

# The Resources We Bring: The Cultural Assets of Diverse Medical Students

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**Abstract** In response to the need for a more diverse workforce, our medical school developed new policies and procedures that focus on the recruitment and selection of diverse students with a specific focus on those considered underrepresented in medicine. To understand what these students bring to the practice of medicine, researchers investigated their perception of their cultural assets and how they plan to use these assets as physicians. A cross-section of 23 ethnically, culturally, and geographically diverse medical students were interviewed and data were analyzed through phenomenographical methods. The results indicate that students view themselves as having multiple assets that could be of significant value in their future practice of medicine, including: a) an interest in science and access to family members in medicine, b) personal and familial struggles with health, c) self and family as immigrants, and d) strong family and community orientations. Students perceived these as cultural assets because they could directly identify where these assets could be valuable in medicine but questioned how to maintain them throughout medical school. Now that our institution has identified these assets, next steps include administrators' investigation of ways to leverage them through curricular and educational programs.

**Keywords** Undergraduate medical education · Diversity · Qualitative research · Cultural assets

## Introduction

In 2010, the Association of American Medical Colleges (AAMC) issued a national call to raise the level of racial and ethnic diversity of healthcare providers (Association of American

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Medical Colleges 2010). This national effort was undertaken to ensure that patients have access to providers who mirror the multitude of languages, experiences, perspectives, and cultural backgrounds of our heterogeneous U.S. population. In response to the need for more diversity in healthcare, the Medical College of Georgia (MCG) developed new policies and procedures that focus on the recruitment and selection of diverse students with a specific focus on those considered underrepresented in medicine (UiM). Now, two years into this initiative, our student population is the most racially and ethnically diverse it has been since the institution was established in 1828 (Medical College of Georgia 2016). Nearly 50% of the 2016 incoming class was African American, Asian Indian, Hispanic, and Asian students with the other 50% comprised of White students recruited from and representative of our rural and urban communities across the state of Georgia.

Now that our school has successfully recruited this diverse body of students, the question remains: *Now what?* We ask this question because our institution recognizes that it is not enough to recruit students; medical schools also need to think about how to support them in myriad ways, including building on their cultural assets. *Cultural assets* are the perspectives, skills, experiences, knowledge, and abilities that students bring with them to an educational setting, which can be leveraged in the development of educational programs (Benson et al. 1998; Borrero 2009; Moll et al. 1992; Nieto 2002). We believe that by focusing on ways to leverage the cultural assets of diverse medical students, we can increase the number and overall effectiveness of racially, ethnically, and geographically diverse physicians in our nation's healthcare system in an effort to decrease healthcare disparities.

To this end, we interviewed a cross-section of medical students from various cultural, ethnic, and geographical backgrounds seeking to understand their cultural assets. We focused on students' cultural assets because we wanted to know what strengths they perceived themselves as having and how they anticipated using these strengths in the practice of medicine. Further, we wanted to provide an opportunity for MCG administrators and medical educators to think broadly about how to integrate students' skills and abilities into the curriculum in ways that will help maintain their assets throughout medical school. In an effort to undertake this exploration of our diverse medical student body, we were guided by the following research questions: a) What cultural assets (i.e. experiences, skills, practices, perspectives, etc.) do students in our ethnically and culturally diverse student body perceive they bring to medical school? and b) How do students anticipate using these assets in the practice of medicine?

## Rationale for increasing diversity in healthcare

In an effort to reduce healthcare disparities, medical schools across the nation have tried to refine their admissions and selection processes so that a more diverse physician workforce may be realized. In our efforts, we have implemented a holistic review process in which potential candidates' cognitive factors are weighed alongside their future potential as physicians committed to the needs of society (Bandiera et al. 2015; Conrad, Addams, and Young 2016; Razack et al. 2015). Holistic reviews aim to expand and diversify the physician workforce in an attempt to address the needs of a diverse patient population. Our efforts at MCG are aligned to this end because studies show that patients' ability to choose their physicians correlates significantly with seeing physicians of their own race (Saha et al. 2000). Non-White physicians disproportionately care for

racialized and minoritized patients when compared to their White counterparts, accounting for 53.5% of minority and 70.4% of non-English speaking patients (Marrast et al. 2014). In addition, we have focused recruitment efforts on expanding the number of rural students attending our institution. This effort was undertaken because many of the targeted patients in this national effort (i.e. disadvantaged, underserved) live in rural communities where it is difficult for patients to find high quality healthcare (Ballance and Kornegay 2009). Research indicates that rural students are 2.5 times more likely to practice in rural settings compared to their urban peers (Woloschuk and Tarrant 2004), although it is unclear whether students enter medical school with this interest or it develops over time (Guilbault and Vinson 2017; Ballance and Kornegay 2009).

