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Centering Black Physicians' Voices: Narratives of Cultural Wealth and The Pathway to Medicine

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Abstract

This paper presents findings from a study on the persistence of fifteen Black physicians through medical school and residency. It employs a qualitative research approach centering narrative interviews and is grounded in Critical Race Methodology and Yosso's (2005) Community Cultural Wealth (CCW) framework. The research explores how Black doctors navigated systemic barriers, including anti-Blackness and institutional exclusion. Findings suggest that familial support, faith, mentorship, and personal resolve were critical to their success. Implications for medical education include reimagining admissions, expanding culturally relevant support systems, and redesigning pipeline programs to amplify the voices and assets of Black medical students.

Keywords:

Black physicians**,** medical school persistence**,** Community Cultural Wealth**,** anti-Blackness in medicine**,** diversity in medical education

Introduction

By 2045, over 50% of the U.S. population is projected to identify as nonwhite. As this shift occurs, a diverse medical workforce becomes increasingly vital to address persistent racial disparities in healthcare. Statistics show that People of Color—especially Black Americans—suffer from disproportionate rates of disease, lack of access to healthcare, and negative health outcomes. Despite these needs, Black physicians comprise only 5% of the profession, despite being 12% of the population. (AAMC, 2019). This disparity points to systemic barriers along the educational pipeline and medical school admissions process.

Benefits of Racial Diversity in Medicine

Diversity in medical education and practice enhances cultural sensitivity, improves training outcomes, and leads to stronger patient-doctor relationships. Research suggests access to healthcare and health outcomes are directly related to race (Saha, 2014). Hence, it is important that the healthcare workforce represent the diversity of its community. This builds trust and rapport with patients as they believe the institutions and hospitals are principled and ethical. Additionally, Black doctors are more likely to serve under-resourced communities, offer culturally sensitive care, and address the social determinants of health. These contributions are vital for closing health disparities and building trust in the healthcare system.

Background and Historical Context

Deficit-Based Framing in Education

Educational systems often view Black students through a deficit-based lens—framing them as lacking skills, support, or cultural capital needed for success. Scholars such as Yosso (2005) and Lewis & Diamond (2015) argue that systemic biases, like academic tracking and disproportionate disciplinary actions, limit Black students' access to advanced coursework, and college opportunities. These biases are compounded by unconscious teacher biases and systemic structures that privilege white students.

Financial and Structural Obstacles

Many Applicants of Color to medical school mentioned finances as their biggest challenge (Hadinger, 2016). Applying to medical school is expensive, with costs for applications, exams, and even airplane travel and hotels for interviews. This figure usually runs into the thousands (Mitra, 2019). Students may decide not to pursue medical school at all, once they are aware of the costs, and may not have financial support from their families (Lucey & Saguil, 2020). Black borrowers also incur more student loan debt and have higher repayment burdens than white peers, further discouraging medical school enrollment. The Education Data Initiative (2023) published a report about student loan indebtedness. Black college students receive 50.8% of all student loans and owe $25,000 more, on average, than white college students. Four years after graduating from college, Black graduates owe 188% more than white borrowers.

Supports and Interventions

Pipeline and Postbac Programs

Many strategies have been successful at improving the pathways for Black medical students. A critical strategy includes pipeline and postbaccalaureate (postbac) programs. These programs are examples of support systems which help bridge the gap presented by the barriers Black medical students face (Figueroa, 2014). Pipeline programs provide academic, curricular, financial, and mentoring support to students who experience obstacles in applying to health profession programs. Postbaccalaureate programs help students, who already have a baccalaureate degree, with their pre-health science coursework or to improve their knowledge in their science courses. Most pipeline and postbac programs seek to help remove cognitive barriers such as lack of academic preparation in science courses and MCAT test taking.

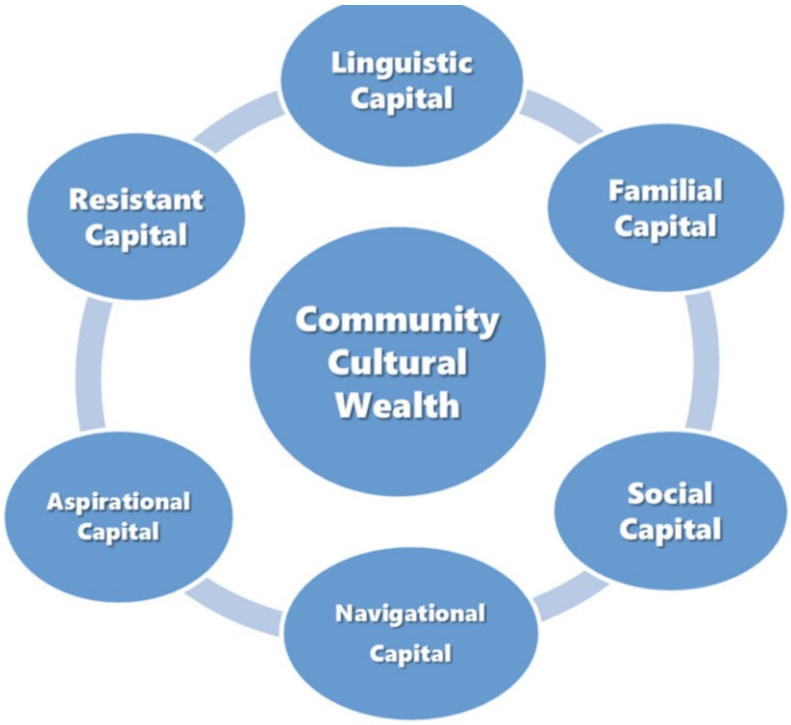
Community Cultural Wealth as a Counter-Narrative

