

# Does Becoming a Professional Mean I Have to Become White?

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This study examined the experiences of nine American Indian and Alaska Native (AI/AN) students in medical school with the purpose of gaining information about how to support students once they enrolled in medical school. In-depth interviews conducted while the participants were in medical school were used to generate data that were analyzed using grounded theory. How students reacted to professional socialization emerged as a key element in understanding their experiences. The study found that participants demonstrated resistance to the professional socialization process, which they resolved by accepting their roles as physician on their own terms.

## NEED FOR ROLE MODELS

**S**tories of American Indian and Alaska Native failure in school continue to concern educators (Meyers, 1996; Pavel & Padilla, 1993; Swisher & Hoisch, 1992). Of Associate degrees granted in the United States, 85.2% go to Whites; only six tenths of one percent (.6%) go to American Indian/Alaska Native students (National Center for Education Statistics [NCES], 2002, Table 265). Of bachelor's degrees, 77.5% go to White students; .7% go to American Indian/Alaska Native students (NCES, 2002, Table 268).<sup>1</sup>

High drop-out rates have depleted the numbers of American Indian and Alaska Native students who can move on into the professions. Eighty-two percent of college faculty are White, while four tenths of one percent (.4%) of college faculty are American Indian/Alaska Native (NCES, 2001, Table 229). American Indians are even more sparsely represented in the medical profession. Of physicians in the United States, only .03% are American Indian or Alaska Native (Randolph, 1997). To achieve parity, there would have to be 27 times more American Indian and Alaska Native physicians in the United States. To succeed in the professions, American Indian and Alaska Native students would be well served by successful American Indian and Alaska Native role models (Cross, 1991). This study focuses on stories of successful American Indian medical students.

Participants voiced the concern that becoming professional might mean relinquishing their American Indian identities. This study explores how students resisted professional socialization and eventually resolved that conflict.

## Perspectives on Learning

While there are limited studies of professional socialization of American Indian/Alaska Native people, these few studies have provided some insights into the nature and quality of their learning experiences. In 1989, Swisher and Deyhle examined the ways children “learn to learn” in various cultures and noted:

People perceive the world in different ways, learn about the world in different ways, and demonstrate what they have learned in different ways. The approach to learning and the demonstration of what one has learned is influenced by the values, norms, and socialization practices of the culture in which the individual has been enculturated. (p. 2)

Swisher’s and Deyhle’s insight helps us understand that American Indian and Alaska Native medical students may perceive the world of learning in a way that is grounded in their cultures—a way that may differ from the world of learning of mainstream medical students.

Cajete (2000) explored how indigenous cultures might influence peoples’ understanding of science. He noted that interconnectedness with the natural world is a foundational understanding in many indigenous communities. He wrote, “Human beings have an instinctual understanding and need for affiliation with other things” (p. 99). His insight raises the possibility that interconnectedness might be important to American Indian and Alaska Native medical students’ understanding of medical science.

## Women of Color in Medicine

Lori Arviso Alvord successfully navigated medical school and became the first Navajo woman surgeon. She wrote with empathy for other Navajo children who face the decision whether “to leave the rez, or to stay and cleave to traditional ways. To let the desert live inside them, or to try to wash it away” (Alvord & Van Pelt, 1999, p. 24). In the end, she found that despite her choice to become a surgeon, the desert lived on inside her. Her experience raises a question: *Is medical education an experience in assimilation for American Indian and Alaska Native students?*

Dawson (1999) examined surgical residency from the perspective of an African American woman. She explored the impact of stress when residents are immersed in the medical training environment and asserted, “A corollary of immersion is distancing—denial, or emotional blocking. This is the process by which residents separate themselves from their own emotional experiences” (p. 91).

Dawson (1999) concurred with Notman and Nadelson (1973), who wrote, “All medical students share a common goal—to develop an identity as a physician” (Notman & Nadelson, 1973). Dawson’s observation poses the question for this study: *Do American Indian and Alaska Native medical students share that common goal to develop an identity as a physician?*

This study was designed to examine the experiences of American Indian/Alaska Native medical students for clues about how to support them once they enrolled in medical school. It was hoped that increasing the numbers of successful American Indian/Alaska Native professionals would, in turn, provide role models for future students.