And yet, although we have made concerted efforts to diversify our student body, research shows minority physicians experience unparalleled challenges, both in training and in academic health careers. Minority students report experiencing less supportive learning environments and feeling subjected to discrimination and racial harassment (Orom, Semalulu, and Underwood 2013). Minority faculty report similar difficulties in that they feel the need to develop skills that force them to be highly self-reliant, develop a wide range of academic skills to succeed, and find multiple sources of support within an institution (Carr et al. 2007). By many accounts, support for minority physicians in academic medicine remains a difficult outcome to achieve (Price et al. 2005), in large part because the climate remains unfriendly. Regardless, our approach to retaining our diverse body of students is to identify and highlight their cultural assets within the medical curriculum.

The purpose of this study is to identify the cultural assets our medical students perceive themselves as bringing from their nascent cultures and communities in hopes of leveraging them within our educational programs. We define cultural assets as the experiences, perspectives, skills or behaviors that originate in students' cultural and social upbringing to provide cognitive and social frameworks for navigating educational and professional spaces (Delgado 2007). Others describe these assets in terms of *funds of knowledge*, a term that includes the historically accumulated and culturally developed bodies of knowledge considered essential for households and individuals to function (Moll et al. 1992). Given that in medicine, only certain assets are considered valuable, while others often go unacknowledged, this study seeks to explore students' perspectives on their strengths and assets, rather than taking the perspective of administrators in medical education.

## Methods

This exploratory study was designed as a phenomenography (Stenfors-Hayes, Hult, and Dahlgren 2013), which aims to understand people's perceptions, perspectives, and understandings of a particular situation. Phenomenographies try to answer the question, "What is it like to experience *this* specific event?" given the historical, social, political and cultural perspective and experiences of the individual. In the case of this study, the researchers wanted to understand students' perspective of their strengths and how they anticipate leveraging their assets in a medical career. Cultural assets were used as an analytical lens because they can be used to improve the educational climate for ethnically and culturally diverse students. Our assumption is that by focusing on students' cultural strengths, students will feel a greater sense of belonging in the institution and profession.

The context for this study was MCG, a large U.S. medical school located in an urban area in the southeastern part of the United States. The school's undergraduate medical student population (M1-M4) is approximately one thousand students, with roughly two hundred forty students enrolling per year. As the only public medical school in Georgia, the admissions department actively recruits racially, ethnically, and geographically diverse students across communities in the state. To understand what assets these students feel they are bringing to medicine, researchers at MCG recruited twenty-three M1-M3 medical students to participate in interviews that captured students' views of their assets. The initial group of seven students was recruited as part of another study that investigated how students' attitudes have changed since coming to medical school, and the subsequent sixteen students (to represent the larger MCG population) were recruited using the snowball method. The final participant count included eight Caucasians, five Minority students (Asians, Asian Indians), and ten Underrepresented in Medicine (UiM) students (Africans, African-Americans, Native Americans, Latino/as). Additionally, 43% of the sample came from rural areas.

**Data collection** Data were collected in the form of audio-recorded semi-structured interviews lasting approximately forty-five minutes each. In an effort to understand students' perceptions of their strengths, interview questions asked them to describe their cultural and familial context, the ways in which they had thought about their identity, and the challenges they experienced in medical school. Students were then asked to discuss these issues in terms of how they planned to use these identified areas in the practice of medicine. Consent was obtained from all individual participants during the interviews. Pseudonyms were assigned prior to interviews being transcribed for analysis.

**Data analysis** To analyze the data, a cultural assets paradigm (Delgado 2007) was employed as an analytical lens following the steps outlined for phenomenographies (Stenfors-Hayes, Hult, and Dahlgren 2013). The cultural assets paradigm challenges notions that some communities are deficient in resources needed for educational or professional attainment and seeks instead to highlight what individuals and communities bring to an educational endeavor. A cultural assets paradigm is appropriate for this study because it is often evoked in research where new populations (i.e. Latinos, African-Americans, etc.) are entering into historically segregated educational spaces and educators are unsure of how to create new programs that respond to their unique needs (Israel and Beaulieu 2004; Israel, Beaulieu, and Hartless 2001).

