# “LEARNING FROM STORIES OF EXPERIENCE: USING NARRATIVE AS PEDAGOGY TO UNDERSTAND RACIAL AND ETHNIC EXPERIENCES IN MEDICINE”

By

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ABSTRACT

"LEARNING FROM STORIES OF EXPERIENCE:
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"*Learning Through Stories of Experience"* is about using first-person experiences, stories, or narratives as a pedagogical strategy from Writing Studies to teach cultural competence in the field of Medicine. The dissertation is a descriptive account of a reflective writing seminar experience, teaching future practitioners about cultural competence. My work, the focus of this study is a beginning of "how", a pedagogical approach, can work to teach future practitioners about developing cultural competence. More specifically, I think my work helps address Medicine's call to bring practitioners to self-awareness and acknowledgment of personal biases that may impede their practice of medicine with cultural competence.

The seminar described in this study starts with critically thinking, reflecting, and writing about ones personal knowledge about racial and ethnic experiences in medicine. At the same time, these future physicians are asked to critically examine the racialized past of medicine, the Jim Crow Era of medical culture and practice and the longstanding public mistrust of Medicine particularly by vulnerable people. During the seminar talked about herein, we read through the New York Times best-selling novel – *The Immortal Life of Henrietta Lacks*, written by Rebecca Skloot. Through Henrietta's reconstructed narrative, a historical and biographical account of the racialized past of medicine unfolds. Skloot's story leads us to the pieces through Henrietta's experiences that shape the practice of medicine today in what's known as human research subject

privacy and consent as well as patient privacy and consent. The book for the seminar, the "what" of this project, provided a starting point, a place for students in, happening in literature now. Where the stories – mine, the students, and even Henrietta's connect, is where the work of self-awareness, and acknowledgement of personal biases starts. It's the first opening to making cultural competence a reality. This connection of stories is captured here, re-told from dialogical notes, personal interviews, or from reflective writing pieces from the students and me.

Racial and ethnic minorities, women, children, prisoners, the poor, the uneducated – were all vulnerable people– and at one time, were most likely participants—albeit unknowingly—in medical experimentation. Some of the most notorious examples of experimentation include The Tuskegee Experiment, the 40-year government sponsored syphilis study that left the poor, illiterate black male prisoners enrolled in the study untreated for the disease. It's stories like this that remind students that there was a time when even the gold-standard of medical practice took advantage of those it deemed "less than" in society.

Writing Studies for some time has used the narrative or personal biography to be critical of the larger culture and practices at work. Using the personal to interrogate the public is something Writing Studies contributes to Medicine through this study. This dissertation shares the narratives—the stories, theories, and experiences of future practitioners as well as myself. Writing Studies gives a theoretical and methodological place for stories, narratives, and personal experiences to stand in Medicine, specifically in the medical humanities. I establish through this study that the work of teaching cultural competence through reflective writing with a pedagogical approach rooted in storytelling or narrative is a viable option for medical education.

Dedicated in memoriam to my parents, Alphonso and Mary,
who instilled the value of higher education and hard work in me:
I'm thankful for their audacity to teach me to believe in and pursue my dreams;
for their love and support and
for faith.
I am not sure what the future holds, but I know Who holds it.
I only wish you could have been here in person for this last hurrah…
Love always,
Your only daughter

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**Thank you God…**this chapter in my life is FINISHED.

#TheGradlife has come to an end and #TheProfLife begins.

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TABLE OF CONTENTS

## Chapter 1:

## An Introduction

### *A* Beginning: Privileging Narrative and Teacher's Personal Practical Knowledge

***"The study of narrative, therefore is the study of the ways humans experience the world,"***

*– "Stories of Experience and Narrative Inquiry"*

*F. Michael Connelly and Jean Clandinin (2).*

Storytelling as a pedagogical strategy to teaching cultural competence in the field of medicine is cause for interdisciplinary conversation.

***A Story…A Researcher's Thoughts***

*It's never easy to move beyond what we may know to something we know for sure is tenuous like race relations in the U.S. Not even medicine has been spared the "Scarlet R" of racism. It's presumed that people in medicine are bias-free, that being altruistic is synonymous with being free of bias. There are pervasive thoughts that someone who pursues medicine is altruistic in nature, selfless by dedication and unbiased. That may be why some can't conceive of medicine using people for experiments or using science to support race-based inferiority.*

*I'm always struck by the call for cultural competence from medicine. The call to challenge the attitudes, and knowledge about something so personal as race and ethnicity and identity is an ambitious but necessary call. That type of work begins with the self and in my mind requires a great deal of introspection, honesty and*

*commitment to actually putting cultural competence in practice. A convened panel of experts from the field of medicine and public health, recommended that practitioners must start by "embracing their own cultural diversity and differences" ("Expert Panel" 3).*

*When I've had the privilege of being in the midst of practitioners, privy to conversations about cultural competence, I've paid attention to the way the group attended to issues of race, diversity, or—whatever the host calls it—the responses were varied. Whenever there is a task of counting people for example, required by the federal government, the conversation gets interesting. As different ones were speaking about counting this and that person or group they said things like, "Well isn't so-and-so Black?" followed by "No, I think she's Hispanic, she looks like she could be." As the comments go back and forth there's usually a brave person who'll finally say, "Aren't we assuming what people are based on how they look?" This comment usually brought any gathering of "counting" conversations to a halt.*

*The categories of race and ethnicity in this country are undoubtedly confusing. Students self-identify their race and ethnicity for the application process for medical school. The questions over the years of how to self-identify has changed. Now all race and ethnicity questions are combined in one category, allowing students to "select all that apply" Amongst the categories to select: are you Hispanic/Latino? Or Are you non-Hispanic/Latino race? Or are you Black or African American, are you American Indian or Alaska Native? I'm always confused when a kid from Bangladesh checks the box of race being "White". I've wondered if this self-identity is something that the student actually identifies with or is this "white box" checking because the proper race/ethnicity category is not available?*

I see the efforts by the field of medicine as being just ahead of the reality that faculty, staff, who teach medical students have work to do on their own efforts to identify let alone embrace their cultural diversity. And yet, the imperative for cultural competence is a high stakes imperative from This all leads me to the reason for my work. I believe we may need to work on both ends of the spectrum – with current practitioners and with incoming medical school students.

My work, the focus of this study later explained more fully, is a beginning of "how" to work with future practitioners toward developing cultural competence. More specifically, I think my work allows medicine to hear from the voices of future practitioners particularly this group who self-identified as disadvantaged. Hopefully through this work, the experiences and the stories shared here will make a difference and give voice to those coming into medicine.

These stories give us proof that students are not blank slates and in fact know and have experienced a number of incidents I'd say were significant and life-changing for them. I can recall a student saying once she wanted to be a doctor because she'd treat patients without insurance especially for cancer. She'd shared in class that if her mother had had insurance, her recovery from cancer may not have devastated her family financially. This has to do with cultural competence in that access to quality, affordable health care is not something everyone has access to. Still.

My study contributes to the scholarship in the field of medicine about identity, cultural competence, and using writing and storytelling in Medicine, borrowing from Writing Studies. Through this study the future practitioners enter the conversation with authority to "talk back" to current practitioners about their experiences with race and ethnicity in medicine. Through reflective writing exercises, and storytelling, a dialogical

approach to learning about racial and ethnic experiences in medicine can be created and beneficial for a learning community. Students offer critical introspection of those experiences and being through class to map those experiences to the larger systemic and institutional practices in medicine that impact the ability of future physicians to practice medicine with cultural competence.

***A Story…A Researcher's Experience…January 2009***

*After working in admissions for a medical school for a little while, I started to think of other ways I could contribute on both sides – to the recruitment of future physicians and to the teaching of current medical school students. The first time I taught the selective, "Medicine, Minorities, and Culture", I went in to the small group discussion room of second-year students with what I knew from the perspective of medicine to recruit a diverse workforce prepared to practice with cultural competence. I'd inherited the course from another preceptor. At the time, I had no way of knowing my trainer and mentor for this selective would later become a colleague in my graduate school's home department. There it is again, a sign. Stuff like this kept happening to bring me back to believing I was on the right track in life and in my research. Stories mattered.*

*One time in class, I remember showing the episode, "The Check Up" of the popular 70s sitcom Good Times when the television family, The Evans, were trying to figure out what was wrong with the patriarch, James. The clip is perfect to talk about representation and narrativizing awareness and activism in popular culture this way. Talking about James' high blood pressure opened the conversation up for the family to talk about the relationship to their father's high blood pressure and their housing conditions, his money and job instability—the larger social and culturally situated*

*issues become visible. This is an example of the health consciousness that Black sitcoms of the era. This type of tradition by Black sitcoms continues into the 80s with shows like Different World, their health issue current with the times spread information about HIV/AIDS including the truth about how it is transmitted and prevention. Television shows like this are examples, starting points for conversations in pop culture about health.*

*When the students heard a statistic from the Good Times clip about the health indices for Blacks and high blood pressure in this 70s show, there was a moment when the students point out that the indices for high blood pressure and related heart or renal failure issues are STILL dismal for Blacks in the 2000s, decades later.*

*I came to my first time teaching in the medical school with the stories from my childhood; the memories of a terminally ill mother who succumbed to Sarcoidosis when I was in undergrad. Her disease had come out of remission. I remember telling my students that the possibility of being motherless was not a reality I had until about the 10th grade when the Sarcoidosis became active again, suddenly and violently. My mother would cough so hard that she'd pass out, losing oxygen. I remember telling them this because I wanted them to know even though I wasn't a doctor, I'd had experiences with illness as the daughter of a patient facing a terminal illness. I told them that story to also remind them that their diagnosis and treatment options should be as multi-faceted as the patients who host the illness. When a mother who takes care of her family full-time is terminally ill, the role of everyone shifts in the household. That's a lot for a kid to deal with.*

*Teaching the medical school course for the first time using narratives was something I was already naturally inclined to do. Stories and narratives was all I*

*knew staring with my work as a journalist-turned composition teacher. I've referred to myself as the writer in medicine who does story work.*

My experiences as a journalist-turned-composition-teacher have given me places to stand in the two fields that inform and benefit from my work: writing studies and medicine. My work makes tangible through stories the awareness of all participants – including me -- as we begin to make sense of our storied lived experiences with race and ethnicity in medicine.

Writing Studies in 2001, published a Symposium Collective of scholars from the field, bringing their work together as a "multi-vocal conversation in a written form" ("Symposium Collective" 41) about the personal and the politics of it in scholarship. The authors in this Collective debate about the politics of the personal presenting several questions like should we or how much should we scholars/researchers put of "ourselves"—into the public or published learning community? "As more of us are beginning to bring the personal into theory, research, teaching and scholarship, we think it is important to reflect on the politics of such efforts," (42). Writing Studies during the 90s theorized about the personal and it's place in teaching and in writing, the use of narrative, and story telling as pedagogy. The scholarship of the Collective is one of the current conversations in Writing Studies germane to this study.

My understanding of the personal and the political through this Collective reading, is that these two voices – the public and the private voice -- are available to researchers to interrogate as well as disseminate their ways of knowing. The personal and the knowing that comes from sharing the personal for me is paramount to what I do. Rhetoric and Composition Scholar Jacqueline Jones Royster says that stories, those

experiences we share are actually, "vital layers of transformative knowledge," ("When the First Voice You Hear" 35).

I've experienced the powerful work of stories on more than a few occasions in my life.

**Personal Practical Knowledge: Experiences of the Journalist-turned-Composition Teacher in Using Stories**

***"[Personal practical Knowledge is] Knowledge which is experiential, embodied, and reconstructed out of the narratives of a teacher's life…"***

*-- " Teachers' Personal Knowledge:*

*What Counts as 'personal' in studies of the Personal"*

*D. Jean Clandinin and F. Michael Connelly (490).*

The case studies as well as my own story throughout speak to an authority, an agency, to enter into the conversation about cultural competence in medicine. Whether practitioner, or intending practitioner, or patient – the public and the private is question is relevant. The personal and political of doing story work is further complicated when story work is used to interrogate the racial and ethnic experiences in medicine. The responses over the years since I've been using this pedagogical strategy has yielded what I believe are fruitful conversations about cultural competence and the knowledge, attitudes, and skills of future physicians. I've been privy to hear students articulate the experiences they already have in medicine concerning race and ethnicity. Their stories offer some insight into their own self-awareness, bias, and attitudes that may impede them from practicing medicine with cultural competence. Their stories also speak to the

challenging and long road ahead of actually changing a profession's rhetorical and cultural practices to achieve health equity for all citizens.