### **Method**

Initial data were generated in open-ended interviews with nine volunteers, each of whom were recipients of Indian Health Service (IHS) scholarships and, therefore, were affiliated with federally recognized tribes or Alaska Native villages.<sup>2</sup> The volunteers were currently pursuing an MD at a major West Coast medical school. Interviews included the following questions:

- What motivated you to train for a career in medicine?
- In what ways is medical school working for you?
- In what ways has medical school been challenging for you?
- What keeps you going?
- To what extent do you feel your training prepares you to work with the population you wish to serve?

Interviews were recorded and transcribed. Then they were analyzed using grounded theory (Strauss & Corbin, 1998). As analysis progressed, further questions were usually generated, resulting in a need to interview most participants more than once. As the data were analyzed, categories of factors that influenced student experiences emerged. Categories were named using the participants' own words.

The categories were verified by testing them on five of the nine participants, who were asked if the categories described their experiences in medical school. In one case, a participant did not agree with a category that was meant to describe an influence on her experience. That category name was discarded and a name was substituted that was more meaningful to the respondent.

To establish the credibility of the findings, strategies recommended by Lincoln and Guba (1985) were used. Students were observed in social, ceremonial, and training settings. Key people were interviewed to triangulate the data, including a physician and a traditional healer, each of whom worked with the students during their clerkships.

The students were at various levels of their four-year program. Two of the participants asked not to be quoted in any publications, so there is no direct reference to them here. One of the participants, Kahlia, was in her first year when the study began. The study continued to track her over the ensuing four years. At the date of publication, the student is in her final year of medical school. She was interviewed seven times.

## Results

As students talked about medical school, they described factors that influenced their experiences. Six categories of influences emerged from analysis of their interviews:

- Mechanics of medicine
- I have a family.
- I have a community.
- Fitting into medicine
- Healing
- Patients touch you.

“Mechanics of medicine” was a phrase one participant used to refer to the healing strategies medical students were taught and the ways in which they were taught those strategies. “I have a family” and “I have a community” were two closely related categories that included the influences of family and community on the students, particularly for those students who had come from reservations, family and community tended to overlap. “Fitting into medicine” included ways in which students were initiated into the medical profession and how they felt about that process. “Healing” included cultural influences that shaped how the medical students understood healing. “Patients touch you” were those ways in which the students were influenced by their patients. Space does not permit a complete description of each category. This paper focuses on the professional socialization of the medical students and on those categories that particularly influenced that process.

### Mechanics of Medicine

At the time of this study, the medical school program consisted of two years of coursework followed by two years of rotating through a series of field practica. In response to four of the interview questions, participants described their experiences in that program.

The question, “To what extent do you feel your training prepares you to work with the population you wish to serve?” prompted uniformly positive responses. Responses to the questions, “In what ways is medical school working for you?” and “In what ways has medical school been challenging for you?” tended to focus on challenges. One student commented on the amount of material they were expected to master in their first two years of coursework. He said, “It’s like trying to drink out of a fire hydrant.” Other students in the first two years of medical school agreed. A soft spoken student, who asked to be called “Jessica,” said, “The first two years are hell and every day I would wake up and wonder, ‘Now, will somebody please remind me why I’m doing this?’”

Over the course of the ensuing three years, all but one of the participants successfully navigated medical school, despite its challenges. One successful

student, who chose the name “Sievert” for the study, was in his clerkship years when he commented, “In medicine, every single day, every single hour you’re proving that you either know something or you don’t. We make mistakes; we feel dumb.”

The academic rigor of the coursework and the demands of the clerkships created challenges with which the participants coped in a variety of ways. In response to the interview question, “What keeps you going?” Sievert said, “I blow off steam. I like to go out with my friends and try to act like I’m not a medical student once in awhile.”

Roger, who earned honors in his program, referred to the sometimes abusive behavior of tired residents and overwrought attending physicians during his first year of clerkship. He shared how he coped:

There’s this thing called the High Plains Buckin’ Horse sale. It’s like a big bunch of cowboys getting drunk, but it’s actually . . . where they sell rodeo stock, and cowboys from all over ride. I mean a lot of them aren’t professional cowboys; they’re working cowboys on ranches and they just ride these buckin’ horses out and half of them are loaded. People party a lot for the weekend and they auction these buckin’ horses off to these rodeo brokers. . . . This is the biggest [rodeo auction] in the country.