Interview data were coded in two phases. Phase one began with the creation of open codes in which all three authors identified assets as the students perceived them, as well as how they planned on using these assets. Following the open coding process, we met to discuss our findings and reconcile differences. These discussions resulted in a code book that defined each code with exemplar statements to guide further analysis. A second level of analysis was then conducted to identify relationships between the codes, a process often described as analyzing data using a constant comparative method (Glaser and Strauss 2009). Once the data had been analyzed in terms of how the codes fit together, all three researchers further refined the codes to create a more manageable coding scheme until a final set of codes was created. To ensure trustworthiness, memos were used to track our thinking about the relationship between codes and how our understanding of a phenomena and how it is similar and different than the other researchers'. Where we were able to contact students, we used member checking to ensure trustworthiness of our analysis.

## Reflexivity

The researchers on this study were purposefully chosen to represent diverse perspectives on the ways in which students' perceived their assets. Author one is a senior educational researcher at the medical school whose role is to challenge traditional ways of thinking about medical education and reframe them to solve local and national health challenges. Author two works as an experimental psychologist and is interested in the social lives of medical students. Author three is a fourth-year medical student interested in investigating how students develop and maintain identity while being socialized into the medical profession. Researchers' perspectives were encouraged throughout the analytical process to ensure that the analysis was rich and representative of divergent ways of thinking. For example, each researcher was asked to keep memos on their thoughts about why a student might identify with certain assets and not others, and why a particular asset may be useful in medical practice. These reflections were discussed from each of the researchers' perspectives as a way to explore the data and potential ways to integrate the findings into the institution's educational program.

## Results

The results indicate that students view themselves as having multiple assets that could be of significant value in their future practice of medicine. Many of these assets can be traced back to various life experiences which helped students to develop important clinical skills and emotional sensitivities. The results are organized by four themes: a) access to knowledge in science and medicine, b) personal and familial struggles with health, c) self and family as immigrants, and d) being family and community oriented.

### Access to knowledge in science/medicine

Nineteen of the twenty-three students indicated that having access to family members interested in science or healthcare professions was an asset. Access to those in the field helped students see some of the possibilities for themselves as they contemplated a career in medicine. In some cases, these impressions were brief, short interactions with family members that ignited an interest. For example, April described witnessing phone conversations her uncle had with patients, "He had that connection with them. The impact he [had] on their lives inspired me." Whereas other students were like Jackie who shared the ongoing impression that her grandfather had on the community and wanted to have that same influence on others for herself. She shared that having a family member in medicine helped shape her identify and feel comfortable with her career choice:

Whenever I go to the drug store or Walmart, whenever I run into people, you hear stories about the effect he had on them, all the community in general. That spoke volumes. I wanted that when I was little. I want that when I'm doing a profession. I want to have that reach into a community. That, in a sense, sparked [me] wanting to be a doctor.

In some cases, students did not have family members who were physicians or working in healthcare but found their way into medicine through a personal interest in the sciences. Being fascinated with science is viewed as an asset because it helps students understand material that may be more difficult for others coming from different undergraduate programs. For example,

one of the rural students, Connie explained, <sup>B</sup>No one in my family, even my extended family is in the medical profession in any way. <sup>A</sup> She found her way into medicine through anatomy beginning with the dissection of frogs living in her yard. She used kitchen utensils to explore the animal's body, labeling each structure using information from various anatomy websites. These early experiences eventually took her to the medical profession where she was already exposed to the inner workings of the body.

Students who found their way into medicine through the sciences believe their interest in science is an asset because it helped push them through the more difficult material they encounter in medical school. For example, Irene explained,

I fell in love with anatomy, the body, the way it works, and what happens when it goes wrong. That is very fascinating to me. To learn it all, top to bottom. Why did these things happen? How does it come together? This masterpiece that everybody is walking around with. It is really fascinating to me. I feel like I will never get bored with it. Ever.

Students indicated that, because there is so much information to learn in the four years of medical school, having family members to discuss concepts with and/or having a strong interest in the sciences provides support for them to succeed. Natalie, a biochemistry major, described feeling as if she had an advantage over her peers with this kind of background, <sup>B</sup>Especially when you start medical school, it is very basic science heavy. I did notice who came from [other] backgrounds [that are] a little less science heavy, they had to learn more starting out. <sup>A</sup> Students perceive their strong interest in science or having family members in the healthcare profession as assets because they have cognitive and social resources to draw on that will help them process information more efficiently.