My study offers the fields of Writing Studies and Medicine a theoretical discourse around cultural competence. Story-work as I call it, takes work. I've looked for a body of scholarship written by physicians about their own racial and ethnic experiences. I came across several physician-writer-researchers like Sanyatani DasGupta, from the Narrative Medicine program out of Columbia University and Vanessa Northington Gamble from George Washington University. I explain later in this study how I came to DasGupta's work, but I came across Gamble's work the first time I taught the "Medicine, Minorities, and Culture" class.

***A Story…A Researcher's Reflection***

*The moment I read "Subcutaneous Scars" I thought to myself, "I know what that feels like." I was moved by Gamble's resolve to not be dismissed. "Just because you haven't heard the stories does not deny their existence" (166).*

*These physician-writer-researchers are allies to the work I do. Gamble's historical work helps document the racialized past of medicine. Her archival research providing proof of the separate but equal doctoring during the Jim Crow Era. I see her archival research as a way to let the texts and documents speak for themselves. Her work on agency has me rethinking some things…*

When I first created the idea of having a seminar that utilized stories as pedagogy, I was just basing this off of my experiences as a journalist. You tell stories, it evokes a response in the story-hearer.

The "Stories and Writing" seminar provided a platform for students to share their experiences thus far with race and ethnicity in medicine. We used these stories often

times in discussion as a way to point to and to point one another back to those touchstones of relating — when students start to "me too" or "I know what you're talking about"' witnessing. Royster says it this way, sometimes there is a "substantive" version of that knowledge already exists…or has already been constructed…already have meanings assigned" ("When the First Voice" 30).

**A Story…Fall 1990-1991.**

*I worked in the newsroom as a young writer, a teenager in high school by morning, a journalist-in-training by afternoon. I started with the tasks of data entry like entering the TV guide, the community journal, birth and death notices, and other data or clerical tasks for my hometown's newspaper. I took my tasks seriously as a high-school intern, eventually entrusted to cover general news, mostly features. I also had the opportunity to have a news column about growing up as an only-child, "over-loved" by her parents.*

*The news column was something of a fluke, a chance truth be told, to get some of my teenage frustrations out. My mother's Sarcoidosis was out of remission, and my father's mobility was declining; a lifetime of being an athlete was calling for a hip-replacement. And there I was, 17, a senior, wanting to go away to college although I'd never lived alone or away from my parents.*

*I'd lived in our small town with my parents until leaving for college. I grew up within walking or short driving distances from my maternal and paternal grandparents, aunts, uncles, first cousins, great aunts and uncles, even some of my grandparents' first and second cousins – all within minutes --and yet, I thought I'd go to college somewhere in the south or on the east coast. Or, I'd try my best to get an internship at the LA Times on the west coast. I was determined to move away from my*

*small town; a daring task for anyone, especially an only-child.*

*I thought the experience of getting out my teenaged frustrations on paper was a one-time thing, a quick spot, a short story to put out there on a slow news day. Instead the column I wrote to vent became a twice-monthly run, driven largely because of reader response. The first time the news column ran, I'd wrote about growing up and needing my parents to give me some space to do that, trusting they'd prepared me for adulthood.*

*My beginnings as a writer for the newspaper are my first experiences with the power of storytelling, narrative, and the first-person voice. In sharing my story with the community then as a teenager, I understood the interest in experiences and the stories of others. And I also understood the responsibility of being the caretaker and "re-teller" of other people's experiences. I have to admit, I was always surprised—pleasantly so—whenever someone wrote back or spoke back about something I wrote. The responses ranged usually from folks just saying they were enjoying the column, to of course, people sharing stories of their own. And occasionally, I'd receive a request to cover or write about a topic for the column, based on one of their stories.*

*I received a letter once from a lady who'd read the first column. I don't remember the exact words now, from some 23 years ago, but I do remember the gist of her letter was encouraging me to see it [growing up] from a mother's point of view – we mother's trust you, it's the rest of the world we're worried about and our "babies" being out there in it. Certainly, this was the crux of the issue as far as my parents were concerned. My father especially worried about the world and me being in it. His career as a corrections officer for the then-largest walled prison in the world influenced nearly every decision he made. He'd guarded men who'd done unspeakable*

*things like murder; some of them serving life or a few life sentences. His view of the world wrote the narrative of growing up was a scary thing to do.*

*My mommy was a stay at home mother. Even though she had Sarcoidosis, she led what I would consider an active life. I never knew her to work or have a formal job since I was born, but she was a wonderful volunteer, church leader, and entrepreneur during my lifetime. My mother was known in our small town for being a Jill-of-all-trades; she catered small dinners and large parties; baked and decorated elaborate wedding cakes; sewed (pants or slacks to wedding dresses); she made flower arrangements and centerpieces and her favorite, she babysat children. Issues of fertility and her battle with Sarcoidosis stopped my parents from having more children. But with all the family in the immediate area, younger cousins and such, my mother routinely took care of someone else's child, most of my life.*

*The best responses from readers though were the ones that challenged me, offered a story a different perspective for me to consider. My experiences with being a writer who's received meaningful responses from readers was the first proof I'd had toward knowing narratives matter.*

*Medical education responded to the need for cultural competency training by creating a space or spaces within the curriculum for this training. Usually these spaces were in the department or units of ethics, or medical humanities.*

The one discipline-friendly place for me as a journalist-turned-composition teacher to stand in medicine is in the medical humanities. It's through my experiences with stories, hearing and receiving them as a journalist that I approached my work in medical humanities. I'd carried the belief that stories and narratives, which I use interchangeably to mean those first-person accounts of experience, do matter. These

experiences led me to create a reflective writing course that made use of the personal knowledge we both had – the students as well.

I use the artifactual critical literacies work of Kate Pahl and Jennifer Roswell to further substantiate what emerges from stories told with objects. The authors write, "Memories of objects are powerful pulls on identity," ("Artifactual Critical Literacies" 1).

***A Story…A Researcher's Reflection…1970s-Early Childhood***

*Hissssssssss-T!!! Hissssssssss-T!!!*

*I guess that's how I would spell it phonetically. This sound describes the big box in the corner of my parents' bedroom that was giving my mother oxygen. I remember that machine because it had a lot of colorful knobs and buttons. It was big and loud like the humidifier at my Granny's house. I can't remember being told exactly what the machine was, but someone must have told me to not touch it. And I didn't. I remember being careful to not step on the hose that wound all through the house so my mother would not be confined to her bedroom.*

*I must have been like five, ready to go to kindergarten. I knew how to dial 911, I knew my address and phone number as well as my Granny's who lived at that time just seven or so blocks away; a 20-30 minute walk in my small town at the least. I knew the real and full names of my parents and my grandparents. When I told this story to my class for the first time, a student asked me did she think my mother taught me those things because she was sick. I hadn't thought about it before then, but I guess one can certainly see it that way. In fact, I have a childhood friend who also had a sick mother growing up, we both talk about how normal we thought it was to handle medication as a kid. As I grew older but still as young as 8 or 9 years old, I could recognize and pronounce my mother's medication and I could make small piles with*

*the right combinations of kind and dosages. I recall a family friend being over once and her remarking that I'd given my mother her medicine like a grown nurse, not a kid. That was normal to me; doctors appointments, machines, medicines, coughing and fighting Sarcoidosis.*

*Early on in teaching at medical school, I told my students about my maternal grandparents being from Neshoba County in Mississippi. The county is known in infamy as the hotbed of the civil rights movement. I told my students about the red clay and how the little town in Neshoba County is also the site of my beliefs and practices when interacting with the medical system, influenced by the family maternal matriarch, my Granny.*

*My Granny grew up in the segregated south, like Henrietta, in the Jim Crow Era. As a kid growing up, my Granny was the first authority regarding any illness I had or my mother suspected. My grandmother had a bunch of home-based potions to "diagnose" ailments as well as remedies. For example, if a swallow or swig of Kayro syrup tasted sour or "ruined" instead of sweet, that was the mumps or measles, something in the glands, per my grandmother.*

*My grandmother's growing up in segregation included her medical experiences. My grandmother talked about being able to be seen by a doctor who saw "colored" folks was a privilege. I shared the story with my students about my grandmother's belief that wearing new underwear to the doctor was an indication of cleanliness and could be viewed as the good "Christian" thing to do. Poor, dirty, colored folks would NOT be seen by a white doctor should the privilege to see the doctor be granted. When I've shared this strange family custom, I have been greeted back by the stories from students similarly, that interacting with the health system required a certain*

*performance of "cleanliness" to be accepted and seen as human in the medical system. The cleanliness thing was also something my grandmother engrained in my mother and her in me about visiting the doctor's office because the examinations of colored folks was done behind glass, like Skloot writes about in "The Immortal Life". The up close and personal privilege of being seen and touched by a doctor willing to see "colored" patients was something of good fortune in those time. The health care of blacks like my grandmother and Henrietta in the south was at the benevolence of charitable hospitals like Johns Hopkins. I'd heard from my grandmother that getting sick in Mississippi back then was a death sentence. She didn't call them "night doctors" like Skloot did in her book specifically, but my grandmother cautioned that "they'd snatch you". Mostly my grandmother was worried about being in the category of "they won't take you" when it came to seeing the doctor*

*When Sarcoidosis was first mentioned and associated with my mother, very little was known then about the disease. I am told by a family member who helped reconstruct my mother's story of diagnosis for me for this study, that my mother was basically sick for a while and doctors thought it was bronchitis, then an upper respiratory infection. She'd told this family member that something wasn't right and that she felt like her doctors weren't asking enough questions – like why she had developed a persistent, violent cough and shortness of breath? Or, why she'd lost nearly 100 pounds in months? Or, why the treatments for bronchitis or whatever was not working?*

*The family member interviewed for this project recalled my mother being persistent that something was wrong. My mother challenged the authority of the doctor and insisted he run more tests. Eventually the diagnosis of Sarcoidosis was*

*finalized. Ironically when a cousin, my mother's first cousin was also diagnosed and subsequently succumbed to Sarcoidosis, my grandmother wondered if there was a link between the two cousins—was it genetic or something they'd "caught" from Mississippi? The distrust or notion of Sarcoidosis of being something conspiratory wasn't far-fetched in my grandmother's mind. I don't believe my mother "caught" Sarcoidosis from anything per se. I do believe as she'd told me once before that she may have been exposed to something when she was working in the shop. The shop, my relative told me was a factory that serviced the auto industry- my mother worked there before I was born, during the early years of her and my father's marriage.*

When I read the "The Immortal Life" for the first time, the experiences from my family were present. My experiences with Sarcoidosis when reading the text provided me a space to know or create empathy for those who suffer like Henrietta with illness and have been mistreated by members of the medical profession. When I read the first page entitled "Deborah's Voice", I had to put the book down. I couldn't deal with the grief of this daughter longing to know who her mother was. That loss was too familiar. I related to Deborah's pain in a particular way and I wasn't alone. One of the students wrote she identified with Deborah's pain from being abused and not being able to stop it. Her sharing this brought about a resolve to work on the lingering pain so doctoring a patient who may have similar experiences will be easier and a less-biased experience.