There is a dearth of literature in which highlights the voices of practicing Black physicians regarding their own interpretation and comprehension of their experiences and how they navigated their journeys to become doctors. Students of Color are often viewed from a deficit-based perspective (Yosso, 2005). Academic research largely focuses on Students of Color possessing deficiencies and emphasizes their weaknesses related to why they do not perform well academically. Additionally, it is assumed Students of Color do not possess the proper cultural capital, and those deficits lead to their failures (Assari, 2018; Winkle-Wagner, 2010). CCW recognizes six types of cultural capital—aspirational, social, familial, linguistic, navigational, and resistant—that Communities of Color draw upon to navigate oppressive

systems (Yosso, 2005). This study explores how Black doctors relied on these capitals to overcome barriers in their journey through medical school.

Figure 1

CCW as Conceptualized by Tara J. Yosso, PhD



Purpose, Significance, and Research Design

The study elevates the voices of Black physicians to explore the research questions which are:

1. How do Black physicians describe their educational experiences?

a) What contributed to their persistence through higher education, medical school, and residency?

b) How did these experiences influence their decision to become a medical doctor?

2. What aspects of community cultural wealth did Black physicians rely on during medical school and residency?

The urgency of this research increased following the U.S. Supreme Court's 2023 decision to overturn affirmative action, a change expected to significantly reduce the number of Black medical school admits and graduates. There have been devastating impacts for the first medical school class since these decisions (AAMC, 2025). There has been a steep drop in Black enrollees by 11.6% despite an increase in applications. However, the enrollment of white students has remained the same. Using Critical Race Methodology of Solórzano and Yosso (2002), qualitative interviews were completed with 15 Black physicians, most of whom trained at PWIs in the U.S. By centering the counter-narratives of practicing Black physicians, this study extends existing pipeline and access research by demonstrating how Community Cultural Wealth operates not only as a survival mechanism, but as a sustaining force throughout medical training and professional practice.

Theoretical Framework

This section explores the broader literature surrounding the invisibility and systemic barriers Black students face in educational spaces, particularly in medicine. The goal is to situate the study within the framework of existing research while demonstrating gaps and the necessity of centering Black voices. Drawing on the lens of Yosso's (2005) *Community Cultural Wealth* and *Critical Race Theory* of Delgado and Stefancic (2023), the theoretical framework examines three key thematic domains: (1) educational inequity and invisibility in academic settings; (2) anti-Blackness within medical education and practice; and (3) the role of resilience and cultural assets in fostering persistence. In the context of medical education, Community Cultural Wealth offers a critical reframing of success, one that recognizes how Black physicians mobilize cultural assets to navigate institutions historically structured to exclude them.

Theoretical Frameworks: CRT and CCW

Critical Race Theory (CRT)

CRT provides a lens for understanding how race and power intersect to create and sustain systemic inequalities. Solórzano and Yosso (2002) argue for the use of counter-narratives to challenge dominant stories that pathologize Students of Color. This study builds on that foundation by elevating the voices of Black physicians who succeeded despite systemic barriers.

Community Cultural Wealth (CCW)

In the context of medical education, Community Cultural Wealth offers a critical reframing of success—one that recognizes how Black physicians mobilize cultural assets to navigate institutions historically structured to exclude them. Yosso's (2005) CCW framework shifts the narrative from deficiency to strength. The six capitals—aspirational, navigational, social, familial, linguistic, and resistant—offer a holistic way of understanding how Black students succeed. First, *aspirational capital* is the ability for one to maintain aspirations and dreams for the future, despite barriers. An example of this would be children of immigrants or children who grew up in poverty. Since the parents want their children to achieve their dreams, they provide nurturing, encouragement, and resources to help their child in their academic endeavors. *Linguistic capital* is the ability to be able to communicate in other languages and styles. Also, according to Yosso (2005), Students of Color inherit a storytelling and oral history tradition. This is beneficial as Students of Color learn memorization techniques and other vocal presentation skills from that tradition. Students of Color also possess *familial capital*. They have a sixth sense in connecting in community. It first starts as their family and extended family and community. Once Students of Color are in school, they find this community in other arenas including sports and religious activities. This instinct allows them to adapt and integrate into settings in which they feel comfortable, thrive, and avoid isolation. *Social capital* are the networks and relationships which Black students build. These relationships can connect them to information which leads to resources that help them persist through school. Once they discover the resources, they seek to give back by bringing the information and resources back to their community. *Navigational capital* refers to the ability to maneuver through social institutions. Historically, social institutions, such as medical schools would not be designed with Black

students in mind. These forms of capital were central to the persistence of Black physicians in the study and counteract deficit narratives that often dominate admissions and academic discourses.