### Personal and familial struggles with health

Ten students discussed how their experiences and reflections of their own and/or family members' struggle with health was an asset. In some cases, students discussed how these struggles exposed them to the healthcare system in ways they would not have otherwise been able to experience. For example, several students discussed the interactions they had with various physicians and how this influenced their decision to go into medicine. Aaron called these physicians *superheroes* because although they could not cure him from a chronic illness, they helped pull him out of a very dark place. He shared the story of how his physicians saved him, which influenced his choice to go into medicine: <sup>B</sup>I was diagnosed with Crohn's disease when I was six years old. I was a very sick child. I grew up seeing a lot of doctors, which influenced [my career choice] ... I always saw doctors as superheroes. <sup>A</sup> Aaron and others who interacted with physicians at an early age perceive these physicians as role models, professionals that students want to emulate, and an asset to their future career.

In other cases, students indicated that seeing family members suffer and feeling helpless to affect change influenced them to pursue a career in medical school. They realized that having a skill set could be of value to others who needed a physician. For example, Ina explained that her brother was often ill and seeing him in this state where she was helpless to improve his condition was difficult:

My youngest brother was sick a lot when he was younger. [It was difficult] seeing how debilitating his condition was. It made me realize how much I wanted to help him, not just as a sister, but in the medical field. That is when the dream started to manifest itself.

In all of these cases, students discussed how early experiences with the healthcare profession helped them develop feelings of empathy and compassion, assets that they will take into their medical practice. Students whose family members had suffered from tragic health issues indicated that they will remember those interactions as they in turn become physicians talking with patients' families. For example, Karen lost her father to cancer as a teenager, but during this tragedy, she learned from physicians how to be attentive to everyone in the family, beyond just the patient. She indicates that this experience of seeing a physician attend to both the patient and family was powerful in framing the way she wants to be with her own patients, *▮*[This experience] embodies how I want to be with my future patients. I have that perspective and I want to be able to use that perspective to treat my patients.<sup>^</sup> The empathy and compassion she felt from her father's physician will continue to guide her and help Karen connect with other families who are suffering at the loss of a loved one.

Others intended to carry forward the need to focus on mental health alongside physical health. They view this ability to see mental and physical health as tightly connected as an asset because so many physicians dismiss this aspect of patient care and healing, which leads to poorer health outcomes. By treating the patients' mental and emotional health, patients will have more energy to get through the healing process. Aaron talked about this awareness of physical and mental health in terms of his own diagnosis with Crohn's disease. He *▮*became aware of mental health problems from a fairly young age<sup>^</sup> and how this is often correlated and at the same time, overlooked in patients with chronic illness. Similarly, students like Nita shared that her own struggle with anxiety forced her to think about self-care and the importance of taking care of her own mental health in medical school. She indicated that this lesson will be influential in her work. She describes its impact in this way,

It is interesting that when I am learning about diseases [I also] think about how [patients'] mental health might be affected in this situation. If they are dealing with any kind of disease, like diabetes, or something like that, they could also be having depression or having some kind of anxiety about their disease. I feel like it kind of adds a different dimension to being a physician that a lot of people don't think about.

She concluded with the idea that coming to terms with her anxiety was a gift that she can give her patients. Whereas, she described it initially as a burden, she later realized that it was *▮*a really big asset.<sup>^</sup>

Although early personal or familial health tragedies could have turned students away from medicine, the students in this study recognized the myriad ways that having an ill family member or experiencing illness themselves can be used as an asset. In some cases, students found role models they currently rely on to shape and build a professional identity and frame their interactions with patients and family members. These experiences also contribute to feelings of empathy and compassion, emotions that will continue to help them emotionally connect with their patients, while also helping students recognize potential issues with a patients' mental health.

### Self and family as immigrants

Within a smaller group of students, thirteen identified how being immigrants or children of immigrants has been and will continue to be an asset as students move into practicing medicine. In some cases, students talked about the cultural knowledge they possess, such as folk remedies that have been passed on through the generations. Others discussed how their

parents provided cultural knowledge in terms of another way of healing patients. For example, Josie, who identified herself as a daughter of a German mother and Caribbean father, indicated that her mother's life experiences of growing up in another country helped her think about the healthcare system from another perspective. From the time she was a child, she remembers her mother describing a more holistic approach to health, focusing on patients' emotional well-being, eating clean and healthy food, and receiving spa treatments as a way to heal patients. She plans to incorporate these ideas into her approaches to healing, adding: "I always have my mother's voice in my head. Growing up, she compared a lot of things to how they are in Germany. [It] is always in the back of my head."

