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“A Doctor Is Less Valuable Than a Working Truck”:
A Phenomenological Study Exploring International Immersion Experiences of Primary
Care Physicians Trained in the U.S.

by

Julie M. Shasteen

A DISSERTATION

Presented to the Faculty of
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For the Degree of Doctor of Philosophy

Major: Human Sciences
(Leadership Studies)

Under the Supervision of Professor Gina Matkin

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“A Doctor Is Less Valuable Than a Working Truck”:
A Phenomenological Study Exploring International Immersion Experiences of Primary
Care Physicians Trained in the U.S.

Julie M. Shasteen, Ph.D.
University of Nebraska, 2017

Adviser: Gina S. Matkin

This phenomenological study describes the experiences of primary care physicians trained in the United States who participated in an international clinical immersion rotation during medical school or residency. Five central themes emerge relating to their experience: (a) Participants chose the international rotation for developmental purposes. (b) The lifestyle in their destination country was different than in the U.S., and this had an impact on participants. (c) There were positive outcomes for participants and their future practice. (d) Harmful external forces (at the rotation site) shortened patients’ lifespans and had a negative impact on their quality of life. And, (e) participants wonder whether they have chosen the right profession.

The process of participating in the immersion experience helped participants grow, think, and feel in new ways, both professionally and personally. They developed observational skills by living in the same environment as their patients. They learned resourcefulness as they solved practical problems with no one to support them. They

became more confident through their daily work and by being considered “the doctor.” They learned to adapt to the ways of people and cultures that “slow down” and live at a different pace compared to people in the U.S.

One particularly significant observation is that they described changes and awareness consistent with growth in cultural competence, even though this was not their primary intention. The essence of the immersion experience is a constellation of developmental growth areas for primary care physicians who participated, but evidence of possible cultural competence development is at the forefront.

Acknowledgements

Completing this dissertation is a testament to the University of Nebraska. I always hated school, and I finally came to the University of Nebraska as a nontraditional student for my undergraduate education. After that, I did not want to stop learning. While classes were engaging and time flew by, the prospect of writing a dissertation was a different story.

I am thankful to my mother for nurturing my internal drive to “finish what you’ve started,” and I am thankful to my daughters, who have always made me so proud. I wanted to do the same for them. The influence, example, and encouragement of my whole family has been an important part of this project.

I want to acknowledge and thank the participants in this study. I am grateful for their openness and frankness. Their trust in me was humbling. Their respect for the research process inspired me as an academician.

I would especially like to recognize and thank the following people who were instrumental in the completion of my academic journey: I am so grateful to my adviser and committee chair, Dr. Gina Matkin. She has the gift of bringing out the best in others! Foremost, she challenges her students academically, but she is also an unwavering supporter and always leads with kindness. I would like to thank the members of my committee, Dr. Lindsay Hastings, Dr. Mark Burbach, and Dr. Ian Newman, for their time, expertise, and feedback. Additionally, Dr. Eva Bachman encouraged me at my lowest points during this process.

The legendary journalist Dan Rather once said, “If all difficulties were known at the outset of a long journey, most of us would never start out at all.” I am glad I did not know how difficult it would be.

Dedication

For Robin.

Table of Contents

Chapter 1: Introduction	1
Statement of the Problem.....	1
Target Audiences	10
Assumptions of the Study	10
Delimitations and Limitations	11
Relevance of the Study	11
Chapter 2: Literature Review.....	13
The Need for Increased Cultural Awareness for Primary Care Physicians	15
Implicit Bias and Health Disparities	25
Experiential Learning for Physician Development	35
Physician Development Progression throughout Medical Training	40
Current Initiatives to Increase or Improve Physicians' Cultural Competence	44
Current Educational Opportunities and Expectations for Primary Care Physicians to Participate in International Clinical Rotations	48
Summary of Literature Review	50
Chapter 3: Methodology.....	52
Qualitative Methodology	52
Phenomenological Inquiry	56
Origins of Phenomenology	58
Philosophical Assumptions and Worldview	60
Study Participants and Sampling Method	61
Research Questions	63
Interview Protocol.....	63
Data Collection	64
Data Analysis	65
Validation.....	66
Ethical Considerations	68
Role of the Researcher	69

Chapter 4: Findings	70
Researcher's Reflections	74
Theme 1: Participants chose the international rotation for broad developmental purposes, not solely for cultural competence development.	78
Subtheme 1.1: Cultural competence is a secondary motivation for participating in the international rotation, not the primary one.....	78
Subtheme 1.2: With self-development at the forefront, the participants sought the rotation for intellectual growth and challenge.	80
Subtheme 1.3: Participants stated the rotation was something they are expected to do or it is part of being the best in their profession.	83
Theme 2: Positive outcomes for participants, especially as it relates to cultural competence.....	86
Subtheme 2.1: Participants' future medical practice was impacted by adding social context and family information to diagnosis and treatment plans.	88
Subtheme 2.2: Participants adapted to resource challenges.....	93
Subtheme 2.3: An interest in primary care became clearer due to increased autonomy and confidence.	99
Theme 3: The lifestyle is different than the U.S., allowing participants to be more observant and contemplative than they were at home, enabling development. ..	103
Subtheme 3.1: Being away from a hypercompetitive environment was a welcome change. .	103
Subtheme 3.2: The pace of each day gave them time to reflect and unwind.	106
Theme 4: Harmful environmental forces shorten patients' lifespans and quality of life. As a doctor, there is limited ability to impact population health.	109
Theme 5: Participants wonder whether they have chosen the right profession, but feel unable to consider a change, primarily due to debt.	115
Summary of Findings.....	121
Textural Description	121
Structural Description	123
Essence.....	123
Chapter 5: Discussion.....	126
Chapter Summary	126
Researcher's Motivation	128
Discussion of Findings.....	132
Significance of Findings and Implications.....	141
Practical Applications	144
Future Research.....	147

Conclusion	148
References.....	151
APPENDIX.....	178
Appendix A. Email Invitation to Participate.....	178
Appendix B. Informed Consent Form.....	180
Appendix C. Pre-Interview Questionnaire – Julie Shasteen	182
Appendix D. Sample Interview Protocol – Julie Shasteen	183
Appendix E. Post-Interview Participant Feedback Email.....	184
Appendix F. Tool for Assessing Cultural Competence Training (TACCT)	185

List of Figures

Figure 1. Issues described in this study.....	14
Figure 2. Location of participants.	74

List of Tables

Table 1. The 15 CLAS Standards	21
Table 2. Medical School Students Who Participated in a Global Health Experience	49
Table 3. Qualitative Research Traditions.....	54
Table 4. Procedures in Phenomenology.....	58
Table 5. Participant Demographic Information	73
Table 6. How Primary Care Physicians Trained in the U.S. Experience International	77

Chapter 1: Introduction

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”

—Martin Luther King, Jr.

Statement of the Problem

The purpose of physician education is to “improve the health of all” (Glicksman, 2016, p. 1). As medical professionals and clinical leaders, physicians have a great impact on the tone, tenor, and outcome of care for a diverse group of patients. Some aspects of medical education and the resulting competencies are measured, tested, and monitored (e.g., technical skills, standard laboratory ranges for particular disease states, medication contraindications); while other aspects of physician development, including cultural competency development, may be more difficult to assess.

Currently, physician education has not shown the capacity to improve the health of all. According to a meta-analysis published in 2015 by equity expert, law professor, and co-founder of the Colorado Health Equity Project, Dayna Bowen Matthew, J.D., reviewing 55 years of data, “Studies show that implicit bias predicts treatment behaviors that are sufficiently correlated with adverse health outcomes [for minority patients in the U.S.] to strongly infer causation” (2015, p. 137). Bias in judgment or behavior resulting from subtle cognitive processes taking place below one’s consciousness, and without intention, may result in attitudes and stereotypes that affect care. A preponderance of evidence dating from 1960 demonstrates a continued need to address cultural competence development in physician education (Satcher, Fryer, McCann, Troutman, Woolf, & Rust, 2005).

The U.S. Department of Health and Human Services Office of Minority Health (OMH), in collaboration with the Agency for Healthcare Research and Quality (AHRQ), sponsored an examination of the impact of cultural competence on health care delivery and quality of related health outcomes in 1998. The final report acknowledges in its education and training section that “currently, there is no consensus on the definition of cultural competence in individuals nor what constitutes a culturally competent health professional. Moreover, there are no standard curricula or universally accepted certification or credentialing for cultural competence, and no standardized measures for evaluating the effectiveness of cultural competence trainings” (OMH, 2013, p. 5).

As a result of the 1998 findings, an executive order was signed by President Clinton on August 11, 2000, requiring all federal agencies to create plans to “improve access to federally conducted or federally assisted programs for persons who, as a result of national origin, are limited in their English proficiency” (U.S. Department of Justice, 2015, p. 7). The intention of this order was to remove language and cultural barriers for limited English-speaking populations, and it resulted in the large-scale modification of language services and access to real-time translation services across both inpatient and outpatient health care settings in the U.S. However, the scope of this order was inadequate to address the overarching cultural disparities in health care.

The second result the OMH analysis was the development of the Culturally and Linguistically Appropriate Services (CLAS) in health care standards, with its first version published in 2000 and later updated in 2013. These 15 national standards were designed for health care organizations, but the OMH also suggested that individual providers incorporate these goals into their practices, with educators, accrediting bodies,

purchasers, patients, and advocates all having a role in understanding and incorporating the new standards. Standards 1–3 describe culturally competent care, with Standard 1 stating that physicians, “Provide effective, equitable, understandable, and respectful quality care and services” (CLAS, 2013, p. 1). The Institute of Medicine’s (IOM’s) report lobbied for all medical schools and organizations to develop “cultural competence” as a core competence for all current and future health care providers (Institute of Medicine, Board on Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003, p. 44).

Aside from the injustice of disparate care, the direct medical costs attributed to health inequities for African American, Hispanic, and Asian American patients in the U.S. over the 3-year period of 2003–2006 were estimated at nearly \$230 billion, or 30% of their total cost of care (LaVeist, Gaskin, & Richard, 2011). Correcting this problem would provide a potential \$69 billion dollar savings in overall health care costs to society. According to a 2009 report by the Joint Center for Political and Economic Studies, additional indirect costs due to illness and premature death for this population during 2003–2006 were estimated at \$1 trillion. Chapter 2 will expand on these concepts, outlining issues pertinent to this study.

How can we learn more about what kinds of cultural competence education during medical training are meaningful to patient outcomes, society, and physician development? There are 145 accredited medical schools in the U.S. that are governed by the Association of Medical Colleges (AAMC) and the affiliated Liaison Committee on Medical Education (LCME), with a multitude of cultural competence programs in place.

Wu (2015) states that, “90 percent of all medical schools (in the U.S.) now offer some form of cultural competence education as part of their training programs” (p. 2).

The Accreditation Council for Graduate Medical Education’s (ACGME) framework for cultural competency training includes varying degrees of specificity and listed training requirements by specialty and subspecialty area (Ambrose, Lin, & Chun, 2013). There is a continuing lack of uniform requirements for the education, training, and evaluation of physicians and other health care professionals in terms of providing culturally competent health care (National Conference of State Legislatures, 2013).

Although there is a consensus on the importance and impact of cultural factors, there is a lack of consensus on the way in which cultural training should be provided (Betancourt, 2006; Betancourt, Green, Carrillo, & Park, 2005; Dogra, 2007; Kripalani, Bussey-Jones, Katz, & Genao, 2006). Some experts suggest a need for further understanding the impact of experiential learning and cultural competence (Bowen Matthew, 2015).

Total immersion programs are recommended as an ideal way to develop cultural responsiveness in pre-service teachers (Mahan & Rains, 1990; Quinn, Barr, McKay, Jarchow & Powell, 1995; Wiest, 1998). Experiential learning advocates Monica Pagano and Laura Roselle (2015) indicate that international experiential education must be more than the mere action of participating in a different working environment; rather, it requires structured, conscious, and critical reflection (which they term *refraction*) to elaborate on the learning experience and create a truly transformative learning process. Qualitative research can provide conscious reflection for study participants.

Given the gaps in understanding about how to best impact cultural competence development during primary care physicians’ medical education and training, qualitative

inquiry may provide an opportunity to make sense of the experience of the immersion rotations of physicians in training and glean insights into the role of these experiences in medical education beyond learning skills and knowledge. While there is limited literature available that pertains to medical education and international immersion experiences, significant scholarly publications are available that discuss teachers' immersion experiences using a qualitative methodology that explores cultural responsiveness and development (Hovater, 2007).

Purpose Statement. The purpose of this phenomenological study is to explore how primary care physicians trained in the U.S. describe their cultural competence development, or other developmental attributes, resulting from international clinical immersion opportunities. My choice of qualitative methodology supports my purpose because, as discussed in Moustakas (1994), phenomenological research addresses two primary questions:

- What are the experiences of the participants?
- What are the contexts of those experiences?

Lived experiences are the direct experiences and perspectives the participants have with a central phenomenon (Creswell, 2007). My goal is to uncover more about these lived experiences through detailed, in-depth descriptions by the participants.

Grand Tour Question. The overarching question of this study is: How do primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international elective rotation?

Sub-Questions. This study also seeks to answer the two following subordinate questions: What are the lived experiences of primary care physicians trained in the U.S.

and the context in which they experience international clinical immersion? And, how do immersion experiences impact physicians, their cultural competence or other development, and their future practice?

Definition of Terms. This study uses the following terms with the definitions assigned below:

Adherence. In medical terminology, *adherence* is the “... extent to which the patient continues the agreed-upon mode of treatment under limited supervision when faced with conflicting demands” (“Adherence,” n.d.).

Affordable Care Act. “The Affordable Care Act actually refers to two separate pieces of legislation—the Patient Protection and Affordable Care Act (P.L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152).” These two pieces of legislation are primarily intended to enhance the quality of health care for all Americans (“Affordable Care Act,” n.d.).

Competence. Having the capacity to function effectively as an individual or as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (OMH, n.d., “Think cultural health”).

Cross-cultural field experience. This type of experience is gained when a person lives with and interacts daily with a group whose culture is different than his or her own and may be thought of as a minority or outsider by the mainstream group (Stachowski & Mahan, 1998).

Culture. “The collective programming of the mind which distinguishes the members of one human group from another. . . . The interactive aggregate of common

characteristics that influence a human group's response to the environment" (Hofstede, 1980, p. 25).

Cultural awareness. The heightened ability of individuals to understand and to internalize their own cultural values, beliefs, and unique characteristics (i.e., their worldview), while comprehending that others may not share those same values, beliefs, and characteristics. Synonyms of *cultural awareness* include *cultural sensitivity* and *cultural responsiveness* (Gingerich, 1998; Villegas & Lucas, 2002).

Cultural competence. In health care, *cultural competence* is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables effective work in cross-cultural situations" (Cross, Benjamin, & Isaacs, 1989, p. 28).

Ethnicity. An ethnic group, or a social group that shares a common and distinctive trait such as culture, religion, or language ("Ethnicity," n.d.).

Ethnocentric. This term "... represents levels of intercultural sensitivity where one's own culture is experienced as central to reality in some way" (Matkin, 2005).

Ethnorelative. This term "... represents levels of intercultural sensitivity where one's own culture is experienced in the context of many cultures" (Matkin, 2005).

Fee-for-service. In the current fee-for-service model of reimbursing providers for health care, physicians and organizations have constructed financial incentives to "do" more. The more tests conducted, the more patients seen, or the more procedures performed, the more fees are billed; and consequently, the more money the health care provider makes, regardless of the quality of care or positive health outcomes for the patient (Dartmouth-Hitchcock, 2016).

Graduate Medical Education (GME). The formal medical education that comes after receiving the doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree, including intern, resident, subspecialty, or fellowship program rotations. After completion of GME, physicians apply for licensure and board certification.

Health outcomes. “A change in the health status of an individual, group, or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status” (“Definition of Wellness,” 2013).

Immersion. Living in and participating in another culture 24 hours a day for an extended period of time (Stachowski & Mahan, 1998).

Immersion experience. For the purposes of this study, *immersion experience* is defined as a clinical experience in a developing nation for six weeks or more, living within a native population (as opposed to segregated from the natural patient population).

Implicit bias. Bias in judgment or behavior that results from subtle cognitive processes at a level below our conscious awareness and without intentional control, which may result in attitudes and stereotypes (National Center for State Courts, n.d.).

Intercultural sensitivity. In the context of this study, *intercultural sensitivity* is defined as “the ability to communicate effectively in cross-cultural situations and to relate appropriately in a variety of cultural contexts” (Bennett, 1993, p. 22).

Intercultural sensitivity development. For the purposes of this study, *intercultural sensitivity development* is defined as “development through stages of personal growth on a continuum of increasing sophistication in dealing with cultural

difference moving from ethnocentrism through stages of greater recognition and acceptance of difference ethnorelativism” (Bennett, 1993, p. 22).

Monocultural. Living one’s entire life in one culture.

Primary care physician. For the purposes of this study, the term *primary care physicians* includes family practice, internal medicine physicians, and pediatricians.

Patient-centered care. Partnering with patients and their families to facilitate understanding and respect for each patient’s unique needs, culture, values, and preferences (OMH, Agency for Healthcare Research and Quality, 2004). This includes the patient’s perspective as to the appropriateness of care (Institute of Medicine, Board on Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003, p. 178).

Patient satisfaction. A patient’s opinion of the quality of care he or she received.

Race. A group of people classified together on the basis of common history, nationality, or geographic distribution (“Race,” n.d.).

Value-based care. Various reimbursement models are value-based in nature, including bundled payments for an episode of care, capitation on reimbursement for each covered patient life, and incentive payments from a shared savings model in which the health providers share in cost savings that statistically result from their care. “A major component of the Affordable Care Act is to change the way hospitals are paid, moving away from a reimbursement model that rewards procedures to one that rewards quality and outcomes” (Cosgrove, 2013, p. 1). Instead of incentives for how many patients are seen, the volume of tests and procedures ordered, or dollars charged as markers of the depth of care, the focus is on the appropriate cost containment and patient outcomes

aimed at quicker recoveries, fewer readmissions to the hospital, lower infection and complication rates, and the reduction of medical errors.

Target Audiences

The primary target audiences for this dissertation include researchers, medical education curriculum development leaders, international clinical rotation directors, physicians, medical students, and policy makers who contribute funds to medical education programs. This study will inform medical education programs, faculty, administrators, and international elective directors as to the effects of their current programs and provide insight into the creation of future programs.

Assumptions of the Study

This study begins with an assumption that the lived experiences of the participants are meaningful, unique, and developmental. I assume that physicians were forthright about their experiences and were open to sharing both professional and personal impacts that may have resulted from their immersion experience. While I do not assume generalizability, I assume that the experiences reported in the interviews are substantial, valuable, and provide insight for me as a researcher. In addition, the following other assumptions apply:

- Preparing physicians to treat a multicultural patient population is an objective of medical education.
- There is a need for greater cultural competence for all current and future health care providers in U.S. (Institute of Medicine, 2003).
- Cultural awareness is not a cognitive process; rather, it is obtained primarily through experiences (Boyle-Blaise, 2002; Villegas & Lucas, 2002).

- Participants in this study were willing participants in their cultural immersion experience. Furthermore, they were interested in seeking a cross-cultural experience. A willingness to participate in an international elective assumes at least a minimal interest in other cultures and their medical needs.
- Participants gained an immersion experience while participating in their international assignment.

Delimitations and Limitations

“Delimitations are the factors that prevent you from claiming that your findings are true for all people in all times and places” (Bryant, 2004, p. 57). The delimitations of this study include the narrow criteria of the selected participants; and conversely, the broad differences inherent in the many diverse countries and communities in which the study participants were located during their immersion experience.

“Limitations are those restrictions created by your methodology” (Bryant, 2004, p. 58). This study is designed around a single research method: qualitative research procedures. “Qualitative research is fundamentally interpretive” (Creswell, 2003, p. 182). The research gathered by one author has the potential to be interpreted differently by different readers. As a researcher, I attempt to view any phenomena holistically; however, the researcher may introduce her own bias into the analysis of the findings. “The personal-self becomes inseparable from the researcher-self” (Creswell, 2003, p. 182).

Relevance of the Study

This study is important for reasons both individual and institutional. Physicians develop patterns of assessment and treatment during training, which can contribute to

variability in treatment and patient outcomes. Studies have found a significant association between racial and ethnic bias and medical decision making (Green, Carney, Pallin, Ngo, Raymond, Iezzoni, et al., 2007; Sabin & Greenwald, 2012). Current research also demonstrates inappropriate variability in treatment and poorer medical outcomes for ethnic minority patients in the U.S., and these are attributed to physician bias (Bowen Matthew, 2015). Current research does not adequately address the effect of role model behavior or informal curricula on medical student development (Dennis, 2001; Hafferty, 1998; Kripalani, Bussey-Jones, Katz, & Geano, 2006; Paul, Ewen, & Jones, 2014). Nor does it explain why resident physicians believe they are not adequately prepared to identify relevant cultural issues that may impact care or provide culturally competent care upon the completion of their education (Weissman, Betancourt, Campbell, Park, Kim, Clarridge et al., 2005).

International immersion experiences may have the potential to influence the selection of physicians' specialties, ingrained diagnostic protocols, related costs, their perception of the patient experience, and their own cultural competence development. This study utilizes physicians' detailed, in-depth descriptions to contribute to our currently inadequate knowledge of physician education activities and, in particular, their international immersion experiences. In addition, this study seeks to help us better understand these experiences and how they contribute to the development of cultural competence.

Chapter 2: Literature Review

“It ain’t what you don’t know that gets you into trouble. It’s what you know for sure that just ain’t so.”

—Mark Twain

The purpose of this literature review is to provide a systematic overview of prior research related to the experiences of physicians who participate in international clinical immersion experiences as part of their educational development as physicians. This review is not designed to make assumptions about the results of my study; rather, it is intended to serve as a historical perspective and a starting point for understanding the context of past related research. Figure 1 serves as a visual guide to the concepts introduced in the remainder of this chapter.

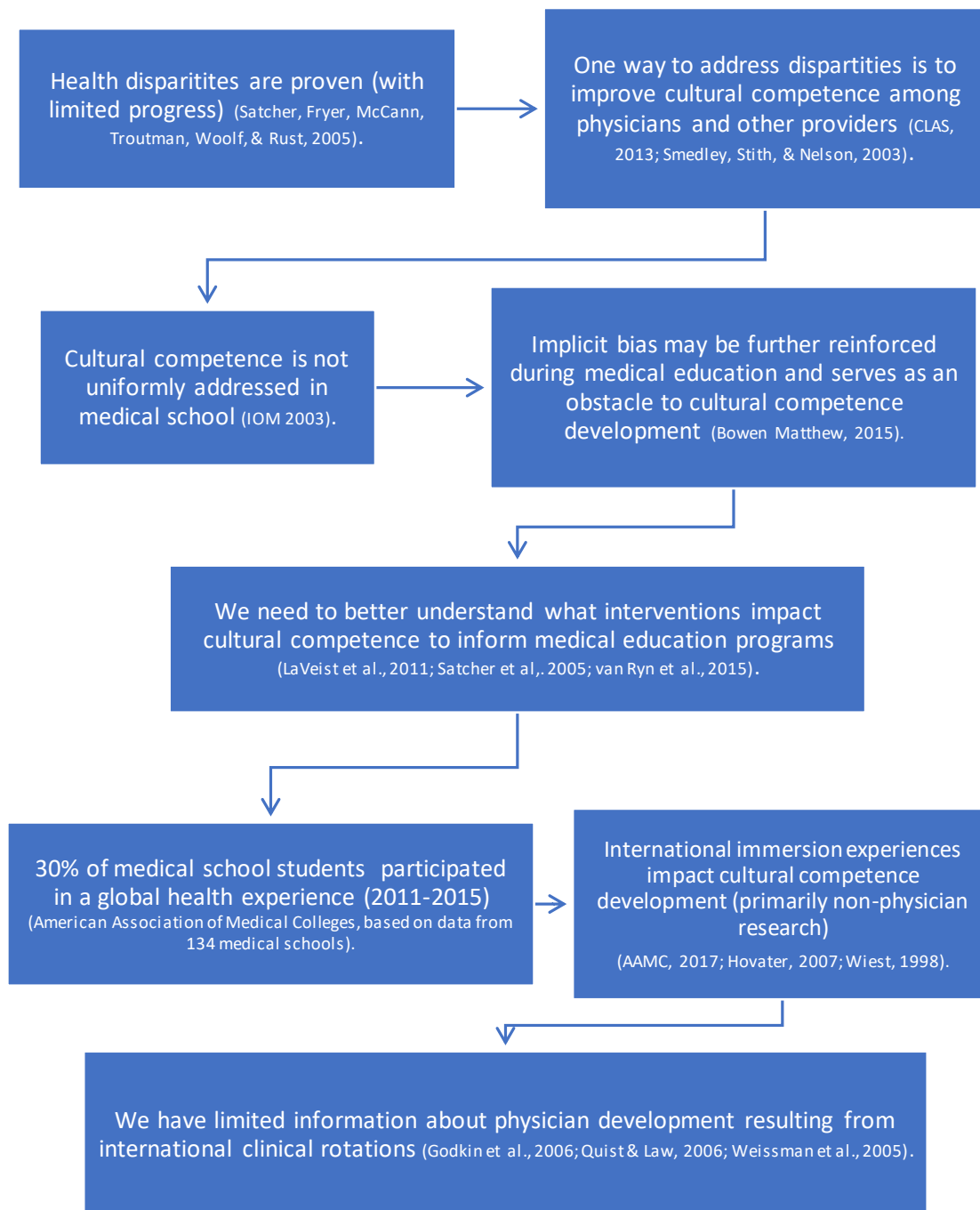


Figure 1. Issues described in this study.

