknowledged that racial socialization has impacted their racial identity. For instance, Dr. Edward said:

> ...growing up in (city) an underserved area, growing up with a good sense of the differences in what opportunities were afforded to people of African American descent in the 80s and 90s and seeing that difference cross racial roots. And growing up able being afforded that opportunity to go forward and still kind of climb the economic ladder, that has pushed me to want to service my community. I am a family medicine physician, which is probably the second or third specialty of the least paid physicians when you look at all specialties. I also want to work in an underprivileged area, in a metropolitan area like (city), or (city), or (city). So, my socialization impacted me to want to contribute to the betterment of the community in which I came out.

Whereas Dr. Patrick, disclosed:

> I think really just more from stereotypes. But I think not overwhelmingly but maybe in the 65/35 ratio most of that was self-perceived meaning I thought that they were looking at me differently or more differently. And I always thought it was more than it probably was.

Also, participants discussed making attempts to treat others equally as a result of their past experiences. For example Dr. Michael shared:

> I think that the inequitable and disproportional treatment whatever it was that I have experienced, I would think that it has made me not want to treat others that way. I would think that as I work here that all patients are the same. That I try not to let there be a gap in between men and women that there are no gaps in gender disparities between white and black. That I am treating everybody equally and that I am putting my hands on everyone to comfort them in the same way. Because although I've had my head in the sand much of the time, I haven't had it there completely. I know there are times when you are treated unfairly so I would imagine that I certainly don't want to be guilty of doing the same things that white people have done to me so I can treat every patient as best I can.

Dr. Richard added:

> So, I'm particularly aggressive about that so I don't let really white folks intimidate me and all too happy to intimidate them first. So, I guess I'm getting old and grouchy and I don't have a whole lot of patience for that kind of stuff. Earlier on it used to affect me but it doesn't anymore. I would say that I do really try to be a mentor to young African Americans behind me and I try to instill confidence.

Some participants talked about past experiences that have contributed to their current approach of service. Dr. Phillip stated:

> It's hard to separate from other contributions to my identity but I would say that overall, race, background, socioeconomics, parenting, everything, I would say that all that has given me an edge. I really feel like it has given me an edge over my fellow medical school classmates, over the residents, over the physicians that I work with now, because it's given me one, I have a tremendous work ethic. Two, I always make sure that I put twice as much work into an effort than it probably took in the first place. Let me give you a perfect example of that. When it came time to study for my recertification. This is a perfect example. When it came time, when us medical doctors get board certified in emergency medicine that means you have to take this two-hour test and if you get above 50% you get board certified. The most physicians and emergency room doctors in my medical experience, at least from what they tell me, they may spend a week studying for that test. They may be happy to squeeze by with a 72% or a 75% and brag that they passed and they're perfectly fine with that. Because of my past and because of the subtotal of all my experiences as an African American and I had different approach. I took a year studying for the test and I got 95% of the questions right. So I would say that if I was not African American, would I put forth that extra effort just to make sure that I'd pass that test? In the back of my mind as an African American male I say to myself if I failed this test I could lose my job where if one of those guys failed the test, they may get a pat on the back and say don't worry about it, you'll pass next time.

Lastly, participants spoke about the importance of networking with fellow African American medical doctors. Dr. Charles divulged:

> I try to at least, almost the same as I was in medical school, looking at it that I see African American resident or students, I try to make it a point to reach at them a little bit. Even if it's just a matter of stopping in the hallway and asking them a little bit about their undergraduate training, where they grew up or what they want to do or how are things going, how are they experiencing things. I kind of feel a bit of an obligation to do that with most men if I can or if they seek them out to give them a hand. Generally I try to help them in whatever way I can and to be a positive role model for them. Something if I'm looking around and they get whatever, I say all of the other kids here are doing the same thing. You can do this. If they need a little guidance into what to do I am glad to do that for them. So it's the same thing, I just try to do whatever was done in medical school that was done for me; I try to continue doing that with someone else.

Resources used for negotiating medical training

Participants discussed important resources they utilized for negotiating the medical training process. In particular, four variant subcategories emerged from this domain. First, participants reported receiving support from African American medical school faculty and other African American medical doctors. For example Dr. Samuel stated:

> I think during school I had more of a mentor within a group of other African Americans. We studied together. People I trained with who were also African American and I guess the mentors were colleges fortunate to have other black physicians in the academic realm. The presidents or the clinical director at the

> medical department was black, in the pediatric department was black so these were African American doctors who are head of their departments and you could go to them with certain issues. When I trained, the head of the nephrology department was black and that's what led me to go down to the field of nephrology. So having these physicians in these power positions was beneficial because you could see that you could achieve and they could educate you on the steps to get you to that level basically.