CCW and Medical School

Research shows that while little is written about the pathways of Black doctors, Community Cultural Wealth (CCW) has proven essential in how Students of Color persist in higher education (Yosso, 2005). Familial, resistance, and aspirational capital are particularly impactful, with family influence being a key motivator for academic resilience (Cooper et al., 2017; Yosso, 2005). Social capital—trusted relationships—also helps students navigate predominantly white institutions.

In medical education, Sanchez et al. (2018) found that URM students are driven by aspirational capital to serve their communities and influenced by mentors and role models—forms of social capital. Family, peers, and church networks further supported their academic persistence (Yosso, 2005; Odom et al., 2007; Thomas et al., 2011; Hadinger, 2016). Students without these supports faced greater challenges. Navigational capital—the ability to maneuver institutions—was another key factor. Despite stress and self-doubt, Underrepresented in Medicine (URM) students maintained resilience through self-confidence, community feedback, and language skills that helped them connect with underserved patients (Yosso, 2005; Odom et al., 2007; Hadinger, 2016). Anti-Blackness persists in both overt and subtle forms, creating a culture that marginalizes and undermines Black excellence. However, counter to deficit-based assumptions, Black students and physicians bring a wealth of cultural capital that enables them to navigate and challenge these systems.

Methodology

This section outlines the research design and methodology used to explore the educational journeys of Black physicians, particularly how they navigated systemic barriers in college, medical school, and residency. The study responds to the persistent underrepresentation of Black students in medical schools despite institutional support and interventions. It employs a qualitative research approach grounded in Critical Race Methodology and Yosso's (2005) Community Cultural Wealth (CCW) framework.

Epistemological Assumptions

This research is grounded in a constructivist interpretative worldview, where individuals create subjective meaning from their lived experiences (Creswell & Creswell, 2018). The researcher aimed to understand how Black physicians interpreted their educational journeys—from childhood through medical training—via personal narratives. Constructivism was selected because it acknowledges how meaning is co-constructed through social and historical contexts.

Positionality

My interest in this topic is shaped by my life as an Afro-Latina woman whose early experiences with health disparities left lasting impressions. Growing up in a low-income family on Medicaid, I often encountered limited resources, which stood in stark contrast to the quality of care I received as a student at Stanford University. Although I dreamed of becoming a doctor and excelled in math and biology, I lacked guidance, mentorship, and support, which left me feeling lost and ultimately derailed my pre-med aspirations. Reflecting on these experiences helps me recognize how my identity and positionality inform my research approach. With over fifteen years working in medical education—as an administrator, clerkship supervisor,

admissions specialist, adviser, and pipeline program administrator—I bring both a unique perspective and potential bias to my research, as my professional background has shaped the kinds of questions I ask and the ways I interpret responses.

Research Method and Design

A qualitative design was employed to explore the narratives and lived experiences of Black physicians, as it allows deep insight into how people make sense of their social environments (Saldaña, 2011). The study used Solórzano & Yosso's (2002) Critical Race Methodology which centers race and racism in the research process and highlights the lived realities and experiential knowledge of People of Color. This approach emphasizes counter-storytelling and oral histories to challenge dominant, deficit-based narratives in medical education. Fifteen Black physicians participated in semi-structured interviews, with data analyzed using descriptive coding and NVivo software. The interviews were transcribed, member-checked, and pseudonyms were used to protect confidentiality.

Participants and Sampling

Participants had attended either a Predominantly White Institution (PWI) or a Historically Black College or University (HBCU) for undergraduate studies. Recruitment targeted a balance in gender and clinical backgrounds, with physicians sourced through SNMA, AMA, HBCU alumni associations, DEI administrators, and snowball sampling. Nine participants were U.S.-born and six were immigrant-born, although the study did not differentiate findings based on nativity.

Figure 2

Participant Demographics

Table 1

Participants

Participant	Gender	1st Generation	Medical school graduation year	Clinical Specialty	Region of practice
Dr. Nicole Harris	Female	X	1989	Dermatology	Northern California
Dr. Hans Braun	Male		1995	Urology	Northern California
Dr. Lisa Klein	Female		1999	Internal medicine	Northern California
Dr. Emmitt Henry	Male	X	2001	Pediatric Neurosurgery	Northern California
Dr. Declan Robinson	Male		2005	Urology	Northeast
Dr. Tasha Johnson	Female		2006	OBGYN	Northern California
Dr. Victoria Brown	Female		2006	Pediatrics	Northern California