This review examines the need for cultural awareness in physician education and explores specific rationales, current efforts, and initiatives to achieve this. As shown in

Figure 1, I begin by describing the need for cultural awareness due to proven health care disparities and outcomes (Satcher, Fryer, McCann, Troutman, Woolf, & Rust, 2005) and by highlighting research indicating that one way to address disparities is to improve cultural competence among physicians and other providers (CLAS, 2013; Smedley, Stith, & Nelson, 2003). I will also discuss the research that suggests that cultural competence development is not uniformly addressed in medical schools in the U.S. (IOM, 2003) along with data suggesting that implicit bias may be reinforced during medical education and could be an obstacle in cultural competence development (Bowen Matthew, 2015).

Next, I present research that suggests a need to better understand which interventions impact cultural competence and inform medical education programs (LaVeist et al., 2001; Satcher et al., 2005; van Ryn et al., 2015). While 30% of medical students in the U.S. participated a global health experience from 2011–2015 (American Association of Medical Colleges, 2016), we have little understanding of the result of this intervention on physician development and future medical practice. Additionally, a review of international immersion experiences from other disciplines indicates that the experience does impact cultural competence development (American Association of Medical Colleges, 2017; Hovater, 2007; Wiest, 1998), yet there is limited research about physicians' development from such experiences (Godkin et al., 2006; Quist & Law, 2006; Weissman et al., 2005). I conclude with a summary justifying the need for this study in light of the literature reviewed.

The Need for Increased Cultural Awareness for Primary Care Physicians

Betancourt, Green, and Carrillo (2002) present the following conclusion:

Cultural competence in healthcare affects the quality of medical services and treatment:

As the United States becomes a more racially and ethnically diverse nation, healthcare systems and providers need to respond to patients' varied perspectives, values, and behaviors about health and well-being.

Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular.

Racial and ethnic minorities make up at least 30% of the U.S. population, with a projected 50% of the population by 2056 (National Conference of State Legislatures Forum, 2013). The OMH, in collaboration with the Agency for Healthcare Research and Quality (AHRQ), sponsored an examination of the impact of cultural competence on health care delivery and quality outcomes in 1998; but as of 2005, only limited progress was evident. Studies suggest that 83,570 minority patients still die annually due to disparities in care (Satcher et al., 2005).

From 1960 to 2000, African American infants and African American men age 35 and older had a worsening standard mortality ratio (SMR), which is the ratio that quantifies the increase or decrease in the mortality of a study cohort as compared to the general population of similar attributes (Satcher et al., 2005). Additionally, the Black–White gap overall changed very little over this 40-year period (Satcher et al., 2005). Compared to Whites, “minority patients are less likely to receive appropriate treatment for cardiovascular disease, cancer, cerebrovascular disease, renal disease, HIV/AIDS, asthma, diabetes, or pain” (Bowen Matthew, 2015). Minority patients receive inferior maternal, pediatric, mental health, rehabilitation, and hospital services compared to

Whites (Institute of Medicine, 2003). Data on the three leading causes of death in the U.S. (i.e., heart disease, cancer, and end-stage renal disease) show sustained disparate treatment (Bowen Matthew, 2015). Citing 25 studies, and controlling for factors that include wealth, ability to pay, and socioeconomic status, Bowen Matthew (2015) found that health inequities are still apparently associated only with race and ethnicity. In fact, health care disparities attributed to race and ethnicity alone actually increased from 1996–2005 (Le Cook, McGuire, & Zuvekas, 2008).

The direct medical costs attributed to health inequities for African American, Hispanic, and Asian American patients in the U.S. over the 3-year period of 2003–2006 were estimated at nearly \$230 billion, or 30% of their total cost of care (LaVeist, Gaskin, & Richard, 2011). These direct medical costs represent spending on treatments, including doctors' visits, emergency care, hospitalization, medication, follow-up care, rehabilitation, and nursing care, among other direct costs attributable to disparities. Correcting this problem would provide a potential savings of \$69 billion in overall health care costs to society (LaVeist, Gaskin, & Richard, 2011). In 2009, the Joint Center for Political and Economic Studies reported that indirect costs due to illness and premature death for this population during 2003–2006 were estimated at \$1 trillion. The indirect costs that result from a disease, a period of illness, or a premature death may include loss of work, wages, and productivity; transportation costs; child care costs; and other similar downstream impacts. While racial and ethnic disparities have been well documented, past research has focused on describing the problem with little focus on identifying proven strategies to address disparities or to make meaningful recommendations for best

practices (King, Green, Tan-McGrory, Donahue, Kimbrough-Sugick, & Betancourt, 2008).

Academic medicine holds an important place in society, overlapping research, care for the uninsured, and preparing primary care and specialty care providers to provide high-quality care to all patients. The seminal work, *Unequal Treatment* (Smedley, Stith, & Nelson, 2003), provides a series of both general and specific recommendations to address disparities in care. Smedley, Stith, and Nelson (2003) offer clear recommendations for academic medicine to participate in interventions to reduce health disparities. However, until academic medicine includes “the elimination of health care disparities as a critical part of its mission” (Betancourt, 2006, p. 500), it is doubtful that positive change will occur.

The effort to define and implement strategies that are practical, effective, and culturally competent models of care is still an emerging field. More progress has occurred in some areas (e.g., language access) than in others (e.g., physician education). Because the current system is poorly designed to meet the needs of our current and future patient population, this study hopes to inform one narrow aspect of practice.

According to the large-scale study by Warner (2012), both leadership and organizational behavioral effectiveness are contextual and, in order to activate others, we must understand and leverage the various norms, values, and beliefs of those we hope to lead in order to be successful. While this study and its predecessor from Gladwin and Hofstede (1981) are both nonmedical, they establish a comprehensive framework of cultural dimensions and cultural clusters that are imperative to leader effectiveness and organizational behavioral effectiveness. The well-validated GLOBE study is salient to

all fields, including medicine and medical education, and it informs us that when deciding how to behave and interact with others, the best course of action depends on the context, the background, and the individual with whom we are interacting (House, 2004).

Despite advancements in cultural understanding, a lack of consensus persists regarding requirements for the education, training, and evaluation of physicians and other health care professionals in terms of providing culturally competent health care (National Conference of State Legislatures, 2013). We still struggle to identify what interventions are effective, despite federal guidelines and mandates such as Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in all programs and activities that receive federal financial assistance (e.g., Medicare, Medicaid, and other federally funded insurance), which constitutes 36.4% of the nation's health care expenditures (Bowen Matthew, 2015).

For historical context, the National Center for Health Statistics (NCHS) has classified and monitored age–sex subsets of the population since 1965 (Satcher et al., 2005). Additionally, the U.S. Department of Health and Human Services Office of Minority Health (OMH), in collaboration with the Agency for Healthcare Research and Quality (AHRQ), sponsored an examination of the impact of cultural competence on health care delivery and on the quality of related health outcomes in 1998. In its education and training section, the final report acknowledges the following:

Currently, there is no consensus on the definition of cultural competence in individuals nor what constitutes a culturally competent health professional. Moreover, there are no standard curricula or universally accepted certification or credentialing for cultural competence, and no

standardized measures for evaluating the effectiveness of cultural competence trainings (OMH, 2013, p. 5).

As a result of the 1998 AHRQ findings, Executive Order 13166 was signed by President Clinton in 2000, requiring all federal agencies to create plans to “improve access to federally conducted or federally assisted programs for persons who, as a result of national origin, are limited in their English proficiency” (Executive Order No. 13166, 2000, p. 290).

Additionally, the OMH analysis resulted in the development of the Culturally and Linguistically Appropriate Services (CLAS) standards in health care. The first version was published in 2000, and they were subsequently updated in 2013. The CLAS standards were intended to be national standards for health care organizations, individual providers, educators, accrediting bodies, purchasers, patients, and advocates; and each stakeholder has a role to play in understanding and incorporating the new standards. Each physician is asked to incorporate these goals into their practice.

The CLAS standards represent a “call to action” with 15 standards organized in three sections: themes described as culturally competent care (Standards 1–3), language access services (Standards 4–7), and organizational supports for cultural competence (Standards 8–15) (OMH, 2013). CLAS standards that refer to language and language access (i.e., Standards 4–7) are federal requirements for all recipients of federal funds, which would include payment by Medicare and Medicaid, for example. CLAS guidelines that are activities that were recommended for potential adoption as mandates by federal, state, and national accrediting agencies include Standards 1–3 and 8–13. CLAS Standards 14–15 were suggested for voluntary adoption by all healthcare

organizations (OMH, 2013). Since CLAS standards 1–3 (i.e., Culturally Competent Healthcare Guidelines, Staff Diversity, and Staff Education and Training) are only guidelines set forth by the OMH and are not government mandates, widespread adoption may not occur without stronger requirements. The primary care specialty is particularly important, since it is the gateway to preventive care and to better healthcare and overall costs savings with quality. This was acknowledged by the OMH (OMH, n.d., “National CLAS standards”).

Table 1

The 15 CLAS Standards

#	Description
1	Provide effective, equitable, understandable, and respectful quality care and services.
2	Advance and sustain governance and leadership that promotes CLAS and health equity.
3	Recruit, promote, and support a diverse governance, leadership, and workforce.
4	Educate and train governance, leadership, and workforce in CLAS.
5	Offer communication and language assistance.
6	Inform individuals of the availability of language assistance.
7	Ensure the competence of individuals providing language assistance.
8	Provide easy-to-understand materials and signage.
9	Infuse CLAS goals, policies, and management accountability throughout the organization’s planning and operations.
10	Conduct organizational assessments.
11	Collect and maintain demographic data.
12	Conduct assessments of community health assets and needs.
13	Partner with the community.
14	Create conflict and grievance resolution processes.
15	Communicate the organization’s progress in implementing and sustaining CLAS.

Note. Adapted from the Office of Minority Health (2013).

Culturally and Linguistically Appropriate Services (CLAS) standards for culturally competent care (2013) support the need to create proven curricula to support culturally competent care into health professional education.

The ongoing need for progress to address cultural disparities, rather than to address language issues, prompted Congress to request an Institute of Medicine (IOM) study to further examine the following:

- To what degree are racial and ethnic differences factors in health care (when not attributable to other factors such as access to care, financial ability to pay, or insurance coverage)?
- Explore potential sources of racial and ethnic disparities in health care, examining the role of stereotyping, bias, and discrimination on an individual provider level as well as an institutional and health system-wide level.
- Provide recommendations to eliminate health care disparities.

The IOM's subsequent seminal report lobbied for all medical schools and organizations to develop "cultural competence" as a core competence for all current and future health care providers (Institute of Medicine, Board on Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003). The IOM's stated intention to reduce ethnic and racial minority gaps in health access and health care delivery required changes in education, research, reporting, and tracking; and these may be additionally influenced by payment models, including quality standards, criteria for provider participation, and reimbursement in Medicare and Medicaid.

The IOM (2003) highlighted health care providers' own biases, stereotyping, and uncertainty (with clinical uncertainty resulting) as key factors for unequal treatment of patients, among other factors. Their report recommended three focus areas for improvement:

- Legal and regulatory changes that must be implemented to promote health system change.
- Improvements in health care workers' cultural competence in an attempt to reduce implicit prejudices, bias, and stereotyping.
- Patient-centered care, defined as care that includes the patient's perspective as to the appropriateness of care.

The IOM (2003) clearly stated a need for more research to identify how and when the processes of implicit bias and stereotyping occur and for research to identify potential improvements, to include the training and preparation of health care providers in their school settings and by accrediting agencies. They also noted that no clear understanding exists regarding the degree to which provider attitudes affect the outcome of patients' care (Smedley, Stith, & Nelson, 2003). Additionally, the U.S. Department of Health and Human Services recommends three key priorities surrounding the health of racial and ethnic minorities and underserved populations: 1) the implementation of the Affordable Care Act, intended to address impediments in care; 2) the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, focused on both access to care and culturally competent care and leadership to eliminate health care disparities; and 3) the implementation of the National Partnership for Action to End Health Disparities, focused on the social determinants of health, community, school, and interagency

collaboration to address factors impacting safe and healthy environments (OMH, 2014). The end goal is a “nation free of disparities in health and health care” (U.S. Department of Health and Human Services, 2014, p. 76).

The largest match of medical students to family medicine residency slots in the history of the specialty occurred in 2016 (AAFP News, 2016). Also, the National Resident Matching Program reported that, for the seventh consecutive year, the number of students graduating medical school who chose family medicine has increased. Despite these positive trends, the current trajectory is still not adequate to meet the future needs of the U.S. population. Forecasts indicate a shortage of primary care physicians that is projected to reach 33,000 by 2035 (Projecting Primary Care Physician Workforce, 2016). Family practice physicians have been the most highly recruited medical specialty by health care systems for nine consecutive years (Merritt Hawkins, 2016). Even with the recent increase in primary care specialty residency applicants, after “Match Day,” 155 unfilled positions were subsequently reoffered to medical students who did not match their preferred specialty or specialties and could choose to reapply during the Supplemental Offer and Acceptance Program period (AAFP News, 2016). To put the shortage of primary care physicians in perspective, primary care positions accounted for 14.5% (4,053 of 27,860) of all positions offered in 2015 (AAFP News, 2016), while the Association of American Medical Colleges Council on Graduate Medical Education recommends “at least forty percent of U.S. medical graduates to enter generalist careers” (AAFP News, 2016).

The U.S. population under the age of 18 is expected to grow by only 5% between now and 2025; however, the population age 65 and over is expected to grow by 41%

during that time, creating increased demand for primary care and the treatment of chronic conditions, which are more often required in this patient population (AAMC Supply and Demand, 2016). There is an increased growth in the demand for primary care due to the expansion of the Affordable Care Act, with an additional 24 million people gaining access to health insurance by 2017 as compared to 2010; this means that more people have access to care, with racial and ethnic minorities disproportionately represented (OMH, 2015). Managed care (insurance) companies and new payment model bundles tied to keeping patient populations healthy rely more than ever on capable primary care physicians and their ability to manage patient flows and improve efficiency while providing quality outcomes for diverse patient populations (Betancourt, 2006; Lewin Group, Inc., 2002). This shortage of primary care physicians, combined with the ever-increasing need for culturally competent providers, makes this study population particularly important at this time.

Implicit Bias and Health Disparities

A National Medical Association Perspective meeting presentation in January, 2010, entitled Health Care Disparities in the Era of Health Care Reform, sought to summarize the state of physicians' attitudes on race and ethnicity in comparison to the IOM's recommendations for cultural competence progress, stating, "In 2002, 69% of physicians said that the health care system 'rarely or never' treated people unfairly based on an individual's race or ethnicity" (Kaiser Family Foundation, 2002). "In 2005, 24% of physicians reported that they were unaware of racial disparities in healthcare" (Institute for Ethics, 2005). Despite overwhelming evidence, physicians are still unaware of the existence of health care disparities, the magnitude of the disparities, and the

deleterious effects on patients' lives and health outcomes (Glicksman, 2016; Joint Center for Political and Economic Studies, 2009; LaVeist et al., 2011; Ohio State University Kirwan Institute for the Study of Race and Ethnicity Forum, 2015; OMH, 2001; Satcher et al., 2005; van Ryn, Burgess, Dovidio, Phelan, Saha, Malat, et al., 2011). Physician behavior and decision making is a documented contributor to inequity in care (van Ryn, Hardeman, Phelan, Burgess, Dovidio, Herrin, et al., 2015). This process of automatic thought (implicit or unconscious) exemplifies the definition of *implicit bias* (Jost et al., 2009). A bias in judgment (i.e., stereotyping) or behavior may result from subtle cognitive processes below our conscious awareness and without our intentional control (National Center for State Courts, n.d.).

Multiple peer-reviewed social science studies have directly tested an association between physicians' racial and ethnic bias and implicit bias with numerous negative outcomes. In 2005, Moy, Dayton, and Clancy demonstrated a high incidence of late-stage breast cancer and colorectal cancer diagnoses, low infant birth weight, increased infant mortality, increased maternal death rates, low immunization rates, and high hospitalization rates from asthma due to health care disparities. Smedley, Stith, and Nelson (2003) documented bias and communication issues that impacted delayed diagnosis and inferior treatment of chronic conditions among African Americans and disadvantaged ethnic groups in the U.S. Discrimination on the part of physicians attributed to physician bias resulting in disproportionate morbidity and mortality among minority ethnic groups was shown in the areas of diabetes, cancer, stroke, and heart disease (Savers, Fagan, Jones, Klein, Boyington, Moten, et al., 2012). A recommendation by Cooper, Roter, Carson, Beach, Sabin, Greenwald, et al. (2012) stated

that better strategies are needed to identify racial bias and disparities within the physician–patient relationship. There is a need for an innovative methodology to combat racism in medical schools and in healthcare institutions (Cooper et al., 2012).

More studies have found a significant association between racial and ethnic bias and medical decision making (Green, Carney, Pallin, Ngo, Raymond, Iezzoni, et al., 2007; Sabin & Greenwald, 2012; van Ryn, Burgess, Dovidio, Phelan, Saha, Malat, et al., 2011; van Ryn, Burgess, Malat, & Griffin, 2006; van Ryn & Burke, 2000). The impact of clinical cognition, behavior, and clinical decision making showed that physicians “contribute to racial inequities in care” (van Ryn & Burke, 2000, p. 199). In the study by van Ryn and Burke (2000), White medical care physicians were shown to hold negative explicit and implicit racial biases and stereotypes, and this influenced their behavior and decision making during clinical encounters with Black patients. Green et al. (2007) discussed implicit bias among physicians as a predictor of thrombolysis decisions for both Black and White patients, and they found evidence of unconscious (i.e., implicit) race bias among the study physicians, which resulted in inferior care for this serious condition.

In a study of 40 primary care physicians, race bias on the part of White physicians showed that interactions with Black patients were “... associated with more clinician verbal dominance, lower patient positive affect, and poorer ratings of interpersonal care” (Sabin & Greenwald, 2012, p. 987). Data collected for the three leading causes of death nationally in the U.S. (i.e., heart disease, end-stage renal disease, and cancer) “... indicate evidence of racial discrimination and treatment even after adjusting for genetic differences in disease rates, socioeconomic status, health behaviors, and unequal access

to care” (Bowen Matthew, 2015, p. 57). While physicians’ scores for implicit bias reflect similar scores as the general population of similar composition, “accessing direct empirical evidence of the link between biased physician decision making and poor health outcomes is more complicated” (Bowen Matthew, 2015, p. 133), which leaves room for future study to understand more about physician’s self-development and its impact.

Bowen Matthew concludes the following:

Well-funded national and state-level efforts to improve access to health care, diversify the health care workforce, finance research, and make health delivery culturally competent have only marginally succeeded in disrupting the persistent relationship between race and poor health outcomes. A plausible explanation for the limited impact these interventions have is that they modify only intervening mechanisms rather than a fundamental cause of disparities. Increasing access to health care, for example, does not eliminate disparities because the health care itself is infected with unconscious racism as a fundamental cause. Again, return to the language of sociologists, disruption of the fundamental association between unconscious racism and inferior health outcomes requires a radical transformation, not merely changes in the resources, knowledge, or access to care that has been the focus of American health policy during the past two decades (Bowen Matthew, 2015, p. 139).

The Implicit Association Test (IAT), developed by Greenwald and Banaji (1998), is a tool used frequently by neuroscientists and social psychologists to measure unconscious bias. It is a computer-based test that asks the subject to associate

photographs with words. The IAT measures both the reaction to the selected photograph and the subject's response time (Lane, Banaji, Nosek, & Greenwald, 2007). The IAT is commonly used in medical schools, and it was studied in a longitudinal survey that involved 49 medical schools (non-African American students only) during the first and fourth years of medical school as a measure of assessing student exposure to formal curricula (van Ryn et al., 2015).

Since one can explicitly have egalitarian beliefs while simultaneously displaying implicit attitudes to the contrary, where should this disruption take place in the development of each physician-in-training to create meaningful progress? When, why, and how does medical training affect physicians' implicit bias and any corresponding influence on medical decisions and outcomes? In one study, during the course of medical school and associated training, physicians were shown to become *more* biased and more like their mentor physician/clinical trainer according to their IAT scores instead of growing in cultural competence or scoring similarly compared to first-year medical students' IAT scores (Haider et al., 2011).

The effect of informal curricula or role model behavior is largely unknown (Dennis, 2001; Hafferty, 1998; Kripalani, Bussey-Jones, Katz, & Genao, 2006; Paul, Ewen, & Jones, 2014). Research indicates that while medical school curricula are important, they are insufficient in accurately describing what occurs during medical school and at training sites with regard to the impact on implicit bias and the "deleterious impact of negative role model behavior" (van Ryn et al., 2015) and the impact of the overall culture of medical school. Much more remains to be learned about the influence

of medical education on the self-development of the physician and the development and outcome of cultural competence training and development.

The historic culture of medical training and the current physician population has a place in this review. Over one-third of today's active physicians will be 65 years or older within the next decade (American Association of Medical Colleges, 2015). While this statistic informs the need for new physicians-in-training to fill the demand for care, this generational divide may also provide insight into the mentor/clinical trainer behavior being modeled, the possible apathy surrounding cultural competence initiatives by medical school leaders, and the area of continuing medical education for all physicians. Senior members of the medical team may not see diversity as a priority (Ferguson, Keller, Haley, & Quirk, 2003) and may reinforce stereotypes of particular groups even while the instruction may be taking place in an environment specifically chosen within the curriculum to provide learning in a setting with a diverse patient population (Turbes, Krebs, & Axtell, 2002). Faculty training and support tends to be lacking compared to the development of staff members in clinical or scientific domains (Dogra et al., 2009; Dogra & Williams, 2006). "Health care disparities are rooted in structural inequities and therefore require structural solutions" and support, including the training and evaluation of educators (Bowen Matthew, 2015, p. 6).

In a 2010 editorial entitled "What matters in health disparities education—Changing hearts or changing minds?", the *Journal of General Internal Medicine* postulated that (a) cultural competence training in an environment dominated by tradition and a biomedical view of health and health care may not leave room for cultural considerations in the minds of medical students and (b) generating solutions for cultural

competence education in medical school must originate from the students themselves in order to activate change (Jacobs, Beach, & Saha, 2010). In the alarming article entitled “Teaching social and cultural awareness to medical students: ‘It’s all very nice to talk about it in theory, but ultimately it makes no difference,’” published in the *Journal of Academic Medicine*, medical students reported that, while cultural competence education in the classroom is sound in theory, it ultimately has no real impact on their future practice, and knowledge and skills to reduce health care disparities seem irrelevant to their future role as physicians (Beagan, 2003).

In a 2005 article entitled “Resident physicians’ preparedness to provide cross-cultural care,” the authors surveyed 3,435 resident physicians in their first year of training (Weismann et al., 2005). The objective of this study was to “assess the self-perceived preparedness of resident physicians to provide quality care to diverse patient populations and to determine whether they reported receiving formal training and evaluation in cross-cultural care during their residency” (Weismann et al., 2005, p. 1059). The article emphasizes that a resident physician’s “enthusiasm and preparation can be affected by implicit training experiences, sometimes called the ‘hidden curriculum,’ within the educational climate” (Weismann et al., 2005, p. 1059).

Weismann et al. (2005) found that “respondents believed they were not prepared to provide specific components of cross-cultural care, including caring for patients whose health beliefs were at odds with Western medicine (25%), patients who were new immigrants (25%), and patients whose religious beliefs affected their treatment (20%). In addition, 24% of respondents indicated that they lacked the skills to identify relevant cultural customs that impact medical care (Weissman et al., 2005). In comparison, the

study showed that participants reported feeling adequate in terms of clinical skill development and surrounding expectations to deliver medical services, with 2% or less saying they were not adequately prepared (Weissman et al., 2005). Residents in the study also reported that “cross-cultural issues ‘often’ resulted in negative consequences for clinical care” (Weissman et al., 2005, p. 1061). These articles support the need for student generated qualitative information that explores awareness and developmental impacts as reported by those who participate in international clinical immersion experiences, so we may gain direction beyond the scope of these survey questions.

Conversely, in an evaluation of the effect of an elective Global Multicultural Track (including international and domestic immersion experiences) on the cultural competence of preclinical medical students, statistically significant, positive, and self-reported changes were demonstrated in the following areas after two years (Godkin & Savageau, 2003):

- 1) The doctor–patient relationship, including measures that show an increased desire to work with this patient population and increased comfort in treating patients of a different background from their own.
- 2) Health and social policy, including support for government policies to correct inequities.
- 3) Knowledge of communities, including awareness of obstacles that immigrants face to receive basic medical care, self-reported knowledge of major cultural beliefs, and openness to explore the various cultural beliefs of different patient populations during clinical encounters.