While Dr. Michael shared, "I remember that any difficulty that I've had, that the chief was Dr. X and he was an African American man and I would go marching into his office if I was getting any too tough of a time."

Another response involved participants' membership in black national professional organizations. For instance, Dr. Jonathan disclosed:

> I was part of something called (national organization), which is a predominately African American organization. It's where African Americans get together and discuss issues that pertain to them and what they can do to help one another out. If others have old test material or books they can give each other pointers or we can kind of help one other. So we met once every month and got together to kind of discuss different issues that we all could relate to such as housing, not feeling like the administration was addressing our needs.

In addition, Dr. Richard said

> I was a member of a (national organization). I was very active in our local chapter. At (name withheld) Medical School we had a black student organization

> that I was very active in. We as a function of that organization, we had study groups and a lot of support for students who were behind us, and likewise students ahead of us gave us pretty good support, exam preparation, and emotional support.

Some participants also discussed the importance of receiving mentorship and support from other medical school students. For example Dr. Phillip revealed:

> Truthfully, we had about 16 African American males and females in my class and we studied together. We studied together, pooled our resources and we had little study groups. And then we would get together and quiz each other brutally. I mean we would quiz each other brutally and if you got something wrong we would make fun of each other if we didn't know the answer. I mean we put a lot of pressure on ourselves that was my biggest resource.

Likewise, Dr. Patrick said, "Professionally, I had some mentors, mostly minority background physicians. But again the others who I just looked up to and who I wanted to be like.

Lastly, participants spoke about the significance of family and spirituality as sources of support. Dr. Patrick shared, "Personally, my family was huge, my church was huge, and my pastor was a good friend....During the actual process really my parents more than anything else.

Furthermore, Dr. Edward stated:

> The first thing, my biggest resource was my spirituality. I had to have a connection with some spiritual source. I am a Christian first and foremost. Prayer, God and having that connection. Number two, my family support. I am actually from (city) so I actually stayed at home or close to school. So that allowed me to come back into the environment that I am familiar with, in which I am accepted whether my failure or success.

Impact of stereotype threat in training and professional life

The emergence of four subcategories regarding the influence of stereotype threat on medical training and practice developed from this domain. Participants discussed their awareness of stereotypes. For instance, Dr. Jonathan stated:

> Tremendously, I think with any African American male or black person, just tremendously. Because you realize you are always going to be questioned, people are always going to question did get here for a quota, are you smart enough are you the best, is there someone else who can be here.

In addition, Dr. Charles articulated:

> I have always tried to counter it on how people would perceive me. I tell my kids this all the time. I've stopped them in the middle of a sentence. They may say that, they may like to drop the "TH" in sounds that they make. And I tell them you know something you guys are black males and people are expecting that you and your speech will be a certain way, that your dress will be a certain way, that you will generally be angry. And I do the same for myself. I kind of go out of my

> way to speak deliberately a little slowly, pronounce your words properly, try not to seem angry or threatening to people as the perception is that we all are.

Some participants also spoke about how feelings of inferiority would influence performance. Dr. Michael said:

> It was really hard and I think that there were times where I felt inferior because you know when you grow up they always say that white people think that they are superior and they're just smarter and actually they often had parents who have had more education who could help them......But when I was not doing well, I felt inferior. And the fact that I was feeling inferior I was not as smart as they are and I don't come from the same family that they do. I'm having a harder time then they are and I imagine that it made my performance suffer even more.

Moreover, Dr. Patrick shared:

> We kind of just didn't want to be seen as the inferior ones. We also had a group of students that were with us that got into medical school through a pipeline program which we thought made others look at us like we were weaker because we had our own blacks getting to our program without taking the traditional steps meaning they were hated. Interesting enough we almost didn't even want to work with those students, even though they were black.

Another variant response from participants was the pressure to succeed and overachieve due to the doubt of others. This was evident when Dr. Jonathan said, "So it tremendously impacts medical training, even more so residency, because you really when

you're dealing with people the first thing they're going to do because you are African American there's going to be a sense of doubt."

Dr. Samuel also disclosed:

> The other stereotype is you got the fellowship or you got the award because people in power are African American. It wasn't like I was actually a qualified candidate and that's how he got it. So it's always that perception, okay you achieved because somebody who looked like you gave you that spot, not necessarily you are talented enough to do it.