The atrocities committed on the Black Diaspora in particular by the medical system have been linked to not only Henrietta's story but to others, like the infamous Tuskegee Syphilis Experience, noted in Skloot's work. I'm reminded of the time when a student said in class, "I know segregation existed, but why do I feel like I didn't know this about medicine?" The student went on to say she felt like medicine kept its racism

hidden. I argue that medicine didn't have to keep its practices hidden per se, the laws at the time Henrietta was being treated, during 1951, didn't protect human subjects in the medical system from anything. The system them sought permission to act with authority and power in all matters of diagnosis and treatment. In fact, the Nuremberg Code was passed in 1947, resulting after the Nazi doctors were found guilty of conducting experiments on prisoners during World War II. It wasn't until 1966 that the National Institutes of Health required the approval of an Institutional Review Board to approve all research experiments using human subjects. In 1974, the Federal Policy for the Protection of Human Subjects was passed and patients were required to provide their "informed consent" to be involved in research.

**The "Western Code" of Medicine's racialized past: Why this Matters to teaching Cultural Competence**

I shared the stories above as a way to establish the knowing from my embodied experiences from my life that lead me to create the course and specifically to start using storytelling as pedagogy.

The examples in the next section provide a look at the identity work mentioned earlier like Rowsell and Pahl mean it. The call to train physicians to access their own knowledge, belief and attitudes about race is a surmountable task that can be accessed by using storytelling as pedagogy and by them doing what I call their identity work. As a matter of achieving cultural competence, improving health outcomes for medically underserved or marginalized folks, and increasing a diverse workforce. During the "Stories and Writing" seminar students share their experiences with illness in general as well as with race and ethnicity in medicine. Some may consider the work of training culturally competent physicians as a sort of activism. The activism is the goal to

eliminate health disparities and increase health outcomes in the most needy of communities populations and people. The focus to create a system of medical practice that embraces and communicates with all citizenry drives the goal of reaching cultural competence.

In his essay "Ethical Encounters at the Intersection of Education and Activism" Geoffrey W. Bateman leads the discussion about human rights depending quoting historian Lynn Hunt. He writes that human rights depended "in part on certain cultural practices…origins in the 18th century. "new kinds of reading (and viewing and listening) created new and individual experiences (empathy), which in turn made possible new social and political concepts (human rights)" (61). I think the connections to reading, viewing and listening to ensure human rights is a strong one. I found that when students shared their stories in the "Stories and Writing" seminar, this certainly was the case – students giving voice to what happened to them is a powerful reminder that their colleagues in medicine are not exempt from unequal treatment.

In his essay, Bateman asks the question what happens when we situate ourselves ethically at the intersection of education and activism? According to him, when describing his project with women who'd experienced homelessness, women who write are provided a "means to think of themselves differently and use such difference as a tool to challenge such denial [of human rights]" (65). The denial of human rights in *The Immortal Life* is the crux or at least one of the important crux's in the book. Henrietta's denial of basic human rights throughout the book are points student often explore in the novel. From the consent form to Henrietta's cells being used to make a profit while her own children can't afford health care – students always react to the loss of or lack of acknowledgement of Henrietta's human rights.

When students from the "Stories and Writing" seminar were asked to write about who they were, self-identify racially and ethnically and share their experiences in medicine, they wrote about time they felt marginalized or misunderstood by medicine. Most of these post-baccalaureate students told stories of becoming a doctor to fulfill some greater call and sense of duty to the communities they racially or ethnically identify.

The work of Bateman suggests that writing is a way to re-imagine the self, to reset one's identity, my translation, to re-imagine what human rights is as the individual level. In the case of my work, Bateman is relevant in the use of writing to establish, examine, re-imagine or reposition ones identity. In teaching 21st century physicians about cultural competence, their new identity as a doctor is also emerging. Students are being professionalized into the field and the culturally competent focus of practice. For some, my class was the first time ever exploring or discussing their attitudes and experiences with race and ethnicity in medicine. Some students struggled at times with giving voice to those stories that marginalized them. Some students were identifying their racial selves and their privilege or lack thereof in society for the first time. For example, one student who self-identified as Native American shared her experiences as being perceived as white – her green eyes, fair skin and reddish/blonde hair read outwardly white. She said the reaction to her "true identity" has been mixed. Some people in her own community thinks she's lucky to look the way she does, while others when they find out she's Native often dismiss her claims in disbelief.

For others in the "Stories and Writing" seminar, their stories located a particular pain, and in some cases a distrust of the profession and its sincerity or efforts to achieving cultural competence. There were stories of being associated with the discourse

of pain-seeking attention by minorities in their particular community. A Black patient appearing in a hospital in or outside of this large urban city asking for pain meds was usually assumed to be a drug addict or pain pill abuser according to the student. Students talked about witnessing the less than empathetic or maleficent acts of racism, sexism, homophobia, and xenophobia. They knew the darker side to medicine's modernity and its racialized past and apparent present from their patient encounters in the healthcare setting. The accounts of the students, their responses to the writing prompts in class could be considered a "narrative inquiry activity the way Coulter et al mean it, " the opportunity to tell, deconstruct, and learn from their own personal stories," (106). Coulter et al., cited author Tim O'Brien on this work of using stories to learn, "What stories can do, I guess, is make things present," (O'Brien). I would argue like the scholars of Indigenous scholars Malea Powell, Lee Maracle, and also Royster that stories make people present. Powell via Maracle says that stories "construct human realities" ( ...)

**A Brief Overview of This Project**

This is a descriptive account of a reflective writing course designated as medical humanities to introduce students to cultural competency standards. This course was offered as part of the summer curriculum of a year-long post-baccalaureate program at a community-based medical school. The course focused on students reading and responding to a contemporary story in medicine that explored the troublesome, racialized past of medicine. This course utilized narrative writing as inquiry, an exploratory form of telling, receiving, and analyzing the narrative of lived experiences.

The requirement to train students with the attitudes, knowledge, and skills, necessary to practice culturally competent medicine is an urgent and constant pressure

on medical education. There is ample evidence documenting the critical role of having health care providers practice culturally competent care. For example, doctors who are culturally competent are better able to deliver care to everyone in our population – including the medically underserved, vulnerable and those who have had limited or less than sufficient access to quality health care.

The methodologies chosen for this dissertation include artifactual critical literacy, identity formation, Cultural Rhetorics and Storytelling or narrative inquiry. The methodologies for this project supports the use of a dialectic process of storytelling and meaning-making that literacy or "story-work" as I've come to call it, to explore the attitudes, knowledge, and skills of these students about cultural competency. At one point a student pointed out that the seminar being studied for this project, "Stories and Writing: Racial and Ethnic Experiences in Medicine", was the first time and probably one of the only times anyone asked about her experiences in medicine in this way. I started thinking I hadn't seen a collection of work where physicians-in-training have had the opportunity to present their experiences and the meaning behind those experiences with race and ethnicity in medicine.

The work of scholars in Writing Studies provide the framework to under gird the approach of teaching reflective writing and to use these writings to understand themselves, their peers, and the experiences in medicine that deal with race and ethnicity. Most students are aware of the importance of cultural competence and the necessity for this type of practice as a benefit to the community of humankind as a whole. Writing Studies guide the choice of storytelling as a pedagogical strategy with reflective writing to gain meaning and insight. I believe my work contributes to the Writing Studies scholarship as a way to theorize reflective writing and meaning making

as a rhetorically and culturally situated practice useful to the work of understanding toward developing cultural competence. Like Writing Studies Scholar Wendy Bishop posits, I am writer-who-teaches and I'm also a teacher-who-writes (14). I tend to teach writing based on the experiences I've had as a writer. I tend to theorize about writing and the power of hearing stories, as well, from the experiences of being a writer. In the capacity of being a teacher who writes, I transport those experiences as a way to understand how writing creates a community of learners and story sharers. I use Writing Studies as a place to stand in medicine borrowing Bishop's title of her 1999 article, "Places to Stand: The Reflective Writer-Teacher-Writer in Composition". Bishop writes that there is a need to understand the learning and the spaces between the writer-who-teaches- and the relationship to being the teacher-who-writes also. What Bishop says about the recursive practice of writing is useful to inform this study and to "report-back" so to speak to Writing Studies what happens when this practice is situated in medicine.

I explore the writer-who-teaches-and the teacher-who-writes relationship in this work, a scholarly moment of getting two fields into a pedagogical conversation through the work and agency I have occupied in both fields. Bishop writes there is a common goal for those who do the work in Writing Studies particularly those who operate like Bishop and myself—exploring the circular relationship of being the writer-who-teaches writing and the teacher-who-writes identities. The goal she writes is for us and our students to "explore for ourselves…how a deeper understanding of the connections between thought, words, and life, may occur when we re-read our own writing. To do that, of course, we must write," (17). To Writing Studies, this work looks at the writing and meaning students produced when they explore the connections between their

thoughts, words, and life as they learn about cultural competence and its bearing on their practice as future physicians.

In 1999, author Cynthia Lewiecki-Wilson, writes a review about four works from Writing Studies that synthesized selected scholarship on the subject of personal narratives and pedagogy. Lewiecki-Wilson uses the example of connecting the personal narratives and pedagogy to her teaching life focusing on the personal writing in public and private places. Lewiecki-Wilson talks about the relationship of personal writing, composition studies, and pedagogy to her work in feminism-feminist studies. She writes, as an advocate or witness about the connected relationship for those "who work in the spaces between power-knowledge at the intersection of institution structures to challenge, disrupt, and dismantle present categories to think and create the new," (105-06). My work to the field of Writing Studies reports back to the connection I've found while doing "story-work" through reflective writing in medicine.

The field of Cultural Rhetorics perhaps contributes in the "newest" way to theorize and connect what the field of medicine has already connected to writing, specifically reflective writing (further explained in this dissertation) and to literature. Cultural Rhetorics is a way to critically interrogate cultural rhetorics theories of race, knowing, and meaning making. If we, as writers, teachers, and those who operationalized or practice cultural rhetorics recognize the power of establishing ones self as a negotiator or translator in cross-cultural work, then we need to recognize that meaning-making and knowledge-production and whatever "thing" materially is produced is rhetorically and culturally situated. The examination of the thing produced whether this is another set of texts or essays with traditional alpha-text, or a digital record of story, or through beadwork or basket weaving—Powell's work in cultural

rhetorics demands we acknowledge and believe there are other ways of communicating and knowing and producing knowledge. Her work in examining the writings of the nation's first female American Indian medical doctor in the country. Dr. Susan La Flesche Picotte, is a useful example of how members of certain communities know and use the rhetorical and cultural practices of writing by dominate cultures to subvert and perform rhetorical tasks that help and advance the communities we come from.

It was Dr. LaFlesche Picotte's understanding through the writings Powell researched from her of her ironic position of her Indian-ness, whiteness, and her understanding of how to use this ironic position through writing to achieve the things she needs, in this case, health care for her people. In her and her sisters co-authored writings to *St. Nicholas* magazine, the LaFleche Sisters declared that in the future, if granted the privilege, Susan would be able to study medicine and use this knowledge to improve the plight of the health of American Indians. She writes then in 1880 that she has an "advantage over a white physician in that [she] know[s] the language, customs, habits, and manners" of her people," (LaFlesche qtd. in Powell (52).

Cultural rhetoricians acknowledge that rhetoric is both rhetorical and culturally situated always, all the time, and already. Powell offers the example of Dr. LaFlesche Picotte's writings and experiences in medicine as a rhetorical contextualized proof that we must be willing to "adapt to different beliefs, different practices," she calls for a "gathering of narratives designed to help us adapt and change as is necessary for our survival," (58). Cultural rhetoricians look at the narratives gathered as evidence and proof worthy of examining the system of practices as work that created or produced the thing being communicated, by whom, how, and where are all culturally and rhetorically situated. The power of the work of rhetoricians in the way of cultural rhetorics engages

the question that rhetorician, writer, and cross-cultural worker, Jacqueline Jones Royster raises in her work. She writes in her article, "Disciplinary Landscaping or Contemporary Challenges in the History of Rhetoric" that the disruption of Western rhetorics and its theories and practices to let others be in the "know" about their lived experiences. Specifically, Royster's work calls for us to disrupt the "Western dominance in interpretive authority and the situating of that authority in male-dominated and elite ways," (150). I agree that medicine benefits from the work of cultural rhetoricians in a way to disrupt the Western dominance of interpretive authority.