Godkin, Savageau, and Fletcher later published an article entitled “Effect of a global longitudinal pathway on medical students’ attitudes toward the medically indigent.” Its stated purpose was “to assess the effect of a Pathway on Serving Multicultural and Underserved Populations, which includes domestic and international experiences with recent immigrant groups, on the attitudes of students toward the indigent” (Godkin, Savageau, and Fletcher, 2006, p. 226). Their sample for analysis was a cohort of medical students from the graduating classes of 2002 and 2003 at the University of Massachusetts Medical School. The Pathway program focused on family practice medicine as it relates to family cultural beliefs, a cultural seminar series, and a 6-week summer immersion program in a developing country. While tracking a change in medical school student attitudes over a 4-year period among participants engaged in the “Pathway program, focused on heavy interaction with a multicultural and immigrant population” (p. 227) versus medical students who did not participate in the Pathway program, the authors found that changes in attitudes among medical students participating in the 4-year study did not show statistically significant differences between the two groups, and the authors conclude by suggesting that more research is needed, both qualitative and quantitative. Their findings cannot definitively state that the study participants who followed the study curriculum actually developed more positive attitudes toward serving indigent patients (Godkin, Savageau, & Fletcher, 2006, p. 231).

In a study examining intercultural sensitivity and competency in physician assistant students, researchers utilized the results of a pre- and post-test survey of intercultural sensitivity (Multicultural Awareness, Knowledge and Skills Survey—Revised, MAKSS-R) over a 5-year period at a Midwest U.S. PA program to determine

whether the students' intercultural awareness, knowledge, and skills improved over the course of the curriculum (Huckabee & Matkin, 2012). During this 5-year period, PA students participated in typical academic experiences and clinical rotations, and they were enrolled in specific didactic studies and clinical experiences in cultural sensitivity and competency. The study focused on addressing the factors associated with a health care provider's role attributable to disparities (Institute of Medicine, 2004), including

- 1) bias or prejudice,
- 2) clinical uncertainty when caring for minority patients, and
- 3) assumptions made by the clinician about minority health care needs.

The results of this study indicated that the interventions they used did produce some changes in the *Knowledge* and *Skills* categories of the MAKSS-R, but the interventions did not produce changes in *Awareness*. Huckabee and Matkin (2012) hypothesized that as students gained more knowledge about cultural issues, they may have become more sensitive to their own lack of cultural awareness. They concluded that “didactic and experiential training resulted in increased knowledge and skills in cultural competency. The more exposure students had to lower income patients, the higher their scores on the MAKSS-R, suggesting increased cultural competency” (Huckabee & Matkin, 2012, p. e60). The authors recommend future studies to identify factors that motivate health care providers in training toward cultural competence development. The incompleteness and the contradictions within the above-mentioned articles suggests a need for further study.

Experiential Learning for Physician Development

Since 1945, some medical students have incorporated an international elective rotation into medical training as part of their formal program (Liebe, 2011). Global health electives were established as international mobility and travel increased and as a result of postwar interest and exposure to tropical diseases (Liebe, 2011). According to the American Association of Medical Colleges (AAMC), the purpose of international experiences is to “enable students to interact with different patient populations, develop cross-cultural understanding, and learn about health systems in other nations” (AAMC, 2017). Participation “guarantees medical residents will see a health system that spends less per capita than the U.S. system” (Emergency Medicine Residents’ Association, 2017). While rotations are often incorrectly described as “mission trips,” they are not volunteer service activities but rather academic experiences intended to expand the scope of medical education (Macfarlane, Jacobs, & Kaaya, 2008).

The Office of International Medicine Programs (IMP) (2017) describes the opportunity to gain clinical experience abroad as important in understanding diverse patients and healthcare systems. International experiences are most commonly gained through electives in medical school, which can add expense to a student’s program completion (e.g., academic credits, travel, living expenses). They are routinely offered over the summer. Less often, international immersion experiences may be offered in conjunction with residency programs, leaving the sponsoring institution with a loss of revenue (i.e., an inability to charge patients for the services performed by the resident during their international experience).

Given the gaps in our understanding of how to best impact cultural competence development during primary care physicians' medical education and training, qualitative inquiry may provide an opportunity to make sense of the experience of immersion rotations by physicians-in-training and glean insights into their role in medical education beyond learning skills and knowledge. While there is limited research available that pertains to medical education and immersion experiences, significant scholarly publications discuss the immersion experiences of teachers using qualitative methodology that explores cultural responsiveness and development. For example, in a study of pre-service teachers from the U.S. working in an English-language school in Taiwan, cultural awareness and development occurred after participants experienced feelings of frustration, a lack of support, a sense of being different, and communication roadblocks (Hovater, 2007). Study participants (a) transitioned from holding mental stereotypes of others to viewing differences in individuals and (b) experienced a reduction in feelings of cultural superiority, leading to an acceptance of one's own vulnerability and acceptance of one's own mistakes (Hovater, 2007).

Total immersion programs are recommended as an ideal way to develop cultural responsiveness in pre-service teachers (Mahan & Rains, 1990; Quinn, Barr, McKay, Jarchow & Powell, 1995; Wiest, 1998). Experiential learning advocates Pagano and Roselle (2015) indicate that international experiential education must be more than merely the action of participating in a different working environment; it requires structured, conscious, critical reflection (which they term *refraction*) to elaborate on the learning experience and create a truly transformative learning process. Qualitative research can provide conscious reflection for study participants.

Since the days of William Osler, the father of the first residency program for the training of specialty physicians at Johns Hopkins Hospital in 1974, medical schools have emphasized bedside training and patient contact during medical education rather than solely didactic work, recognizing the principle of “you learn by doing” (Bliss, 1999). Yet, medical schools and residency programs report that, despite curricular efforts, “students often feel unprepared to deal with culturally biased statements in clinical contexts and have difficulty acknowledging the influence of self-awareness in culturally competent patient care and viewing patients as individuals” (Lypson, Ross, & Kumagai, 2008, p. 1079). Medical schools also report that the most common methods of imparting cultural curricula are still clinical case presentations, standardized patient experiences, and student surveys (Mihalic, Dobbie, & Kinkade, 2007).

Some question the teachability of cultural competence within formal curricula and advocate that students interact in an environment where they are not familiar, as this may push medical students in new ways and force self-reflection and growth (Crosson, Deng, Brazeau, et al., 2004; Lypson, Ross, & Kumagai, 2008; Shapiro, Lie, Gutierrez, et al., 2006). When students participated in international experiences, this has still produced limited information in terms of describing their experiences. In the 2006 study of medical students who participated in an international elective in either Ecuador, Mexico, Costa Rica, Nicaragua, Guatemala, Brazil, India, or on a Native site in remote Alaska, compared to their peers who did not participate, the participating students showed no significant differences on the Medical Students’ Attitudes Toward the Underserved (MSATU) survey instrument. The MSATU assesses attitudes toward underserved populations, attitudes regarding professional responsibility, and services ranging from

basic to extensive to which individuals should have access regardless of the ability to pay (Godkin, Savageau & Fletcher, 2006). Recommendations for future in-depth qualitative research by Godkin and Savageau (2003) and problem-solving cases designed to assess medical students' ability to ascertain culturally relevant information during patient encounters in Crandall, George, Marion, and Davis (2003) indicate a need for further study.

Historically, cultural competence training during the undergraduate medical education process has focused mainly on three approaches (Kripalani et al., 2006):

- A traditional knowledge-based approach, which teaches practical skills by relying on assumed heterogeneity within cultural groups, often using Berlin and Fowkes' (1982) guidelines or Kleinman's (1978) questions for eliciting a patient's explanatory model of illness.
- Interactive models, such as standardized patient encounters using patient actors and other roleplay exercises, self-reflective journals, and Web-based training vignettes meant to challenge the medical student, promote awareness, and potentially prompt attitude changes.
- Direct observation and feedback, usually by a faculty member following a patient encounter.

Data from medical schools suggest that service learning in underserved areas (both in the U.S. and abroad) leads to more positive attitudes toward the individuals served (Tippets & Westpheling, 1993, 1996), and the data also suggest that an appreciation of others can result from service learning (Chickering & Reisser, 1993). However, the educational effect of clinical rotations completed while immersed in

another culture have been mentioned in the literature primarily as anecdotes or results from narrow questionnaires. And, over time, the literature has actually featured less in-depth information on this topic rather than more information. Despite the rapid changes and the uncertain future evident in the health care system, this issue seems to have taken a back seat to pressing cost concerns and other business issues in the academic literature about physician training.

Cultural competency in health care is not cultivated through the acquisition of information about cultural beliefs that may lead to cultural grouping, generalizing, and potential stereotyping (i.e., it is not knowledge-based) (Fiore, 2008); rather, cultural competency is “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Cross, Benjamin, & Isaacs, 1989, p. 28), and this suggests a need for a skills-based approach to spur internal development that impacts physician behavior. Broadly stated, I have found insufficient evidence to determine whether cultural competence training for primary care physicians in its current state has served to improve health care, and this study may inform future research.

Previous studies of international clinical immersion experiences for primary care physicians in particular report increased confidence in their skills, an enhanced sensitivity to cost issues, more appropriate resource utilization, a greater awareness of public health and global health, a greater appreciation for the role of family, and better assessment and diagnostic skills following an international clinical immersion experience (Bissonette & Routé, 1994; Brach & Fraser, 2002; Haq et al., 2000; Miller, Corey, Lallinger, & Durack, 1995; Ramsey, Haq, Gjerde, & Rothenberg, 2004).

Limited surveys also suggested that close to 70% of medical students who participated in international clinical electives chose to enter a primary care career as opposed to a specialty care career (Bissonette & Routé, 1994; Drain, Primack, Hunt, Fawzi, Holmes, & Gardner, 2007; Godkin & Savageau, 2003; Gupta et al., 1999; Ramsey et al., 2004). Participants were more likely to care for patients on public assistance and immigrant patients (Gupta et al., 1999) and were more likely to practice in a rural community (Grudzen & Legome, 2007). While these participants may possess other attributes in common that drew them to an international clinical rotation, the suggestion that an interest in primary care is fostered rather than diminished during these electives seems promising, even if only as a self-reinforcing effect.

The typical medical student's desire to work with underserved communities has been shown to decline as she progresses from preclinical training through residency training, but international immersion experiences have demonstrated a positive impact on this typical decline and documented loss of empathy. These experiences somehow fortify students' idealism and continued interest in humanitarian efforts, compassion for the underserved, and volunteerism (Abell & Taylor, 1995; Grudzen & Legome, 2007; Haq et al., 2000; Ramsey et al., 2004; Woloschuk, Harasym, & Temple, 2004). The need for more research can be addressed by this study.

Physician Development Progression throughout Medical Training

It is helpful to familiarize oneself with the overall process of medical education and training for physicians in order to understand the context of cultural competence experiences in physician training. The typical path to becoming a medical doctor in the U.S. is a long journey requiring intelligence, dedication, patience, stamina, and financial

resources. The educational sequence required to become a practicing M.D. in the U.S. is as follows (Thompson, 2014):

- Four years of undergraduate education that fulfills appropriate prerequisites for medical school (e.g., biology, physics, chemistry).
- Four years of medical school. Years 1 and 2 are dedicated mostly to classroom work focused on health and disease. Years 3 and 4 are comprised of core rotations or required clerkships and time spent working in a teaching hospital. This is a time to apply classroom knowledge to patient care.

Required clerkships include:

- Internal medicine
 - Obstetrics and gynecology
 - General surgery
 - Pediatrics
 - Psychiatry
 - Family medicine or neurology
- Completion of Steps 1, 2, and 3 of the U.S. Medical Licensing Exam (USMLE) during the student's junior and senior years of medical school. This requirement, along with graduation from medical school, confers the degree of Medical Doctor. However, the graduate may not practice, become licensed, or apply for board certification at this juncture.
 - Application and acceptance to a medical residency (i.e., graduate medical education) the summer before the graduate's senior year of medical school (typically). Residency is constant clinical training.

- Completion of medical residency, which requires two or more years, depending on the specialty. Family medicine, internal medicine, and pediatrics specialties are 3-year residency programs.
- Completion of Step 4 of the USMLE after completion of residency and any state licensing requirements. Only at this point can one be a practicing physician.
- The physician could now complete a medical fellowship or board certification to become qualified within his or her specialty, receive additional training for that specialty, or add another specialty.
- *Maintenance of Certification* requirements must be fulfilled through continuing medical education (CME) and through retaking the certification exam regularly (about every 10 years).

While “the structure of medical school has not fundamentally changed since 1910, when the seminal Flexner Report prescribed nationwide standards for educating doctors” (Grossman & Abramson, 2016, p. A11), the requirements for training after medical school have increased, so much so that some propose a change for undergraduate medical education from the current four years to three years to address the shortage of physicians. Currently, 12 U.S. medical schools offer this accelerated path to a Doctor of Medicine degree, and in a 2015 survey of 100 medical school deans, 35% stated that they were currently considering or developing accelerated programs (Grossman & Abramson, 2016). These accelerated programs would reserve little time for electives such as an international clinical immersion experience.

In the analysis by Weissman et al. (2005) of the Graduate Medical Education (GME) programs governed by the Accreditation Council for Graduate Medical Education (ACGME) and the program requirements for specialty and subspecialty programs, the framework for cultural competency training was described as “overly generic,” “lacking specificity,” and “highly variable” (p. 1066). The World Health Organization’s 2008 analysis of cultural competency domains in ACGME specialties focused specifically on primary care specialties (i.e., family medicine, internal medicine, obstetrics and gynecology, and pediatrics), and the ratings of program requirements showed that 56% of the programs did not contain any specificity in cultural competency elements. Contrasting analyses of similar measures from 1996 (National Research Council, Primary Care) and 2012 (Accreditation Council for Graduate Medical Education, 2013), show almost no progress, with more primary care programs rated in the lowest scoring category (60%) than any other category in the 2012 analysis (Ambrose, Lin, & Chun, 2013).

More broadly, the Association for American Medical Colleges (AAMC) and the ACGME identified a growing need for a master taxonomy of general competency domains for physicians in 2012 and sought to organize curricula more uniformly surrounding these competencies in the future (Englander, Cameron, Ballard, Dodge, Bull, & Aschenbrener, 2013). With growing public demand for accountability in health care, several educational institutions accredited by the ACGME are transitioning to competency-based education (Englander et al., 2013). In a comprehensive analysis of the existing competency frameworks used in medical education and health professions published in 2013, the authors used a process for comparing competency frameworks to

determine a reference list of general physician competencies. The following eight competency areas were identified:

- 1) Patient Care
- 2) Knowledge for Practice
- 3) Practice-Based Learning and Improvement
- 4) Interpersonal and Communication Skills
- 5) Professionalism
- 6) Systems-Based Practice
- 7) Interprofessional Collaboration
- 8) Personal and Professional Development

Under Competency 2, Competency 2.5 states that physicians should be able to “apply principles of social-behavioral sciences to the provision of patient care, including assessment of the impact of psychosocial and cultural influences on health, disease, care seeking, care compliance, and barriers to and attitudes toward care” (Englander et al., 2013). This competency most specifically addresses the skills related to culturally competent care.

Current Initiatives to Increase or Improve Physicians’ Cultural Competence

In 2000, the Liaison Committee on Medical Education (LCME) introduced a standard that encouraged medical schools to emphasize cultural competence as a feature of the undergraduate medical curriculum and outlined comprehensive recommendations and institutional requirements. While these requirements have not shown measurable progress since 2000, they serve as a starting point to further this important discussion.

The major domains of cultural competence training were identified by LCME in conjunction with the AAMC, which represents all 145 accredited U.S. medical schools and their affiliated 400 teaching hospitals. “To date, 90 percent of all medical schools (in the U.S.) now offer some form of cultural competence education as part of their training programs” (Wu, 2015, p. 2). This cultural competence education is usually embedded within required courses (Rapp, 2006) and are often didactic or case-based in the first or second year of medical school (Kripalani et al., 2006). Fewer programs feature integrated or longitudinal continuation throughout all four years (Crandall et al., 2003; Tervalon, 2003). Studies have evaluated the effect of this training on the future performance of the physician or the self-development of the physician (Betancourt, 2003; Carter et al., 2006; Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1997; Family Medicine Clerkship Curriculum Resource, 2004; Kagawa-Singer & Kassim-Lakha, 2003; Peña Dolhun, Muñoz, & Grumbach, 2003; Price, Beach, Gary, Robinson, Gozu, Palacio, et al., 2005; Schilling, Wiecha, Polineni, & Khalil, 2006; Tervalon, 2003; Thom, Tirado, Woon, & McBride, 2006).

In the LCME Functions and Structure of Medical School Standards for Accreditation (2016) guidelines, Standard 7 summarizes the requirements for cultural competence training during medical school as follows: “The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process” (LCME, 2016). The medical curriculum includes instruction regarding the following:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
- The basic principles of culturally competent health care.
- The recognition and development of solutions for health care disparities.
- The importance of meeting the health care needs of medically underserved populations.
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society.

In 2003, key recommendations from a Commonwealth Fund report entitled *Medical education and cultural competence: A strategy to eliminate racial and ethnic disparities in health care* and three commissioned papers (Betancourt, 2003; Kagawa-Singer & Kassim-Lakha, 2003; Tervalon, 2003) created the infrastructure and development of the resulting Tool for Assessing Cultural Competence Training (TACCT). The TACCT has been broadly implemented in U.S. medical education. This instrument is intended to provide curriculum recommendations, offer optimal educational and evaluation strategies, and assist schools in meeting the LCME objectives (AAMC, 2005). The TACCT assessment tool is self-administered by medical schools, and they self-define the standards of compliance for any skill development in cultural competence. It is intended to address the categories of attitudes, knowledge, and skills, with a corresponding evaluation strategy for each of these. Examples of evaluation strategies include self-awareness surveys, video-recorded clinical encounters, and the presentations of clinical cases. There is no recommendation to include 360-degree feedback or patient feedback. There is also no mention of immersion experiences or electives as part of the

developmental framework, although mock patients (actors) in clinical encounters often relate their perceptions if asked. We do not yet have studies to demonstrate the change or impact that may have resulted in cultural competence development scores since the widespread implementation of the TACCT model in medical education, nor did I find any baseline scores or comparative resources in any current study specific to TACCT use. Further data are needed to understand the impact of the TACCT guidelines on physician education after its implementation.

A systematic review of 20 years of the literature regarding the most common cultural competence measures and educational resources in medical schools suggests that practitioners seek repeated exposure to those unlike themselves, or the *Other*, to become familiar with those unlike themselves and broaden their capacity in clinical practice (Kumas-Tan et al., 2007). Results are mixed on the impact of this practice, however. Additionally, “[t]ools that measure knowledge, attitudes, and skills reflecting cultural competence of health professionals have not been comprehensively identified, described or critiqued” (Gozu et al., 2007).

In an analysis of 45 articles that review self-administered instruments, 45 unique instruments were identified to measure cultural competence in medical education training. Among these 45 instruments, 32 were learner self-assessments and 13 were written exams (Gozu et al., 2007). Only one-third have shown either validity or reliability, and only 13% demonstrated both. Interpreting data accurately about the result of cultural competence training in medical education is not possible until valid tools are developed and used. Lie, Boker, and Cleveland (2006) found that “no separate grade was given for students’ cultural competence in any instructional setting.” In a residency

survey, 66% of residents stated they received “little or no” evaluation of the cross-cultural aspects of doctor–patient communication (Weissman et al. 2005). If it is not evaluated, how important can it be? These data coexist (briefly) with the use of the TACCT structure, with a majority of residents surveyed stating that they felt “very unprepared” or “somewhat unprepared” to treat patients from diverse cultures or from racial or ethnic minorities (Betancourt, 2006; Peña Dolhun, Muñoz, & Grumbach, 2003). If we hope to move forward, “[a]ccreditation standards need to be more precisely defined” (Quist & Law, 2006, p. 425), and they must consist of evidence-based recommendations, assessments, and improvement feedback (Hobgood, Sawning, Bowen, & Savage, 2006).

Current Educational Opportunities and Expectations for Primary Care Physicians to Participate in International Clinical Rotations

The AAMC published a report in 2015 that compiled data from responses to a Medical School Graduation Questionnaire. This AAMC report found that less than one third of medical school students participated in a global health experience. Table 2 presents the results of the survey.

Table 2

Medical School Students Who Participated in a Global Health Experience

Year	Participating Students
2011	30.5%
2012	30.4%
2013	30.2%
2014	29.0%
2015	31.2%

Note. Adapted from Association of American Medical Colleges (2015). Figures based on data from 134 U.S. medical schools.

International clinical immersion experiences are most often elective courses, so the time dedicated to the experience causes significant expense for the student. For example, the time required for the experience could be devoted toward progressing more quickly on a student's educational path, and the experience involves significant travel or housing expenses. This typically adds to the student's debt, which averages \$161,000, according to a 2012 study by the AAMC (Grossman & Abramson, 2016). For those participating in an international experience as part of their graduate medical education, this can impact reimbursement for patient care to the academic medical center where they study and practice. The hospital loses the benefit of the Medicare adjustment payment when a resident works outside the training site that pays his or her salary (AAMC, 2007; Grudzen & Legome, 2007). Because of this financial impact, some medical centers now disallow outside electives (Grudzen & Legome, 2007).

A review of studies of medical students and residents who participated in international clinical rotations ranging from six weeks to 10 months shows that the vast majority of students report that these rotations were the best part of their educational experience (Gupta, Wells, Horwita, Bia, & Barry, 1999; Imperato, 2004; Miller, Corey, Lallinger, & Durack, 1995; “The overseas elective,” 1993; Schultz & Rousseau, 1998). In one study of 133 students who completed an international clinical rotation, 100% of them stated they would “recommend the program to their peers” (Pust & Moher, 1992, p. 93).

Interestingly, programs that have substantial staff participation in international clinical rotations show the highest participation rates among their student populations that seek similar experiences (Drain, Primack, Hunt, Fawzi, Holmes, & Gardner, 2007). In a study of 144 family medicine residency programs, the most strongly correlated factor showing a high rate of resident participation in an international experience was that the physician-in-training had contact with a faculty member who had completed international clinical work in the previous two years (Pust & Moher, 1992). Similarly, in a survey of 106 pediatric residency program directors, any program that had two or more faculty members recently involved in global health activities in other countries had significantly higher rates of resident participation in a 4-week or longer international rotation (Smedley, Stith, & Nelson, 2003).

Summary of Literature Review

Many questions about the influence of an international immersion experience persist, despite the historical data that suggest that international clinical rotations may influence physicians to (a) choose primary care as a specialty, (b) develop a greater

awareness of costs and improve their diagnostic accuracy, and (c) be more likely to work in public health settings or with underserved, rural, low income, or immigrant patient populations.

This literature review provides information about (a) health care disparities and the limited progress in this area, (b) cultural competence development and the overall education of physicians, (c) the history of implicit bias studies overlapping medical school, (d) international immersion experiences effects on participants, (e) the breadth of interventions by medical schools to address cultural competence training, and (f) the scope of international clinical immersion experiences by medical students and residents who later become primary care physicians. This review does not provide insight into the internal development of the physician during this time or describe the potential impacts with regard to cultural competence development or future practice by these physicians. With an absence of qualitative literature on this subject, this study asked participants how they experienced international clinical immersion and how it impacted their overall development as physicians. This fills an important gap in the knowledge on this subject.

Chapter 3: Methodology

“One of the most sincere forms of respect is actually listening to what another has to say.”

—Bryant H. McGill

This study seeks to describe the experiences of primary care physicians trained in the U.S. during an international clinical immersion experience. The qualitative research methodology used in this study seeks to convey the “essence of human experience” (Creswell, 2007), while exploring how physicians develop during an international immersion rotation.

Qualitative Methodology

Qualitative research takes place in a natural setting, it is emergent, and it uses open-ended questions (Creswell, 2007). Qualitative methodologies allow for *sensemaking* and *meaning* to arise from these natural settings (Denzin & Lincoln, 1984).

Creswell (2007) tells us that a qualitative research methodology should be used to explore perceptions and to seek understanding of complex experiences. Since 1988, the U.S. medical system and the U.S. medical education system have both shown a strong awareness of the need for cultural competence development. However, little is understood about the impact of experiential learning related to cultural competence, particularly the experience of a clinical rotation in other countries by physicians-in-training. Understanding the context, experiences, and stories of participants immersed in such training may inform us as to future directions in the education of physicians. An

understanding requires us to hear the voices and experiences of physicians in a natural setting, making a qualitative approach best suited for this study.

Creswell (2007) describes the five common qualitative traditions: *narrative*, *grounded theory*, *ethnography*, *case study*, and *phenomenology* (as presented in Table 3). While each of these traditions is appropriate and relevant in certain settings, they are specific to answering certain research questions. Table 3 describes each of these traditions briefly, delineating its purpose and its “fit” with the current study. Justification is provided for the chosen research tradition.

Table 3

Qualitative Research Traditions

Tradition	Types of Tradition	Unit	Origin or discipline	Purpose
Narrative	Biography, autobiography, life history, oral history.	Traditional: A single individual.	Humanities and social sciences, including anthropology, literature, history, psychology, and sociology.	Exploring the life of an individual.
Phenomenology	Hermeneutical and transcendental. Describing what all participants have in common as they experience a phenomenon.	Several individuals.	Psychology and philosophy.	To understand the essence of the experience.
Grounded Theory	Systematic, constructivist. To generate or discover a theory.	Several individuals' experiences.	Sociology.	To develop a theory grounded in data from field work.
Ethnography	Confessional, life history, auto-ethnography, feminist ethnography, ethnographic novels, realist ethnography, critical ethnography.	Entire cultural group.	Anthropology and sociology.	To describe and interpret a culture-sharing group.
Case Study	Single instrumental case study, collective case study, intrinsic case study.	One issue, through one or more cases in a bounded system.	Human and social sciences and applied areas (i.e., evaluation research).	To develop in-depth descriptions of the case or cases.