Participant	Gender	1st Generation	Medical school graduation year	Clinical Specialty	Region of practice
Dr. Joshua Randall	Male		2008	Radiology	Northern California
Dr. Ayo Adeoye	Female		2010	Psychiatry; Addiction Medicine	Northern California
Dr. Anthony Campbell	Male	X	2011	Radiology	Northern California
Dr. Juliet Shepard	Female	X	2011	OBGYN	Northern California
Dr. Essie Agwuegbo	Female		2014	Colorectal oncology	Northern California
Dr. Kim Fuller	Female		2014	Urologic surgery	Northern California
Dr. Philomena Chege	Female		2014	Family medicine	Northern California
Dr. Julian S. Landon	Male		2022	Pediatrics/General Psych/Child and adolescent psychiatry	Midwest

Data Collection

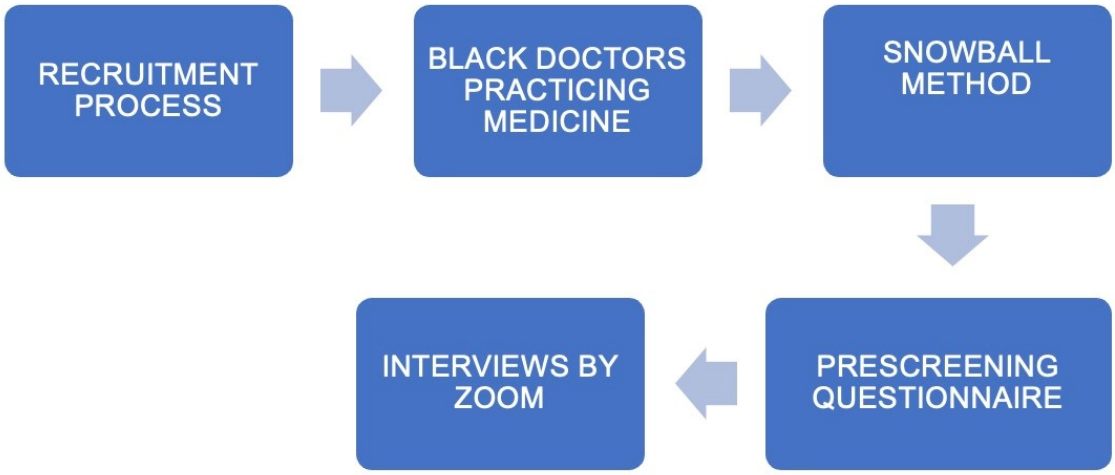
Semi-structured Zoom interviews lasting 45–60 minutes were conducted and recorded. A prescreening questionnaire collected demographic and educational data. Interviews explored each element of Community Cultural Wealth (CCW)**:** aspirational, familial, social, navigational, and resistant capital. Physicians were asked about educational influences, systemic barriers, and advice for future Black medical students. Transcriptions were completed using Rev.com and participants reviewed their transcripts for accuracy (member checks).

Data Analysis

An open coding process was used to identify descriptive themes. Codes were created using participants' own language and organized into categories via NVivo software. A codebook was developed through multiple rounds of coding. Field notes and memos were kept during interviews to strengthen analytical rigor (Saldaña, 2011).

Figure 3

Data Collection Process



Credibility and Trustworthiness

Credibility was established through thorough documentation, participant transcript review, and alignment between research questions, theoretical framework, and methodology (Saldaña, 2011).

Limitations

The sample was limited to 15 participants, mostly based in Northern California. Time constraints affected the depth of some interviews. There was also a slight gender imbalance (9 female, 6 male), and local context may have shaped findings. Despite these, the depth of narratives offers rich insights into systemic inequities and resilience strategies.

2. Findings

There is a dearth of academic research which has captured the personal narratives of practicing Black physicians. Systemic barriers persist throughout their educational pathways, especially during medical school and residency. This study addresses that gap using Yosso's (2005) Community Cultural Wealth (CCW) framework, which emphasizes the strengths and cultural resources Black physicians draw upon to persist and succeed. Taken as a whole, the findings show that Black physicians' persistence emerges from the dynamic tension between structural obstacles and cultural resources, exposing the harms produced by anti-Blackness while underscoring the lasting strength of community-based assets. Based on semi-structured interviews with 15 Black physicians, the study presents their journeys through four themes:

1. **Entering the Path** – motivations to pursue medicine and early educational experiences;
2. **The Rocky Path** – barriers faced in medical school and residency;
3. **Stepping Stones on the Path** – sources of support and cultural wealth that enabled their persistence;
4. **End of the Path** – reflections on being a Black doctor today, including advice for aspiring physicians and recommendations for improving the medical school pipeline.

The findings offer critical insights to help medical schools strengthen support for future Black physicians.