You can get in a lot of trouble there, especially if you’re a smart-ass doctor or something. Any rate, one of the ways that I deal with residents and attendings who are just way too pompous for me is, first of all, I know that they truly have no power over me. You know, they can’t do anything to destroy me, because I know in my heart that I don’t need to be pompous to prove my self-worth and they do. And secondly, I sometimes imagine them pullin’ that off in the Bison Bar in High Plains City in the middle of the Buckin’ Horse Sale and just imagine them gettin’ the s--t beat out of them.

Roger’s imagination helped him cope with irritable residents and attending physicians. He demonstrated the steely determination he employed to complete medical school in another story:

It was the summer and fall of—how old was I? Thirteen? Thirteen. We lived in a camper trailer for about a month and then we moved into this shell of a house—we had to pound a piece of plywood up for the door and had that paperboard sheeting; no insulation; holes in the floor; wood stove. In the winter on the high plains, it was damned cold. We lived like that for a couple years. That’s one of the reasons I can say that there’s no spoiled, smart-assed, silver-spooned, arrogant attending physician that will ever beat me down, because they don’t have the tools.

Roger finished medical school the following year with a stellar academic record and was matched for his residency in a remote hospital on the plains. At this writing, he is just finishing his residency, where he has been delivering excellent medical care in a rural setting.

Jessica’s reply to the question of how she coped was much shorter. She said simply, “The biggest support is my family.” Jessica was not alone. Family was an important influence in the experience of many of the participants.

## I Have a Family; I Have a Community

Interestingly, the studies already cited on dominant culture medical school students did not mention family, except as a passing reference to family support. Their research focused on student relationships with faculty and with each other. In *Boys in White*, a study of a major West Coast medical school, Becker, Geer, Hughes, and Strauss (1961/1997) described the medical school experience as so all-encompassing that students had little time for relationships outside of medical school. In this study, the dominant culture students they studied responded by creating a medical school subculture.

No protocol questions in this study asked about family or community; nonetheless, every participant talked about both. In some cases, talk about family was triggered by the question, "What motivated you to train for a career in medicine?" Jessica answered,

My family has been plagued with serious and terminal illnesses. . . . Seeing people that I loved suffer. . . . I thought [medicine] would give me more insight into what the problems were.

For Kahlia, who was in her first year of medical school when the study began, her children were a motivator. She responded, "My children are pretty compelling reasons to go to medical school."

In order to have adequate time for her children, Kahlia expanded her four years of study and took five years to complete her program. As of this writing, she is in her fifth and final year. For part of that time, she was a single mother. For Kahlia, there was a relationship between her children and her medical studies. Referring to her tribal traditions, she said, "Women in our culture don't become healers until after child-rearing."

Family was both a strong motive for becoming a physician and an obstacle to success in medical school. Sievert was unmarried and not closely tied to his home community. He realized that was an asset in medical school. "It's easier," he said, "for me to make choices; I don't have a family to worry about."

John was one of the participants who voiced a concern for balance between medical school and his home life, "I need time on my own, and time with my wife." He later added that, given a choice, "I'd pick my wife and my family over med school without even thinking about it."

John had experienced a time when he was not included in an American Indian or Alaska Native community. He had been adopted. When he returned to the community from which he and his adoptive family believed he had come, he found that the community was responsive:

Everybody in the community was just kind of rackin' their brains trying to figure out what family I was related to. I'd walk around town and high school kids or elders would say, "Hey, come here. Where you from?"

I'd say, "Well, I'm a student workin' in the clinic for a week."

They'd say, "O-oh, you're the one." So, I think that was—feeling comfortable.

John resolved his experience by concluding, “If I wasn’t adopted, maybe I wouldn’t be in the position I’m in to go back to my community or another Native community.”

For one student, attachment to family was so strong, and her family lived at such a distance from medical school, that her academic standing suffered. She eventually was dropped from the program. (She asked to be called “Lena” in this study.) Lena described her identity in terms of her family and community:

I guess it’s hard for me to think of myself just as myself. I see myself only in the context of my family and our community and our beliefs and our life. I don’t know. I guess I don’t know how much I mean as a person just plain. It’s like, I don’t even know how to stretch and talk about that.

Lena was eager to be a physician because she believed that her community would receive better care from American Indian physicians than from non-Indian physicians. Her goal was thwarted by community pressures to continue to fulfill her ceremonial duties while in medical school. Eventually, it became impossible to do both.