Note. Adapted from Creswell (2007).

A *narrative* method is chosen by researchers to explore the life of one person and to tell the stories of his or her experiences. This research is intended to yield a narrative

about the stories that portray an individual's life. The central research question of this study seeks the common essence of the lived experiences of the participants, and therefore cannot be answered with the narrative method.

A *grounded theory* approach is designed to develop a theory grounded within the data discovered over the course of the study. Personal interviews were the primary method of data collection, and the participants who were chosen for the study have had similar experiences. Grounded theory data are gathered from a large number of participants (Creswell, 2007). The researcher develops a theory of the experience based on the collected data. Because the current research question focuses on the meaning of experiences, and not on developing a new theory, the grounded theory approach is not suitable for this study.

The *ethnographic* approach focuses on large groups of individuals who share a culture, including patterns of behavior, beliefs, and language for the researcher to examine as a group (Creswell, 2007). With a variety of types of ethnographic inquiry, none are the correct course of inquiry for my research question and study participants, largely because my participants would have experiences in different locations and would lack the group cohesion typified by ethnographic research. Additionally, it is not a pattern of a shared culture that is being investigated by this study, but rather the experiences of the participants in relation to varying cultural immersion placements.

Case study research utilizes a single case or multiple cases to examine one or more issues in a bounded system. The prerequisite of having a similar setting for a case study was not appropriate for my study participants, who participated in immersion experiences in a variety of settings and locations. While a case study searches for

detailed and in-depth information, it gathers such information over time and from multiple sources. I sought the voice of each study participant and a rich description of their own perceptions and experiences. The case study method was not well suited to my research question and objective.

Last, the remaining qualitative research tradition, *phenomenology*, is utilized to provide the “essence” of human experiences demonstrating a phenomenon, as told by the study participants (Creswell, 2007). The “lived experience” is the hallmark of phenomenological research (Creswell, 2007). Since my research question seeks the most vivid and accurate descriptions possible from a natural setting, the phenomenological approach is the most appropriate for this study.

Phenomenological Inquiry

Given the central research question, I have chosen the *phenomenological* research design as the most suitable qualitative research methodology for this study. My interest in this topic was prompted by, and the design of my study was guided by, the recommendations for further qualitative inquiry in the article “Effects of a global longitudinal pathway on medical students’ attitudes toward the medically indigent” by Godkin, Savageau, and Fletcher (2005) and in “The effect of medical student’s international experiences on attitudes toward serving underserved multicultural populations” by Godkin and Savageau (2003). In addition, my study was guided by the article “Applying theory to the design of culturally competency training for medical students: A case study” by Crandall, George, Marion, and Davis (2003), which elaborates on problem-solving cases designed to assess medical students’ ability to ascertain culturally relevant information during patient encounters.

To learn how primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international clinical rotation, participants described their experiences and the context of those experiences during interviews. The phenomenological method provides information on the lived experiences of study participants and can illuminate the meaning of a concept or a phenomenon (Creswell, 2007). Given the opportunity to talk about those experiences during the research interview, participants may reveal the true essence of a shared experience or phenomenon and construct meaning out of their experiences (i.e., follow a constructivist paradigm).

For phenomenological research to be reliable, the structure of the inquiry and analysis must rely on proven procedural steps (Moustakas, 1994). Table 4 shows a simple outline of the steps I took to structure my research.

Table 4

Procedures in Phenomenology

Step #	Procedure Step	Completion of step
1	Determine the approach.	I selected phenomenology as the approach for describing how primary care physicians trained in the U.S. describe their development experiences resulting from international clinical immersion opportunities.
2	Determine phenomenon.	Common lived experiences of primary care physicians trained in the U.S. following their international clinical immersion rotation.
3	Recognize philosophical assumptions.	Guided by the social constructivist worldview, this study focuses on the participants' views, voices, and their own realities. I bracketed my own experiences while remaining reflective, fully present, and engaged (Moustakas, 1994).
4	Determine individuals who have experienced the phenomenon.	I identified 12–16 participants who were suitable and met my criteria.
5	Collect the data.	I utilize Moustakas' (1994) recommendation of two broad questions: first, to describe experiences and second, to describe the contexts of those experiences.
6	Analyze the data.	I analyzed the data from the interviews with 12–16 participants (Creswell, 2007).
7	Write description of participants' experiences.	I described any themes or "meanings" that resulted from the interviews.
8	Write composite, or "essence," of the phenomenon.	I synthesized the descriptions and wrote about the findings.

Note. Adapted from Creswell (2007).

Origins of Phenomenology

Phenomenology is popular in current social science research, the health sciences, psychology, and the field of education (Moustakas, 1994). However, the first notations of the method occur as early as the 1700s in reference encyclopedias, and these were discussed at length in 1928 by the scholar and mathematician Edmund Husserl (Creswell,

2007). The method was considered more as philosophy than applied science at the time, but Husserl refers to the idea of *epoche*, as described by Descartes. Most important to the framework of phenomenology, as described by Husserl, is the “elimination of suppositions” (Moustakas, 1994) to discover the true nature of things (i.e., their essence).

Some characteristics of qualitative research include conducting the research in a natural setting, viewing a social phenomenon holistically, and self-reflection by the researcher to clarify any bias. Phenomenological research seeks meaning from experiences by focusing on subjects as they are and asks broad questions rather than seeking to prove something thought to be true (Creswell, 1997).

Creswell (1997) outlines two different types of phenomenology: (a) the *hermeneutic* or *interpretive*, as proposed by Max van Manen (1990) for Human Science Research; and (b) the *empirical*, *transcendental*, or *psychological* phenomenology (Moustakas, 1994). While both methods are descriptive, van Manen’s method maintains a special focus on “how something is in the world or the manner in which its existence unfolds” (Magrini, 2012). Moustakas elaborates on this, emphasizing the importance of bracketing one’s preconceptions as a researcher with a view that “the reality of an object is only perceived within the meaning of the experience of the individual” (Creswell, 1998, p. 53).

Moustakas (1997) describes the phenomenological method as ideal for human sciences research, because it has the following characteristics:

- Phenomenology addresses the appearance of things just as they are, within everyday routines, in the natural world.

- Phenomenology speaks to wholeness, looking at experiences from many sides, and examines perspectives until the essence of the experience can be defined.
- Phenomenology seeks meaning from experiences, and it can lead to new ideas as a result of this reflection.
- Phenomenology is committed to the description of experiences. The explanation or analyses of those experiences are not the goal. Underlying meaning can be discovered, but the description itself is intended to “stay alive.”
- In phenomenology, the subject and the object are integrated. The researcher’s focus guides the investigation, and the researcher’s thinking, intuition, and reflection are part of the scientific investigation and evidence. The researcher has a personal interest in the question and wants to know more.

The phenomenological method described above is the guiding process that consistently aligns with my central research question. I utilize Moustakas’ “cluster of meanings” to express psychological and phenomenological concepts in order to provide both a *textural* description of *what* was experienced and a *structural* description of *how* it was experienced (Creswell, 2007). The empirical, transcendental, or psychological phenomenological approach, as described above by Moustakas, most accurately conveys my research approach.

Philosophical Assumptions and Worldview

I must bracket my assumptions and biases to answer my central research question, because I bring certain preconceptions to the study due to my previous experience

working closely with physicians and working in the health care system. Even with every effort to avoid bias, my background influences my interpretation of the experiences reported during participant interviews. I rely on the participants' unique views and perspectives about their experiences during an international clinical immersion rotation, while bracketing my assumptions as much as possible. The constructivist paradigm and philosophy allows for the emergence of information and discovery through the participation of both the research participants and the researcher (Creswell, 1997).

I anticipated my own self-development as the study progressed. Moustakas (1994) suggests that as researchers more fully understand the phenomena they are studying, they also grow in self-awareness. My central research question invited a variety of views from participants, and they themselves described how they construct meaning from their experience. The social constructivist worldview allows for both my interpretation as one element of the research while focusing on the essence of the participants' lived experiences. I hope to share the voices of the study participants and provide a space for multiple realities while uncovering new information that may be useful when applied or information that encourages a new direction for future research.

Study Participants and Sampling Method

To best answer the research question, a researcher must be purposeful in selecting the study participants (Creswell, 2007). I first interviewed four study participants and then interviewed 12 subjects before completing the entire interview process. Emerging themes from the first four interviews helped shape the focus of the interviews with the rest of the participants, while also seeking new information that may deviate from the initial themes as subsequent data are analyzed. The iterative interview process is not

repetitive and mechanical, but instead is a reflexive process in which each iteration revisits the data, connecting them with emerging insights from each subsequent interview, which can lead to deeper focus and understanding (Srivastava, 2009).

To access an appropriate population, I solicited study participants throughout the 21 medical schools who currently participate in the American Medical Association “Medical School Innovation” cohort and through an email distribution list of general members of the American Medical Association, sorted by medical specialty and time in practice (11,100 members).

To achieve maximum variation, I presorted respondents for demographic and geographic variation by utilizing a screening email that included the following questions:

- Are you a primary care physician (family practice, internal medicine, or pediatrics)?
- Did you complete residency within the last five years?
- Did you participate in an international clinical immersion experience during medical school or residency of six weeks or longer?
- What is the name of the medical school or residency program you were participating in during your international elective?
- What was the country and location of your immersion experience?

My criteria for the selection of study participants included a requirement that study participants were currently a primary care physician, and had worked no more than five years beyond the completion of their medical education. Furthermore, participants must have spent six weeks or more immersed in a clinical experience in a developing nation, living within a local community (as opposed to within a segregated physician

cohort or environment). To qualify for participation, study participants must have received their medical education in the U.S. Maximum variation sampling ensured a variety of geographically and demographically diverse responders who were reflective of the new physician workforce. This study did not include physicians who had dedicated their career to nonprofit, international, medical, or humanitarian organizations, such as Doctors Without Borders. Instead, I selected typical primary care physicians.

Research Questions

My use of the phenomenological method addressed two key questions (Moustakas, 1994):

- 1) What are the experiences of the participants?
- 2) What is the context of those lived experiences?

The central question for this study is: How do primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international clinical rotation? Multiple sub-questions resulted during the interviews, especially guided by the first four participant interviews. Of interest are how immersion experiences impact physicians' development and their future practice. By exploring the lived experiences of the study participants, I gained direct information about their perspectives on the central phenomenon (Creswell, 2007). My goal was to uncover more through their detailed, in-depth descriptions.

Interview Protocol

The interview protocol included the following questions. Prompting questions were only used as needed to further the conversation.

- Tell me about your international rotation.

- Thinking back, how did this experience feel at the time? Please share everything you can remember.
- How did you end up participating?

Other prompting questions were asked, if needed, to elicit more information:

- Are there experiences that were particularly impactful? How so?
- What situations and people stand out to you?
- What was the influence of that experience?
- Have you shared everything you think might be relevant with regard to your own personal or professional development?
- Did this experience impact your future practice in any way?

Data Collection

I obtained approval from the Institutional Review Board at the University of Nebraska–Lincoln to begin my study. I contacted potential study participants via email to solicit their participation. I pre-screened possible participants using a Pre-Interview Questionnaire (See Appendix D). I used an informed consent waiver to provide information about any risks to the participants (See Appendix B).

The primary technique for data collection was conducting interviews, because this provided the most purposeful methodology suited to my particular question. Because qualitative research does not collect events themselves, but rather representations of those events, “making data” out of those representations is a collaborative process between the participant and the researcher (Creswell, 2007, p. 87). My listening, concentration, and attention during the interview was important in guiding the interview without “leading” the participants (Creswell, 2007, p. 90). I used semi-structured interviews, using the

questions listed in the Interview Protocol (See Appendix E). Correct interview techniques can derive new understanding from complex, unstructured data (Creswell, 2007). I subscribed to the structure and analytical methods suggested by Moustakas (1994) for phenomenological research, as well as methods proposed by Lincoln and Guba (1994).

In addition, participants were offered the opportunity to give a second interview to add any information they may have forgotten, or later thought was significant. None of the participants chose to participate in a second interview. During the pre-screening process, participants were asked whether they had journals or emails from the time of their immersion experience. They said they did not. One participant kept a clinical case log, but strictly as a medical record for review by the participant's managing physician, so this was not appropriate to share.

Despite participant interest in the study, I had to make a great effort to schedule and re-schedule with the participants around the demands of being a physician. Several participants re-scheduled multiple times, and I had multiple "no-shows" due to an unexpected work-related need. All physicians who initially agreed to participate rescheduled and completed the interview process. Given the comprehensive nature of the first interview, it became apparent that the depth and clarity of the events reported were sufficient to provide adequate data to inform the central research question; therefore, no additional attempts were made to develop any other source of information.

Data Analysis

Both Creswell (2007) and Moustakas (1994) include the following components that are central to data analysis:

- Reflect upon and describe my own experiences with the phenomenon or my biases related to the phenomenon.
- List significant statements from the interviews after reviewing individual statements. Both the statement and the meaning of the statement according to the individual participant are part of the classification process.
- Identify, classify, and group statements from the original transcripts and transcript notations of the interviews to create codes, themes, and “meaning units” derived from participants’ statements. Each statement that contributes to a meaning unit is both a single unit of information and part of a larger common whole.
- Use verbatim quotes from the participants’ descriptions of their experiences to identify the central phenomenon (textural description) and to aid in the integration of ideas for phenomenological reduction (Moustakas, 1994).
- Write my description (structural description) of how the participants’ experiences happened (Moustakas, 1994).
- Synthesize the meaning and essence of the phenomenon or experience.
- Create a composite textural description that represents the essence of the integrated experiences of the participants as a group (Moustakas, 1994).

The above framework helped me organize the information transcribed from my interviews. The results of this analysis are further described in Chapter 5.

Validation

I use member-checking, peer review, and detailed, in-depth descriptions as validation strategies. Creswell (2012) recommends the use of two or more of the

following validation procedures for qualitative research studies: triangulation, pre-survey, observations, member-checking, peer review, and detailed, in-depth descriptions.

Member checks occurred after the participant's interview and analysis. This was an opportunity to share the information gathered with the participant to verify the accuracy of the statements, ask follow-up questions, and clarify anything that could impact the credibility of the data. I communicated a synopsis of the interview to be reviewed by the participant along with any quotes that may fit into identified themes resulting from the study data that could be part of a vignette that describes the phenomenon. I received a limited response when I sent this email to each study participant during the member checking process. No one saw a need to meet again, and subsequent feedback was extremely limited. I received three replies out of 12.

Peer review can uncover biases and assumptions on the part of the researcher and help confirm that the themes defined by the researcher are plausible. "It is a process of exposing oneself to a disinterested peer in a manner paralleling an analytical session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308). Having a peer who is committed to familiarization with the purpose of my study, willing to review my coding for themes, and then review my coding in relation to the central research question was critical for validation. Following their review of the transcripts, our conversations explored my interpretation of the data, and they proposed alternative interpretations of the data.

Detailed, in-depth descriptions use the participants' words to lend emotion, detail, and context to create understanding about their first-hand experiences that represent the

phenomenon (Creswell, 2007; Denzin & Lincoln, 1984; Geertz, 1973). I use the participants' words as much as possible to illuminate any themes. The body of knowledge in this subject area will not advance with merely a superficial account of the participants' experiences. Only through a detailed, in-depth description can I achieve external validity using sufficient detail to evaluate these lived experiences and draw conclusions. This study is needed precisely because of the detailed, in-depth information that can only come from extensive time and attention given to understand the participants' lived experiences. This type of data serves to provide adequate information and context for understanding by multiple researchers, and a qualified peer may identify important alternatives to my original interpretations.

Ethical Considerations

There were no known risks to this study. I followed standard privacy and security protocols for the protection of information and of my study participants. This included utilizing a transcription service that signed a confidentiality agreement (See Appendix C) as prescribed by the University of Nebraska Institutional Review Board (IRB). Additional protocols were followed to ensure confidentiality and to de-identity quotes from the interviews, including:

- Conducting the interviews in a private office.
 - Assigning pseudonyms to participants at the time of the interview.
- Conversations between researchers referred to participants only by pseudonym.
- Changing some participants' characteristics (e.g., school names, exact rotation locations, spouses' names, hometowns) for the purposes of anonymity and to

enable the research to be shared later in articles or presentations without any risk to any study participant.

- Sending only de-identified transcripts to the seconder coder for review.
- Storing audio recordings in a locked cabinet accessible only to the researcher.
- Using password protection for transcript storage.

Role of the Researcher

The importance of bracketing one's own experiences cannot be overstated when discussing the role of the researcher (Creswell, 2007). "Evidence from phenomenological research is derived from first-person reports of life experiences" (Moustakas, 1994, p. 84), and this evidence cannot be altered by the suppositions or biases of the researcher. It requires listening, looking, and becoming aware, as if naïve, in an attempt to "suspend everything that interferes with fresh vision" (Moustakas, 1994, p. 86). I suspended and bracketed my beliefs and expectations as much as reasonably possible throughout the course of this study to protect the integrity of the data, while recognizing that I am also part of the data-making as the interpreter.

This chapter has provided a detailed explanation of the phenomenological research method that will be used to answer the central research question. It has also provided an overview of other qualitative research designs that were considered. Data collection methods, validation strategies, and ethical considerations were also discussed. The next chapter will present the findings of this study.

Chapter 4: Findings

“A mind that is stretched by a new experience can never go back to its old dimensions.”

—Oliver Wendell Holmes, Jr.

In order to answer the primary research question, this study sought to describe the experiences of 12 study participants, all of whom were primary care physicians trained in the U.S. who participated in an international clinical immersion experience of six weeks or longer during medical school or residency training. The interview data from these study participants allowed me to answer the primary research question by documenting their personal and clinical experiences that took place in developing nations, with each location being culturally distinct from the U.S. Additional criteria for participants in the study included:

- The physician was 5.5 years or less past the completion of his or her medical residency.
- The physician was a primary care physician performing services designated as family practice, internal medicine, or pediatrics for the purposes of this study.
- The physician lived among his or her patient population and not in a segregated geographic area or housed with multiple physicians or other persons from the U.S.

This study did not include physicians who now dedicate their careers to humanitarian organizations, such as Doctors Without Borders.

This chapter describes how study participants experienced international immersion, filling an important void in previous research. These findings explore the

lived experiences of study participants, and they provide insight about how immersion experiences impact physicians, their development, and their future practice. The study began with the assumption that the lived experiences of participants were meaningful, unique, and developmental. I found that the experiences reported during the interviews were substantial and valuable. They provided new insight to the field of medical education, cultural competence development, and physician development in general.

I determined that the best method for describing these experiences was through a phenomenological approach. The framework of phenomenology is the “elimination of suppositions” (Moustakas, 1994, p. 60) and a focus on lived experiences to describe the nature of things. Participants were asked broad questions in accordance with Creswell’s protocol and in contrast to methods that attempt to prove whether something is true (Creswell, 1997). Inquiring about the wholeness of the international rotation gave participants a chance to reflect and brought forth new ideas and meanings. While an iterative interview process was used, codes and clustering of meaning emerged early in the process, and this suggested the themes. This process was both inductive and emergent, as defined by Creswell (2007), and coding and analysis determined the resulting phenomena. Because I recognize my own philosophical assumptions, my analyses of the interview transcripts are also included as part of the investigation, thus integrating the participant and researcher into the outcome of this study.

I invited physicians to participate in this study using a “purposeful” technique in which a “snowball” recommendation was chosen from one participant. Participants came from diverse backgrounds in terms of race, ethnicity, gender, and a variety of medical schools and locations. Table 5 provides demographic information about the participants.

All study participants, with one exception, chose a destination country for their immersion experience from a relatively small number of countries that hosted students who were affiliated with their institution. Figure 2 lists these destination countries. No program or geographic location hosted more than one study participant.

At the time of their international rotation, one participant was in medical residency, and two participants had completed their final year of medical school. Eight participants departed for their destination countries during the summer before their last year of medical school, and one participant left during the fall of the last year of medical school in lieu of a clinical sub-internship rotation in family medicine. These experiences were six to twelve weeks long and occurred between 2010 and 2014. Language skills were aligned with the rotations that participants chose, and only one participant was dependent on a full-time interpreter.

Table 5

Participant Demographic Information

Participant Designation (Pseudonym)	Rotation Year	Birth Year	Race	Ethnicity	Gender	FP/IM/Ped**	MS or Resident	Immersion Period (weeks)
Adams	2011	1985	White	not Hispanic	F	FP	MS	8
Benton	2011	1987	White	not Hispanic	F	FP	MS	6
Caldwell	2012	1986	Black/AA	N/A	M	Ped	MS	8
Davos	2014	1989	White	not Hispanic	F	IM Res now	MS	12
Franklin	2013	1984	White	Hispanic	M	IM	Resident	6
Murray	2011	1980	—*	N/A	—*	FP	MS	8
Nelson	2011	1985	Asian	not Hispanic	M	Ped	MS	6
Peppard	2014	1985	White	not Hispanic	M	IM Res now	MS	7
Rapp	2011	1986	White	not Hispanic	M	IM	MS	6
Simpson	2010	1985	Asian, White	not Hispanic	M	IM	MS	9
Tomball	2012	1986	White	not Hispanic	F	FP	MS	6
Vargas	2011	1986	Asian	N/A	M	FP	MS	8

Note. * Subject chose not to identify. ** Family practice, internal medicine, or pediatrics.

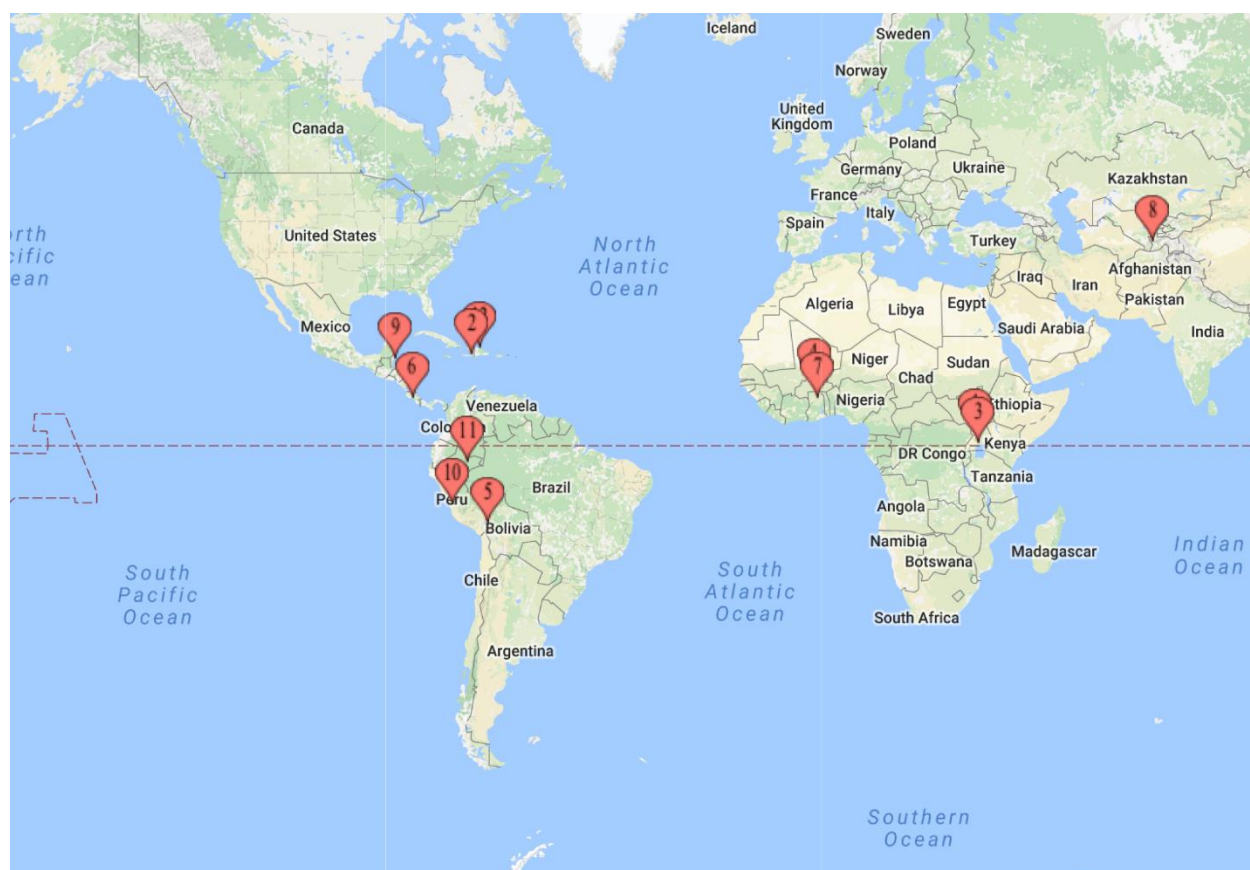


Figure 2. Location of participants. Reprinted from Mapcustomizer.com.

Researcher's Reflections

Physicians who participated in this study were very busy people. I am thankful for their interest and commitment to my dissertation. Several participants responded to my solicitation email and stated that they certainly wanted to participate, but they canceled three times or were a “no-show” for the interview phone call. One participant rescheduled four times. The most common interview time was 6:00 or 7:00 a.m. in the physician’s time zone. It was difficult to schedule and re-schedule time with the study participants around the demands of their practice. When we did connect, I was grateful for the distraction-free way they approached our time together. They almost seemed as if they were doing dictation, devoting concentration to the task. They stayed very close to a

1-hour time frame for our interview, since that is the time they had allotted to this project. The length of the interviews ranged from 52 to 76 minutes. Even so, I did not feel that any interview was cut short or was incomplete due to this tendency.