Participants typically felt pressure to work harder in order to counter stereotypes (e.g., laziness). For example, Dr. Phillip stated:

> When you're working in the emergency room, there may be two or three doctors on hand. And you are responsible for all of the patients that come into the ER (emergency room) and you may have three doctors and over the course of the day, you may have over 100 patients come. And there's always, it's always obvious that some doctors work harder than others. Some doctors pull their weight and try to take as many patients as possible in a timely fashion to get them from point A to point B and doctors slack off. And as you know, some of the main stereotypes of African Americans is that we're lazy. No one has ever accused me of that because from residency to any job I have ever had, I've always been the guy in the emergency room that's going to see more patients, that's going to work harder, that's going to not let any patients sit in the room for two hours to wait for the doctor to come see them……… Part of it's because I have a good work ethic

> because my parents have a good work ethic and part of it's because the stereotype out there exists that black people are lazy and nobody would ever accuse me of that. That's just an example of how that stereotype has really impacted me in my actual performance in the ER in terms of how productive I am in seeing them in a timely fashion getting them from point A to point B, and not letting people ever accuse me of slacking off.

While Dr. Richard disclosed:

> I know that I wasn't lazy and I've always indicated I wasn't lazy and that's how I addressed it. I don't think anyone in this day and age is bold enough to just come out and say you're lazy. So I think it's more of a covert self-accounting thing where you have to deal with that. But, I think the best way to address it is to simply work hard and do the job right.

Advice for African American male doctors

In the process of participants offering advice for future African American male doctors, four variant subcategories emerged. First, participants encouraged future African American male doctors to work hard despite barriers. Dr. Phillip said:

> So, for the medical student, go to the library for six to 10 hours at a time on the weekends, each weekend day. And for the resident, when you're on the floor and you're rounding, get there earlier in the morning two hours ahead of everyone, go around to your patients, figure out what's going on with them, read through the charts and be prepared for rounds and to impress people. Make sure you read and study whatever field you're going into. If you realize in your third year of medical

> school that you want to study internal medicine, keep the internal medical textbook out and be sure to read through it and master it.

In addition, Dr. Charles disclosed:

> It's not easy for, except a particularly super gifted person, everybody else is doing the same thing and struggling along. If they can all do it, you can. There is nothing wrong with you getting in early, still me I do the same thing. I am probably the first person to work every day. I get my day organized and I did the same thing through residency. I used to say to myself look there are a guys here who are really smart and really very good. And for some of the guys, the only way I will be able to compete is if I outwork them.

Another response regarding advice had participants discuss the importance of utilizing resources. Dr. Samuel divulged:

> And when you're there that you should seek out as much help and mentorship as possible because it's important especially for African American males because going through the system can be difficult and there are certain ways to negotiate the political ramifications in the medical world. So it helps if you have upperclassmen or African American male doctors, which are few and far in between.

While Dr. Edward revealed:

> Often times in medical school and higher education people feel alone because they are so focused and pinned to workload. They need to understand that there is

> a support network that exists and they need to be able to reach out and talk to people. And we need to all find ways to bring people through. There is a saying in my high school whatever hurts my brother hurts me.

Some participants also encouraged potential African American male medical doctors to be knowledgeable, confident, and professional. For instance, Dr. Jonathan stated:

> Most important thing I would say is knowledge overcomes anything. If you know your stuff, you are confident and know your stuff and professional that will break down all barriers.

Additionally, Dr. Richard shared:

> I think as long as you are intent on trying to become the best physician you can be and learn what you need to learn and I think you've got to work hard. I think the rest will take care of itself.

Lastly, participants advised potential African American male medical doctors to disregard stereotypes. Dr. Charles disclosed, "It's not going to be easy, but you can do it."

Furthermore, Dr. Samuel stated:

> I would tell them to do the best you can possibly do and disregard the stereotypes that are going to be placed upon you. Just let your true talents take off and that people will recognize whether black or white how talented you are.

Possible reasons for participating in research

Participants discussed possible reasons for participating in this study. Some participants volunteered for the current study because they wanted to help provide helpful information for other African Americans. Dr. Edward disclosed:

> I chose to participate because there is a need to tell my story so that we could be able to let other children who look like me, talk like me, walk like me, understand that these are opportunities available to you.

Also, participants typically partook in the current study because they wanted to help another African Americans. Dr. Phillip shared:

> I kind of had the feeling that somehow it would be helpful to someone at some point. I mean if someone is taking the time to study African Americans in medicine then I have to help someone along the way.

Experience of participating in research

Participants discussed the experience of participating in research and typically felt the interview was a positive experience. For example, Dr. Edward shared:

> It was a really good experience. I thought that [the] questions were good and open ended. I was able to get my thoughts out there.