This work shifts the interpretive authority and the knowledge-making from the fields largely to the individually, in this case of post-baccalaureate students from disadvantaged backgrounds pursuing medicine. Traditionally, medicine informs future physicians about cultural competence – what it is, and why it's necessary to practice this way. Traditionally, medicine informs physicians from the perspective of patients about the cultural nuances useful to practice medicine with cultural competence. There is a body of scholarship from those who follow the pattern of relationships borrowing from Bishop of physicians-who-write and writers who are physicians. I mean this to say that medicine has folks like writing does that "do and reflect" on the thing they do. For example, as a physician-who-writes and a writer-who-is a-physician, Dr. Rita Charon uses the work of medicine and literature and writing studies to create the field she pioneered knows as Narrative Medicine. This clinical practice with the attention to stories told by patients and the empathetic witnessing of physicians-who-write-diagnose-treat through stories of their patients continues to gain traction beyond it's beginnings at Columbia University Medical School in New York. The body of scholarship from physicians-who-write-and/or-teach-writing-and doctor – that

connects storytelling even in medicine is culturally situated and if listened to attentively can offer insight into the practices of members of various communities.

My work is a way for all of us across the various fields of "scholarly relations" identified in this dissertation, to borrow from Powell, to see how together we gather narratives to learn about the lives we live. The community described in this project is a way to communicate or report back to our respective academic communities (disciplines or fields) and to introduce at the same time how the work of these academic communities work together to theorize, understand, and make new knowledge and meaning.

The brief genealogy of the methodologies and theories used in this dissertation foreshadows the work that comes to bear on how cultural competence can be taught in the 21st century. Medicine has outlined ambitious goals for cultural competency training, but has left the interpretation of "how" to accomplish this open. I think this open space provides a meeting of the exigencies as outlined earlier to the fields of Writing Studies and Medicine. The next chapter of this study provides the details.

## Chapter 2: The Who, What, When, Where, How and Why This Study Matters

This study describes the reflective writing course I designed as an educational strategy in response to addressing the attitudes of future practitioners towards cultural competence. This course meets the threshold of competency in the category of attitudes and the self-assessment of how, "one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service," (8). I created the reflective writing course, "Stories and Writing: Racial and Ethnic Experiences in Medicine" to provide students a way to:

- Recognize and understand their personal biases that may positively or negatively influence the practice and delivery of culturally competent care to all patients
- Recognize and understand biases in medicine as systematic and culturally-based and influence the practice of medicine
- Explore the knowledge, skills, and attitudes necessary to practice culturally competent care

This study is a descriptive account of a reflective writing course offered at a community-based medical school designed to meet the goal of introducing students to cultural competency standards in medicine. This study describes using narrative writing as a pedagogical model in medical education, making use of various reflective writing practices to give students tools to compose, present, and explore the meaning of their experiences with race and ethnicity in medicine. Students can use narrative writing to identify meaningful experiences in this context that have the potential to influence their perception and practice of cultural competence in medicine.

This study presents several examples from students narrativizing their biases, self-perception and awareness of racial and ethnic experiences in medicine gained through this reflective writing course. The students present the importance of understanding how and what physicians-in-training experience and know about racial and ethnic contexts in medicine. This understanding may provide insight in to the students themselves but just as importantly, this work provides insight as well to both fields about how these experiences -- and the meaning made from them -- influence these students' future potential to practice medicine with cultural competence. My study provides examples of how the student's experiences construct and influence their knowledge, skills, and attitudes about cultural competence. And, at the same time, the students in this study present experiences that support the importance of understanding the myriad and complex ways in which patients engage with the health care system. The potential outcomes of this work is for students to first understand and locate for some for the first time their perceptions of race and ethnicity in medicine. My work uses the home knowledge of these students and their experiences already to first understand then to use their attitudes, knowledge, and practices to become culturally competent physicians.

Paulo Freire in his work, "Pedagogy of the Oppressed" talked about how important it is for critical educators to remember that students are not blank slates that we "deposit" knowledge into. I agree with Freire; students are replete with information, experiences, and stories about those experiences that they are making meaning from all the time. I think what is shared here from the students in this dissertation study gives insight into the mindset of future physicians' racial and ethnic experiences in medicine and their thoughts about cultural competence.

One of the key things I believe missing from the conversation about cultural competence and getting the field of medicine to a place of health equity or eliminating health disparities, is the collection and analysis of the experiences of physicians and physicians-in-training with race and ethnicity in medicine. I want to know, as Indigenous scholars Powell via Maracle, posit what proof students in medical education today have about racial and ethnic experiences in medicine from what they have experienced personally, professionally, socially, and so on?

To the public, to the patients who come to physicians with their maladies, this work matters in a number of ways. Research published by the Association of American Medical Colleges (AAMC), supports the mandate for cultural competence in medicine. The AAMC is the not-for-profit association representing accredited U.S. and Canadian member medical schools; major teaching hospitals and health systems, as well as a number of academic and scientific societies. This group since 1876 has been an advocate for the aforementioned entities in medicine, ("About Us").

The recommendation by this Association leader for medicine to be practiced with cultural competence offered several benefits of such practice. Among other things, practicing medicine with cultural competence can lead to better innovation and more effective programs and services for society's most vulnerable. The goal of cultural competence in medicine is geared toward the end of achieving health equity or the elimination of health disparities in medicine for the old, the young, racial and ethnic minorities, and the impoverished—most souls in society fit in one of those categories, and some souls fit into a few or all of those categories. The research says that when the health indices for the most vulnerable are improved, the health of communities—the larger society as a whole improves (AAMC).

In concluding the remarks of the importance of my work, I believe the field of medicine could look to my work to gleam a viable way to design and implement a reflective writing course that could be used in cultural competence training in medical education with a variety of learners. The field of composition could look to my work to learn how reflective writing and narrative as pedagogy operates in medical education as theory and method of inquiry to make meaning of the things students have experienced and know about racial and ethnic experiences in medicine.

**The setting and research design**

This project seeks to provide a descriptive analysis that explores how using narrative as pedagogy can illuminate through reflective writing an understanding of self, society and the professionalization in to medicine for students exploring racial and ethnic experiences in medicine toward developing cultural competency.

Scholarship from the two fields—writing studies and from the field of medicine-- provides a framework that informs the research design of this project. This project is a qualitative analysis that describes a pedagogical approach using narrative as pedagogy. My research analyzes the process of reflective writing toward the end of being a viable means to teach cultural competence in medicine.

**About the setting…**

The seminar "Stories and Writing: Racial and Ethnic Experiences in Medicine", is offered as the medical humanities course as part of the curriculum for a specialized post-baccalaureate program at a community-based medical school in the Midwest. The Seminar is one of the required classes for the selected 15 students for this program. The students also take gross anatomy lab and lecture and an intensive physiology review, to name a couple of the other courses offered along with my writing

seminar for the program.

For four weeks during the summer, these 15 students receive intensive science-based instruction, the medical humanities course and educational development sessions. Students accepted into the post-baccalaureate program receive year-long support in this special program, following the four-week summer session. The sciences increase in difficulty throughout the year. Successful completion of the post-baccalaureate program's curriculum facilitates entry into the next first-year medical class at the community-based medical school. Students from this post-baccalaureate program are given credit for the courses taken during the summer and start the first – year of medical school with room in their schedules to just adjust to the first year in medical school—a larger class of students and the full, rigorous medical school curriculum.

Some students from the special program take time that first year to do some related research or volunteer to fill the extra "free" time allotted by being given credit for the courses taken during the post-baccalaureate program. Students are introduced to several educational development interventions such as test-taking and learning assessments to prescribe and prepare a planned, effective approach to studying for medical school.

The four weeks during the summer also introduces students to the surrounding areas near the community-based medial school through social outings like a free bus ride to the local mall or dinner with the Dean at or sponsored by a local restaurant. Also students participated in community-service events such as volunteering at the local hospital. The community-based medical school has a standing history of 20 plus years of offering the post-baccalaureate program as an educational enrichment

opportunity for selected students from disadvantaged backgrounds. The program is part of the pipeline model, to help students from disadvantaged backgrounds successfully prepare and enter into medical school. The pool of students identified for this program are not quite ready to enter medical school but show promise toward being successful academically as well as possess the potential to persist to graduate medical school and practice medicine in the future.

Over the years, the AAMC called for a collective and robust response for all Association members, like the community-based medical school in this study, to begin to actively prepare to respond to the impending, predicted shortage of physicians; numbered to estimate at some 124 thousand nationwide by 2025 (AAMC). Inside the shortage of physicians overall is the important need to educate doctors who are from racially and ethnically diverse backgrounds. Over the years, the AAMC has expanded this call to be inclusive and more expansive in what is "diverse" and is considered "diversity" to include demographics like social and economic status, gender, etc. Doctors today and those in training today will practice medicine in an ever-changing, globally diverse society on all accounts like those aforementioned. The AAMC called on medical schools and colleges to recruit, admit and educate a student body ready to contribute to the medical profession "...that looks like America" (AAMC). It's important perhaps to note here, the program admits students from disadvantaged backgrounds as they self-identify through the application process. The federal government has designated certain groups as minorities or underserved in medicine. The students in the program represent collectively the broad and expanded definition of diversity.

**About the research design and methods…**

The focus of inquiry for this dissertation project started with a literacy artifact- the final reflection paper written by the students at the end of the four-week "Stories and Writing" seminar. I analyzed the artifact (later described in depth), then invited selected students to revisit the artifact in a 90-minute interview with me to explore the meaning made from what they'd written and its relationship to how they envision practicing medicine in the future with cultural competence.

I conducted 90-minute in-depth interviews with the five students. I used the artifacts as an approach to literacy using various artifacts from class during the 90-minute in-depth interview to illicit richer stories as Kate Pahl and Jennifer Roswell state in their work "Artifactual Literacies". The authors write, "Memories of objects are powerful pulls on identity," ("Artifactual Critical Literacies" 1). Pahl and Roswell's development of the artifactual literacies theory has import to my study. The authors posit that these objects bring in everyday life. In cultural rhetorics it is Michele DeCerteau who admonishes us to examine the everyday life for true meaning in context to the larger systems moving us, and the meaning slipping by in that movement.

The in-depth phenomenological interview with the students was a way for me to follow-up to clarify statements from the final reflection paper that were unclear, to make sure I understood what the student meant. The interviews also allowed me to ask follow-up questions from things of interest in the final reflection paper, like their before and after statements I coded in the process of close reading (later explained),

which allowed the students to open up and share their thoughts since our class last met, some six months prior to the time of the interviews.

**The methods of research consisted of**

- A first pass, an initial close-reading of all 15 submitted final reflection papers from the four-week reflective writing course, first looking for passages of interest, looking for themes of connection across the 15 papers
- A second-pass, a second close-reading of the final reflective papers to identify and code for before and after statements as a way to mark or indicate a change in behavior, self-awareness to act or re-act, or a redirect of learning something new to replace previous thoughts or perceptions on the issues from the class. This process narrowed the paper samples from 15 to 8
- A third-pass, a third close-reading of the reflective paper to identify what I called "future statements" the development or changes in personal philosophy either about any of the issues raised in class pertaining to racial and ethnic experiences or to their personal philosophy about their future practice as physicians. Of the 8, I narrowed it down to 5 salient case examples or "illustrative" case examples to use medicine's model of the kind of cases sufficient for this type of study.
- I last looked at the 4 case studies for moments when a student told their own story or that of a person "one removed" – i.e., a friend not a friend of a friend – that could corroborate the experiences one could tell with it's details, knowledge, and intended meaning in tact.

- I interviewed all five students from the case studies as a follow-up to my observations and notes from their final reflection paper

**The Idea of Cultural Competence: What it is and Why It's Important…**

Cultural Competence in medicine is believed to be key in eliminating health disparities and providing care to an ever-changing, and increasingly more diverse society. Census data says minority populations, particularly Hispanics, will grow exponentially in the next decade. As society becomes more and more diverse, so does the need to have a physician workforce just as diverse and trained to provide culturally competent care.