As physicians, they clearly understood the role of research and the affiliated privacy guidelines. Therefore, they were exceptionally trusting, open, and candid as they provided deep, personal information in their interviews. This unique understanding made the phenomenological approach particularly appropriate for providing depth of research with this participant cohort, and it produced sufficient data to address the central research question. The interviews felt like the floodgates were open! I heard about their self-doubt, resentment of their parents, drug use, marital issues, illicit relationships, and the mistakes they made while practicing medicine. I heard phrases such as “I’ve never told anyone this before,” “I’ve never talked about it,” and, “It’s good to talk about this.”

After the interview and initial coding, participants received a follow-up email that detailed key quotes presented here, in case they would like to add, correct, or further explain the viewpoints captured and interpreted. Despite participant interest in the study, I received limited response when I sent this email to each study participant during the member checking process. No participant expressed a need to meet again, and subsequent feedback was extremely limited.

I received three replies out of 12 follow-up emails. Two participants affirmed that I should “go ahead,” and the third sent an email asking me to call. During the call, this third participant brought up a personal statement that he had made in the interview that was not coded as significant and was not intended to be presented in this paper. He stated that he remembered making this statement, and he did not want it to be included. I

assured him that it would not be included and it was therefore redacted from the transcript in storage. Although validation through member checking was somewhat nonproductive, the peer reviewer examined the participants' transcripts and found and coded themes and meanings that were remarkably similar to mine.

In capturing the rich descriptions of these participants and by gathering insights from the participants' shared experiences, I was able to formulate a clearer meaning of the phenomenon of the international immersion experience undertaken by primary care physicians during their training. Table 6 presents the five themes that emerged from the data, and these themes describe the phenomenon of the international clinical immersion experience.

Table 6

*How Primary Care Physicians Trained in the U.S. Experience International**Immersion: Data Themes and Subthemes*

Theme	Subtheme
Participants chose the international rotation for broad developmental purposes, not solely for cultural competence development.	<p>Cultural competence is a secondary motivation for participating, not the primary one.</p> <p>With self-development at the forefront, they sought the rotation for intellectual growth and challenge.</p> <p>Participants stated the rotation was something they are “expected to do” or is part of the “being the best” in their profession.</p>
Positive outcomes for participants, especially as it relates to cultural competence.	<p>Participants’ future medical practices were impacted by routinely adding social context and family information to diagnosis and treatment plans.</p> <p>Participants adapted to resource challenges.</p> <p>An interest in primary care became clearer due to increased autonomy and confidence.</p>
The lifestyle is different than the U.S., allowing participants to be more observant and contemplative than they were at home, enabling development.	<p>Being away from a hypercompetitive environment was a welcome change.</p> <p>The pace of each day gave participants time to reflect and unwind.</p>
Harmful environmental forces shorten patients’ lifespan and quality of life. As a doctor, there is limited ability to impact population health.	
Participants wonder whether they have chosen the right profession, but feel unable to consider a change, primarily due to debt.	

The first theme that emerged was participants’ indication that they chose an international rotation for development as a physician in general. Study participants indicated that their choice was more about advancing their career than satisfying a hunger for cultural experiences.

Theme 1: Participants chose the international rotation for broad developmental purposes, not solely for cultural competence development.

When asked what led them to participate in the international experience, all 12 participants referred to their own development. During my time with them, I heard many stories and descriptions that indicated they either felt that (a) they were expected to participate, (b) participation was part of being the best in their program or profession, or (c) they desired intellectual growth or a challenge. Each participant required some prompting before they included cultural competence development as a motivating factor. It seemed to be a secondary factor and not a primary reason, according to interview responses. Their responses focused on self-development and being the best doctor they could be. The first subtheme related to Theme 1 is that cultural competence is a secondary motivation for participants, not the primary one.

Subtheme 1.1: Cultural competence is a secondary motivation for participating in the international rotation, not the primary one.

When I asked participants directly about cultural competence development, 11 of the 12 participants stated that, of course, the experience was intended for cultural competency development. However, this aspect was not immediately mentioned when I asked what led to their participation, and it was less directly discussed during participant interviews. It was an assumption of participating, and instead, participants spoke at length of other reasons for participating in the rotation abroad. I received the following replies that illustrate evidence of Subtheme 1.

Dr. Vargas illustrates the first subtheme, that cultural competence was a secondary motivation, stating,

Of course. It was more relevant than the other cultural competency classes that were vignettes and patient types, videos—that kind of thing—kind of stereotyped. Everyone's named *Maria* or *Muhammad*. I was thinking about getting experience more than cultural competency.

Dr. Peppard told me, without elaboration, “Sure, sure, that too: Cultural competency is important.” And, Dr. Murray, who was anxious to “see the world,” replied to the direct question about cultural competency development with, “Yeah, obviously.” Dr. Rapp concurred, answering, “Yes. Sure. All that.” After stating that the experience would teach him how to cope and serve, Dr. Simpson replied to the same question, “Yeah. Yeah. The point is to develop [long pause] and be able to cope while you serve on behalf of [school name redacted]. We have to be leaders in the world.” Dr. Tomball discussed efforts to measure his cultural competence development: “I remember taking a standardized questionnaire. You know, before the trip, and then the same instrument as a post-test. I don't think I ever saw the results. We never discussed it. I was on to the next block.” Dr. Benton emphasized that the international elective was part of achieving the final goal of being a doctor subtheme, not necessarily just for cultural competence development. He provided further evidence of the subtheme by echoing other participant statements, saying, “They tout cultural competency, but there is more bias and discriminatory talk that goes on day in, day out. I just wanted to be a physician. This was part of getting it done.” Dr. Adams found that her driving motivation for her trip was the opportunity to apply her clinical skills and truly practice medicine before she would have been able to practice independently at home in the same way. She told me,

Sometimes *cultural competence* is just a buzzword. Now that I'm a physician, I get it. There's only so much time. You do what you can. I was motivated by the clinical opportunity, and being in another country gave me a chance to practice at a higher level than I was allowed to here.

Dr. Davos recalled, "The global scholars program got me interested in cultural competency, but everything we studied seemed so irrelevant once I got there."

These quotes, when taken as a collective, illustrate Subtheme 1.1 by describing how cultural competence served as a secondary motivation for participating in the international rotation, not the primary one. While 11 of the 12 participants indicated that cultural competence was a secondary motivation rather than a primary motivation for their immersion experience, most participants indicated that their primary motivation for the immersion experience was a need for self-development, intellectual growth, and challenge, which emerged as the second subtheme.

Subtheme 1.2: With self-development at the forefront, the participants sought the rotation for intellectual growth and challenge.

All 12 participants described a need for self-development, challenge, meeting expectations, and professional growth as key drivers for choosing the international experience, rather than cultural competence as a primary goal. This subtheme dispels an assumption that participants engage in the international rotation for the programs' stated purpose, cultural exposure, and it informs the central research question of this study. The most compelling evidence for Subtheme 1.2 can be seen in comments from Dr. Benton. She attended a prestigious East Coast medical school and was interested in returning to Haiti. She had visited Haiti in the past with her parent, who was a French professor in

middle school. She wanted to feel that she was differentiating herself from her peers. She said, "It's important to do everything you can in med school to distinguish yourself." Similarly, Dr. Vargas illustrates this subtheme by describing how demanding more of himself feels like the right path to a better future. Dr. Vargas attended a Top 20 private medical school on the East Coast. He stated,

What was I going to do? Sit in my parents' basement, while everyone else is on some great rotation? I didn't make it into a Top 10 med school, so a good residency could be hard to secure. I needed clinical experiences to talk about in my interviews.

Unlike Dr. Vargas, Dr. Tomball attended an exclusive medical school that expected most students to participate in an international elective. Dr. Tomball is now a family practice physician. So, while her medical school background required an international elective, she echoed Dr. Vargas's comments, providing further evidence of the subtheme by clearly demonstrating her interest in accelerating her development. She stated,

Our program expects it, really. Plus, I knew I'd see a wider range of cases that I would never see here. It seemed like a fast track to clinical experience. I wanted to see tropical diseases. I've always thought of myself as someone who does it all. If the program offers it, I'm doing it.

She cherished the opportunity to test herself and her clinical skills as soon as possible in her education. Dr. Rapp gave another viewpoint on looking for a challenge. He attended a small Midwestern medical school and has since become an internal medicine physician. He described wanting a change from the typical protocols of medical school, stating,

I thought it would be a real challenge! Not like standing in a group around a patient talking a diagnosis to death or shadowing a mentor physician on rotation.

It served as a substitute for one 4-week clinical sub-internship in family medicine, so it was time well spent.

Dr. Adams participated in the MD/PhD combined program at a mid-Atlantic state school. She had already chosen the family practice specialization, had applied for residency, and been accepted at the time of her rotation. Her trip was originally scheduled the year before the study, but she had to defer due to illness. She told me that medical schools expect an international elective, and it would enhance her career. She reinforces the subtheme when she said, “I was definitely interested to go someplace completely different to see how I would do.”

Dr. Davos chose the experience as an opportunity for intellectual growth. She spoke with excitement about feeling challenged. She is currently completing her internal medicine residency. She attended a private, East Coast medical school. And in 2014, she participated in the longest international rotation among the study participants: a 12-week rotation. She stated,

Well, I wanted to do it all in med school. College went fast and was actually boring. I was going along and during Year 2 at [name of medical school redacted]; my roommate was getting excited about the Global Health Program. I sat in with her at a seminar and wanted in!

The subtheme of broader self-development as the primary motivation seen in the participant quotes above supports Theme 1, in that participants chose the international

rotation for broad developmental purposes, not solely for cultural competence development.

The third subtheme identified was that participants felt they were supposed to take advantage of this aspect of their curriculum, since it was offered. Participants felt that in order to “be the best,” they needed to take advantage of opportunities for development. They also described rotations as something one is “expected to do.” This subtheme relates to the first subtheme by providing insight into participants’ motivation to participate, with the second subtheme also telling us why participants actually chose the international experience. Subtheme 1.3 relates to Theme 1, revealing the underlying reason why cultural competence development is not a primary motivation for participating in the international rotation.

Subtheme 1.3: Participants stated the rotation was something they are expected to do or it is part of being the best in their profession.

Eight of the participants’ stories expressed this subtheme through a variety of ways. They saw the rotation as key to their capacity and status as a medical student and future physician. This emerged subtheme further elucidates Theme 1 by showing us that participants chose the international experience for reasons other than cultural competence development. Dr. Franklin illustrated the third subtheme by indicating that he chose an immersion experience as part of his southeastern U.S. private medical schooling, because he wanted to get ahead and because he wanted every opportunity to succeed and develop. He stated,

I knew I needed to prepare for more than just the narrowness of practicing in the United States. To be a true scholar and a good physician takes a larger view, for

sure. I didn't want to go through all this—years of education and work—and then have my options limited, you know, because I wasn't prepared and someone else was.

Dr. Caldwell, who is now a pediatrician, attended a highly ranked, public medical school on the West Coast. He chose his immersion experience location for personal, cultural, and professional reasons. The experience affirmed his desire to be a pediatrician and gave him a chance to see and feel what it is like to be a doctor and also to obtain the residency of his choosing. His comments represent the third subtheme, indicating the general expectation associated with international immersion experiences:

It's pretty routine at [name of medical school redacted]. The rotation is eight weeks, but one week is preparation, six weeks are clinical, and one week is an exit class. Skipping it seemed foolish. My dad used to go on mission trips before he died and always said it made him a better doctor. Frankly, I've never lived where most people are Black. I wondered what that's like, so I chose my rotation site partially because of that. It's strange: I don't know if I've ever told anyone that before.

Dr. Nelson said he felt that the international experience was expected and that others expected him to do it all. He spoke with pride, but I also heard frustration. Additionally, he emphasized that he himself wanted the challenge:

I visited my grandparents [in India] three times as a child, but hadn't traveled internationally otherwise. We were always saving money so I could go to school. So, I wanted to go places. I always wanted to be a physician. It was just assumed. I remember looking at the coursework for each year just after I was

accepted and my mother asking where I would go for the international rotation. I wanted [the] intellectual challenge to take all the classes I could. By the time I was done with the first year of medical school, I was tired of studying facts and wanted to figure things out on my own.

Like Dr. Nelson, Dr. Peppard said he was expected to go. Dr. Peppard was in an accelerated BA/MD 6-year program and participated in the international elective the summer after his fifth year. It was just part of the plan, he said:

I was in the BA/MD 6-year program, so I went during the summer after Fifth Year. It was seven weeks, but with a month of elective studies and readings pertaining to the geography and social history prior. I don't remember deciding. It was just part of the plan. It was more like you would need to opt out instead of decide to go.

Dr. Simpson described how international electives are a focus at his school:

[Name of school redacted] talks about international medicine and global health all the time. It is part of the prestige of the program. We are positioned in the most respected medical district in the world.

These quotes provide a thick, rich description of motivating factors beyond cultural competence development, aligning with Theme 1.

The three subthemes that emerged from participants' interviews show a deep desire to develop multiple skill sets and advance professionally during this time. We see through their descriptions that the meaning of an international immersion experience is more than a cross-cultural one for them; it is also a clinical and developmental process they were anxious to experience. We also hear emotion and introspection relating to their

self-image and their concept of what it means to progress as a physician, including progress in comparison to their peers.

While participants chose the international rotation for cultural experiences, this was only one piece of the puzzle. Theme 1 illustrates the complexity of participants' desires and expectations surrounding the immersion experience. This means that we may need to alter our assumptions about why physicians-in-training engage in international electives, and we have come to understand that this choice is likely driven by more than a desire for a cultural experience alone. These revelations help frame our understanding of how primary care physicians trained in the U.S. describe their cross-cultural field experiences directly addressing the research question. We are enlightened about their vision of the experience, and we can further understand their description of experiences during their international immersion when compared to their initial expectations.

It may seem surprising that the next theme reveals the multiple ways in which study participants describe experiences relating to cultural competence, although they were not focused on this as their primary goal. They grew in ways that positively impacted their future medical practice by becoming more socially aware and by adapting to resource challenges. In addition, their interest in primary care as a chosen specialty was often cemented as their autonomy increased and they became more confident clinically.

Theme 2: Positive outcomes for participants, especially as it relates to cultural competence.

The second theme identified by this study was that the international experience yielded positive outcomes. All 12 participants described this in a variety of ways, but

especially in the area of cultural competence development. It is of particular interest that participants' descriptions of the immersion experience seem deeply connected to skills in the area of cultural competence development. Participants developed observational skills, living in the same environment as their patients. They spoke about developing empathy and being humbled by the experiences. They talked at length about how social context and family information has now become part of their diagnosis and treatment plans, and this habit resulted from their international experience. While all physicians in this study engaged in an international immersion experience, they did not necessarily see cultural competence development as the primary goal, or the result, yet there is some evidence that this may have been an outcome.

The first subtheme identified as a positive outcome for participants was their growing ability to add social context to their treatment plans. Time spent in another country promoted, or sometimes forced, greater openness to differences in everyday living. Eleven of 12 participants told me this created a need to analyze and include social and family information in the treatment of their patients. This subtheme relates to Theme 2 by describing the ways in which learning to add social context and family information is a positive outcome related to cultural competence. It informs the research question by further describing how participants experienced their international clinical rotation, and it highlights developmental features and experiences, particularly cultural development experiences.

Subtheme 2.1: Participants' future medical practice was impacted by adding social context and family information to diagnosis and treatment plans.

Ten of the 12 participants told me that the habit of including social context has stayed with them, meaning that this experience led to an ongoing change in the way they practice medicine. They described a variety of ways in which they incorporate social information into their practice as a result of time spent participating in the international rotation. Their curiosity, observations, and adaptations during this time were not necessarily described as cultural competence development or a change impacting their future practice. Nonetheless, their stories tell describe their attention to family standards and community norms which were different from their own and increased their awareness. Through their recollections, we also hear how the mental habits and frameworks within each doctor's future practice were expanded due to the influence of their experience.

Dr. Peppard recalled,

After the first week, I realized which house was delivering my meals, and I walked over to pick up my dinner instead. They were surprised. I'd been there a week but hadn't seen inside anyone's home. I didn't know anything about them. . . I didn't go into that many households during my stay, but I started taking my meals outside so I could watch everyone pass by. Even *that* was informative.

Later, he added the following social observation: "Patients don't go it alone there. It was really obvious when you live down the road. I pay more attention now to what else is going on in their life."

Dr. Peppard told me he changed as a result of his experience, saying, I can't help it now. When I get a new patient, I wonder: Who is this person? What do they do all day? Who else is there? In the States, though there's a lot of anonymity, lots of people are alone. It doesn't always help me, but it's become automatic.

Dr. Simpson gave another view of the importance of knowing more about the culture and needs of the patients he was serving:

Privacy's not expected there. See, the family can help you or hurt you when you are trying to get things done. I learned to look around before I went ahead. The dynamics of how it *really* works. It's the same now. Noncompliance is often from some misunderstanding or social obstacle. I've got to pull in someone else from the patient's life.

Dr. Adams told me she now realizes how little she knows about a patient at a medical appointment: "Social history and medical records are so deceiving, like, 10% of the story." And, later in my conversation with Dr. Adams, she reflected on how understanding a patient and his or her needs is not so simple. She said,

Culturally, no one would question a doctor [there]. Language wasn't the issue: It was understanding their life enough—views enough—to say it in a way that made sense. I quit handing out pieces of paper and looked into their eyes. [long pause] Lots of families shared a cell [phone], and I would get the young person to enter alarms, etc., for the treatment plan. Otherwise, they just kept coming back, deteriorating, doing nothing I'd recommended. It takes a village. Ha! I think about it here too. It changed me.

She also told me about the seriousness of medical training and how making the correct choice for a patient is a decision that requires cultural information. She describes resuscitating a newborn with a serious genetic disorder shortly after birth, saying:

She [the newborn] had a serious genetic disorder—syndrome—that was clear by her physical presentation. I was elated [after resuscitating her]! I'd never done that before. Then, I looked around the room, and they all had their hands over their mouths. I knew I'd done the wrong thing. They said she died a few days later. Christ. I mean, she wouldn't have lived long anyway, but I think a well-meaning relative took care of things. [snorts] There was no place for her there. The right thing is—well—it's fucking subjective. I catch myself now, wondering about it when I counsel a patient with a serious diagnosis. I think what's right is what's right for them.

I heard how his time in a new culture gave Dr. Murray a new understanding of the interconnectivity between people. He told me his experience made him more conscious of his patients' everyday lives, their family relationships, and their daily habits, leading to more creativity and cultural awareness in his future practice. He said,

How is it different? Well, Jaco is small. Rural. Several people share a truck, a bicycle. Everyone is connected, like, they are all cousins. I could see it. When I walked—who was with who: all the combinations throughout the day, different times of the day, who drove the same truck, who had the children, and so on. . . . Being in it makes you a better doctor. You see their lives, . . . ask a few more questions, and pitch the treatment plan—well—more creatively than we were

taught. Maybe I would have never figured that out on my own. It gave me perspective there—lifted—the *one* way to do it.

Dr. Davos is still completing her internal medicine residency, but like Dr. Murray, she looks back on her rotation experience and relates its influence to her current practice. She told me how she longs for more context about her patients' lives as a result, saying:

In the clinic, I only know what the patient tells me. There [during the immersion rotation], I could see everything. I think about that. I volunteered to do the telemedicine pilot, even though it's extra work. I figured at least I could see into their homes—ya know—a natural setting.

Dr. Caldwell also compared the international experience to his current practice. He contrasted living among his patients and the ability to see a whole family together during the immersion experience to his current pediatric practice in the U.S. He said,

There are so many influences day to day that I can't see here. . . . It was simpler there. I'm always looking to fill in the story: the social setting, the family.

There, it was an open book. I'm still looking for that.

Dr. Tomball said the cultural challenges created confusion. This new and foreign place forced her to look for clues and use her senses to learn. She acquired a new cultural lens, and this remained with her. She told me,

Everything was so different, so *nothing* made sense automatically. It was like slow motion getting through the cases. . . . I could hear myself, inside my head: *What's going on here? How did this happen? Where did these people come from?* It was exhausting trying to figure out medicine, never being on my own, and social customs and new presentations [of disease], and it was as if I knew

nothing [emphasis]—that everything was a thought built from scratch, one painful step at a time along the decision tree. . . . Assuming is such a shortcut. Family customs and the expectations. God, I couldn't have guessed them, so I started asking. I still do.

Dr. Rapp observed these differences as well:

Medical school is very prepared and regimented. Patients come to you: a tidy exam room, a hospital bed. In Belize, they come *at* you, especially when you're outside of the standard clinic. Context matters! Here, we put people in a box to examine them, but they don't live in the box.

The next positive outcome identified as a subtheme was how participants rose to the challenges from a variety of resource shortages, difficulties, or new situations. They coped and adapted and felt accomplished—if not proud—afterward. This subtheme like the one prior, stems from descriptions of positive outcomes for participants, supporting Theme 2. The description gives evidence that aspects of cultural competence development were involved in the day to day interaction and coping with this new place and environment. This informs the research question telling us how participants experienced the international immersion. These stories of adaptation to the resources available often resulted in a shift in perspective. There was a great deal of humility and empathy expressed in these stories, which could be indications of developmental growth. Participants described ways in which their experiences contributed to their overall development as well as their awareness of cultural and individual differences that might affect patient needs. Coping made them feel stronger and more capable as well.

Subtheme 2.2: Participants adapted to resource challenges.

Participants adapted to practical challenges, such as a shortage of needed resources. Overcoming these challenges resulted in positive growth and development for the study participants. All 12 of the participants described ways they adapted to these resources challenges.

Dr. Peppard went from a Midwestern medical school to a 7-week rotation in a very basic clinical setting with an immensely diverse patient population. He illustrated how he was forced to adapt to new cultural standards—in fact, multiple standards. He also described how he became aware of the vast differences in his patients as individuals with different cultural needs, how he adapted his clinical approach because of these demands, and how his diagnostic options and protocols had to become more varied to meet the needs of his community. He became more open and creative in his approach to patients. He told me how he adapted:

My situation was OK: Kind of crude, without good laboratory resources, but I always had Internet connectivity. What I couldn't remember or didn't know, I looked it up. I've always learned fast. Patients came to me at the clinic, so I felt prepared and organized. I had one staff person who was as diligent as the day is long. I did a lot of prep and reading beforehand, but sometimes you can't even touch a patient during an examination, given a religious or ethnic constraint, and I had a devil of a time telling who was who. I had to trust [name redacted] with everything. I had to suspend some arrogance, and I had to think of new ways to [do] diagnosis without tests. Going "old school," I call it. One time, I followed a patient the next day for an hour just trying to get more information from

observation. She was stoic around others, but when she was walking alone, I could see her pain, and it informed the next protocol. Sometimes I didn't know what to do, but I just kept going. I figured, *this is temporary*. I missed one important diagnosis, but maybe I would have at home, too. I don't know.

Like Dr. Peppard, Dr. Nelson found that his concept of being a doctor had to expand. In order to meet the needs of his patients, he expanded his daily routines to comply with local cultural expectations, needs, and standards. Dr. Nelson had more duties than that of a typical physician in the U.S. He did what needed to be done, and he told me, "I saw patients. I cleaned the room. I drove the transport to the hospital sometimes. I always tried to bring back a few supplies. We needed 'em." Dr. Murray echoed the need to adapt to new cultural expectations and says he was "cut down to size" by learning how to use the supplies available in Costa Rica. He still thinks about how to use resources as a result of his international elective experience. He stated,

I got a lecture right away about using too many squares [of gauze] from my nurse. She called me a "wasteful American." The clinic is paid for. Everyone gets care, but supplies are an annual allotment. You gotta *ration*: Ration your way through the year. I catch myself when I pull open the drawer now. I look at the trash and the sharps and shake my head. It's so much.

Similarly, Dr. Adams was confused to see that in a new culture, the doctor is not at the top of the hierarchy, and he was forced to adapt. She went on a long journey to her destination, a small township in West Central Africa. It was made longer when no one picked her up as planned. She recalled,

I took a plane, a train, and finally a truck when I arrived. I could have flown into Gulu. They have an airport, but instead I was routed to the capital. The train station was less than an hour from my post. But after traveling all day, no one came to pick me up. I mean, it's a government-sponsored program! They told me to wait. I ended up waiting overnight. I sat on a chair in a cubby to rest my head. The station master brought me a plate of dinner. It was crazy to just be sitting there. Mid-morning, a truck came for me. It had rained, and with the ruts in the road, they didn't want to risk damaging the truck. A doctor is less valuable than a working truck. I learned that [on] day one.

This was the beginning of Dr. Adams' education about conserving critical resources for the community. She was humbled to see that village residents often chose to go without medical care, but they viewed a functioning, communally shared truck as the lifeblood of their economy.