Figure 4

Four main themes and subthemes

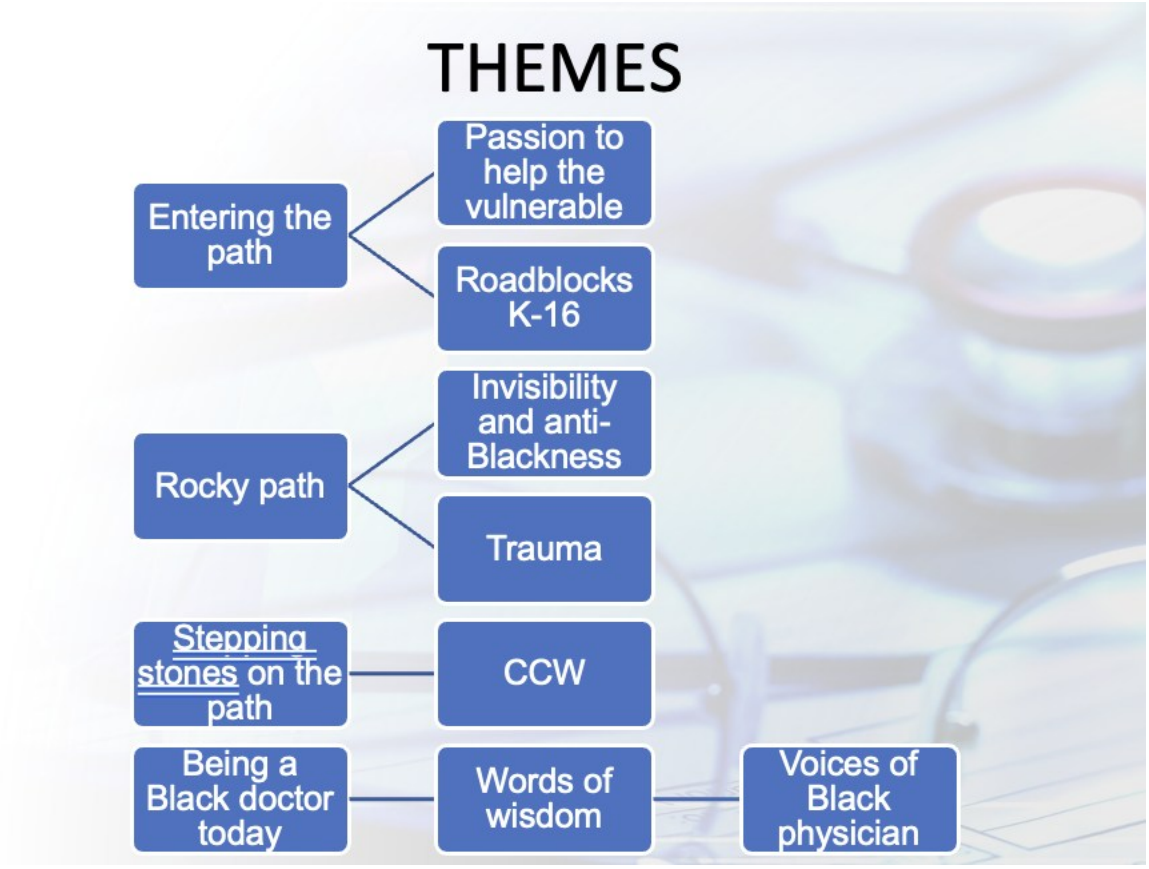


Table 2

Themes, Subthemes, and Theoretical Connections

Theme	Subtheme	Theoretical Connection
Entering the Path	Passion to Help the Vulnerable	Aspirational capital
	Being a Doctor is a Trade	
	Being Exposed to the Profession/Representation	Social capital from Black physicians and mentors
	Roadblocks	Navigational capital
	College Track	
The Rocky Path	Invisibility and Anti-Blackness	Resistant capital
	Trauma	
	Self-Doubt and Imposter Syndrome	
Stepping Stones on the Path	Self-Resolve and Community Cultural Wealth	Familial, social, navigational capital
Being a Black Doctor Today: The Path Continues	Current Clinical Experiences	Navigational, Resistant
	Value of Having a Black Doctor	
	Words of Wisdom	
	Cultivating Future Black Doctors	
	Voice of the Black Physician	

Entering the Path

Early Motivations and Influences

Motivations to become a doctor were varied. Some were inspired by a desire to help the vulnerable. Many reflected on childhood feelings of helplessness in the face of illness within their families, which later fueled their commitment to medicine. Dr. Essie Agwuegbo, a colorectal oncologist doctor practicing in Northern California, shared that while residing in Africa with her cousin, he died from a diarrheal illness which could have easily been treated with a rehydration solution. She recalled how this not only sparked her desire to become a doctor, but it was a continual motivator to help those in need. Dr. Essie Agwuegbo said,

> When I think of my persistence and commitment to medicine, I think [about] the kind of pivotal life events would be [the death of] my 11-year-old cousin…That was a very important moment for me…my persistence, if not to medicine, but to at least trying to serve the underserved stems directly from that.

Early exposure to Black physicians through shadowing and community events was also influential. Some participants viewed medicine as a stable and lucrative profession, offering a pathway out of poverty.