Twice in its history, in 2005 and again in 2012[1] Cultural Competence has been defined and established standards and evaluative tools by the AAMC. In 2005, the AAMC published an important document, the first focused publication of its kind; "Cultural Competence Education". This 18-page document on Cultural Competence, a written text, was the first articulation of the-then newly required competency standard requiring schools to create a curriculum across the board that dealt with cultural competence.

This standard, from the governing, accrediting body for medical schools, the Liaison Committee on Medical Education (LCME) responds to the emerging scholarship in the field of medicine that confirmed the practice of culturally competent care as being directly linked to improving health outcomes of the nation's most vulnerable populations (also described earlier in this dissertation) in particular

[1] In July 2012, the AAMC convened a joint expert panel convened by the Association of American Medical Colleges and the Association of Schools of Public Health. (SEE: "Expert Panel" on Works Cited Page)
1

("Cultural Competence Education" 2). The cultural competence standard from the LCME first introduced in 2000 stated explicitly that faculty AND students must "demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness…" ("Cultural Competence Education" 1). Medical schools were required to respond and according to the AAMC, this charge was also a call for a cultural competence curriculum to create content to introduce and hopefully integrate cultural competence into medical education. Specifically, "Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient," ("Cultural Competence Education" 1). With these standards in place, faculty in medical humanities across the country can now develop curricula around this new standard.

Schools of medicine responded in a variety of ways to meeting the newly required cultural competence standard. Some schools simply identified more clearly and explicitly what's been commonly called "the hidden curriculum" to substantiate their response to this standard, meaning many schools began making evident their cross-cultural curricula. Other schools, like the site of this study, responded in overt ways over the years since this new standard started by adding or restructuring their current medical humanities offerings. The community-based school where this study takes place restructured its required four-week, medical humanities selective from offering a menu of themed topics in humanities individually to offering the themed course that covered all the topics together. This new common approach included a boilerplate syllabus, required readings, guiding questions for discussions, and required assignments to explore the meaning of the artifacts examined in the current medical

humanities course. The topics included obesity as the new discrimination, historical cases of discrimination or abuse in medicine such as the Tuskegee Experiment.

**What is Cultural Competence? A Definition**

In 2012, seven years after the first publication about Cultural Competence, and just for the second time the AAMC researched and published a special edition related to cultural competence. This time the document, "Expert Panel on Cultural Competence" was in collaboration with the Association of Public Health. The panel of experts convened, putting forth a new definition of cultural competence. The new definition reads:

> "Cultural competence is defined in the broader context of diversity and inclusion as "the active, intentional, and ongoing engagement with diversity to increase one's awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions" (Milem, as qtd. in "Expert Panel" 2005).

The two entities were sure to identify students in schools of medicine and schools of public health or graduate programs of public health. The joint panel presented a set of recommendations with the goal of "fostering innovations in the development of educational experiences that integrate culturally competent knowledge, skills, and attitudes," ("Expert Panel" 3). The Panel made a set of recommendations based on looking at existing curricula, related competencies, other recommendations about cultural competence and expertise from medical education literature. The joint commission cited the fields of behavioral and social sciences as allies to understanding this cultural work. Again, the use and interpretation of these competencies left schools of medicine ample room to be flexible with designing curricula and for that matter to

develop evaluations that address this area.

The listed cultural competencies between the two schools produced a set of longer bullet points in the areas of knowledge (cognitive competencies), skills (practice competencies) and attitudes (values/beliefs competencies). A few new points included student being able to appreciate that becoming culturally competent is a lifelong learning type of commitment. This makes sense to me especially as the lives and experiences of humans are not fixed. And neither is the culture/ or context in which these experiences happen. The recommendations for the future included promoting and improving faculty skill in cultural competency training. The report encouraged schools to get faculty involved immediately in the "curricular transformation" to sustain the efforts toward promoting cultural competence across the curriculum and the medical education training more widely.

In the next chapter, I review the relevant scholarship in medical literature and in writing studies that explore the question, what might the field of writing studies know that is news to medicine?

## Chapter 3

## A Review of the Literature: Gathering Scholarly Relations

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"***As more of us are beginning to bring the personal into theory, research, teaching and scholarship, we think it is important to reflect on the politics of such efforts."***

*—"The Politics of the Personal: Storying Our Lives Against the Grain"*

*Symposium Collective, Brandt et.al. (41).*

The works here in this literature review are NOT exhaustive nor should it be. Rather the works here is a gathering of my scholarly relations from the fields of Writing Studies, Education (Teacher Education, specifically), and Medicine. My goal is to provide a variegated view from the literature that grounds the theory of using stories and provides the footwork of understanding the methodology of using stories, writing, and the personal to make meaning.

### Gathering Relations…The Personal and The Political

**"What is personal is at once socially, culturally, and personally defined"**

*—"The Politics of the Personal: Storying Our Lives Against the Grain"*

*Symposium Collective, Brandt et.al. (47).*

I realize I need a place to stand in both Writing Studies and in Medicine. When I read the work about the politics of the personal written by the Symposium Collective, I wondered how what I do might be related and how I can contribute to this

conversation? For sure the multi-vocal Collective reminds me to pay attention to the politics of the personal. Each author offered another vital layer of information for me to consider relative to using storytelling as a pedagogy. The different voices in the Collective piece at times may appear to be out of harmony on the issues of what is personal and why a researcher chooses to reveal his or her positionality. But I agree that each researcher may have a different view of when the "methodological imperative" makes it necessary for a research to share the personal of their background and identities. (Herrington 47).

I've thought about the subjective-objectivity issues of using stories to teach I was trying find a methodology that would allow students to engage in analyzing their lived experiences with race and ethnicity in medicine.

***A Story…A Researcher's Thoughts and A Response***

*When I first read the Collective piece, the part from Deborah Brandt's, I thought to myself, "Yeah, how can you pulverize (her words) a conversation down to bare empirical evidence and leave them [participants] human too?" It wasn't until I looked at the data matrix I'd made for this study that I understood what Brandt meant. When stories appear in research for teaching, when we use the witness of others so the reader or story-hearer may learn something, we don't want who participants are to overshadow the public interest of the what their experience contributes to the research. For that matter, as echoed throughout the Collective, I don't want the researcher's positionality to overshadow the public's interest as well as dampen the benefits of my research in the scholarship either.*

*I believe my work speaks to the public interest how medicine is practiced. I believe my work at some level can cause individuals who come to it to hear the story*

*and say, "that's a different way of considering us," (14). I felt like using reflection, writing, and storytelling together in a pedagogical trio works to create new considerations of lived experiences. I want my work to position the stories shared as well as my interpretation of them to understand the socially and culturally situated problems in medicine that may hinder the goal of achieving cultural competence.*

*I understand now what Brandt means. It's important for me to not have readers fixate on who's telling the story or to "psychologize" the story's host (43). Rather it's important to examine the bigger social and cultural clues being transmitted through the story. What reality does this story construct? For example, Mo's story (shared in depth later in this work) illustrates what one may encounter when training future physicians. Mo reads on the outside as a Black American man; that's how he looked to me. But in fact he is a Black Egyptian man and Muslim, his self-description. Mo said during our conversation that in addition to studying for medical school, he's had to become a quick study on the Black American male identity and the politics of U.S. race relations. Mo came to medical school knowing who he was, but was caught off guard when confronted with the representation or identity that others assigned to him; including me. His agency was disrupted and reassigned. How many future physicians in training are confronting this same issue? Can being miss-assigned an identity affect the goal of achieving cultural competence in medicine? I work through that line of thinking later in this study.*

There are still a lot of taboos still when it comes to talking about race, especially the racialized past of medicine. Anne Herrington in her work reminds me that an evolving discourse is important as what is personal is at once "socially, culturally, and personally defined" (47). There are those in medicine that I've worked with who think

cultural competence should be the "color blind" approach. Others take the "it's not me" or "I didn't create the problem" of racism stance. And then there are those who understand the issues of race in medicine are deep and the work to deal with one's biases and attitudes is just one side of the equation. There is much resistance to owning or taking ownership of feelings of bias or attitudes about race. I think it sometimes takes hearing another's experience to break that resistance or even to redirect their assumptions to the truth being shared.

"I didn't think your kind of writing required the library" ("Symposium Collective 50). I've been part of that scrutiny before when discussing my dissertation project about using storytelling as a pedagogical model. Some question the validity of using narratives and stories; "Will medicine take the research of storytelling seriously?" I encountered methodological classism, "Why are stories the best way to deal with race stuff?" There are still schools of thought in medicine that only science-based quantitative methodologies can provide critical, unbiased analysis.

My response is the critical autobiography is not less "academic" or scholarly because it works in the "I" voice from the personal-to-public fashion of making meaning and sharing knowledge. The critical autobiography works to make visible the systemic and institutional practices at work and that's not an easy feat. But using stories is academically rigorous work.

I include the personal in my work to offer the students something back. I don't think it's fair to use storytelling as pedagogy and not be willing to share in the learning community. During the course of teaching "Stories and Writing" I've asked in different ways what students got from one another in the learning community, including from me. When students have remarked about my stories in the learning community, the

personal things I shared was seen as a way to keep "the patient" experience in the room; a reminder of what happens when a diagnosis goes home with the family. And students also thought my stories showed them ways to question in the private-to-public fashion their experiences. I see my stories as a way to model narrative inquiry – guiding students through how to question and examine their experiences in the context of the larger systems at work.

**Gathering Relations…A Call for Theory and Methodology**

***"We can only retell and live by the stories we have read or heard,"***

*—"Stories of Experience"*

*Clandinin and Connelly (2).*

Scholarship from the field of medicine works to theorize the importance of and the need for cultural competence in medical education. The call to address the bias and attitudes at the individual level for physicians and physicians in training bears on reaching the goal of practicing medicine with cultural competence. Physician-researchers from the AAMC and ASHP point to a set of scholarship to underpin the cultural competence call. Physician-writer-researcher, Joseph R. Betancourt's work brings a perspective that supports the use of storytelling as a pedagogical approach to creating what he calls cross-cultural care. "The foundation of cross-cultural care is based in the attitudes central to professionalism — humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences" (561). Cultural rhetoricians understand the outside influences are socially and culturally constructed and are not fixed. Researchers in medicine recognize the same that the contemporary

health system is interpreted through our experiences and are often "reflections of different cultural viewpoints about health and the health care delivery system" (570).

Clinicians are not equipped on their own to respond to creating a curriculum to teach cross-cultural points of patient care largely because clinicians may not be trained on how to effectively bridge differences when they come up in the stories from students. One of the ways my work is relevant in the medical scholarship is because of what can be done with stories.

> "…if the clinician recognizes the cultural context of the encounter [doctor/patient/family] and can assess and negotiate among all participants' potentially conflicting interpretations, expectations, beliefs, and values, he or she may be better able to provide optimal care to the patient and family (Kagawa-Singer and Kassim-Lakha 578).

At the crux of the public interest in cultural competence is the benefit of better care being provided to all. The scholarship from Melanie Tervalon, MD, MPH, examines this point in the unfixed context of power, privilege and culture. Self-examination by providers, analyzing their own negative stereotypes, and biases is needed to support the change of medical practice to allow cultural competence to become the new culture of medical practice.

Narrative as a method of inquiry as explained by Clandinin and Connelly in their work "Narrative Inquiry" is four-directional – inward, outward, backward, and forward (Narrative Inquiry: Experience 50). The researchers remind me as I'm theorizing to build support for methodologies that use testimonies as evidentiary and

change-agents in systems of practice. In the case of exploring race and ethnicity in medicine, asking questions in each direction is key.