She further remarked: "There was always Coke and beer in town [snorts], but when the autoclave broke, it took three days to swap it out. I sanitized my small instruments by hand, but never had to use them." She told me that while some aspects of the experience were unpleasant, and the equipment she had was out of date, the demands of the rotation prepared her for the future. She adopted excellent professional habits as a result of the experience. She said,

Supplies are another thing. I never ran out of gloves, but the equipment is out of date or even if it was made [in] 1990 or later. . . . Something's missing, like, a bulb is out. You have to approach every patient as if they are HIV positive: Half

are [HIV positive]. I developed methodical habits. During the Ebola scare here [in the U.S.], I was prepared.

Dr. Adams told me, “No one has money or excess anything.” While she wanted to go home, the experience clearly broadened her horizons, and she gained new skills. In closing, she said, “You have to expect the unexpected and just deal with it.” Similarly, Dr. Davos resigned herself to “making do,” and she grew in creativity and gained coping skills from the experience. She stated,

It’s the first time I didn’t have a car or—ha!—clean water! I used the sanitizing tablets the whole time. I felt like a fraud. At first, I was looking for this or that. When you realize a lot of standard items are not equipped in the clinic, you [pause] finally quit looking. You start looking at what you have and [pause] what you can do with it.

Dr. Franklin told me he did things he would never do at home, saying:

The people are great. They always want to help, but I needed a greater variety of antifungals and antibiotics. I became a scrooge. I took back the old meds if I switched them to a new one. They didn’t seem to mind.

Dr. Simpson recalls how he felt and how he adapted. His evolution as a practicing physician was clearly impacted by the experience. He grew both clinically and personally due to the demands of the rotation. This new environment and culture tapped his internal resources and expanded his functional capacity. He told me:

We did a week of bedside orientation at the hospital before we went for seven weeks to our clinical assignments. Once I got out into the field, it took a week or more to turn around labs. I was on my own. Every day became an improvisation.

I was used to being the best, but now I was living by my wits. And socially, you're really alone. No family. I made a habit of re-reviewing my cases.

Sometimes being fresher or a few days later, I thought of something else. I could pivot, make a change, or follow up.

Dr. Benton describes coping with life during her rotation, but she also told me how her appreciation for what she has and her empathy for others grew during this time. She told me, "It takes a little while to get used to sleeping under the [mosquito] net, especially without electricity at night if you have to go outside." Later in the interview, she explained,

And, I love taking showers now. I never appreciated it before: hot water—all you want. I was a sponge bather and washed my hair once a week. It was obvious I was taking a lot. I could tell right away not to ask for more of anything, unless it was for a patient need.

Dr. Benton also observed herself becoming more mindful of her practice habits and her increasing empathy with her patients, saying, "Making a referral is so easy. Maybe it was better there. I really had to think it through, because my patients had to travel so far."

Dr. Tomball looked for another person to help her with sense-making when she became stymied by cultural differences. She realized that asking about patients' lives was a continuous task, and no one could do this for her. Her curiosity persisted despite her frustration. She says she learned to think independently. She described her development as follows:

I wanted someone to explain things to me. I even had a boyfriend there. I had [a] boyfriend at home, too. Ha! But, we really just slept together every night. He

didn't understand my questions. It was all on me. I had to keep asking. There's no one [to] help you make sense of life there. I could examine someone, but it's not like knowing everything they did that day, or week. I became self-reliant. I felt smothered back at school—being told how to think.

Dr. Peppard told me how he matured during this experience. He learned to value a different culture, and the culture of medicine when challenged in a new resource paradigm. He stated,

It was more important for me to go than for them to have me. They operate without a doctor 70% of the time. The vaccine program and triage of everything else, frankly, is under the direction of a bright medical assistant with a degree in *history* from Russia who knows a lot of languages. She's culturally adept: my dedicated interpreter. I couldn't even read there or do charting. They don't keep records much, except for the vaccine program. So, who's more valuable? An interpreter or a doctor? I mean, they need a doctor, but they get by anyway. They let her provide limited types of antibiotics after a phone consult. She's kind of the village medicine woman: an apprentice—self-taught, and she knew more than I did most of the time. I learned that was okay. . . . This strange place—so many different ways of doing things—I had to adapt. They weren't going to adapt to me in seven weeks. I thought my lodgings were rough, but during the fifth week, I realized I'd displaced [name redacted], that she usually lives in my lodgings. There were just so many things I didn't know. You can't beat yourself up over it. Somehow, this time helped me suck it up and not be embarrassed. At home, in

med school, you can't make a mistake, or you become notorious. Here, it was an everyday event.

The participants saw their experiences as contributing to their overall development as well as their awareness of individual differences that might affect patient needs. These stories clearly illustrate how participants adapted to various resource challenges because they were in a different cultural context and grew as a result. We must wonder, in the absence of the international immersion experience, whether physicians-in-training would encounter similar independent challenges that would stimulate rapid adaptation and development in these ways.

The final subtheme identified as a positive outcome for study participants was an increased interest and commitment to primary care as a specialty. While coping with resource challenges described in the previous subtheme, participants described stronger feelings about primary care as a future specialty choice. Each functioned as a primary care physician, mostly with very limited supervision or support during the international rotation. This informs the research question telling us how participants perceive and describe their cross-cultural experience, especially in descriptions of their lived experiences and first-person narratives, in which they realized that their experiences supported their choice to become a primary care physician.

Subtheme 2.3: An interest in primary care became clearer due to increased autonomy and confidence.

Participants functioned quite autonomously during their rotations and gained clinical confidence, affirming their interest in primary care. They described times when they decided more clearly that they were going to be a primary care doctor. Having this

broad clinical experience providing primary care created enthusiasm for doing so in the future. Nine of the 12 described how an interest in primary care became clearer in some way.

Dr. Peppard recognized the value of the experience and how it inspired him, saying,

It made me more excited about primary care—always learning. I saw *so* clearly how you learn by doing. . . . As I failed, I became weirdly confident. I mean, I knew I could do it, even if I didn't do it right the first time. I think it helped me keep my head on straight now, during my residency.

Dr. Davos realized how much she grew from the demands and independence of her rotation. The variety of each day indicated to her that staying in primary care was the obvious choice for her future. She told me,

Some days I didn't have that much to do: well child checks, a prenatal, an HIV follow-up call or consult. Some days I did everything! The variety was good! I got over my awkwardness. I had a managing physician, but when I called there, he always just agreed with me. When the heat was really on—well—I'd react and forget to call. Maybe it sounds arrogant, but I figured I'd get bored if I was a specialist. Staying in primary care seemed right, even though it's a hassle, and the pay [heavy sigh]. I stayed with internal med. It clicked. I was doing it.

Similarly, Dr. Tomball felt both challenged and validated during her time in Peru. She wanted the challenge of treating “the whole body” to continue throughout her career. She described her view, saying,

There were more unknowns there: tropical diseases. I had to diagnose things I'd never seen presented to me. It's a bigger range. They thought I was the doctor—the authority. It made me confident after some time—some correct diagnoses. Seeing patients improve. People calling me doctor. I felt good about it: like a power for good instead of the slowest one at [redacted school name] to get through labs. I wanted that big range: all the body systems.

Dr. Murray was initially overwhelmed with uncertainty, but this quickly subsided. He describes the validation he felt during the experience, saying,

The first week or two was tough. Every patient was a new diagnosis. I struggled with each one and second-guessed myself. Then, I saw hookworm again, and I was like, “hey, I know this.” After that, I realized it would be fine. I was on the right track. When I dreamed of becoming a doctor, it was a primary care doctor. That's what I am.

For Dr. Nelson, this time provided hands-on experience that connected him to his purpose as a future pediatrician. He told me, “It confirmed what I already knew. . . . Being hands-on, being on my own for those weeks, helped me be true to what I wanted.” Dr. Benton surprised herself by spontaneously declaring after the rotation that she was a primary care physician, while still being a medical school student:

There's a lot of stress to decide and bid on residency slots for match. You need to make the right decision. I realized, I'd already decided. On the plane trip back, a girl asked me what I do. I said “I'm a physician, primary care,” even though I had a year to go. It just came out of me.

Dr. Simpson described enjoying having the first encounter with each new patient. After his international experience, he trusts himself more than another physician to do a proper history and intake of a patient. He said,

When you're internal medicine, people come to you first in the process: the intake, the history—the completeness matters. On rotation, I got good at that. Really good. I had to ask so many questions, make no assumptions. I didn't want to give it up or trust it to someone else with all that. I knew I wasn't going to be a specialist. I want them to come to me first.

Dr. Adams knew family practice was right for her after her time in Uganda. She told me, I liked treating the whole family! They'd come in together, everyone talking at once. I was just trying to figure out who was who. Natural chaos! It helped to see them interacting during the office visit. It made me feel more caring somehow, like I knew them even though I didn't. It was so different in training—so controlled. But, I liked this better. And, I figured things out even in the noise and with the chaos and the kids. That summer, I quit worrying about being incompetent and starting thinking about what kind of practice I wanted. I felt in charge of my future.

Through these comments, participants gave a very rich description of working autonomously, gaining confidence, and ultimately choosing primary care as their future practice area as a result of their international immersion experience and is a positive outcome from the experience, supporting Theme 2. Given the critical shortage of primary care practitioners in the U.S. currently and projected into the future, this study data may indicate that future research focused on the impact of international experiences,

and a possible relationship to a physician's choice of specialty, may be warranted.

Participants' self-concept changed from one of medical student to one of doctor, and more precisely, to a primary care doctor as a result of these experiences.

Theme 3: The lifestyle is different than the U.S., allowing participants to be more observant and contemplative than they were at home, enabling development.

The third theme was described by 11 of the participants. Theme 3 relates to Theme 2 in that they are both typified by the ways in which life in a different culture felt different. This theme informs the research question telling us more about how the context of the experience impacted participants. As different as it was, participants quickly adapted to the lifestyle and the environment. The pace of living there was something they were very aware of compared to medical school and their daily habits in the U.S. Participants named several factors that made daily life different for them on their rotation. Away from home there was a pause compared to their frantic lifestyle in the U.S. The break from a competitive environment gave them time to make real cultural observations instead of feeling pressured, posturing, or striving to measure up. This was a key part of the experience and may be important to their development and ability to integrate cultural information.

Subtheme 3.1: Being away from a hypercompetitive environment was a welcome change.

One of the reasons that participants felt the lifestyle was different was being away from the hypercompetitive environment of medical school and that this was a welcome change. This was identified as the first subtheme that impacted participants, with 9 of 12 participants indicating this was meaningful. They were acutely aware of the difference

and their associated feelings. It was a time of independence and a time to gain perspective on their medical school experience. This informs the research question, in that participants' lifestyles were sufficiently different in the new culture to encourage or allow contemplation, reflection, and focus, which resulted in personal development and evidence of possible cultural competence development. The experience allowed participants to expand their scope and may have altered their developmental path. Dr. Peppard told me,

I stayed off social media. I just didn't want to hear it. It was good to be away from school. Before you go to off med school, you are always the smartest kid in the class. After you go, you feel inadequate most of the time.

Dr. Vargas was delighted, saying, "It's the first time no one was watching everything I do." Dr. Murray commented on the social pressure of medical school and the desire to work: "It was nice to be 'the' doctor. Sometimes I could have used help, but mostly it was good to leave the pack. I was working, not being judged." Describing the freedom from rigid medical school protocols and a competitive culture, Dr. Rapp told me,

Sometimes I didn't know what to do, but at least I didn't have someone looking over my shoulder every minute or have four classmates giving a sideways correction trying to distinguish themselves [or] "up" themselves. When everything is a competition, you get robotic. There's no time to think. The entire culture is passive aggressive at school. It makes you a doctor. I guess, but it makes you defensive, not collaborative.

He told me later in the interview that reflecting on the experience gave him insight, and he referred back to this point in our discussion. Dr. Davos was excited as she described

being on her own, saying, “At first, it was awkward because there really was no one to evaluate me. I was on my own. It made me nervous at first, but then I felt free!”

Throughout the interviews, I heard the fear of inadequacy as part of the internal makeup of these doctors. Perhaps the importance of the job requires an internal barometer of continuous self- evaluation. Dr. Benton sums up feeling “good enough”: “Here, I was good enough. I was bumbling around, but I could correct myself before [pause] I got caught. What a gift that was!”

Dr. Franklin said the locals were glad to have a doctor, and he told me how this affected him:

They were glad I was there. I mean, at [school name redacted], you are always told someone better is waiting to take your spot. I was the best doctor there [laughs and laughs]! Not like I was confident, but hey, no one was nipping at my heels. I had time to work. I had more focus and energy. It was kind of a break.

Dr. Nelson told me that, while the days were challenging, there was less pressure building inside him while in Ghana. Even with increased responsibility, he was able to let go of the stress he felt was ordinary. He said,

At home, you’re always supposed to do more. Most of the world doesn’t think like that. I was busy, but it was like a decrescendo compared to home. I let it happen. There was a new kind of pressure—no—a responsibility, because I was actively in practice—more independent. But, the pressure was less. A lot less.

Through these participants’ comments, we see how they describe the cross-cultural experience as different and how it impacted them. Time spent away from competitive pressures and from peers created mental space and freedom to work rather

than compete. This brought forth more energy for daily tasks, even while working in a demanding environment, as well as mental clarity and self-affirmation. The next subtheme relates to Subtheme 3.1, showing the result of time spent, now that participants were no longer in a competitive environment each day. The ways in which participants spent their time in the hours outside their clinical work were often relaxing pursuits, a much different lifestyle than they experienced in the U.S. This subtheme informs the research question by telling us how participants experienced and described their international rotation experience.

Subtheme 3.2: The pace of each day gave them time to reflect and unwind.

This second subtheme, describes a self-reported, observable change in lifestyle and its effects, demonstrating a need for doctors in training to relax, unwind, and reflect each day. Participants adapted to the pace of their new society and often described feeling different or content from doing so. This subtheme was described by 7 of the 12 participants.

Dr. Vargas revealed feeling that he always had something to do next from a very young age, I was struck by the importance of understanding more about the physician experience and the development of physicians through listening. He told me,

When you want to be a doctor, you are on a hamster wheel. It was foreign to come here and have nothing to do every night. I did my next year of readings, but after that, I surrendered to it. I wasn't preparing for anything, just being quiet, taking walks, listening to night sounds, looking at the sky. I have always been working on what's next. I don't remember feeling like this since fourth or maybe fifth grade.

Dr. Peppard summed up what happened to him:

Here, the day ends. You are supposed to unwind after chores, after dinner.

People are genuinely tired. Things slow down, and the whole town seems to be asleep. I reflected on more than just my cases. Sometimes I thought way back in my life—times I thought I'd forgotten—funny things. It cleared my head. Things didn't stack up. Even if I was tired or exhausted, I felt lighter.

Dr. Murray also observed these differences, saying, “No one expected me to see 24 patients a day here. I walked on the beach. I always took lunch.” Dr. Davos told me she saw a definite slowdown in herself:

All the walking there did two things: First, it made me tired! But, it also became a routine where my mind slowed down. I was sort of contemplative, and that's not me. Usually, my mind is racing. Sometimes, I was thinking about nothing.

Dr. Benton also articulated concern about the change in herself, saying,

I wondered if the lifestyle there would make me lose my edge. It's slow just naturally because it takes time to accomplish anything. When I got back home, I thought how stupid that was. I started cooking for myself and quit multitasking on purpose in the evenings.

She made a conscious and permanent change as a result. Dr. Tomball adapted to the pace of her surroundings and their social habits, saying,

Families there come together every day. I started to question why we think going here and going there is so great in U.S. I was an outsider and even I got used to the idea, just being near them—of sitting down together. . . . The lady who was paid to make my meals every day asked me to stay several times. At first, I felt

like it took forever, but I started to like the rituals and I liked the smells. I should have paid more attention. I still don't know how to cook. Here, I just don't notice those things: pleasant smells, little noises.

Her thoughtful introspection was very moving to me. Dr. Adams talked about how the pace of life made her feel, saying,

After a while, I felt like a different person. I don't mean being a real physician, I mean having different thoughts. At first, I thought I was homesick or depressed, but I was content, not depressed. I thought about things for long periods of time. Not in a stressful way, in a good way.

Dr. Caldwell, intentionally disengaged from some opportunities for communication with loved ones back home, and gave himself permission to “do nothing”:

I had “What's App” to text back home and emailed my parents a few times. . . . But, I wasn't tied to [the Internet] like before. More like a text here and there to my girlfriend, more at first and then every other day, later. She got a little miffed, but I didn't care. The trip was temporary. I even quit keeping my clinical journal. I didn't want anything to do at night. I read some and cleaned up, but mostly I did nothing. In the mornings, I'd wake up too early just make coffee and sit around.

Dr. Franklin, stationed in Bolivia, observed,

People sat outside and talked there about meaningless stuff—the weather and the like—at the end of the day. Mostly men. So, I did too. I could always fall asleep in a few minutes, which is unusual for me. Sitting out in the dark, slowing down, nodding, listening. Not really talking much. Maybe it made a difference.

Each of these descriptions reveals the lived experiences of these study participants, who found that the lifestyle and pace of their new surroundings impacted them. Being away from their normal competitive environment changed some of their habits and views. This break from the routine gave them time to think, reflect, and feel. Participants said they were more balanced and contemplative in this new environment, adding to their development. They also increased their time spent with local inhabitants or observing cultural aspects of the community during their downtime. Subtheme 3.2 describes how different life was because of a different pace of living in their new surroundings. This subtheme related to Subtheme 3.1 as it is unlike the competitive nature of the medical school environment, and connects to Theme 3, showing us ways this lifestyle enabled development. Overall, Theme 3 provides a positive outcome of the sometimes tragic descriptions of experiences found in Theme 4.

Theme 4: Harmful environmental forces shorten patients' lifespans and quality of life. As a doctor, there is limited ability to impact population health.

The fourth theme identified was that study participants came to see health in a broader sense during their immersion experience. This theme, like Theme 3, provides insight surrounding the context of the experience and informs the research question, helping us understand more about the participants' experiences and perceptions. In reporting on the experience and the context of the international experience, 10 of the 12 participants described how obvious the environmental impacts were on the health of the community. The new culture, norms, needs, and the surrounding environment made them rethink the capacity they had as a physician to keep their patients well. They admitted, with frustration, that a doctor's skills are no remedy for a lack of clean water or

a safe place to live when evaluating the overall health needs of a patient or a patient population and were humbled by this realization. They described ways in which external forces shorten patients' lifespans and quality of life. They told me they felt helpless to change these circumstances. For example, Dr. Peppard told me,

Tajiks haven't documented lifespan for that long. It's an incredibly diverse population. The economy is an important population health factor. They get remittances from Russia as a big income source. They had a civil war that's still fresh in their minds. They have pollution and runoff from aluminum mining that's significant. It's mountainous. If you need to go to the doctor, it's a journey, depending on your district. More often than not, they don't go. They get better anyway [laughs]. The biggest boon to health there are economic stabilization and peace and not having industry poison the people. What can a doctor do about that? They are worried about taxes and lots are refugees or immigrants, I guess. They think about food and droughts. People are laborers: workers who barely get by. Farming uses chemicals we don't allow in the U.S. Even if they had a full-time doctor, what could he do? I heard it's better now, becoming more modern, but I think that will result in more cancer and other deleterious effects down the road. Sometimes, I wonder if it was healthy—ya know, safe—for me to live there for seven weeks.

Dr. Adams gave another view of what is and what is not important, and her frustration about it, saying, "If they had safe water, it would advance population health, period. So much money is spent on various interventions with no real result, changing nothing. The basics are needed for health. For life. I can't fix that." She recognized that

economic and cultural constraints are real and that health is not simply a matter of choice or values. Dr. Benton's reflection on her practice in Haiti supported this theme and the corresponding frustration that resulted. She illustrated how this experience provided growth in cultural awareness and personal humility by integrating the challenges encountered in Haiti into her reality as a physician. She told me,

Earthquakes and hurricanes are real threats here: obstructing water supply, electricity, sanitation, you name it. We were 92 kilometers from the capital: low priority. We don't use electricity all night. Every season, people just seem to be trying to recover from the last disaster. Farming is always inconsistent. And people are supposed to be healthy? People still get cholera here! Maternal death! Mosquito netting is really important there. HIV has leveled off in the area and is well managed through an NGO. But, there are more things working against you that you can't control as a doctor. Sometimes there's nothing you can do. To them, it is normal, but it made me feel useless many days. If I came back 20 years from now, it will probably be exactly the same.

In contrast, viewing the community as lacking in its own care, Dr. Caldwell recalled how many challenges there are, telling me,

Proper waste management and safe water are needed here. I was powerless because it is considered a progressive area for the region. They don't see it. And shoes! I mean, parasites, hookworm: We can avoid a lot of this. Mpigi is a transportation district. It makes pollution, excess trash, waste. These are not medical issues. They are community issues to create and design solutions.

Commenting on the environmental pressures on patients, Dr. Davos described daily living in West Central Africa as follows:

There are state hospitals in Ouagadougou. I was 12 kilometers away. I walked my routes a lot to see patients, and shared a moped. It made me fit walking all the time. Better than three months at the gym. It sounds close by, but it's a genuine sacrifice for a village resident to afford to go for treatment outside of a local pharmacy. Some people only trade and never have money, so they have their own economy and couldn't pay a bill. Each village varies, but health and earnings are tied together. Even if a family can get a prescription, they may not have food to take along with it. That's the dichotomy of this area. There are three universities there, but most people are illiterate. They had an extremist attack this year. But, I've been gone two years. You know, some things look refined, but they are dealing with hunger, safety, transportation. These are health issues. Survival issues. Sending eager doctors—Brits, Americans—on rotation there won't change a thing.

Dr. Davos comments show a great deal of thought and analysis about the local community.

Dr. Rapp also described problems that are out of a doctor's control, telling me, You can't believe how much crime there is! Crime because they are poor. And trash in the streets with open gutters. Open trash, combined with a long rainy season, is a breeding ground for everything. They want tourism and port business but don't spend money on infrastructure. The islands are lovely and made for

tourists or plain for fishermen, a bit rustic sometimes, but the city is a disaster in terms of management.

Dr. Rapp circled back to the topic of crime resulting from poverty later saying, “I have people getting mugged and stabbed, so I stitch them up for free. Can’t we find a way to just give the thug the money to buy food instead of paying for sutures?” An important part of the international experience for Dr. Vargas was the realization that progress can be deceiving. According to Dr. Vargas,

It’s a city with paved roads and pretty palm trees, but air quality is bad from industry—manufacturing. I saw too many kids with asthma and ongoing inflammation to be a coincidence. For them, this is progress: having industry.

It’s disproportionate, so I have to believe it’s the environmental causes.

According to his interview, the economic advancement in the area had downstream consequences that negatively impacted the health of residents and the future health of children.

Another participant, Dr. Tomball, described routine health problems in the area and how insurmountable they can feel. She stated,

Flooding is seasonal and causes more mosquito- and insect-borne illness. Infested water, malaria, yellow fever, TB, hepatitis, all water-borne illness and prevalent food-borne illnesses. I was sick for the first three weeks and lost 11 pounds even with my cautious habits. Maybe it just took time to get used to things, but clearly, it’s not easy to be healthy there. How much influence does a doctor have to improve population health when you can’t change the surroundings? I couldn’t even keep myself healthy! The mosquito net program, the midwife, vaccines: So

many things are more needed than my contribution. I came and went. The problems stay.

And finally, Dr. Franklin summarized what several participants suggested, saying, “I doubt I made a difference. The world keeps churning.”

The cross-cultural experience created a new way for participants to view health, describing individual health and the health of the community as intertwined. Their comments suggest an expanded view of societal problems that impact health and a humbler definition of the role of physician in impacting health than when they arrived.

In the U.S., we view medical care as key factor for the overall health of our citizens, and tend to minimize the social determinants and environmental impacts that cause harm. These study participants now question the supposition that physicians are the answer. Being immersed in another society created a strong awareness that health is about more than the practice of medicine.

The final theme I relates to participants’ future practice and follows Theme 4 because this theme also illustrates the frustration participants are dealing with. These comments were often couched among wistful longings for another life, with participants sometimes referring back to how it was “over there” (i.e., the location of the immersion experience). Participants wondered aloud whether their sacrifices and investment to become a physician were worth the burdens they carry now. This informs the research question as these comments are continuously interwoven in the discussion of their international experience and may affect their future practice.

Theme 5: Participants wonder whether they have chosen the right profession, but feel unable to consider a change, primarily due to debt.

The final theme addresses the research question related to how the experience impacted participants' future practice. Participants wondered throughout the interview if they had chosen the right profession. Eleven of the 12 participants described general doubts surrounding their chosen profession, particularly given the expense of their education and the debt that resulted from this investment. While they talked about multiple factors when describing these feelings, the dominant theme was financial pressure. Student loans and debt keep them moving forward in their profession out of necessity. This topic resurfaced repeatedly in the interviews. Experiencing another cultural context and another way of living may have changed physicians' views about their quality of life and life choices, although this link was not directly stated.

According to Dr. Simpson,

After a couple years in practice, I see how fruitless it can be. My main job is to stay on schedule. I spend more time documenting than with patients, and I'm faster on EPIC than most of my peers. The only patient I felt like I knew and was making progress with on a chronic syndrome had an insurance change and disappeared at the turn of the new year last January. There's nothing else I know how to do, and I'm \$180,000 in debt. My Medicare patients need social bonds, support, listening, coaching, not just prescriptions. I'm always interrupting them and cutting them off to stay on schedule.