Barriers and Roadblocks

Despite early aspirations, participants encountered numerous barriers such as poverty and lack of resources**.** They also faced racial isolation and microaggressions. For many, attending predominantly white schools often left participants feeling isolated or targeted. Some experienced teachers' low expectations and discriminatory assumptions based on race or names, which they had to overcome through academic performance and resilience.

The Rocky Path

This section explores the experiences of Black physicians during medical school and residency, focusing on the emotional, structural, and racial challenges they faced. The journey through these stages of their training was marked by feelings of invisibility and anti-Blackness, often resulting in trauma, self-doubt, and imposter syndrome. Despite reaching this level of education, many Black physicians encountered systemic racism and microaggressions, ranging from being mistaken for non-medical staff to patients refusing their care. These moments underscored the deeply embedded racial biases within medical and clinical environments. Many found their personalities unfairly targeted, particularly when perceived as quiet or introverted, traits that were misinterpreted as disengagement. Dr. Ade Adeoye recalled situation with tears in her eyes, painfully recalling encounters that were psychologically violent. She felt singled out not because she performed poorly. She concluded that she was targeted for being Black. She said,

> … I did very well on my testing…The spotlight was constantly on me. I see fellow white residents not doing well and nobody's talking to them…I couldn't say anything because then I would be playing a victim and deflecting instead of taking responsibility…I felt like I could not win and I shut down and I remember going to therapy and at one point I [thought], maybe they're right about me…

One physician shared a story of a colleague whose life ended in tragedy after being wrongfully accused, highlighting the life-threatening consequences of unchecked bias and presumption of guilt. Others described how patients and even healthcare staff refused to recognize them as legitimate members of the medical team, reinforcing their sense of exclusion. Dr. Joshua

Randall, who is a radiologist, recalled an instance when he was on surgical rotation and assisted a resident with a procedure:

> People [did] not recognize[e] that I was a medical student and sort of mistaking me for someone else on the care team or not on the care team at all. Those sorts of experiences definitely stayed with me and were, at times, difficult to process. Either a nurse or a nurse practitioner (NP) that was also working on the unit…was trying to redirect me to take down…a large garbage can to the basement.

In the face of these challenges, they found support in peer networks, family encouragement, and a personal commitment not to let temporary setbacks define them. Ultimately, the adversity they faced—ranging from external discrimination to internal conflict—became a catalyst for developing the strength and resolve needed to complete their path.

Stepping Stones on the Path

Despite the many challenges Black physicians faced throughout medical school and residency, they also described the critical external supports and internal strengths that enabled their persistence. A central theme was the importance of social capital derived from family, community, institutional programs, mentors, peer relationships, and faith. These support systems functioned as equalizers—bridging gaps in resources, knowledge, and access—particularly within a field historically structured to exclude Black individuals. Peer networks formed in these intense environments were likened to familial bonds and credited as key to their endurance. Additionally, mentorship emerged as a defining factor in the persistence of many participants. Strong mentorship relationships not only opened doors to professional opportunities but also affirmed the physicians' identities and potential. Faith was also a deeply embedded source of

strength throughout medical school and residency. Many physicians leaned on their spiritual beliefs and church communities for solace, moral grounding, and emotional renewal.

Participants also drew heavily on their internal self-resolve, which they described in terms such as resilience, determination, mental toughness, and internal drive. Many credited these qualities, which are familial and navigational capital, to formative experiences in childhood or their parents' examples of perseverance, hard work, sacrifice, and persistence in the face of adversity was normalized. These lessons became psychological anchors in their training. Other doctors described a form of navigational capital like specific strategies along their pathways. For Dr. Joshua Randall, creative writing became an outlet for him in medical school when he was having a hard time:

> [It] became a very important toolkit that I developed to be able to process difficult experiences that I was having with race and medicine in terms of being able to understand what was shaping the interactions between myself and another individual person, but then also the larger systemic forces at play that were resulting in what was maybe a negative interaction…

Finally, some participants described a desire to challenge the status quo (resistant capital) and expand opportunities for other Black medical students. These physicians used their positions and personal experiences to advocate for systemic change within medical education institutions. For example, Dr. Kim Fuller and her Black medical student colleagues were dissatisfied with the number of Black male physicians, and she spoke out:

> Seeing people who look like you who are in the same spaces as you is…very affirming…I remember the institution that I went to listened. There were no Black males in my class, and I remember people making a big stink about that. They heard us the

> following year, I think there were like seven [male Black doctors]…That's a huge difference. It was those organizations coming together and approaching leadership and administration and saying…you really need to make a change…

Their collective stories revealed the power of both support systems and self-determination in resisting marginalization and paving the way for those who would come after them. The convergence of these forms of cultural wealth equipped them with the tools necessary to succeed despite the persistent barriers they encountered.