Chapter V
DISCUSSION

The purpose of this research was to study the experiences of racial identity and stereotype threat in African American male doctors. Research has shown that African American medical doctors experience race pervading their workplace encounters, impacting interpersonal exchanges, and determining their institutional environment. (Nunez-Smith et al., 2008). Moreover, racial minorities, particularly African American medical school students, report the highest rates of oppression and more perceived stress in medical school than their white counterparts as a result of their minority status and racial discrimination experienced during their medical training. (Liebschutz et al., 2006) This chapter specifically discusses the detailed findings obtained from this study, presents general limitations of the study, and provides possible future directions for research. Next, a summary of findings will be provided, followed by general implications of the study.

Description of findings

Findings from the current study showed that participants, whose mean age was 48 years, were cognizant of perceptions of African American males. It is important to note the age of participants should be considered while discussing the impact of racial issues. In particular, participants believed African American males have been successful and made professional accomplishments despite social barriers and obstacles. In addition, they also reported having a sense of obligation and pride that came along with being African American. Moreover, participants feel pressure is assigned to African Americans to achieve while remaining resilient despite their past experiences. These findings appear

to be consistent with Franklin and Boyd-Franiklin (2000), who asserted the assumptive perspective of most individuals is manipulated by the attitudes of their racial group.

Participants also discussed the salience of race throughout their lives and the current significance it has in their work. Some participants reported race being important because it determined how a person is treated in society and gives them identity. Conversely, some participants felt that race was not important to their lives. This is an important discovery, especially since a study conducted by Shelton and Sellers (2000) found that African Americans who considered race to be a central component of their identity were more likely to attribute uncertain discriminatory experiences to race compared to African Americans who viewed race as a less central component. Additionally, participants are typically aware of race and receive daily remainders about it. However, they have an awareness of differences unique to the experience of being African American, while also focusing on thoughts of perception and acceptance as a result of their race. According to Phinney (1996), African American identity formation seems to focus on understanding and acceptance of the group in the midst of lower status and prestige in society, stereotypes, and racism.

A main area of concern for most participants was their experiences with race and racism. Some participants were aware of racial differences throughout their childhood; however, other participants acknowledged being unaware of racial differences while growing up. Other than awareness, participants reported experiencing racism during childhood, which ranged from mistreatment from teachers to being stopped by law enforcement. Moreover, participants typically encountered some form of racism (i.e., blatant, institutionalized, aversive) during medical school or residency. Although the

participants' encounters with racism were diverse, they ultimately impacted the experience of the medical training process, which illuminates the significance of race in professional education. On the other hand, some participants did not experience racism during their medical training process. Furthermore, participants typically reported not receiving unfair treatment or racism in their current job. In contrast, some participants encountered both direct and indirect forms of racism in their current positions. This seems to be congruent with Betancourt and Reid's (2007) assertion that the healthcare environment exacerbates a medical doctor's "minority" status and its supplementary difficulties. Lastly, participants discussed vivid accounts of negative interactions with law enforcement.

Each participant shed light on both obstacles and barriers to succeeding in medical school. For the most part, participants generally experienced difficulty in medical school due to the rigorous curriculum, preparation, and performance. Besides experiencing struggles as a result of their course work and clinical efforts, participants did not report encountering obstacles and barriers related to race. Although some participants experienced racism during medical school, they did not view it as a barrier toward negotiating the completion of their training. This finding appears to be inconsistent with past research conducted by Taylor and Rust (1999), who found that African American medical students encountered considerable social barriers that made them feel inaccessible. Similarly, research conducted by Garlant and colleagues (2002) found that African American medical doctors reported greater dissatisfaction than their white counterparts with their interaction with medical school faculty, administrators, and over the social environment.

Participants discussed the impact of racial socialization on their professional lives. More specifically, racial socialization had an impact on racial identity for some participants, yet other participants reported that there was no impact. As a result, some participants attempt to treat others equally due to their past experiences. They also felt networking with other African American medical doctors was important for their professional lives. In addition, the participants' past experiences contributed to their current approach of service and treatment. For example, in response to stressful effects of perceiving mistreatment or racism, African Americans may use various means of coping, which range from confrontation to treating others equally and fairly (Clark, 2004).

Participants typically found utility in a few resources for negotiating their medical training process. Some participants received support from African American medical school faculty and other African American medical students. Likewise, some participants obtained mentorship, advisement, and support from other African American medical doctors. Thus, this assertion is consistent with Green-McKenzie (2004) who contends African American medical doctors are needed to serve as mentors and role models for both current and prospective students. In addition, participants belonged to predominately Black national professional organizations, which provided support, opportunities for networking with other African American professionals, and other helpful resources. Lastly, another beneficial resource for participants was family support and spiritually.