Dr. Murray wondered aloud about his future and said that he felt discouraged. He's interested in living in another country. He told me,

Sometimes I think about what it would be like to live in another country, but I've got student loans, so really my only option for that kind of lifestyle is to negotiate longer vacation blocks or work hard and try and retire early. Sometimes, I think I should have gone into emergency medicine, so I would be a week on and a week off, but I hate the pressure and the intensity is not for me, plus I'm older and can't stand the idea of going back for another residency and taking on more debt. [long pause] Once you get on this track, there is no way out. [long pause] I always wanted to be a doctor, now I am, and most days, I wonder why. Other countries pay for university, and I think the doctors continue to want to be doctors because of this, even if the expectations and life are not ideal. Plus, they get a solid month of holiday to refresh every year. I can't afford to buy a house. Work is mostly negative. I have to stay happy with a few small victories. I just didn't think it would be like this.

Dr. Nelson expressed his frustration about wanting to move on in his life, saying,

My family thinks I've got it made. My parents are so proud that I'm a pediatrician. I was chief resident, the best in my cohort. But, they both make better money working in the lab than I did last year after my loan payments. I'm employed by the healthcare system, so I should bonus out next year. This year, I had to pick up an extra day on weekends to make it, so I'm working six days a week. Being a ped is my calling, but dealing with patients' parents and their Internet opinions is time consuming beyond what my schedule will allow. When am I going to have a life? I'm ready to quit striving and start living. I've earned it.

Dr. Adams, a family practice physician who is both a PhD and an MD, described feeling limited, saying,

Dating with debt sucks. I'm trying to get into academia, but I probably can't afford it. I meet men who are in medicine. They have their own loans, and I don't meet that many smart men outside of work—you know? It's rare. No one else understands this lifestyle.

Dr. Benton vehemently echoed the lack of choices in life due to debt, stating, My future practice is dictated by what happens in the insurance industry and the evolution of what we call health care! I don't know how much I even impact that. Anything. Or my practice—I mean, as compared to another doc. I mean, sure, the experience changed me in some ways, but mostly I'm trying to get through each day and hit my benchmarks. I feel like I can't even think clearly today, most days, about the future. What choice do I have now? This is it. I'm too far in debt for it to make sense given a PCP salary and expenses. I just try not to think about it.

One of the pediatricians, Dr. Caldwell, reflects on what it takes to be a physician now, given the reward. He stated,

There's no prestige in the profession now, not like when my dad was a doctor. Parents treat you like you work for them and that they will get Starbucks speed with over-the-top customer service. I care about the kid's growth and development in the exam room, not getting five stars. They come in upset because they had to take off work, and we made them come into the office in person. There are ethics involved. I have to see the kid! My sister is a realtor

and makes the same money that I do when you count my loan payout. I went to school for years, and she took an 8-week class! I always thought I would be a physician, but I didn't do a real economic assessment. When you say you want to be a doctor, everyone acts like that's great: Your mom is proud, they brag about you. But it is a lot of time, suffering, expense, and lost money for the years you could have been working. Functionally, I do the same work as my NP most days with five times the debt. But, I have all the responsibility. Our salaries aren't that different. Maybe that's the way to be in medicine, or maybe better not to be in it at all.

Dr. Davos emphasized that she will be paying for her decision for 20 years due to educational debt. She was wistful, telling me that in Africa she was a full-time doctor and in the U.S. she feels like half a doctor and half a typist, saying,

I'm still finishing my internal medicine residency. It was only a couple years ago, I was in Africa, but it feels like forever. I love medicine, but I'm only a part-time MD here, more so [*sic*] its charting and documentation, plus I have the bureaucracy of residency and sexist bullshit. I hope it gets better in the real world. I even chose my residency between two offers partially because I already knew the EMR inside and out, the same one I started on in med school. That shouldn't be deciding factor, but at least I'm as fast as I can be. In Burkina Faso, I was a full-time doc, even though I didn't know what I was doing yet. I accomplished more. Yeah, I'm staying in primary care, even with the headache slash pay ratio. Someday, I want to be happy I did this, or will I always feel

halfhearted, like half a doctor? I will be paying for my decision for 20 more years: loans. [long pause] This is reality.

One study participant, Dr. Vargas, is no longer in active practice and feels detached from the importance of his international rotation practice. He has zero individual debt from his education, although his specialty physician spouse recently graduated with \$300,000 in student loans. He described how he now feels that a career in medicine may not be right for him, revealing multiple factors. He told me,

I was in active practice for a year, seeing patients, telling them to do things my family couldn't even manage: eat healthy, breastfeed, exercise as a family—exercise at all. I became a family practice physician to practice preventative medicine to keep people healthy! . . . I'm doing chart reviews for [insurance company name redacted] now. I've got a home office. It's all paperwork and denials. It doesn't feel like medicine, except sometimes I catch a drug interaction or something. I'm hoping to consult more on delivery reform in the future, but it's a living. . . . I'm a doctor, I guess, but sometimes I think I could be a science teacher or something. . . . I don't know if there's a way out, between the loans and just what everyone expects. Once you decide to become a doctor, it's like being swept away down a path. That decision automatically makes a lot of other ones. I know I'm lucky, but is this right for me? After all this time, I just starting thinking about what the decision to be a doctor means. . . . Maybe it's not healthy to be a doctor [laughs a few times]. Just because I'm a doctor doesn't mean it was the right thing to do. . . . I feel stuck.

Dr. Vargas' frankness and openness was typical of the study participants. They trusted the research process and gave of themselves in very personal ways throughout the interview, helping fulfill the research goals.

Dr. Rapp was similarly transparent, stating,

The crazy thing is, even when you have a good day, you get that *ping* on your phone that your automatic student loan payment has pulled out of your bank account, and [sigh] the weight of it deflates you. Is it worth it?

And, poignantly, Dr. Peppard added, "Sometimes, you want to say *I wish I had never become a physician*, but there is no one to tell it to." Dr. Tomball concurred, telling me, "I think about leaving medicine every day."

While the turmoil participants feel about their choice to be, or to stay, a physician seems tangentially related to development stemming from a cross-cultural elective, it does indicate that the experience caused them to consider how they want to move into the future. The comments were so intertwined and frequent that this theme could not be ignored given the context of the interviews. It was the most frequently coded theme from the transcripts and one of the most emotional topics discussed. The cross-cultural experiences are embedded in these ambivalent remarks, which were almost always in juxtaposition to a wistful recollection from the rotation, or how it is "in other countries." They frequently couched these comments comparing "how it is here [in the U.S.]" to "how it is there" (the international elective).

Taken together, these themes and subthemes answer the overall research question, "How do primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international elective rotation?" by providing rich and

often compelling stories of broadened understanding, increased awareness, personal stories of humility and growth, and a clarification and/or questioning of their future path as a physician. All of the physicians were open and attentive in sharing these stories.

The next section will provide a summary of the findings and will highlight the Textural and Structural Descriptions as well as the overall Essence of this study.

Summary of Findings

This phenomenological study sought to answer the central research question: How do primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international elective rotation? In addition, this study seeks to answer related questions: (a) What are the lived experiences of primary care physicians trained in the U.S., and in what context do they experience international clinical immersion? And, (b) how do immersion experiences impact physicians, their cultural competence or other development, and their future practice?

The textural summary of these findings describes *what* study participants experienced. Next, the structural description summarizes the setting or context of their experience, letting us know *how* they experienced the phenomenon. Lastly, the textural and structural descriptions merge, providing the essence of the participants' experiences.

Textural Description

Participants shared their experience of self-development while on rotation, seeking intellectual growth and challenge. They shared the view that they are expected to “be the best” and often the international rotation was part of “doing all you can” to progress and develop as a physician. As a result, they said cultural competence

development was a secondary motivation for participating in the rotation, not the primary one.

Reflecting on these experiences led to common comments about the relief they found in being away from the hypercompetitive environment of medical school or residency and about how the pace of life in the new culture was different than in the U.S. This allowed them to be more observant and contemplative than they were at home, enabling development.

The experience provided positive outcomes for participants in three ways: (a) The participants benefited from the common experience of overcoming and adapting to resource challenges. (b) Participants developed a deeper interest in primary care as a result of the “hands-on” experience and the confidence the experience imbued. Most importantly, (c) participants’ future medical practice was impacted as they learned to routinely add social context and family information from the surrounding culture to their diagnosis and treatment of patients during the rotation.

Even in light of these positive outcomes, participants shared the experience of feeling helpless to address the external forces that shorten patients’ lifespan and quality of life. Participants viewed the problem of harm from the environment, often manmade, such as pollution or unsafe water, as being outside a doctor’s influence. They felt that these environmental problems were more important factors in population health than a physician providing medical support.

Furthermore, participants wondered whether they chose the right profession. They all felt constrained by student loans and debt to such a degree that they told me they *must* move forward on their career path because they have no choice. Their experiences

indicated that they will “soldier on” even though on many days they do not know whether a career in medicine is right for them.

Structural Description

All the participants found their international rotation to be meaningful and developmental. The participants acknowledged feelings about their growing identity as a primary care doctor. Many of the participants were surprised by how different they felt in a different place. They experienced these feelings not only in the clinical setting, but in their day-to-day movements around the village and during non-clinical times.

Participants viewed their environment, their patients, and any feelings and effects from the experience in relation to themselves, mostly reporting on how any circumstance affected them or their future as a physician. They discovered the importance of “context” in dealing with patients as they made mistakes, felt humility, and developed empathy. They started to clearly identify themselves as a physician (more specifically, a primary care physician) during this time, intertwining their professional and personal self-concepts. Participants closely connected details about the place, the tasks, and their reactions throughout the interviews. Because their clinical practice was mostly or wholly autonomous for the first time, many of their recollections were impacted by the overall experience, not just the clinical factors.

Essence

The overall essence, or common lived experience, in this study is that physicians did not choose the international immersion experiences in order to develop their cultural competence, nor did they identify that this happened during their experiences. Instead, they cited multiple other ways in which they grew and developed. However, the stories

and experiences they shared were stories of increased awareness, developing empathy, learning humility, and realizing the importance of context and individual patient histories. Each of these is an indication of possible cultural competence development in some way.

In this study, participants were determined to become the best doctor they could be. They wanted opportunities for growth and challenge. The process of participating in the immersion experience made them grow, think, and feel in new ways, both professionally and personally. They developed observational skills, living in the same environment as their patients. They learned resourcefulness as they solved practical problems with no one there to support them. They grew in confidence through their daily work and by being considered “the doctor.” They learned to adapt to the ways of a people and a culture that “slows down” and has a different pace of living compared to the U.S.

Most important in the participants’ descriptions are the ways the immersion experience seems deeply connected to their development in the area of cultural competence. Physicians in this study engaged in an international immersion experience, but they did not necessarily view cultural competence development as the primary development that occurred as a result. It is particularly significant that they describe skills and awareness that may be indications of growth in cultural competence even though this was not stated as their primary intention.

Through their descriptions, we come to understand the internal expectations of physicians in this study. Because of their experience, they say they were changed. Many of the participants described their reactions and feelings throughout the immersion experience as surprising—to themselves—and that the rotation gave them time to think. I

heard participants say this was a time of both professional development and personal development. Participants described ways in which they grew in empathy, humility, and cultural awareness. With cultural competence as a critical component in addressing healthcare disparities, we must consider the potential importance of international experiences when redesigning more consistent and evidence-based physician education curricula.

Chapter 5: Discussion

“Everyone thinks of changing the world, but no one thinks of changing himself.”

—Leo Tolstoy

Chapter Summary

As a nation, we bear the burden of a healthcare system in crisis. One factor in this crisis is the disparate care that certain patient populations receive. We have made inadequate progress in addressing these disparities, and research demonstrates the need for cultural competence development in healthcare providers as an important factor for further progress.

The purpose of this phenomenological study is to explore how primary care physicians trained in the U.S. describe the cultural competence development or other developmental attributes that result from international clinical immersion opportunities undertaken during medical school or residency. The participants in this study engaged in an immersion experience in 2010–2014. While 30% of all medical students in the U.S. participated in a global health experience between 2011 and 2015 (American Association of Medical Colleges, 2015), the relationship between cultural competence and international experiences is not well understood.

Bowen Matthew (2015) demonstrated the malleability of *implicit bias*, a phenomenon described as an ongoing learning process, and also documented a decline in cultural competence over the course of physician education. Bowen Matthew (2015) attributed this decline to experiential factors and indicates a need for further

understanding of the impact of experiential learning as it relates to cultural competence and healthcare disparities.

Global health experiences are one of the experiential learning modules available to medical students and most medical residents in the U.S. In this study, I explore how an international immersion experience may educate medical students, inform them, and promote developmental opportunities for students and for medical residents who later become primary care physicians, particularly in the area of cultural competence. This study was designed to expand our understanding of this experience and its impact on the future practice of participating physicians. I asked how primary care physicians trained in the U.S. describe their cultural competence development or other developmental attributes that resulted from international clinical immersion opportunities using a phenomenological qualitative methodology.

A phenomenological approach addresses two primary questions: What are the experiences of the participants? And, what are the contexts of those experiences (Moustakas, 1994)? The overarching question for this study has never been asked before: How do primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international elective rotation? This study also sought to answer the two following subordinate questions: What are the lived experiences of primary care physicians trained in the U.S. and the context in which they experience international clinical immersion? And, how do immersion experiences impact physicians, their cultural competence or other development, and their future practice?

Researcher's Motivation

Throughout this study, I considered how much we esteem the reputation of physicians while not knowing how individuals become physicians. We care so deeply about physician development and their continued performance in the U.S. that taxes fund a portion of their long education, insurance companies force rank measures from their daily practice, patients post reviews of their care online, and electronic medical record (EMR) systems are designed to help them “learn” when they have a clinical diagnosis outside the bounds of usual variation compared to their peers.

We want access to capable physicians. We expect them to be fair, smart, equitable, and correct about our treatment plans. We all care about the healthcare crisis in monetary terms, even if we have failed to notice—or we have failed to be appalled by—the waste of billions of healthcare dollars attributed to disparities in care. At some point, everyone becomes a patient, and this fact means we all have a stake in the process of physician education and development.

I was inspired to do this research because it seemed to be the right way to marry my academic and professional interests. While my doctoral program kindled my curiosity and provided my research skills, there was a profound disconnect between the educational possibilities I had learned about and what I observed in my professional life working in hospitals and working directly with physicians. I read academic papers daily about how physicians are trained and prepared for the demands of modern practice, but I saw something different. I saw doctors who moaned when they entered an exam room with four “extra” family members in attendance who wanted to make sure their *abuela* was treated well. I saw the doctor who resented two family members staying in a

hospital room 24/7 to care for an aging family member, when their culture would consider doing anything less to be appalling. I saw the leadership committee, comprised of physicians, decide to omit Spanish from the wayfinding signage they were revamping in a hospital system that served a community in which 47% of the residents were Spanish speakers. This committee stated that they omitted Spanish signage because they did not want people “to get the wrong idea” that their hospital system sought to attract Medicaid patients to their facilities.

As I researched premature death and the difference in outcomes for patients due to health disparities, along with the direct cost of healthcare for those substandard results (a pressing healthcare issue in and of itself), I felt it was necessary for me to become involved in a research area that had the potential for improving some aspect of the status quo. While the National CLAS standards were initially established in 2000, a systematic review of the CLAS standards that have been implemented on a state by state basis since, shows that no state has specifically addressed (non-language) cultural competence recommendations or requirements aimed at physician education and development during medical school or after (U.S. Department of Health and Human Services, Office of Minority Health, 2016). I wondered whether there was simply insufficient time during the typical medical school curriculum for students to experience a culturally distinct natural world, and I wondered whether the 30% of medical students who participated in a global health experience were markedly different from their peers who did not. I wanted to know more about their motivation and how they perceived the time they devoted to the international elective.

Cultural competence is considered a standard of care within the educational objectives described by the Accreditation Council on Graduate Medical Education (ACGME), but this is a lifelong process of ongoing development (Fisher-Borne, Montana Cain, & Martin, 2015). In my quest to learn more, I found research that specifically evaluates the effect of an international experience on the future performance of physicians or the development of individual physicians, mostly using quantitative instruments and producing mixed results (Betancourt, 2003; Carter et al., 2006; Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1997; Family Medicine Clerkship Curriculum Resource, 2004; Godkin, Savageau & Fletcher, 2006; Kagawa-Singer & Kassim-Lakha, 2003; Peña Dolhun, Muñoz, & Grumbach, 2003; Price, Beach, Gary, Robinson, Gozu, Palacio, et al., 2005; Schilling, Wiecha, Polineni, & Khalil, 2006; Tervalon, 2003; Thom, Tirado, Woon, & McBride, 2006).

I read a qualitative analysis of nursing students who participated in a cultural immersion experience in Guatemala (Larson, Ott, & Miles, 2010). Three themes emerged in the study. First, “navigating daily life” with normal hardships during the experience gave participants insight and empathy into the lives of others (Larson, Ott, & Miles, 2010). The second theme was “broadening the lens” (Larson, Ott, & Miles, 2010). Nursing students said they were impacted by new experiences and reported less bias after the experience, reporting new openness and understanding about differences. The third theme was “making a difference” (Larson, Ott, & Miles, 2010). Participants stated that their role inspired them to do more, and it also gave them respect for natural healers and local alternative providers.

In another study small study by Altshuler, Sussman, and Kachur (2003), the intercultural sensitivity of 24 pediatric residents was assessed using the intercultural development inventory (IDI) based on Bennett's Developmental Model of Intercultural Sensitivity (Bennett, 1993). The assessment was administered as a baseline and was administered again after a didactic intervention and behavioral rehearsal aimed at cultural awareness. While a profile emerged showing low levels of denial and defense and moderate levels of acceptance and cognitive and behavioral adaptation, the minimization factor was considered surprisingly high, leaving us with ongoing questions as researchers about physician development.

In the 2006 study of medical students who participated in an international elective in either Ecuador, Mexico, Costa Rica, Nicaragua, Guatemala, Brazil, India, or on a Native site in remote Alaska; the participating students showed no significant differences on the Medical Students' Attitudes Toward the Underserved survey instrument (MSATU) compared to their peers who did not participate. The MSATU assesses attitudes toward underserved populations, attitudes regarding professional responsibility, and services ranging from basic to extensive, to which individuals should have access regardless of the ability to pay (Godkin, Savageau, & Fletcher, 2006). These gaps prompted my interest and helped guide the design of my study, along with recommendations for further qualitative inquiry by Godkin and Savageau (2003) and problem-solving cases designed to assess medical students' ability to ascertain culturally relevant information during patient encounters as described in Crandall, George, Marion, and Davis (2003). It felt that it was imperative for me to attempt to fill in the gaps regarding what happens to physicians-in-training and the context of the international experience.

Discussion of Findings

The overall essence, or common lived experience, of this study is that participating physicians did not choose an international immersion experience in order to develop their cultural competence, nor did they identify that this happened during their experiences; instead, they cited multiple ways in which they grew and developed. That revelation surprised me, refuting our common assumption that the intended goal of immersion experiences as described by medical schools is for cultural learning opportunities. However, the stories and experiences participants shared were stories of increasing awareness, developing empathy, learning humility, and realizing the importance of context and individual patient circumstances. Each of these is an indication of possible cultural competence development.

Many cultural competence development models include increased awareness, humility, and empathy as key features that enable growth and development toward increased cultural competence (Bennett, 1993; Berardo & Deardorff, 2012; Addleman, Nava, Cevallos, Brazo, & Dixon, 2014; Marx & Moss, 2011; Bentley & Ellison, 2007) while others focus on acceptance and respect, leading to assimilation or multicultural views (Hoopes, 1981; Bhawuk & Brislin, 1992).

One model of cultural competence development is Bennett's Developmental Model of Intercultural Sensitivity (Bennett, 1993). It is derived from a constructive perspective and is phenomenological in nature (Bennett, 1993). It is a stage model that describes how people experience and construe in different ways along a continuum that ranges from *denial* to *adaptation* (Bennett, 1993). One moves through this continuum by "resolving" the issues found in each stage and then moving into the next. This model

seems to accurately describe many of the experiences of this study's participants. While I cannot say that participants "progressed" along this continuum (and that was not part of the research question I investigated here), I found interesting evidence that they are able to articulate their experiences through the various lenses represented in this model. Participants engaged in a significant living experience in the host culture providing time to adopt multiple cultural frames of reference.

Bennett's model identifies the cognitive process that individuals undergo as they try to understand cultural difference in new situations (Bennett, 1993). The DMIS framework describes how individuals experience and engage in cultural differences and how they progress through these developmental stages with increased experiences in diverse settings (Bennett, 1993). It is organized into six stages of increasing sensitivity to difference (Bennett, 1993) and provides a useful framework through which to view the findings of this study.

The perspectives and behaviors that are exhibited when facing cultural difference often begin with the ethnocentric stages of *denial*, *defense*, and *minimization*, according to Bennett's model. Ethnocentrism implies that one's own worldview is central to reality (Bennett, 1993). The *denial* stage is the first ethnocentric segment on the continuum, and this is described as a desire to isolate and separate oneself from a new culture because of a lack of interest or to protect one's worldview (Bennett, 1993). While participants in this study did not use language that alluded to denial, they did describe feelings that may correlate with the second segment, which in Bennett's model is described as a defense against cultural difference.

Defense involves thinking one's own culture is superior to others. Recall Dr. Adams' statement that her community always had beer, but they could not fix the autoclave or obtain the correct light bulb for modern equipment. She went on to say that she learned to sterilize instruments by hand. In addition, recall Dr. Caldwell feeling overwhelmed by the lack of waste management in the streets or dealing with parasites, again. "Why don't they just wear shoes?" he retorted. Some participants also described situations that mirror Bennett's idea of *reversal*, another possibility occurring within the defense stage. *Reversal* involves a feeling that the newly adopted culture is actually superior to one's original culture. Dr. Adams in Uganda remarked that "they have the right idea" when she witnessed whole families together during a doctor's visit. And, both Dr. Rapp and Dr. Vargas commented that everyone in Belize and Costa Rica can receive medical treatment and that this is only right.

Bennett's next ethnocentric stage is the minimization of cultural difference represented by feelings of universalism. Participants used language describing the ways in which we are all human. Recall, for instance, Dr. Peppard informing us of how his neighbors in the host country simply wanted to work and live and survive along with their families, free from war or strife, just like any other person.

Bennett's model next describes the journey towards ethnorelativism, which supposes that understanding behavior takes place within the context of a particular culture (Bennett, 1993). The ethnorelative stages are described as moving from *acceptance* to *adaptation*, and then *integration*. The acceptance of cultural difference involves the recognition that one's worldview is just one of many others and involves respect for the values, beliefs and behavioral differences of others. Participants in the

study described situations that relate to this stage. For instance, participants described ways in which individual patient health and the surrounding community are intertwined, seeing this as culturally bound. Dr. Peppard commented that using unhealthy pesticides grows more food, and he stressed that his neighbors needed food. Dr. Adams told us that a working truck is the lifeblood of her community. Initially, she was shocked that a truck seemed more important than a doctor; however, over the course of her time in Uganda, she recognized and accepted that, given the context, it was true. Dr. Franklin describes how “doing nothing” was a foreign concept initially, but he found himself “doing nothing” too as the experience progressed.

As individuals progress along the continuum within ethnorelativism, having already experienced acceptance of cultural differences, they may further develop intercultural sensitivity (Bennett, 1993). This next stage is identified as adaptation to cultural difference (Bennett, 1993). Empathy is an important part of adaptation and is exemplified by the ability to shift perspectives, to use another culture as a frame of reference, and to act in culturally appropriate ways (Bennett, 1993). *Adaptation* also means that the individual can internalize more than one worldview and the individual’s understanding takes place within the context of the relevant culture (i.e., pluralism).

When talking to participants, I heard language in the stories of their experiences that would be consistent with the *adaptation* stage of Bennett’s model. While language is not evidence of growth, participants spoke in detail about ways they grew in empathy and began to apply more than one worldview. Recall Dr. Murray describing how there is more than one way to live and that he found benefit in adapting treatment plans to fit the lives of patients and the way they do things, instead of the way he thought they should be

done. Dr. Benton realized that one can live without electricity at night or without hot water. Dr. Adams changed the way she recommended care when she realized that, while her language skills were excellent, she was not being understood; and she learned to leverage local routines and others in the village as support. She also told the poignant story about a newborn with a deadly disease, and how she felt heroic in resuscitating the child. However, in her reflection, she articulated that she probably did not do the right thing given the cultural circumstances, seeing the incident through new a cultural lens. Each of these stories of empathy and understanding align with Bennett's adaptation stage, suggesting that participants' experiences gave them language to describe this level of cultural competence.

The last of the ethnorelative stage described by Bennett's model is that of *integration* (Bennett, 1993). The integration of cultural difference means that an individual at this stage can manipulate multiple cultural frames of reference and does so according to the situation. This stage is both contextual and constructive in nature. Individuals create their own reality that is not based on any single culture. Participants in the study used language describing different cultural lenses, much like Bennett's concept of integration. Dr. Tomball told us that family customs and expectations are not facts but rather are fluid and context-specific. She learned to quit assuming things, and she no longer compares her patients to what is "normal." Dr. Benton stated that she saw a change in herself. She told she can now take her typical American lifestyle on and off at will, and she no longer attaches value judgements to the attitudes and behaviors of others.