Other students, however, wondered whether they would be able to hold on to this knowledge once they were fully socialized into medicine. For example, Annie's parents are from Mexico, and she grew up as a migrant worker moving between harvesting apples in Michigan and onions in rural Georgia. She explained that there were a lot of home remedies made from herbs that her mother used to cure her when she was sick, which she hopes to bring into her medical practice. Yet, at the same time, she wonders how her knowledge might be replaced by Western ways of practicing medicine. She explained:

I think it is fascinating to think about the extent to which you will hold on to that cultural knowledge, or if at some point you will be asked to let go of it, or you will find conflict and you will say to yourself, I have to give this up in favor of medical knowledge.

Although students carry with them alternative views of healing, they recognize that these methods may be replaced by more conventional methods. They wonder if the climate in medical education will replace the knowledge they bring with them in favor of other forms that are more commonly accepted. However, even if they do not use these methods, by virtue of being from an ethnically mixed background, students may be at an advantage compared to their peers in terms of their sociocultural sensitivities. For example, Connie, who self-identified as Irish and Puerto Rican, felt that being of mixed ethnicity will help her see patients in a larger sociocultural framework and perhaps identify and empathize with social determinants of health affecting her patients. She explained, "I feel like my background lets me view those populations in a different way and I'm a little more empathetic to their situations." She hopes to use her unique experiences as an immigrant to help her patients problem solve health issues in the ways she and her family had to.

Students also saw their parents' immigrant status as an asset because they learned to work hard and be disciplined in ways that their peers may not have learned. Immigrants often face greater odds, barriers, and fewer opportunities, however these students used their experiences as immigrants to their advantage. Annie's parents worked in the field and didn't pressure her to go to college or become a physician, but their work schedule and conditions under which they worked were constant reminders for Annie to choose a career path different from theirs. She explained that it didn't matter if they were hot and sweaty or cold and freezing, the conditions were harsh and a constant reminder to work hard and get a good education: "I felt like my mom and dad would be like, if you don't really do anything with yourself this is what you are going to be doing." Other students talked about their immigrant experiences as advantageous because it afforded opportunities to problem solve and develop fortitude during challenging times. Ina, a child of Nigerian immigrants, feels that the early political and social challenges she experienced as an immigrant child will inform her approach to medicine. She anticipates that she will draw on these hardships and use them to continuously seek answers for her patients. She explained:



I feel that when I become a physician in a couple of years, any type of obstacles or hurdles, such as a patient who has a really bad disease, [where] I don't know what is going on, I don't know how to deal with them, I don't know what treatment regimen to use. Instead of giving up on them ... I need to continue to be perseverant to figure out what is going wrong with them.

For Ina, and the other students with immigrant parents, their life in the U.S. has been one of observing their parents' hardship, as well as their perseverance. Students believe these observations and early experiences will carry forward to their clinical practice in that students will be tenacious in their diagnosis and treatment. They will maintain steadfast when challenges come up, recalling the experiences they and their family members have experienced as immigrants.

### Community and family oriented

Ten of the twenty-three students also talked about their orientation to families or the larger community as an asset that will be taken into their practice. For example, students such as Lona plan on serving in disadvantaged Latino communities as a way to better understand how healthcare policy needs to shift for this population. As a Latina herself, she recognizes that her cultural background is advantageous for both her patients' health but also in influencing how the nation's healthcare system interfaces with her community. Students anticipate that being community and family oriented will shape their practice patterns in ways that bring the community or family to the forefront of healthcare. For example, Annie described how in the Mexican culture, women don't leave their children at home to go to the doctor, yet clinical practices are often not organized in a way to support this value. When Annie sets up her clinical practice, she plans to develop the waiting room so that children have a caregiver who watches over them while their mother is being seen by the doctor. She thinks it is important to have a place for children to be cared for while the patient is being seen and sees her role as a physician to incorporate the community's values around family. From her Latina perspective, she indicates that her role as a physician is to care for patients but also be aware that patients are going to have families and they are going to bring their kids with them.<sup>^</sup>