When I consider this explanation of inquiry, I applied it to the seminar, the subject of this study, and for example the goal to get students to recognize their biases; this is very much a four-direction process. To further elaborate, when students first encounter the text for the seminar, "The Immortal Life" it's hard for them to conceive of or think of a time when doctors would abuse a patient or even use them knowingly for experimental means without their consent such as the case of Henrietta Lacks. Students in this seminar look outward to understand the social context that medicine is being practices in. During the Jim Crow Era, the separate but equal status was practiced in medicine. Students in the seminar using the four-directional process begin to understand that the attitudes of physicians even if they were liberal and accepting of all, their actions were legislated by racial segregation. For instance, students read the description in "The Immortal Life" about Black patients being seen by physicians behind glass in "colored" only hospitals or in the colored only wing of the hospital. For some reading this passage in Skloot's book is the first time they can imagine the practice of medicine during the time of segregation. Naturally, it's come up, "why didn't the doctors just see the Black patient, like they did the White patients?" I usually remind the students that Jim Crow was law. I use the example that signs that read "Whites Only" were required and the enforcement was legally binding and often times violently defended. Those "Whites Only" designated areas of life went beyond the drinking fountains and school houses…students map the rest of the way through the story of Henrietta Lacks the racialized past of medicine. Finally, the other direction of thinking and inquiring is backward and forward – or as Clandinin and Connelly say –

the "past present and future of a thing" (Narrative Inquiry: Experience 50). The racialized past of medicine bears on the present concern for future physicians of "how" they are going to become and practice cultural competence? I explain to them that the stories they tell as well as the ones they gather will point to "how" – when you see an opportunity to make a needed change or attitude adjustment – do *you*?

In the same way that Clandinin and Connelly explain that the researcher is always in the narrative inquiry too, that is our research is based on our own experiences and shape the interest and direction of our inquiry, I posit the same for students—they locate their own stories of what interests them and they follow-up in the learning community to share and learn from the stories they get back from the community.

The framing of inquiry in a narrative way by the field of Writing Studies is important to medicine. "The study of narrative, therefore is the study of the ways in which humans experience the world," (Clandinin and Connelly "Stories of Experience" 2). Medicine has a need for more studies about how humans experience the world. My research shows how physicians-in-training experience the world of medicine through the lens of race and ethnicity and what they know of themselves, society, and the profession based on those experiences.

Writing Studies scholars posit that sharing and receiving stories is a learning event; we have a tendency to explain through stories what we know. The practice of listening or receiving stories brings can bring about change; seeing "…something essentially human by understanding an actual life or community as lived," (Clandinin and Connelly "Stories of Experience" 8). In a way understanding stories as theory

offers great import in being used as a pedagogical tool in the problem-posing, critical education classroom.

I think if we take the thing produced — the story, the narratives the students share — and examine them for meaning we get both an individual story and a social story — a theory of the thing being studied. When students in my seminar recognize their own biases, they followed up with where or why these biases come from. They develop their own theories about race in medicine in the company of the stories of their colleagues. As a community of learners, theorizing together through stories about racial and ethnic experiences can lead to changing the larger culture of medicine.

As a pedagogical model, narrative in the "Stories and Writing" seminar worked for students to examine their past experiences in medicine with race and ethnicity. This backward movement a student remarked was key in getting them to go back to the "beginning" of a story about race and ethnicity in medicine and their own presentation of themselves as racial or ethnic person in a medical setting. One of the students from the seminar, expressed tears at remembering a sibling's serious illness and the need for translation services, "We were poor," she reflects. Taking her back through her story of her impoverished upbringing was hard.

**Gathering Relations…Reflective Writing and Literature in Medicine**

**"When health professionals write…about clinical experiences, they as a matter of course discover aspects of the experience that, until the writing, were not evident to them"**

—"Narrative Medicine: Attention, Representation, Affiliation"

Rita Charon (266).

In the medical literature, writing and more specifically reflective writing appear to be viable in teaching such clinical skills as effective doctor/patient communication, and empathy for example. In the 2012 Commentary, "A Sense of Story, or Why Teach Reflective Writing," authors Rita Charon, MD, PhD and Nellie Hermann, MFA explore the gains we might have in teaching reflective writing in medical education. They write, "The field of reflective writing in medical education is at a most productive and perilous stage," (5). In this regard, those of us who do writing the authors posit, know the importance of reflective writing in education, but have trouble establishing what the field can do or how the field already does it (uses reflective writing).

The authors point out the work in reflective writing and what it does in medical education is largely informed from the concepts of adult learning and psychology. However, Charon and Hermann conclude from using narrative theory that reflection-- part theory and part phenomenology-- is recognized as "a narrative and narrarating toward presence, identity, self-awareness, intersubjectivity, and ethical judgment," (6). This understanding of reflection makes most sense to me in regards to my own work. This is the also the strongest contribution I think Writing Studies does – provide the theory of understanding phenomena of living life using narrative, reflection, and writing together as pedagogy, practice, and process and inquiry, respectively.

Also in this Commentary authors Charon and Hermann explore teaching reflection by teaching writing. The thought is that the act of writing is the process necessary to get out our experiences (5). In this case, writing is used to give the complex notions of experiences some context as well as representation of these notions and more importantly to explore the meaning. Writing may help students deconstruct the meaning of their actions and to decode the nuances of their biases, a possible

positive outcome for teaching writing in a medical school. In the work of teaching cultural competence, the potential outcomes can translate into meaningful insight to bear on the knowledge, skills, and attitudes of physicians-in-training.

In the medical literature, there is a call for narrative medicine—the deployment of reading and writing narratives used in medical education to train students to care for patients. In her solo work and founding text, "Narrative Medicine: Honoring the Stories of Illness" Charon, the Founder of the academic medical field of Narrative Medicine at Columbia University in New York. In defining Narrative Medicine, Charon writes, "…narrative medicine came to me as a unifying designation to signify a clinical practice informed by the theory and practice of reading, writing, telling, and receiving of stories…" ("Narrative Medicine: Honoring" Preface, viii).

***A Story…A Researcher's Experience***

*There was plenty of what I call signs that kept happening during the course of giving my research work life that kept reaffirming my work mattered. The inaugural conferences of stakeholders in Writing and in Narrative Medicine happened. Both The Examined Life Conference at the University of Iowa and The Narrative in Medicine conference in New York at Columbia University happened alongside my beginning graduate school.*

*At The Examined Life Conference, there were scholars sharing their knowledge in medical humanities broadly and writing, and literature more specifically. I attended the session of a young physician-writer-researcher, Dr. DasGupta. I found her talk fascinating as she talked through her writing about her identity work – being a new mom, a woman, and a woman of color in medicine – all identities that shifted for her as experiences changed her outlook on practicing medicine. Her story*

*and her presence comforted my inclination then that physicians may not be able to see the value of writing. I learned at that conference thought that some of them are writers-who-doctor and doctors-who-write. I think physicians who write can relate to writers who teach; both get the duality of having a place to stand in several fields and maintain multiple agencies.*

*Also at the same Examined Life conference was Dr. Wald and company presenting their work in progress, a rubric to use in medical education classes that use writing and reflection as educational strategies. The first time seeing this rubric excited a lot of us. We had something to look at, something to point to including how to train faculty on providing feedback to reflective writing. I'd forgotten that happened actually until I was looking at the transcripts and final reflection papers from the "Stories and Writing" seminar and needed SOMETHING to do…a method to handle the narrative data I'd received. I was so glad Wald and company had done this work and published it…just two years ago, right about the time I was finishing up coursework.*

*I've always felt like these two experiences were the beginnings of my understanding that my work has important in the world, and in the fields of Medicine and Writing Studies.*

*How is it that scholars in the field of medicine and Writing Studies (or English in the case of Wald) were establishing theory and methodologies to deal with narratives and stories as data and tools to encourage transformative learning…at the same time I was beginning to work on my research? Divine order.*

*It's stuff like this along this journey that kept happening…giving me Light that my work mattered and that I was on the right track. The relationships between*

*stories, writing, and reflection have a place in changing the paradigm of practice in medicine.*

What medicine knows about practicing Narrative Medicine is useful in understanding the value of a reflective writing course focused on cultural competence. The fact that there is a clinical practice with an orientation and particularly inclusion of patient and doctor stories is remarkable. What medicine knows about the clinical practice of using stories is particularly useful in making entry for my work that examines the "thing" or story being produced and its meaning – my work examines narratives IN medicine—the story itself, the writing and narrativizing itself and the meaning made and communicated behind it all. "When we understand circumstances, events, or conflicts from other people's perspectives, we can identify and implement better strategies for addressing these problems," (Coulter, et. al. 107).

In their 2009 work, authors Karen Mann, Jill Gordon and Anna MacLeod present a useful review of reflective writing in medical education. In their article, the authors identified three things that build a supportive rationale for reflective writing in general. First, the authors write, the reflection must be critical and across the practice lifetime in order to lead to change being made at the individual level; second, reflection can be a gateway to understanding one's beliefs, attitudes, values and how becoming doctor or professionalizing into medicine is integrated at the personal levels and professional levels around beliefs, attitudes, and values. Finally, the authors continue, "...building integrated knowledge bases requires an active approach to learning that leads to understanding and linking new to existing knowledge, (596). That last point about understanding and linking new to existing knowledge informed my methodology and pedagogical approach to designing the reflective writing course at the community-

based medical school described in this study, a point further discussed in detail later in this dissertation.

These authors find in their review of literature two major dimensions noted in reflection: iterative and vertical. The iterative dimension is believed to produce a new understanding, which may cause a different response in an experience in the future. The vertical dimension, explains the different levels of reflection, for example, surface reflections are less analytical or lightly interrogate a thing (597). Mann, Griswold, and MacLeod, remind me that the literature in medical education exists regarding reflective writing as it related to using this tool for three things; learning, professionalizing into medicine, and thinking critically.

Researchers in medical education use a variety of methods of instruction with students to aid in examining their experiences including, for example, requiring learning logs or diary entry--recording their experiences in clinical training; or reflective portfolios, or also by responding to writing prompts (602). All of these ways mentioned can be used to guide the development course curricula in reflective writing. And some of the ways, like the diary entry for instance, are entered into some digital space. The authors conclude in their research that reflective practice can be taught and learned. Particularly, reflection may be used as a "learning strategy" (614).

In 1993 and again in 2004, studies about using reflective writing to teach empathy were published. In 1993, William Branch, et. al and a mix of medical of Harvard and Rockefeller Foundation researchers published their work, in the "Occasional Notes" section of The New England Journal of Medicine. Their study of "critical-incident reports" a term to mean reports of those striking encounters in medicine that causes some kind of meaningful exchange, usually a moment for the

student to think and even project about their future practice in light of their current experiences. The learning directed from the task of simply selecting an event and writing it up as a learning experience, (1130).

This particular piece of scholarship directs my attention to other concrete ways reflective writing has been used in medical education. What I learned from this piece of scholarship is that the researchers saw the work in this class just as much if not more of a benefit for them to better understand the students troublesome transition from student to doctor.

In 2004, the folks out of Columbia University, shared the results of their study, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy", by Sanyantani DasGupta, MD, MPH, who is joined by Charon as second author, on this piece to discuss using writing like this in medical education. Columbia University offers the only accredited graduate degree program of Narrative Medicine, the clinical attention to practicing with narrative competence (351). In this article, they establish that in order to demonstrate empathy in the context of communication, one must be able to "elicit, interpret and translate the patient's illness story," (351). Their work further establishes that reflection and empathy are bi-directional, meaning, "mutually nourishing" (352). In this course, students evaluated this opportunity to sit and reflect in this way with high regards. Perhaps most important, scholars acknowledge the "rarity of the opportunity in medical training to share emotional and physical vulnerability," (355).

**Gathering Relations…The REFLECT Rubric A New Method**

**"Curriculum initiatives that include reflective writing have created the need for a valid, reliable evaluative tool,"**

—"Reflection Rubric Development: Evaluating Medical Students' Reflective Writing"
Hedy S. Wald, Shmuel P. Reis, and Jeffrey M. Borkan

Medical education provides work about reflective writing that reports back if you will to Writing Studies about reflective writing in this field. In 2004, a study about using reflective writing in medical education was added to the body of scholarship. This time, the study included a rubric to train and develop faculty on providing feedback to students on their reflective writing in class.