When queried about Stereotype Threat, participants spoke about experiences that occurred during their training and professional lives. For instance, participants reported being aware of stereotypes focused to feelings of inferiority, which would affect their performance. This finding seems to be congruent with Steele and Aronson's (1995)

argument that a person can focus on the instantaneous situational threat that develops from dissemination of negative stereotypes about one's group and the threat of possibly being judged and treated stereotypically, or of possibly self-fulfilling such a stereotype. Moreover, participants felt pressure to succeed and overachieve partly due to the doubt of others. Similarly, participants typically felt pressure to work harder to counteract stereotypes (e.g., laziness).

Although participants shared information about their own personal experiences throughout the medical training process, they also provided advice for potential African American male medical doctors. Some participants advised potential African American male medical doctors to work hard despite encountering barriers while other participants suggested utilizing available resources (i.e., African American male alumni, upperclassmen, faculty, community). Additionally, participants recommended that it is important to be knowledgeable, confident, and professional while also disregarding stereotypes.

When asked about the reason for their participation in the current study, participants were typically in agreement. Furthermore, many participants participated in the study in order to give back to the Black community. Additionally, some participants wanted to provide helpful information for other African Americans, especially for those interested in pursuing a career in healthcare. Lastly, some participants wanted to assist in the research because he was African American.

Limitations

A general limitation of this study is the use of CQR), which shares similar restraints of other qualitative research. CQR utilizes a smaller participant pool (i.e., 8-12) in order to both extensively and comprehensively research understudied populations and phenomena. This study employed the use of eight participants, which limits the finding's generalizability to all African American male medical doctors. In addition to the low number of participants, this study predominantly included participants from the Northeastern region of the United States. Regardless of the aforementioned limitations, CQR was an efficacious research method for studying this population, which remains understudied.

According to Hill et al. (2005), researcher bias is unavoidable and should be extensively discussed prior to research to keep it in check. The primary research team involved in this study discussed individual biases and expectations prior to the data analysis process in order to reduce partiality. In doing so, this process was helpful and constructive while analyzing the data. The discussion included assumptions about participants experiencing issues with race throughout their lives and their medical training process, while also being cognizant of their racial identity. Conversely, research has shown qualitative research to be impacted by researchers' attributes and knowledge.

Another limitation to this study is the participants' recollection of past experiences as the primary source of data. In particular, participants were questioned about early childhood, educational, and social experiences that occurred several years prior to the interview. As a result, their current knowledge of social constructs may have

different insight and understanding Moreover, this could be less impactful of their functioning with the passage of time.

Future directions

With regard to future directions for research as a result of this study, there are several possible paths to be explored. For instance, the current study can be modified to research other phenomena (e.g., academic self-efficacy) salient to the lives of African American male medical doctors. Another direction for future research could be replacing African American male doctors for African American female medical doctors, and exploring their experiences with racial identity and stereotype throughout their training and current work. Although there is a possibility for similar experiences of African American male and female medical doctors concerning medical training and race, there is also the possibility of different encounters due to gender differences.

Summary of Results

The findings of this study uncovered information about participants' experiences with race and performance while they negotiated the medical training process. In addition, findings showed that participants encountered various forms of racism (i.e., blatant, aversive, institutionalized) throughout their lives, which has contributed to racial identity, career specialization, and patient care. Furthermore, participants displayed resiliency and were driven to overachieve despite encountering several barriers throughout the medical training process. Moreover, the findings highlight participants' sense of pride and obligation with attention to giving back to their community.

In addition, the findings also showed that participants appeared to be cognizant of race; however, it was not important to all of them. Conversely, participants were aware of racial differences during their childhood and also experienced racism at an early age. Furthermore, participants had conflicting experiences during medical school and residency with some participants encountering racism and others denying racist encounters. Participants also reported contrasting accounts of racist experiences at their current jobs.

Lastly, participants who encountered stereotype threat reported utilizing supportive resources (i.e., mentors, African American faculty, African American medical doctors, professional organizations, family, spirituality, community) in order to cope. Therefore, participants were motivated to work harder in order to oppose stereotypes. Although some participants reported that feelings of inferiority would affect their performance, they would channel this pressure to succeed and overachieve. Additionally, some participants recognized that racial socialization contributed to their identity, while others denied it.