Other students, such as Natalie, plan on helping patients see the role of their own communities in shaping health outcomes and plans to advise patients to seek out community companionship, advice, and housework in times of recovery. She explained that communities provide support in ways that are often underutilized in healthcare but can be leveraged when someone is in need. For those students who also identified as having an immigrant background, many of them attributed this orientation to how their family cared for distant family members who later immigrated to the U.S. For example, Alena described how when family members from West Africa came to the U.S., they often lived with her family in Atlanta. She explained, "Growing up my mom would always have family members who were going through a rough time at our house, so I don't remember a time that [we] didn't have somebody staying with us."<sup>^</sup> This experience sensitized her to the idea that it is her responsibility to assist the community and its members, which she has both the ability and group affiliation that makes her responsible. In each of the above cases, students see the value in being a part of a community for themselves as physicians and the importance of considering the larger community for the health of their patients.

## Discussion

In this study, the cultural assets of a diverse medical student population was explored in an attempt to understand the assets and strengths students perceive themselves as having and how they plan to incorporate these assets into the practice of medicine. In interviews, students identified their assets as early experiences with other physicians, a fascination with science, compassion and empathy as a byproduct of personal/familial struggles with health, perseverance in the face of difficulty, and an orientation to families and the larger community. Students perceived these life experiences as cultural assets because they could directly identify where they could be utilized in medicine. However, it is important to note that in these interviews, students identified many other skills they had developed in their lifetime such as being bilingual, yet these skills were not labeled as assets because students felt that the field of medicine did not see them as valuable, compared to the assets they identified.

Regardless, the results demonstrate that students do not come to medical school as blank slates (Stubbing, Helmich, and Cleland 2017). Rather, they carry diverse learning and life experiences from their cultural backgrounds that influence both their trajectory and development as physicians (Fergus et al. 2018). In fact, many of the students in this study were most likely accepted into medical school in part because of the assets they identified in their interviews. The challenge for medical schools is then how do we, as institutions, help students graduate from our programs with their assets intact? How do we create a learning environment that supports students' assets and ensures students understand the importance of these assets?

The solution to this problem can be found in helping students maintain aspects of themselves while being introduced to medicine. An earlier study that utilized this same data set demonstrated that students feel they are being trained as robots with all their humanistic qualities being stripped of them (Wyatt and Varpio under review). This feeling is supported by research that shows medical education is essentially a socialization process, one in which students must give up parts of their identity in favor of developing new identities (Crues et al. 2015). Students are consistently exposed to discourses that pull them in multiple directions, where on the one hand, medicine sends messages on the importance of standardization, and on the other, the importance of diversity (Frost and Regehr 2013). This tension is resolved when students make choices about who they are, and who they are going to be, which in some cases requires them to leave parts of themselves behind.

As medical educators, we can begin by acknowledging students' cultural assets as both valid and valuable within the field of medicine, and then draw on students' diverse experiences in the classroom. For example, rather than telling students to respect patients' autonomy around sharing their health concerns, educators can ask students to provide perspective on why they think some patients share their health problems with family members and others do not. By reflecting on their own cultural values and then comparing and contrasting them with others', educators can create educational spaces to open up conversations that utilize students' experiences to understand issues in healthcare, a practice that has been shown to help prepare students to serve diverse populations (Saha et al. 2008; Niu et al. 2012).

Medical educators can also work to set up mentoring programs that help empower students to embrace their unique experiences and find ways to leverage them into the practice of medicine (Fergus et al. 2018). Part of the difficulty for students entering this new field is that they do not always understand where and how they can leverage their assets in a clinical environment. However, with the assistance of someone who is actively searching for these opportunities, students will learn to identify them, and with time, begin to feel comfortable

with taking them. Developing these kinds of mentoring programs provides targeted assistance on how to help students identify areas where they can maintain aspects of who they are while being socialized into medicine.

Regardless of how new programs are developed to support students' cultural assets, the first step to creating change in our healthcare system is to acknowledge that in order for our recruitment efforts to yield our desired outcomes, we must ensure that our ethnically, culturally, and geographically diverse students maintain their assets throughout medical school. This study brings attention to this important endeavor and provides a potential first step for other institutions interested in helping to solve our nation's healthcare challenges.

#### Compliance with ethical standards

**Ethical approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed consent** Informed consent was obtained from all individual participants included in the study.

**Conflict of interest** Tasha R. Wyatt declares that she has no conflict of interest. Sarah Egan declares that she has no conflict of interest. Cole Phillips declares that he has no conflicts of interest.

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