The work of Hedy Wald et. al., the same work Charon and Herman write about in their Commentary of the same edition, was mentioned earlier in this dissertation. Wald and company created a rubric to use in the reflective writing curriculum, documenting in the literature an evaluative training tool to assess the products produced a rubric to evaluate student's reflective writing pieces. While Charon and Herman "worry" about making rubrics essentially to satisfy the critics who can only appreciate research as it measures the "quantifiable markers of individual learners' achievement," (7). The rubric though, by Wald, et., al, helped get at the challenge of dealing with writing in medical education.

As the authors state, reflective capacity or reflection "is integral to core professional practice competencies," (41). In medical education, when it comes to cultural competence, reflective capacity is important. Their scholarship recognizes the importance and the mutually beneficial gain of understanding professional

development and training but to also "help guide pedagogic initiatives aimed at supporting this process," (46). In medical education particularly when writing courses are offered, the ability to give meaningful, constructive feedback is important. The authors explained that the sustainability of Reflective Writing (RW) programs is coupled with the ability to effectively evaluate the curricula. This led to the creation of the REFLECT: Reflection Evaluation for Learners' Enhanced Competencies Tool. The new rubric the authors claim reflected the RW pedagogy and was an "innovative approach to assessing reflection" (42).

Scholarship about the rubric published in 2012 was actually a culmination of other studies Wald and et. al., (not always the same et. al. across publications) had been working on all along. Twice in 2009 (two separate publications) and once in 2011, Wald published a solo piece on RW in medical education. Their body of scholarship in this time frame shows a linear development of the articulation of RW at their school and in medical education more broadly. The work by this group (excepting the Wald solo article) speaks to the relevance of RW in medical education and also deals with what to do or how to evaluate this kind of writing.

The REFLECT Rubric was the impetus for thinking and creating a Cultural Competence Reflective Writing Rubric or (CCRWR), explained next in this dissertation. This is the part of Rubric that could be used in a cultural competence course with narrative writing as a focus in other medical schools.

**Gathering Relations…Concluding Thoughts**

**"Being treated as if one is worthy, as if one's life is important as if what one has to say is significant and deserving attention…even the silenced comes to voice,"**

— "Narratives of Literacy: Connecting Composition to Culture"

Beth Daniell (402).

All of the preceding points have bearing on my research including the course design itself and the use of stories as a mode or lens to examine the products made. The selected literature review of writing, specifically reflective writing, provides an overview relevant to understanding what medical education has done with writing, including mapping theories of narrativizing and in some cases as the scholarship of REFLECT provides, the field of medicine is starting to create evaluative tools to use with student's reflective writing. In the research there is an interchangeable exchange of words such as narrative, first-person narratives and stories or storytelling. Before we go any further, I should explain that I use them interchangeably as well, but I am always talking about the narrative, the first-person account of experience from the point of view of the storyteller.

## *Chapter 4: Disruptions of Identity and Belonging and Responding: Two Illustrative Cases*

"When the First Voice You Hear is Not Your Own"

"...I have concluded that the most salient point to acknowledge is that 'subject' position really is everything." -- Jacqueline Jones Royster (29

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The two cases in this chapter are examples of disruptions in identity. I talked with Mo, a medical student from Egypt and Brea's, a young woman from metro Detroit. Each of them describe their own sense of disruption to their identity. For Bea, she became frustrated that patients "that look like her" cycled in day after day with the worst health indices at the dialysis clinic she worked at. She talks about this being her main motivation to work in her community to prevent and promote good kidney health and function.

Mo's story, and my own come together to highlight another issue in this conversation – the assumptions we make about one another based on race and ethnicity. As medicine calls for cultural competence and practitioners to deal with their own biases around race and ethnicity. these are some of the things that came to light during the four-week seminar experience.

**An Illustrative Case: "I'm not Black like you understand being Black."**

The interview with Mo, a Black, light-skinned, Egyptian Muslim man (his self-description), offers a compelling story, a special case, that connected for me with Royster's call to action, the need for someone to function in the the role of negotiator to "cross boundaries and serve as a guide and translator for Others," ("When the First Voice" 34).

In his written final reflection artifact, I selected a passage, the story he shares about a dinner out with a friend. In the passage below taken from this artifact, Mo writes,

"My friend looked at me with a smile and said—"whether you like it or not you are going to be able to serve your community better than anyone else. Think of this scenario. An old uneducated immigrant from your community gets sick; who do you think she is going to go to for help? That's right no one.

The truth is no one trusts anyone about these sensitive issues. But, here is Mohamed from her community. She knows who you are, she knows your family, she knows that you are just like her and most importantly she has the idea that if she tells you what is wrong, you will understand."

Indeed, my friend shed some wisdom on me that night. I had never thought about those points before. Reading "Under the Shadows" by Gamble and watching Medical Apartheid, however, solidified that wisdom to me."

When we talked for this project six months since the seminar, Mo took a break from studying with a group of medical students from the Program's co-hort. He started the interview reminding me of his background, being born in Egypt, a detail, I honestly hadn't given another thought until the interview, exploring his artifact. Mo makes with this point,

> "Racism in the U.S. is something that goes really deep into its roots. And, especially for immigrants who come outside of the United States, something they [medical schools] really don't take that into consideration is [racism] is different. People who have had generations in the U.S. are very well aware of racism's history here, but not all the time…" (Mo, personal interview).

When I consider Mo's experiences, I realize he's in a triad learning situation-- he's learning the science of medicine, becoming a doctor; he's learning about U.S. Race History, and he's learning about the history of race, (or cultural competence or healthy equity issues) in medicine. Immersion in learning, particularly when the education comes from real life, happens when different types of humankind are selected to live together for an intensive summer program, preparing them to enter into the next medical school class. Mo continues his story:

> "For me personally it really was the first time that I kind of really interacted with African-American professionals; or students, seeking a professional career who were African-Americans. Even though I've dealt with Black people before, it's completely different to deal with like Africans or Blacks in Egypt than [U.S.] African-Americans, because there is that history. But, just hanging with them, that is just kind of new to me, was something I'd never really thought [about] or had been exposed to until the summer really," - (Mo, personal interview).

It was in that moment of hearing Mo's words that I felt embarrassed. I was one of those people who'd "read" Mo wrong. When I looked at Mo, I read what looked familiar to me: he's Black like me, a brother, of the light-skinned hue, a shade common from my own family tree. Even when I heard his name I assumed correctly he was Muslim, and even then I assumed he was the Black kind of Muslim; still a U.S. orientation different than being middle eastern Muslim.

This entire rhetorical moment in my inner dialogue revealed something about my own bias and experiences. I'd worked for the House of Representatives in the Midwest and one of my assigned constituencies included a large Muslim community

outside a major urban, predominantly Black area. I knew from doing work around language rights in the school district of this Muslim community that there were many different kinds of Arab-speaking people. And in this same community, some were also Christian, Persian, Chaldean, and Egyptian and Muslim too. And it was all different-- I'd understood the diversity and the complexities in this context. But with Mo, I missed it.

Honestly, one thing I wanted to make sure of was Mo's freedom to practice his Muslim faith as his discipline required. We've supported the cultural and religious practices of all students, regardless of faith or creed. For example, students who are Seventh-Day Adventists are excused from required Saturday events for the observance of their Sabbath. So Mo's religious freedoms and accommodating as necessary took precedence for me. But the biggest goof, was the assumption that Mo had been around Black people before, and had certainly lived with them. With us. We laughed about this; my ignorance and his adjustments to his new living situation.

In this exchange, I thought of Royster again, this time her comments about hybridity. Mo's hybridity puts him in position to perhaps help medicine traverse more deeply into cultural competence in this particular community. Royster said, the goal in this type of cross-boundary exchange is not to continue the talking at (my emphasis) one another, but to foster a "talk back' across communities , "so that we can exchange perspectives, negotiate meaning, and create understanding…" (38).

Mo's experiences of being read wrong, like I admitted to doing, will I imagine be a commonplace experience throughout both his medical education and practice. The construction of race in this country, its own literacy of tropes and what Henry Louis

Gates calls “biological misnomers” of race, the metaphors of the fiction of race can get lost in translation; a dangerous predicament.

Gates’ comments about how the discourse of race hides the structures of power and knowledge can be seen throughout the history of medicine. In fact the structures of power and knowledge spoke loudly and with many voices in the seminar’s selected text, “The Immortal Life of Henrietta Lacks”. Gates’ assertion that the inscription of race and its interpretation of race are not always clear-cut is right.

In the scholarship about cultural competence, reference earlier in this dissertation, the field of medicine is clear that practicing medicine in this way is a requirement to achieve health equity. I wondered when I read this definition of cultural competence from 2005 how we can understand the complex ways of knowing through story and experience, theorizing our racial and medical lives, without the stories of the people who’ve lived it? How can you know what meaning they are making from those experiences?

Largely that’s what’s missing to me in the body of knowledge in medical education as it pertains to cultural competence--there’s no download of experiences, no place for students-- or faculty to elucidate their prior experiences with race, to deconstruct their own biases and interrogate their own meaning(s). Understanding what is inscribed on ones body from the assumptions of what we know about race is key to breaking through cultural competence and the experiences therein. Mo’s words made me think about this statement he made,

> “You know the history of Africa is obviously completely different than the Black history I grew up learning about. We grew up learning of the kingdoms of African constituents and how they were always highly

> regarded, just [equitable] rulers and everything, but here whenever you talk about Black history, it's always oppression, it's always injustice and it's a completely different start. For example [in elementary school in Egypt], when we learned African history, it always started out amazing, at the time when they were prosperous and later comes the stories of exploitation. But in Black history, it's the complete opposite. At the start [of Black history] is the tragedy and you say 'where's the happy ending' and we say it's not here's yet, but hopefully it's coming" (Mo, personal interview).

This detail made me think back to a friend of mine, a beautiful Bahamian man I'd met in undergrad. Everyday, this young man and I would cross paths, literally on a little worn space of dirt students walked everyday between on-campus housing and one of the large lecture halls.

My friend was over six feet and a sizeable man, striking light brown eyes. It irritated me that upon seeing me coming his way, he would look anywhere, any direction other than my eyes. I was annoyed that he was breaking the code I thought was universal - you see another black person you speak. Which is what I told my friend in our "Coming to America" conversation. My friend responded, "I am not Black, I am Bahamian," I told him he was in the U.S. now and nobody looking at him he looked like another Black man. I remember explaining this to my friend as a way to help him understand why I expected him to greet me in that familiar, "black" way. I'd grown up in the ways of exchanging a formal, friendly greeting of some sort upon sight of another face a color like mine. I also shared this with him as his lack of greeting was making him look aloof and cold. Or worst yet, rude.

In his future practice, Mo talks in the interview about creating a space of leadership and advocacy in his community. His desire to build institutions and organizations in health care ran by people who are responsible and ready to serve its community.

**Another Illustrative Case: Bea's Story**

My adopted definition of reflection comes from the work of Mann, et., al., mentioned earlier in this work. The authors summarily define reflection or the quality of reflecting as the "...purposeful critical analysis of knowledge and experience". During the first close-reading of the final reflection paper from the class (the artifact), I highlighted "before and after" passages that indicated to me either directly or indirectly the student's prior experience, thoughts, impressions or emotions about a particular topic. I looked for key words like, "before and after", or statements, like "I once...but now..." or "I didn't know then...but I know now...". I looked for ways students arranged either chronologically or sequentially, their experiences in the "now and then" sense.

The passage below from the final reflection artifact of "Bea" (all names are pseudonyms) is an example of what Mann, et., al., call "iterative learning", one of the two dimensions of reflection that takes the experiences one has had and through analysis, a new "understanding and the potential or intention to act differently in response to future experience" is fostered ("Reflection and Reflective" 597).

In one of her before statements in the written final reflection artifact, Bea writes:

"Before reading the book, I had a preconceived notion that the story would be somewhat of a fairy tale. A story of how a black family overcame an injustice, instead I

was wrong," ("Bea's Artifact).