Being a Black Doctor Today

This section explores the lived experiences of Black physicians in clinical practice today, the value they bring to the profession, and their perspectives on widening the pipeline for future Black doctors. Many physicians reported that anti-Black racism and exclusion persist in clinical spaces. Some shared stories of being overlooked for promotions or excluded from key decision-making conversations, often despite having more experience than their peers. The continued marginalization, even decades into their careers, reflects deep systemic issues that have not significantly improved over time. In her reflective essay Dr. Olayiwola (2016), a UCSF physician, discusses racism she encountered in her clinics. She described it as a "power shift" in that some respected her when she donned her white coat. On the other hand, patients' racist outbursts diminished the typical power dynamic exposing her vulnerabilities. Despite such challenges, the physicians strongly affirmed the importance of Black doctors in improving patient care and addressing health disparities. Research supports the idea that Black patients often prefer and trust Black physicians, who they feel are more culturally sensitive and better able to relate to their experiences. These physicians provide not only competent care but also

culturally affirming, compassionate relationships that foster trust. Their presence helps dismantle medical mistrust and ensures better health outcomes, particularly in underserved communities. Many participants described their professional work as a form of service and advocacy, whether through direct care, research, or efforts in diversity, equity, and inclusion (DEI).

Physicians called for holistic admissions practices that assess applicants beyond test scores, focusing instead on well-rounded individuals who possess the qualities that make effective doctors. Dr. Tasha Johnson suggested that representation should come in the form of sponsorship and advocacy and providing the social capital they need:

> These people were there to not just mentor me, but they were sponsoring me. They were speaking my name in these rooms and I had no idea. So it's not just about mentorship. We talk about sponsorship…I just think it's really important to have [representation in those] places [of decision making] …and not just because they look like me, but really so that they can advocate for these young people…We just have to keep pushing to have more diversity in these areas and not just at HBCUs…

Several noted that standardized testing often disadvantages students with learning differences or those without access to expensive test preparation resources. A shift toward whole-person evaluations would broaden access to medical education and better reflect who will thrive in the profession. While his path was not easy due to learning disabilities diagnosed during his training, Dr. Declan Robinson hoped that his story could be a source of hope for those who have struggles along the way:

> I'm embarrassed a little bit about my story, particularly about my struggles about taking exams. I wish that my struggle was I didn't have those struggles, but everybody's path is different…At the end of the day, if you stick with it and you stay focused, you can get to

> where you want to be in life, even in medicine…I didn't start off with a straight path going…[I am] here with all the bumps and bruises and scars and [despite] low grades and low scores…

The physicians' experiences reveal how cultural wealth supported their perseverance despite systemic racism. Their stories highlight the need for structural reform in medical education to better recognize and support Black students. Discussion and Recommendations

The experiences of Black physicians, as captured in this study, provide a critical lens for evaluating medical education policies and practices. To combat invisibility and systemic racism in medicine, institutions must take transformative steps toward racial equity. Below are key policy recommendations derived from the data:

Holistic and Equity-Oriented Recommendations

One of the central recommendations involves the need to transform how Black medical students are evaluated during their training. The study found that these students are frequently perceived through a deficit-based lens, which undermines their knowledge, skills, and legitimacy. To counteract this, medical institutions should adopt evaluation methods grounded in the CCW framework. This means shifting the focus from subjective traits, often interpreted through racially biased perspectives, to culturally relevant and strengths-based evaluations that recognize the students' resilience, leadership, and capacity to serve diverse communities effectively. Faculty members, particularly white supervisors, should be trained to understand and apply these frameworks in their assessments and interactions. Equally important is creating safe, empathetic, and culturally relevant environments in which Black students can thrive rather than merely survive. These environments should be designed to recognize and nurture the talents and contributions of Black students, not marginalize or ignore them.

Admissions

Medical school admissions processes must move beyond overreliance on standardized tests like the MCAT, which reinforce inequity (Lucey & Saguil, 2020). Admissions committees should adopt a holistic review framework that considers cultural capital, community engagement, and resilience as critical indicators of potential. In addition, implicit bias training for admissions officers and interviewers is essential to ensure fair evaluations of URM applicants.

Inclusive Curriculum Reform.

Curricula must be restructured to include accurate and comprehensive content on health disparities, systemic racism, and the lived experiences of Black patients. This includes teaching about the history of medical racism, such as the Tuskegee Syphilis Study and modern disparities in maternal mortality. More representation of Black scholars, researchers, and practitioners in course content and guest lectures is also needed.

Mentorship and Support Systems

Institutions should build structured mentorship networks for Black medical students and residents. These networks must include racially and culturally congruent mentors where possible. Griffin, et al. (2010) emphasized the importance of this type of mentoring. They found that faculty mentors supported students not only in advancing through STEM but also in shaping how they, in turn, advocated for and mentored other students of color. Participants valued the opportunities their mentors gave them, particularly early exposure to research. They highlighted sponsorship and collaboration as critical for raising awareness of research pathways. Mentorship also influenced how faculty addressed race and racism, with some preparing students of color for the extra scrutiny and effort required to gain recognition and using that awareness to mentor

more proactively. This preparation could help mitigate racial battle fatigue is a nonstop stress experienced by Black students, especially in PWI settings. Racial battle fatigue parallels combat fatigue in the military and stems from the cumulative strain of navigating persistent racism—manifested through daily slights, indignities, unfair treatment, hostile environments such as contentious classrooms, and ongoing exposure to potential threats or dangers, including those that may escalate to violent or life-threatening conditions (Smith, 2004). Support systems should also address emotional wellness, counteracting racial battle fatigue with dedicated wellness spaces and mental health professionals trained in racial trauma (Smith et al., 2007).