Implications for Research and Practice

Since there continues to be a lack of research with African American medical doctors, this study can serve as a conduit for other research with this understudied group. Past research pertaining to African American medical doctors has focused on, admission and enrollment (JBHE, 2007), race (Betancourt & Reid, 2007) and residency experiences (Green-McKenzie, 2004). While scholarship in these areas remains important, it is also imperative to study the experiences of African American males who have successfully

negotiated the medical training process and are currently practicing. More importantly, this research sought to explore participants' experiences with stereotype threat, racial identity, racism, and racial socialization.

As evidenced by the findings, many of the participants encountered some form of racism or mistreatment throughout their lives. Yet, despite being oppressed, they used their past experiences as a lesson for treating others, more specifically their patients, equally.

In addition, the study also explored obstacles and barriers, beneficial resources, motivational factors, and advice for both prospective and current African American male medical students. Several themes emerged; however, the consistent barrier in medical school appeared to be the difficulty of the course load and clinical work. Thus, participants experienced hardship that was similar to other medical school students regardless of race. Conversely participants endorsed being aware of their race and receiving daily reminders, which is unique to African American males, especially since negative stereotypes are often associated with them as a group.

In order to cope with mistreatment and the hardship of medical training, participants found utility in a few helpful resources. For example, participants discussed the importance of their membership in a predominantly African American national professional organization that provided support, networking, guidance, and advisement. Another useful resource was mentorship from other African American medical doctors and faculty, whom participants sought for direction and assistance. It should be noted that participants did not mention receiving support from their medical school non-African

American faculty or staff, which raises the question: "What are medical schools doing to ensure African Americans and other students of color are receiving the support they need?" Although participants were thoroughly trained by their institutions to competently work in the medical field, there were also needs the medical school did not fulfill for the studied group. It is recommended for medical school faculty and staff to provide direction and support that addresses the social concerns of African American students.

Therefore it would be helpful for future research to expand this study in order to explore the experiences of other ethnic groups. In addition, future research can also investigate possible ways for medical school training programs to meet the needs of their African American male students and other students of color. Moreover, this research can also explore the efficacy of the aforementioned initiatives and their impact on attrition rates.

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Appendix A

Solicitation Email

Dear Potential Participant,

I am interested in examining the experiences of African American male medical doctors during the medical training process (i.e., medical school, residency) and practice. Currently, I am a doctoral student in the counseling psychology program within the Department of Professional Psychology and Family Therapy at Seton Hall. I am a Black male healthcare professional and brother of a practicing medical doctor. I am aware that your time is valuable, so I will be conducting an interview that takes approximately 60 minutes to complete.

If you are an African American male medical doctor (18 or older), who has not received medical training (i.e., medical school, residency) at a Historically Black College and University, I invite you to take part in this study. The purpose of this study is to examine the role of racial identity and stereotype threat in African American male doctors. Your participation in this study is completely voluntary. You may withdraw from the study at any time without consequence. Your confidentiality will be maintained throughout all aspects of the study. Any publication of the data from this study will in no way identify you and results will be reported in combined form only. All material will be collected in the strictest confidence. Completed responses to questionnaires will be kept in a secure location and will be accessible only to myself and my academic advisor, Dr. Lewis Schlosser. The data and transcripts will be stored and kept in a locked, secure physical setting.

Your participation provides useful information about the perceptions and experiences of African American male medical doctors regarding the negotiation of issues related to race and academic/occupational success. In addition, this study may also be useful to increase your self-awareness and further research.

To participate in this study, reply to this email with your name, number, and the best time for you to be contacted. Participants may only complete the study one time in one of two stated modes: in person or over the phone.

This project has been reviewed and approved by the Seton Hall Institutional Review Board (IRB) for Human Subjects Research. Questions about the research subject's rights should be directed to the Director of the IRB at Seton Hall University, Mary F. Ruzicka, Ph.D. at (973) 313-6314. Questions about the study can be directed to me, Christopher

Beaumont, Christopher.beaumont@shu.edu, or my faculty advisor, Dr. Lewis Schlosser, lewis.schlosser@shu.edu.

Sincerely,

Christopher G. Beaumont, M.A.

Tel: (973) 761-9000 ext. 5191

Email: christopher.beaumont@student.shu.edu

Appendix B

Informed Consent to Participate in Research

1. Researchers' Affiliation

Christopher G. Beaumont, M.A., the primary researcher, is affiliated with the Department of Professional Psychology and Family Therapy in Seton Hall University's College of Education and Human Services.

2. Purpose and Duration of Study

The purpose of this study is to explore the experiences of Racial Identity and Stereotype Threat among African American medical doctors. There is very little research on African American male physicians, which makes this study relevant in several areas (i.e., medical training programs, and the social constructs of racial identity and stereotype threat). Additionally, this study will also serve as a contribution towards research in this area since there continues to be a lack of diversity and discriminatory treatment of minorities in the field of medicine.