For me this passage signaled Bea's recognition on a personal level of how "lulled to sleep", my expression, physicians in training can become to conversations about certain patient populations. The stories are so familiar, their outcomes so predictable. I wonder if these stories of experiences from marginalized or medically disenfranchised patient populations are locked in an iterative or repetitive dimension of reflection for physicians in training? In other words, are stories about certain experiences relegated to being just another one of those stories about health disparities when students reflect on their knowing about that particular population? If this is the case, in part or theory-- then all the more imperative the call for new patients stories and experiences.

In the second close-reading of the written final reflection artifact, I coded for "future statements" or those statements where students who are professionalizing into medicine, project or predict -- either definitively or in abstract form some aspect of becoming a doctor and how they will approach doctor-patient relationships in future practice.

The passage following from Bea's written artifact illustrates her future statement, She writes:

> "After reading this story I took a vow, to be the best physician I can be, not only taking care of the physical ailments of patients, but also at least referring them and following through with their psychosocial needs as they tremendously affect health outcomes," (Bea, "Final Artifact").

In an in-depth follow-up interview, Bea explained what she meant by the before and after and future statements highlighted above. It has been nearly six months since the seminar and writing the final reflection paper at the time of our talk. During the

interview, Bea again culls her reflections from her story repository of experiences working as a dialysis technician; a position she held for over three years to develop and practice skills with actual patients. During the interview, thinking back to the passages she'd written in her final reflection paper, Bea says,

> "I guess when I finally read the book and at the point of having worked in three different dialysis clinics--inner city and in the suburbs-- for three years, ***AND*** (her vocal emphasis; my typesetting to emphasize her exasperation) after watching so many African-Americans struggle through the renal failure and the diabetes issues…
>
> I think when I finished the book it was kinda like. 'Okay, you know what? I'm tired of this, I'm tired of the you know, 'I didn't know' [patients comments about their renal failure]…

Bea's expression of frustration in the interview, I noticed triangulated a moment in the written artifact where she "vows in the future to be the best physician I can be, not only taking care of the physical ailments of patients, but also…their psychosocial needs as they tremendously affect health outcomes."

In the interview, she was emphatic that this vow was not only in tact, but attainable. She says, "I think that I think inequality can be reduced through educating, implementing and educational program that starts in kindergarten…"

When given the opportunity, the space to focus, critically think, reflect, and write, students can cull their own story repositories and inwardly challenge their biases and outwardly plan to or project future actions in practice. They can begin in reflecting to think through a number of possibilities to problem-solve patients' problems.

## Chapter 5: A Cold Case and Mistrust: Two More Illustrative Cases

### "I was trained as a scientist…" Phay's Story

Prior to coming to the post-baccalaureate program at the community-based medical school, this student worked in a research laboratory. She writes in a statement coded as "before", "Prior to having read the book…the only exposure I had to HeLa cells was working with the in an isolated, cold room inside a sterile, ventilated biological cabinet." She continues, "I was working with human cells, but lacked the human connection to the donor."

When I spoke with Phay about her training as a scientist and the impact it's had on her practicing with cultural competence, she was starting to become more aware of the fact that she'd been training into the science of the laboratory, even working with HeLa Cells, but she'd been trained out of the human part. The laboratory experiences prior to coming to medical school had an imprint on how the student felt and on how she viewed herself in an ancillary position to medicine prior. The laboratory is a place where anonymity is the order of the day and everything is stripped of any human identity. "We get the part of the specimen and it's labeled, sample blah, blah, blah – we have no idea, what the person was, who they were, nothing, the anonymity deduces them to the sample number" (Phay Final Artifact).

When we talked for her in-depth interview, Phay revisited how her training as a scientist made her work dehumanizing and makes the person invisible in research labs. Phay remembered a time she felt deduced, felt anonymous. As an immigrant to this country, she has been deidentified before and knowing how that felt, she was careful to and never wanted to make any one else feel anonymous. In fact, she wondered aloud during our interview if there was a way for scientists and workers like her in the labs to

know the story of the person behind the story. "Would knowing the story of the person behind the sample, remembering the human part of it make the scientists and little workers like me work harder [to find cures]?" (Phay Personal Interview).

I wondered as Phay did what would happen if scientists in labs had the stories behind the people who'd donated their body to science? Would this make the process of science more humanizing for those who work with the cells like HeLa? This comment in my mind was a moment for the student to think through the professionalizing into the anonymity of human beings in medical research. It was also a moment to think through the invisibility of those who do gain access to medicine. I imagine Phay connects her own anonymity and that feeling before to how she plans to practice in the future.

**Another Case: "I don't trust medicine, myself." Nadine's Story**

Nadine wasn't from the Midwest. In fact she and her parents are from the West coast in the state of Washington by way of Tanzania. Seattle doesn't offer a lot in terms of diversity in the way socially or environmentally, and most certainly not in medicine. In the example below, she connects her prior experiences with narrative and patient history to the importance of listening to the patient's story and just letting it unfold. She writes in her "before" statement:

> "I find it most valuable, clinicians, who practice narrative competence, take into consideration the patients' environment when examining their health. I realized how important this type of care is, particularly, in low income and poorly educated populations, when I volunteered in Costa Rica with VIDA." "The experience taught me to take patient histories by allowing the patient to merely speak. And as the patient in the "Narrative and Medicine" article, my

patients were enlightened that they had control over how to convey to me what their illness was."

During her interview, Nadine elaborates on her experiences in Costa Rica with patient care. The few volunteers with virtually none to a little bit of medical knowledge assist the volunteering doctor at the make-shift clinic. Nadine reminded me in her interview that she knew the health of the patients she saw at the clinic was detrimental as the people who came to the clinic would only visit the yearly makeshift clinic for their needs.

Nadine said, "I didn't know what was really going on with this woman I was seeing. She just said she needed some medicine. I didn't see or think anything was physically wrong with her, but her story told me more." The patient Nadine was seeing shared her story that she was a widow and the death of her husband, the provider of the family, has left her and her children without the basics including limited resources for food. The patient also explained that the headaches she'd been having were severe. Nadine later learned the patient's electricity was cut off and she had no income to get the electricity turned back on.

When recalling that story during our post-class interview Nadine said, "There's no amount of medicine that would have stopped what was really going on at home, what was really affecting her was her environment," Nadine said. "I spoke with the attending doctor and suggested the real problem here is depression due to these problems in her environment or personal life. The doctor agreed. The electricity was temporarily restored after a phone call at the clinic. For that moment, her headache was bearable."

Nadine presented some thoughts about her own understanding after carefully considering the patients story, she writes in her final reflection paper the following "after" statement:

> "The physical symptoms, I now understand, are not independent of the entire human body experience. One's mental health as well as everyday experiences with their surroundings impacts their overall health and can lead to physical symptoms that cause some people to finally seek medical assistance."

A number of times during class, Nadine referenced her own history as an immigrant in this country, second generation. She talked about the impact of environment in her home-life and how the physical and the entire human experience are related. She explained what she meant with the story of her brother, a child who suffers from a speech impediment due to poor ear health and what Nadine believes is neglect due largely to her parent's denial.

> "My brother has a condition that honestly we ignored. We didn't focus on it, we didn't talk about it, and we didn't seek help for it. The sad thing is my brother's condition, his speech problem, could have been corrected if it was dealt with early on." Nadine explained that her parents who were immigrants to this country were very distrusting of the US medical system. She said, "It's not like my parents grew up in a time [like Henrietta Lacks] that they'd know what that was like. They didn't experience that in Tanzania, but coming here, they have a serious mistrust. They know the stories though about what happened here to Blacks."

Nadine's story about her parents quoted here from her interview was something Nadine also shared in class. She linked this story to her own mistrust and the quandary of not trusting medicine herself based on her familial and premedical clinical experiences yet she's pursuing a medical degree. Nadine said, "It's funny with me wanting to be and studying to be a doctor, I don't go to the doctor myself."

Nadine's confession revealed her own bias and mistrust of the medical profession, the one she is training to enter. Her story illustrates in my mind an important thing to know about today's 21st century doctors that are immigrants, inherently the students who's parents like Nadine's and like Nadine herself have an understanding that is culturally located in their prior experiences. The inclusion of these experiences and the influence on the future practice of culturally competent care is important. So much so, The Education Commission for Foreign Medical Graduates (ECFMG) has expressed concern that International Medical Graduates of IMGs recognizes there are problems within creating a community of culturally competent physicians amongst IMGs. Researcher Harriet P. Bernstein, in her work quoted a statement from the ECFMG website, "There continues to be obstacles and challenges for IMGs and those with whom they interact with respect to their full integration into American culture, American Medical culture, and the American medical system," ("International Medical Graduates" 1). The reminders from Bernstein's work validates the experiences of at least Mo and on some level I think Nadine too. For Nadine this reminder of not being fully integrated into the medical profession may be interconnected with her own avoidance to being a patient herself within the healthcare system.

**The significance of these cases…Concluding or Continuing to Find a Place To Stand in Writing Studies and Medicine**

The work of teaching cultural competence through reflective writing with a pedagogical approach rooted in storytelling is a viable option for medical education. Stories, particularly those stories associated with artifacts, or objects, can open up what's inscribed on each of us when it comes to racial and ethnic experiences in America for that matter, but in medicine.

I keep thinking back to the statement the student made after class, that no one had asked what her experiences were with race and ethnicity in medicine. I wonder then if no one is asking, then how do you deal with or sort through developing the attitudes, knowledge, and skills necessary to practice cultural competence? I submit through this research that courses like "Stories and Writing" are necessary. I assert also a critical approach to using storytelling as pedagogy and using reflective writing as the recursive act is a viable strategy to explore the experiences students have with race and ethnicity in medicine. In her article, Yiannis Gabriel, London based narrative researcher points out that there is ample evidence to support that "narratives and stories enable individuals and groups to discover their voice, articulate their experiences and even shape their self-identities," ("The Voice of Experience" 169). It seems to me that medicine recognizes the power of story in its clinical practice (though Narrative Medicine continues to grow). Medicine has also come to see the power of how stories can move from the who to the what. If we ask people who they are, they are required to consider how to construct this narrative. Royster talks about voicing and its need to be understood as a phenomena, "a thing that is constructed and expressed visually and orally…and has important also in being a thing heard, perceived

and reconstructed," ("When the First Voice" 30). I would agree that voicing needs to be understood.

Within the context of the specific cases and the linkages to the literature relevant to its meaning and application, I offer this stories for consideration that these stories together constitute the knowing that can result from using stories as pedagogy. It constitutes a way that stories can be used to open up meaning about cultural experiences in medicine. I offer these illustrative cases to also depict 21st century exposure and understanding that today's medical students may have about medicine's racialized past and its continued practices of racism, Othering, excluding instead of including – and the like. I think these cases offer thought that storytelling as pedagogy supports the field of Writing Studies notion that all we are are stories anyway and that learning from them; narratives is one way for people to uniquely share who they are and learn about others.

In my work that lies ahead, I hope to continue using *"The Immortal Life"* and additional artifacts to teach cultural competence. The notion of using narrative as inquiry of the self and systems at work in society overall and medicine specifically is significantly sound methodology. I also believe these cases and the work herein provide a context and support for a conversation between the fields of medicine, writing studies, rhetoric and composition and cultural rhetorics. I think what each field knows and has presented as theory and /or method, and about creating curricular innovations will continue to provide a rich framework to draw from in teaching cultural competence and other factions of medicine where storytelling and the sharing of "the personal" is particularly compelling and can/will effect practice.

The theories of experience and the relativity of these theories from rhetoric and composition and writing studies is particularly useful in doing what Royster says happens when we understand "subject position really is everything, ("When the First Voice" 29). When Royster talks about the ability to be a hybrid and negotiator in the instances of sharing experience that give voice or voicing as a phenomena of a "…thing being heard, perceived, and reconstructed" (30). I believe like Royster that voicing is rhetorical in nature and I would say selective when used with survivance like Powell means it, "survival and resistance" (400).

The work between the fields of rhetoric and composition, medicine, and cultural rhetorics establishes a strong relationship between story, reflective writing, and reading culture and text. My work is at least one bridge between the fields.

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