Accountability and Institutional Culture Change

Anti-Blackness within medical education culture must be addressed directly and intentionally. The research reveals that systemic racism continues to pervade medical school curricula, evaluation practices, and institutional norms. Many physicians in the study shared painful experiences of being excluded, mistreated, or unfairly evaluated because of their race. Medical schools and residency programs must commit to measurable outcomes in diversity, equity, and inclusion. This includes tracking graduation rates, performance evaluations, and faculty representation disaggregated by race. Equity audits, climate surveys, and anti-racism task forces should be institutionalized—not temporary responses to national events.

Family Engagement

Many participants emphasized that the emotional and financial support of their families played a pivotal role in their success. These relationships served as a foundation for their aspirations and helped them endure the stress and isolation often associated with medical training. Therefore, medical schools should actively engage families in the educational pipeline.

This could include outreach efforts to educate families about the medical school admissions process, as well as opportunities for parents and caregivers to support their students through events and mentorship.

Rules of Engagement

Furthermore, the study recommends that Black students be equipped with what it calls the "rules of engagement." This refers to the often-unspoken knowledge that is critical for navigating the pathway to medical school. Black students must be taught how to prepare their applications, select courses, schedule and prepare for entrance exams, find research opportunities, and identify mentors. This information is frequently withheld from or inaccessible to students of color, which places them at a disadvantage. To remedy this, schools should develop comprehensive advising and coaching models that provide step-by-step guidance for each stage of the journey. This includes regular check-ins, progress reviews, and individualized support to ensure that students remain on track and have the resources they need to succeed.

Setting the Foundation for Lasting Change

There needs to be a collaborative effort in which Black physicians are consulted and can advise any cultural changes, changes in the curriculum, examination of the evaluations, or any other change which would affect current Black medical students or processes for aspiring Black doctors. There needs to be a detailed exploration into what cultivates success for Black students. There should be check ins with Black physicians and Black students during a regular interval, biannually or annually, to oversee the progress of any changes which have been instituted. Yet, the onus should not be on Black faculty and students to do all the work for these changes. Their

white counterparts need to share the work that needs to be done in admissions, curriculum, recruitment, and mentoring. Anti-racism work needs to be done. Bias training and self-reflection are important but not sufficient for this process. White counterparts, administrators, physicians, and students need to advocate for inclusion and call out any discrimination and anti-Black actions or activities.

Conclusion: Limitations and Future Research

While this study offers rich, qualitative insights into the lived experiences of Black physicians, it is not without limitations. First, the sample size, while adequate for phenomenological analysis, was limited to 15 participants, most of whom practiced in California. Geographic and institutional diversity could yield additional insights into regional differences in training and medical culture. Second, although participants represented diverse specialties and training backgrounds, the study did not disaggregate findings by gender or immigrant status. Intersectional analysis of these identities would deepen understanding of how layered oppressions manifest in medical spaces. there is limited research that explores the academic achievement gap between US-born and immigrant-born Black students. In their research, Tauriac and Liem (2012) discussed how immigrant-born Black students outperform US-born Black students, academically, throughout high school. They also demonstrate an increased inclination to attend college. Researchers could track their pathways, separating immigrant-born and US-born Black doctors to determine if there are other reasons why they are successfully persevering through medical training. Additionally, there were six male and nine female participants. Additional research could include a deeper dive into the unique experiences of the intersectionality of Black women physicians and the microaggressions they encounter.

Quantitative studies could also examine how institutional policy changes—such as holistic review or anti-racism training—impact URM student success. Additionally, it would be useful to explore differences in experiences between those who attended historically Black colleges and universities (HBCUs) and those who trained at predominantly white institutions. Given the supportive campus cultures of HBCUs, such a comparison could yield valuable insights into best practices for supporting Black medical students.

Overall, the study emphasizes that institutions must move beyond superficial diversity efforts and take intentional, systemic steps to dismantle the structural barriers that Black medical students face. This includes embedding a strengths-based approach at every level of the educational system, from pre-med programs and pipeline initiatives to admissions, curriculum development, clinical training, and faculty evaluation. Black physicians must be given not only a voice but also power in shaping the systems that govern medical education. The work of inclusion, anti-racism, and equity must be a shared responsibility among all educators, administrators, and students—not just those from underrepresented backgrounds. If institutions are willing to engage in honest reflection and sustained action, the pathway to medical school for Black students can be made more accessible, affirming, and ultimately, transformative.

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