3. Procedures

It will take approximately 60 minutes to participate in the study. Individuals who choose to participate in this study, should sign both copies of the *Informed Consent* and keep one for their own records. The other *Informed Consent* and completed *Demographic Sheet* should be returned in the self-addressed stamped envelope provided. Once the researcher receives these forms and confirms participant's eligibility, he will be contacted via telephone to schedule an interview. The interview consists of participants answering open-ended questions pertaining to their thoughts, feelings, experiences, and recommendations as an African American male medical doctor negotiating the medical training process and current practice. Once all the data is collected, participants will receive a copy of the results by mail for review to ensure that their thoughts and experiences were described accurately.

4. Questionnaires or Survey Instruments

The *Demographic Sheet* is the only questionnaire in this study. On it, participants are asked to provide demographic information, including their age, medical school attended, residency program, number of years practicing medicine, specialization, and current place of employment. There will be 12 questions pertaining to medical training, current practice, racial identity, and stereotype threat. Two examples of questions that will be asked during the interview are: "What barriers did you have to overcome during your medical and/or residency training?", and "How has your own racial identity

impacted your medical school and residency training?".

5. Voluntary Nature of Participation

Participation in this study is voluntary. If at any time a participant would like to withdraw from this study, he is free to do so without any penalty. The participant can end the interview and participation at any time by telling the researcher he wants to end the conversation. Should a participant decide to withdraw from this study, all material related to their participation in the study will be destroyed.

6. Anonymity

Due to the need of phone contact, the researcher will be aware of participants' identity. However, this information will be kept confidential as discussed below.

7. Confidentiality of Data

Confidentiality will be maintained by assigning code numbers to the tapes, transcripts, and demographic sheets. All tapes will be destroyed after they have been transcribed. Transcripts will use code numbers, so participants' identity will not be connected with their responses after the tapes have been transcribed. Summaries of participants' interviews that may be cited in publications related to this research project will use a pseudonym. All data will be secured in a locked cabinet maintained at Seton Hall University by Dr. Lewis Schlosser, my graduate advisor.

8. Access to Research Records

No one other than the primary investigator, Christopher Beaumont, his faculty advisor, Dr. Lewis Schlosser, and the other two members of the research team will have access to the data received from the participants. All data identifying participants by name or location will be destroyed when this study concludes.

9. Anticipated Risks

It is not expected that participation in this study will involve significant risk or discomfort. However, if participants' experience any discomfort from the questions asked, they may want to consult a mental health professional. Referrals are listed below in the section entitled, *Procedures to Follow in Case of Distress.*

10. Anticipated Benefits

By participating in this study, participants will have the opportunity to share their personal experiences in a safe environment. This study will also provide participants with indirect benefits by increasing the knowledge about African American male medical doctors and how they negotiated the medical training process. In addition, participation in

this study will have a direct impact on the mental health profession by providing professionals with insights into the best possible ways to understand African American male medical doctors.

11. Compensation

Participants will not receive any type of compensation for their involvement in this study.

12. Procedures to Follow in Case of Distress

Participants should not experience any risk or discomfort when completing this study. However, if participants experience significant distress, they are encouraged to discuss these feelings with a counselor or another health professional. Attached is list of possible referrals in the area.

13. Alternative Procedures

This study does not involve any clinical treatment; therefore, there are no relevant alternative procedures.

14. Whom to Contact for Additional Information

If participants have additional questions regarding this research study, they may contact the following individuals:

Christopher G. Beaumont, M.A.

Doctoral Student

PPFT Department

Seton Hall University

400 South Orange Avenue

South Orange, NJ 07079

(201) 207-8395

Lewis Z. Schlosser, Ph.D., ABPP

Associate Professor, Advisor

PPFT Department

Seton Hall University

400 South Orange Avenue

South Orange, NJ 07079

(973) 275-2503

Mary F. Ruzicka, Ph.D.

Director, Office of the Institutional Review Board

Presidents Hall

Seton Hall University

400 South Orange Avenue

South Orange, NJ 07079

(973) 313-6314

By signing the *Informed Consent Form*, participants give the researcher permission to audio-tape their interview for the purpose of this study.

_____________________________ _____________________

Subject Date

List of Referrals

- Eileen A Kohutis, Ph.D.