In summary, study participants described ways in which they were impacted, how they developed while living in the same environment as their patients, and how they

acquired a new viewpoint, or *lens*, on the culture. They used language similar to the stages described in Bennett's Developmental Model of Intercultural Sensitivity (DMIS). They described examples consistent with acceptance around the values and behaviors common to the culture, learning to integrate multiple worldviews. They described adapting to the ways of a people and their culture and becoming more aware, empathetic, flexible, and humble. Each of these descriptions point to the possibility of increased awareness or possibly even advancement in cultural competence.

Additionally, during participant interviews, conversations that explored cultural competence development brought forward the phenomenon of broader self-development as a physician, and this was well described. Participants described, in depth, both what happened during their experience and how it happened. Even with participants' diverse rotation experiences, their stories brought forth phrases, feelings, and observations that showed common descriptions in multiple areas, including, but not limited to, clinical skills development, diagnostic improvisation, increased confidence in skills, and integrating family information into treatment plans. This study supports and advances the limited research by Bissonette and Route (1994) that suggests that participation in an international elective may help physicians acquire better assessment and diagnostic skills, have increased confidence in their skills, gain a greater awareness of public and global health, acquire enhanced sensitivity to cost issues, and develop a greater appreciation of the role of family.

Past studies have indicated that physicians who participate in a global elective recommend the experience to others, which shows that they were satisfied with the experience (Crandall, Volk & Cacy, 1997; Godkin, Savageau, & Fletcher, 2006;

O'Toole, Gibbon, Harvey, & Switzer, 2002). However, we knew little about what made them decide to go in the first place. This study begins to shed some light on this issue. Participants told me they were determined to become the best doctor they could be. They sought out this opportunity for growth and challenge. The process of participating in the immersion experience made them grow, think, and feel in new ways, both professionally and personally. The first theme I identified was that participants sought the international rotation for more than a cultural experience. They certainly wanted a developmental experience, but primarily because they viewed it as a chance to accelerate their clinical independence and surpass their peers.

While participants were exceptionally open and descriptive during the interviews (and this yielded sufficient data to identify clear themes), I was surprised by the way the interview discussions most often focused on the individual physician rather than the people or place they experienced. I could not have predicted this, especially given that my interview prompts included questions such as: *Are there experiences that were particularly impactful? How so? And, what situations and people stand out to you?* These questions posed during the interview seemed to result in the physicians talking about themselves. While the purpose of this study is to explore their experiences, I was surprised that they did not share more information about the people or places associated with their immersion experience. The time in the interview promoted internal reflection and participants spoke about their sense of self more than anything. They evaluated their experiences by how it affected them.

Participants spoke about how the international experience had a positive impact on them, from learning to cope with resource shortages to realizing that they “felt” like a

primary care physician as a result of the rotation. Living in the same environment as their patients, they expanded their observational skills and the scope of each patients' day-to-day life. They learned resourcefulness as they solved practical problems with minimal outside support. They grew in confidence through their daily clinical work and responsibilities. They learned to adapt to the new norms and social standards within the culture. They unconsciously applied social context to patients' treatment plans, and they still do this in their current practice. These positive impacts had long-lasting effects on the way they practice medicine. The most important element of the participants' descriptions are the ways in which the immersion experience seems to be deeply connected to their development in the area of cultural competence.

Through their descriptions, we come to understand the internal expectations of physicians in this study. They say they were changed by their experience. Many of the participants described their reactions and feelings throughout the immersion experience as surprising to themselves, and they reported that the rotation gave them time to think. They described this time to think as "new" for them, and they described their time away from constant competition with their medical school peers as "a gift." Even the interview process for this study was in stark contrast to their usual way of reporting information. Instead of dictating according to a standard outline, they had a deeper, thought-provoking conversation that required reflection and elaboration. Participants told me frequently during their interviews that they had "never thought about" the events and topics we discussed. Experiential learning is not complete without reflection (Geary, 1995). Reflection provides the mechanism that transforms experience into knowledge, and gives initial observations social meaning following reflection, allowing for interpretation and

comprehension (Kolb, 1984; Searle, 1995). The reflection needed to participate in the study interview became part of the education process for study participants.

Participants told me that during their immersion experience, they grew in confidence through their daily work and by being considered “the doctor.” They described with emotion how humbling it was to realize, during their rotation, that the environment often dictated the health of an individual or the health of the community they cared for. They told me throughout these conversations that they were not sure whether they chose the right profession, but they planned to continue practicing medicine (with one exception).

As illustrated above, physicians in this study engaged in an international immersion experience, but they did not necessarily see cultural competence development as the primary development that occurred as a result. It is particularly significant that they seemed to grow in cultural competence even though this was not stated as their primary intention. The most important finding in this study remains that the immersion experience does indeed seem deeply connected to participants’ development in the area of cultural competence, even without participants intending this. I wonder whether similar development would have taken place without these international experiences. With cultural competence as a critical component in addressing healthcare disparities, we must consider the potential importance of international experiences when redesigning more consistent and evidence-based physician education curricula.

Significance of Findings and Implications

A shortage of primary care physicians in the U.S., combined with the need for culturally competent healthcare providers, makes this study important at this time. Past research has speculated that doctors predisposed to primary care may be more likely to choose to participate in an international experience (Chiller, DeMieri, & Cohn, 1995; Ramsey, Haq, Gjerde, & Rothenberg, 2004). Past research also suggests that medical students who participate in an international clinical elective were much more likely to choose primary care as opposed to specialty care as a career path (Bissonette & Route, 1994; Drain, Primack, Hunt, Fawzi, Holmes, & Gardner, 2007; Godin & Savageau, 2003; Gupta et al., 1999; Ramsey et al., 2004). This was echoed in participants' comments. Given the shortage of primary care physicians in the U.S., an international elective may be an important curriculum offering to address the primary care shortage.

This study is significant on multiple levels. First, physician development takes place both during and after medical education. Second, both individual and intuitional implications stem from this inquiry. This study not only describes how primary care physicians integrate their experiences during and after an international clinical immersion experience but also suggests how these participants view themselves in their profession.

While I framed participants' experiences as most meaningful in terms of cultural competence development, I also gleaned information and potential new areas of study from some of the themes around self-concept and motivation to join the profession. Additionally, participants expressed career dissatisfaction, and this may indicate a need for further understanding of the first few years of practice immediately following residency. We know from prior research on physician satisfaction that newly minted

physicians are not alone in questioning their career choice; however, observing this mindset so early in a physician's career seems especially disturbing. We now see how negative a physician's view of the profession can be, since 40% of the practicing physicians surveyed stated they would not enter the medical field if they were choosing their profession again (James, 2016), and even more stated they would not recommend medicine to a qualified college student (Hojat, 2016) or to their own children (James, 2016).

Individual physician specialties have been studied in relationship to career satisfaction, and while there are no specialties in which physicians are statistically less happy than peers from other specialties (Zuger, 2004), in one income study of physicians earning \$125,000–\$149,000 a year, half as many physicians reported being satisfied, compared to those earning twice as much (Leigh, 2002). The pay scale of the less satisfied physicians would correlate most frequently to a primary care physician's level of income. Participants in this study indicated that sometimes, it just “doesn't seem worth it,” given the required investment of time in education, student loan debt, and the daily bureaucracy of a primary care practice.

In a study that identified common values among physicians and common drivers of clinical decision making, the authors indicated that physicians struggled with the dichotomy between the requirements of the healthcare system and their values of being a humble servant who is trustworthy and compassionate (Keller, Crowley-Matoka, Collins, Chrisman, Milad, & Vogelzang, 2017). The drivers of clinical decision making revealed in this study were reimbursement paradigms, referral networks, volume, and other business metrics. Some participants indicated that the wrong incentives are in place to

support core physician values. “Clinicians felt that altruistic values were important but are often undermined by unsupportive environments that create insecurity [for the physician]” (Keller et al., 2017, p. 12). These study participants were “driven by autonomy, mastery, and a sense of purpose” (Keller et al., 2017, p. 2), much like the participants in this study. From a sociological perspective, some suggest that physicians “espouse values but can’t live up to them” (Zuger, 2004, p. 4) due to nonmedical administrative issues. When the system incentivizes practices that undermine autonomy, mastery, and a sense of purpose; “it can ‘sap’ physicians of their internal drive” (Keller et al., 2017, p. 2), leading to physician dissatisfaction.

In a 6-year qualitative study of professional identity development learning cycles and career satisfaction among medical residents, authors found that an important factor in development was that resident physicians’ perceptions of “integrity violations” that occurred while practicing medicine were relatively minor (Pratt, Rockmann, & Kaufmann, 2006). In this study, integrity violations were described as a conflict between and what individual physicians did each day and who they perceived themselves to be. During medical training, physicians’ self-definition and identity construction changed according to the context of their organizational life (Pratt, Rockmann, & Kaufmann, 2006). The primary care cohort’s identity set was affected by residents doing the work they expected they would be doing and by their perceived competence about the work they were engaged in, tempered with a low incidence of events or tasks that negatively impacted their self-concept as a physician (Pratt, Rockmann, & Kaufmann, 2006). Affirming aspects of primary care physicians’ self-concept included social validation surrounding identity construction as a physician, and this resulted in increased

satisfaction (Pratt, Rockmann, & Kaufmann, 2006). Perhaps the participants' international experiences described in this study were particularly suited to self-concept development and social validation that defined participants as a primary care physician but was not sufficient to sustain career satisfaction in the long term.

Zuger (2004) suggests that (a) the key to reversing low satisfaction is for educators to provide more accurate expectations for a medical career and (b) that the concept of a luxurious income as the automatic result of being a physician was an era that really only existed in the U.S. from the prosperous postwar years up through the 1980s. Last, professionals from other fields, including lawyers, teachers, and nurses, also have documented decreases in career satisfaction and engagement since 1997, citing restrictions of autonomy, a decrease in respect for their profession, stricter regulations, and increasing demands (Avraham, 2010; Dorelan, 1997; Kravitz, 2002; National Center for Education Statistics, 1997; Schlitz 1999; Zuger, 2016). It seems that physicians are not alone.

Practical Applications

While many questions remain about implicit bias, medical education, and health disparities, this study provides information about the essence of the experience of an international clinical immersion rotation undertaken by primary care physicians trained in the U.S. during medical school or residency and may advance the further analysis of programs aimed at supporting cultural competency development for physicians. Currently, cultural competence development during medical school has a curricular design framework, the TACCT. While this framework does not require evidence-based

interventions nor require standardized measures to evaluate educational impacts, it does guide medical schools in the development of curricula with cultural competence in mind. The value and outcomes of cultural competence development interventions are difficult to assess and compare because of the variability seen as adequate in different programs and non-standardized reviews of the effects of each curriculum. Additionally, while participants in this study described their international experiences as developmental and valuable and we consider the outcome to be positive, we do not know if resulting behavior will be sustained.

The purpose of the international experience is to “enable students to interact with different patient populations, develop cross-cultural understanding, and learn about health systems in other nations” (AAMC, 2017). These programs are intended to provide the opportunity to shadow a practicing physician in another country, but they typically become assignments with high independence and serve as clinical immersion experiences where many students are on their own in an underserved area, as described by participants in this study. According to this study’s participants, they embark on the international elective for purposes other than cultural competence development. The intention of the medical school international elective program may be somewhat disregarded by those who apply to participate, yet it seems that even without intentionality and without overt attention, medical students have valuable experiences overall and valuable experiences related to cultural competence development specifically. Would these experiences become even more valuable through further emphasizing the value of an international experience as a cultural opportunity? Or, is important progress made when medical students simply enter an environment where there are no mentors or

educators who may negatively impact their cultural competence development (Bowen Matthew 2015)?

Given the findings of this study, medical education programs, faculty, administrators, and others may want to further explore the potential effects of their current programs to help inform the success of future programs. While this study's findings are not generalizable, the voices of these participants suggest that we do not fully understand the developmental effects of international clinical rotations. We can see that intention does not shape what someone takes away from the international experience. We may be able to improve these experiences and make them more valuable for the individuals who participate (and perhaps the research community) by providing better advance preparation before the experience, building in reflection throughout the experience, and eliciting "sense-making" of the experience afterward. Participants may have benefited more from their experience if they had been given the opportunity to reflect and explore their feelings earlier.

In order to sustain positive behavioral changes that may result from an international, clinical immersion experience, medical education programs offering international electives may consider implementing more structured developmental models that can further provide support surrounding the international experience for participants (Velsor, Mccauley & Ruderman, 2010). Implementing a cyclical model of *assessment*, *challenge* (with the international experience as one of the developmental challenges), and *support* as recommended by McCauley and Wakefield (2006) to strengthen individual talent and provide lasting change may contribute to both skill retention and reinforce positive outcomes experienced by physicians during the

international rotation. This intentional cycle of assessment, challenge activity, and support may increase the benefit for participants by providing them with a baseline assessment to track development, to have an opportunity to reflect on their experience at designated intervals through journaling or reflective writing, and to have the opportunity to demonstrate growth in important developmental areas as they reiterate the cycle with a variety of challenge assignments. With assessments in place, medical education programs can track both individual and aggregate student progress in key areas.

Future Research

What will change after integrating the results of this study? While this is a small study, it reveals new insights about how primary care physicians trained in the U.S. view themselves, their time spent on an international rotation, their careers, and their future practice habits. It revealed that, for these physicians, cultural competence development may occur even when it is not the primary objective. This finding suggests that there is more to study in our quest for understanding cultural competence development among physicians and that it is worth learning. This study also suggests that if we offer a different format when researching physician development, it may yield abundant results. While we assume that physicians will not take the time to participate in in-depth interviews, we may be missing opportunities for ongoing inquiry as they progress through medical school, residency, and their career.

Future qualitative studies could produce additional discoveries in each of the thematic areas described in this study, as well as new themes. Additionally, mixed methods studies including pre-testing, during the immersion experience testing, and post-testing with validated instruments, combined with qualitative reflection throughout, may

yield new insights. There may be value in replicating the 2006 study by Godkin, Savageau, and Fletcher assessing medical students' attitudes towards underserved populations and their attitudes regarding professional responsibility utilizing both the Medical Students' Attitudes Toward the Underserved survey instrument (MSATU) in conjunction with the Intercultural Development Inventory (IDI) based on Bennett's Developmental Model of Intercultural Sensitivity (Hammer, Bennett, & Wiseman, 2003).

Conclusion

In this study, study participants reported a constellation of developmental results. This study, while reaching saturation, was small, and it focused on the thick, rich descriptions provided retrospectively about the experiences of participants who were involved in an international rotation during the years 2010–2014. This limited cross-section of physicians captures just one slice in time. Further research must be conducted if we hope to understand the value of international immersion experiences for physicians, especially as we view as an attempt to advance cultural competence in healthcare. As someone concerned about the future of healthcare and the preparation of healthcare providers, I was dismayed during my literature review to find that a common elective during medical school had such an absence of descriptive information following the rotation, that qualitative inquiry was absent from this area, and that it was largely absent from physician development in general. As a student and researcher, I was surprised that ethnography was not reported as a common tool for cultural understanding or empathy development, nor were other similar sociological and anthropological constructs mentioned by this study's participants as part of the application of their medical education while on rotation, with the exception of a mention of a "natural setting" in a

comment referring to clinical practice in the U.S. and the benefits of telemedicine. Even when medical students or residents participate in an international immersion experience, there may be little reflection on what was learned.

While these research findings cannot be generalized, we can learn from the experiences and voices of the study participants and may benefit from the truth they provide about the essence of their experiences. This study shows insight into participants' motivation to practice medicine, their motivation to participate in an international rotation, their ongoing development as physicians, and their doubts about themselves and their careers. Their voices made it clear that cultural competence development may be nurtured in the right setting, even when they do not view it as the primary goal or when they are motivated by other factors. The interviews provided an opportunity for mindful reflection, which is a kind of reflection that seems to escape physicians in their busy day-to-day life. This study tells us that there is much to hear if we will only listen and prioritize what is heard as meaningful and important.

Medical school and residency programs may be interested to know that students who participate in global health electives feel that they have "never talked about it," even with the institution that sponsored their experience and accredited them. Participants told me that "life moves on," and they rarely had an opportunity to reflect on or discuss the experience. Before we ask what more we should do with medical school curriculum development, there may be value in having a greater understanding of what we are already doing. This study may help us begin.

“Inequality is a human generated problem and therefore can be changed”

(Fisher-Borne, Montana Cain, & Martin, 2015).

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APPENDIX

Appendix A. Email Invitation to Participate

Dear Dr. (participant name),

I received your contact information from the American Medical Association or American Academy of Family Physicians. I am studying the impact of international electives during medical school or residency. The purpose of this phenomenological study is to explore how primary care physicians trained in the U.S. describe their development experiences resulting from international clinical immersion opportunities.

I am writing now to ask if you would be willing to participate in this study if you qualify and are selected. If the answer is “yes” for each of the participant selection criteria, please continue.

The participant selection criteria:

- Are you a family practice physician, internal medicine physician or pediatrician? Did you receive your medical education in the United States?
- Did you complete your residency within the last 5.5 years?
- Did you participate in an international clinical immersion experience during medical school or residency of six weeks or longer?
- Did you live among a native population/ local community during your stay (as opposed to a segregated physician only cohort or environment)?

If you meet the criteria above, please reply to this message now to indicate your interest in participating.

If you indicate interest in participating, I will send you a brief demographic questionnaire and request that you return it to me prior to scheduling the interview. I will accommodate your schedule demands to meet at a time that is possible for your lifestyle and practice needs. The primary interview will take approximately 60 minutes (up to 75 minutes) and will be audio-taped. A second audio-taped phone interview lasting 15-20 minutes will take place a few weeks later to review any additional thoughts, reflections, or comments. Interviews will be transcribed and analyzed. Participants and any identifying information such as institutional affiliation will be given pseudonyms. All records will be confidential. Data gathered will be reported in aggregate and any quotes used will be de-identified. The data gathered will be reported in my dissertation and possibly included in future presentations and publications. Every effort will be taken to keep study participants' information and identity anonymous.

Thank you for considering participating in my research project. Interviews will be conducted in August and September. Your cooperation and contribution will greatly strengthen my data collection efforts.



Participation is voluntary and there are no known risks associated with this research. You are free to decide not to participate in this study. You may withdraw at any time without negative consequence. If you have any questions about your rights please contact the University of Nebraska Institutional Review Board at (402) 472-6965.

Thank you in advance,
Julie Shasteen, M.S.
Principal Investigator
Doctoral Candidate – Human Sciences
University of Nebraska-Lincoln
Phone/Cell (402) 440-4444
jmshasteen@hotmail.com

Gina Matkin, Ph.D.
Secondary Investigator
University of Nebraska-Lincoln
Phone (402) 472-4454
Gmatkin1@unl.edu

IRB Approval #: 20160716280EX

Appendix B. Informed Consent Form

		IRB # 20160716280EX Date Approved: 07/31/2016 Valid Until: 07/21/2021
INSTITUTE OF AGRICULTURE AND NATURAL RESOURCES DEPARTMENT OF AGRICULTURAL LEADERSHIP, EDUCATION AND COMMUNICATION		
<p>Informed Consent Form</p> <p>Title of Project: How Primary Care Physicians Trained in the U.S. Experience International Immersion: A Phenomenological Study</p> <p>Purpose of the Research: This research project explores how primary care physicians trained in the U.S. perceive and describe their cross-cultural field experiences during an international elective rotation. In what context did their experience occur? How do immersion experiences impact physicians, their development, and their future practice?</p> <p>Procedure: Participation in this study will include completion of a brief demographic questionnaire. This questionnaire will be sent to you via email along with a request that you complete the questionnaire and return it by email to the researcher. Participation in this study will require approximately 60-75 minutes of your time for a one-on-one interview to discuss your international immersion experiences and a second phone interview a few weeks after that of 15-20 minutes to review any additional thoughts, reflections, or comments. The interviews will be audio-taped with your permission and conducted by telephone.</p> <p>Benefits: There are no known benefits to you as a research participant.</p> <p>Risks and/or Discomforts: There are no known risks or discomforts associated with this research.</p> <p>Confidentiality: Any information obtained during this study that could identify you will be kept strictly confidential. The data will be password protected on the Principal Investigator's private computer and audio recordings and transcripts will be kept in a locked drawer in the investigator's office accessible only to the Principal Investigator during this study. The information obtained in this study may be published in scientific journals or presented at scientific or academic meetings, but the data will be reported as aggregated data. Any quotes used from the interview will be de-identified to protect your privacy.</p>		
<small>143 Filley Hall / P.O. Box 830947 / Lincoln, NE 68583-0947 / (402) 472-2807 / FAX (402) 472-5863</small>		



IRB# 20160716280EX
Date Approved: 07/31/2016
Valid Until: 07/21/2021

Compensation:

You will receive no compensation for participating.

Opportunity to Ask Questions:

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study. You may contact the investigators at the phone numbers listed below. Please contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965 to voice concerns about the research or if you have any questions about your rights as a research participant that are not sufficiently answered by the research investigator.

Freedom to Withdraw:

Participation in this study is voluntary. Your consent confirms that you have read, understood, and agree to participate in this study, as explained above.

By checking below, you are confirming that you have decided to participate.

_____ I grant permission to be audio-taped.

_____ I do not grant permission to be audio-taped.

Please type your name and date and return via email to jmshasteen@hotmail.com

_____ Your name _____
Today's date _____

Name and Phone Number of Investigator(s)

Julie Shasteen, M.S., Principal Investigator
Doctoral Candidate – Human Sciences
University of Nebraska-Lincoln
Cell (402) 440-4444

Gina Matkin, Ph.D., Secondary Investigator
University of Nebraska-Lincoln
Office (402) 472-4454

Appendix C. Pre-Interview Questionnaire – Julie Shasteen

Pre-Interview Demographic Questionnaire for: How Primary Care Physicians Trained in the U.S. Experience International Immersion: A Phenomenological Study Name:

Date:

Age. In what year were you born? Race. Please specify:

- ☐ American Indian of Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity. Please specify:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino Gender. Please specify:
☐ Female
☐ Male
☐ Prefer not to answer Are you a:
☐ Family Practice Physician
☐ Internal Medicine Physician
☐ Pediatrician

Were you a medical student or a resident at the time of your international rotation?

- ☐ Medical student
☐ Resident

Name of the university or program at the time of your international rotation (this information will be de-identified in the study findings).

Length of international experience:

Geographic location of international experience:

Thank you.

Appendix D. Sample Interview Protocol – Julie Shasteen

Title: How Primary Care Physicians Trained in the U.S. Experience International Immersion: A Phenomenological Study

Date:

Participant Assigned Pseudonym: Interview location: via telephone

My dissertation explores how primary care physicians trained in the U.S. describe their development experiences resulting from international clinical immersion opportunities. The interview will take 60-105 minutes and will be audio-taped. In the final study you will be given a pseudonym. Do you have any questions before we begin?

Questions:

Tell me about your international rotation.

Thinking back, how did this experience feel at the time? Please share everything you can remember.

How did you end up participating?

Other prompting questions, if needed to elicit more information: Are there experiences that were particularly impactful? How so? What situations and people stand out to you? What was the influence of that experience?

Have you shared everything you think might be relevant with regard to your own personal or professional development?

Did this experience impact your future practice in any way?

Do you know anyone else I should contact who may be interested in participating in this study?

Thank you for taking time to participate in this interview and study. Your answers will be transcribed verbatim, as will the other interviews I'm conducting. Your confidentiality will be maintained in the summary of my findings. If you are interested in seeing a copy of the results or have any questions, please let me know.

The University of Nebraska-Lincoln wants to know about your research experience. You will receive a follow up email from me, two to four weeks after our interview date. It includes a 14-question, multiple-choice survey and is anonymous; however, you can provide your contact information if you want someone to follow-up with you.

Appendix E. Post-Interview Participant Feedback Email

Dear (Study Participant):

Thank you for contributing to my research during your phone interview on (date). I am in the process of preparing preliminary findings from my research.

Please review the selected quotes, results, and initial analysis listed below for any additional input. My interpretation may benefit from additional explanation from you and from your perspective.

(Quotes and analysis listed here)

If you have additional comments please contact me within a week of this email.

Additionally, The University of Nebraska-Lincoln wants to know about your research experience. They offer a 14 question, multiple-choice survey that is anonymous; however, you can provide your contact information if you want someone to follow-up with you. This survey should be completed after your participation in this research. Please complete this optional online survey at: https://ssp.qualtrics.com/SE/?SID=SV_aVvINCf0U1vse5n.

Thank you, again.

My very best-

Julie Shasteen jmshasteen@hotmail.com

Tool for Assessing Cultural Competence Training (TACCT)

Pre-Clinical Course Names

Orientation

TACCT Domains

Domain I	Rationale, Context, and Definition	A. Definition of cultural competence																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																								</
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I(b). Domains (Overview)

Person Completing Form and Function

Course Name/Curriculum Year/Type of Course

Institution and Date Completed

[illegible]

II(a). Specific Components (Knowledge=K, Skills=S, Attitudes=A)

Person Completing Form and Function

Course Name/Curriculum Year/Type of Course

Institution and Date Completed

TACCT Domains

Pre-Clinical Course Names

Orientation

[illegible]

II(a). Specific Components (Knowledge=K, Skills=S, Attitudes=A)

Institution and Date Completed

Pre-Clinical Course Names

[illegible]

II(b). Specific Components (Knowledge=K, Skills=S, Attitudes=A)

Institution and Date Completed

Clinical Clerkships

[illegible]

II(b). Specific Components (Knowledge=K, Skills=S, Attitudes=A)

Institution and Date Completed

Clinical Clerkships

[illegible]