  2 W Northfield Road, Suite 209
  Livingston, New Jersey 07039
  (973) 310-2087

- Deirdre A. Kramer, Ph.D.
  320 Raritan Avenue, Suite 303B
  Highland Park, New Jersey 08904
  (908) 229-2549

- Gianine Rosenblum, Ph.D
  Center for Family Resources
  323 Main Street
  Metuchen, New Jersey 08840
  (732) 548-8143

- Rodger Goddard, Ph.D.
  Success Skills, LLC
  South Orange, New Jersey 07079
  (973) 862-4868

- Maria Masciandaro, PsyD
  890 Wyoming Ave
  Elizabeth, New Jersey 07208
  (908) 351-2892

- Maureen J Gallaghe, Ph.D.
  103 Park Street, 3rd Floor
  Montclair, New Jersey 07042
  (973) 310-2093

- Lauraine Hollye, Ph.D.
  185 Broad Street
  Bloomfield, New Jersey 07003
  (973) 968-5419

- Elizabeth M. Gagnon, Ph.D.
  294 Washington Street
  Boston, Massachusetts 02108
  (617) 451-0055

- Rachel Redlener, Ph.D.
  Commonwealth Psychology Associates
  185 Devonshire Street, Suite 803
  Boston, Massachusetts 02110
  (617) 259-1895

- Jenai Wu, Ph.D.
  5 Longfellow Place
  Boston, Massachusetts 02114
  (617) 262-1423

Appendix C

Demographic Information

1. **Your age:**______________________________

2. **Number of years practicing medicine:**______________________

3. **Medical school you attended:**______________________

4. **Residency program you attended:**______________________

5. **Your current place of employment:** ______________________

6. **Your area of specialization:**______________________

Appendix D

Interview Protocol

1. Please describe your current medical practice.
2. What does being an African American male mean to you?
3. Please describe the salience of race in your life.
4. Please describe your experiences with race and racism growing up.
5. Please talk about your experiences with race and racism during your medical school and/or residency training.
6. What barriers did you have to overcome during your medical school and/or residency training?
7. What resources did you utilize to negotiate the medical training process
    a. Probe: Mentors, community supporters, professional organizations
8. Please talk about your experiences with race and racism at your current place/s of work.
9. Racial identity is defined as the "socialization of group specific development in particular sociopolitical contexts." How has your own racial identity impacted your medical school or residency training process?
10. Stereotype threat is defined as "self-assessed stress associated with confirming a negative stereotype about one's group as a conceivable self-characterization that may be viewed by others." Discuss your experiences with stereotype threat throughout your medical school and residency.
11. What advice would you give African American males who are currently in medical school or their residency?
12. Why did you choose to participate in this study?

13. How was your experience during this interview?

Appendix E

Table 1.

Domain/Category	*Frequency/ # of Cases*
1. Perception of African American male identity	
a. Professional accomplishments.	Variant/ 3
b. Sense of obligation and pride	Variant/ 3
c. Pressure to achieve	Variant/ 3
2. Salience of race in life	
a. Race is important	Typical/ 5
b. Race is not important	Variant/ 3
c. Awareness of race	Variant/ 4
d. Unique differences	Variant/ 2
e. Perception and acceptance	Variant/ 4
3. Experiences with race and racism	
a. Awareness of differences	Variant/ 2
b. Experienced racism	Typical/ 5
c. Racism in medical school	Typical/ 5
d. Didn't experience racism in medical school	Variant/ 4
e. No unfair treatment at current job	Typical/ 5
f. Racism at current job	Typical/ 6
g. Negative encounters with law enforcement	Variant/ 3
4. Obstacles and barriers to success in medical profession	
a. Difficulty in medical school	Variant/ 3
5. Impact of racial socialization on professional life	
a. Socialization didn't impact identity	Variant/ 3
b. Socialization has impacted identity	Variant/ 2
c. Treats others equally	Variant/ 3
d. Past experiences impact approach	Variant/ 2
e. Networking	Variant/ 2
6. Resources used for negotiating medical training	
a. Support from faculty	Variant/ 2
b. Professional organization	Variant/ 3
c. Mentorship	Variant/ 4

d. Family and spirituality	Variant/ 2
7. Impact of stereotype threat in training and professional life	
a. Aware of stereotypes	Variant/ 4
b. Feelings of inferiority	Variant/ 2
c. Pressure to succeed	Variant/ 2
d. Pressure to counter stereotypes	Typical/ 6
8. Advice for African American male doctors	
a. Work hard	Variant/ 2
b. Utilize resources	Variant/ 3
c. Be confident, knowledgeable, and professional	Variant/ 3
d. Disregard stereotypes	Variant/ 2
9. Possible reasons for participating in research	
a. Helpful information	Variant/ 3
b. Give back to community	Typical/ 6
10. Experience of participating in research	
a. Positive experience	Typical/ 6