For some participants, attachment to family and community was a factor in their resistance to professional socialization. They had strong family/community identity and did not want to be pulled away.

### **Fitting Into Medicine**

Participants were cognizant of their own socialization and commented insightfully on the process. They experienced a pressure to “fit” into the profession, as Kahlia termed it. Medicine was not Kahlia’s first career. She had been a successful freelance photographer before moving with her children to a new city to begin medical school.

Sievert, although a few years older than some medical students, had chosen medicine earlier in his own life than had Kahlia. In his final year of medical school, he related a clear idea of what becoming a physician meant to him:

Medicine is not just a job. It’s a profession. It’s a way of life that you choose to live. When you get called in the middle of the night, if you’re a family physician and somebody’s having a baby, that’s the biggest event in those people’s lives. Even though you’ve done it for the last four nights in a row and you’d rather not be going to the hospital, as a physician, you have those kinds of responsibilities to your patients. That’s what it means to be a physician rather than just a medical person.

Sievert had come to identify as a physician: he had become comfortably socialized into the profession. Roger, who had indicated that he was comfortable in the midst of the buckin’ horse sale, had analyzed the professional socialization process. He said he first became aware of it when an instructor told his class,

Most people don’t look at the world the way you’re going to look at it after you’re done with medical school. And if you think that you’re not being shaped and even warped, in some ways, then you’re very naïve.

In his third year of medical school, Roger agreed, “Medical school is—not mind-warping, but certainly a perspective-altering experience.” He added,

We’re really being indoctrinated into a way of thinking about the world—a way of approaching problems; approaching people; people’s bodies; people’s minds—that’s not necessarily well accepted throughout society.

Roger’s claim that “no . . . arrogant attending physician will ever beat me down” suggested that, much as he wanted to be a doctor, he drew the line at compromising his integrity. Nonetheless, he understood the function professional socialization served. Roger argued that professionalization was necessary because students would become better physicians if they could examine people and problems as physicians did. He said, “You just look at people differently,” and elucidated:

I had a friend who was just talking to me about exercise and how she had been getting tired and I said, “I think you’re anemic and I think you need to take some iron.” It was just a random thing. . . . I didn’t just see my friend, I saw her pale lips and her pale nails and, you know, that her tongue wasn’t very red.

A month later, Roger saw his friend looking ruddy and able to run twice as far as before. “You know, you guys are really good,” she said, talking about medical students, “And you guys just think differently from other people.”

Roger had noticed, as Swisher and Deyhle’s (1989) research had pointed out, that people perceive the world in different ways depending on their culture and, like Becker et al. (1961/1997), he understood that he was being socialized into a culture. He believed that looking at people as physicians did serve a powerful purpose:

The way we look at the world is unique. And it’s *powerful*, too, because we’ve been able to . . . help people live through crises. I’ve had three or four patients in just the last six weeks that I swore were dead when I walked in the door—that we were just going to help them die. They walked out of the hospital three weeks later. It’s incredible: We can help people’s bodies get through a crisis of infection or trauma . . . then the body can heal itself.

Roger’s passion for the healing power of his profession convinced him that the purpose of professional socialization was valid. He watched as he and his colleagues were admitted into an inner circle as they began to share physicians’ experiences:

If you have gone through this training of having to save somebody’s life because they’re having a cardiac arrest at 2:00 a.m. after you’ve been up for all day and worked all day and seen patients all day—it’s actually life-forming. It’s an indelible experience on your life—on your psyche. Unless you’ve been through that . . . you can’t really understand. We give up trying to talk to anybody about it. We can talk to each other.

The profession claimed Roger. For him, others were, to some extent, outsiders. But Roger was a complex person who was more than physician. He understood there were trade-offs:



If you totally focus on medical school, you really become an inhuman machine. Medical school is—I'm going to say this, and I don't mean it to be derogatory as it sounds—but it's an extremely dehumanizing experience.

One of the things he did to keep himself from becoming a medical machine was to ride a motorcycle. He described a ride:

You can never be as cold as when you are cold on a motorcycle and you can never be as hot, but you can never travel and smell smells like you can on a motorcycle. . . . You go up a mountain and it feels warmer and you can tell you're near a river at night before you ever get there, because it's cooler. And, you know, you can smell deer, if there are a lot of them or if it's that time of year and you're in Eastern Montana. . . . The wind almost just washes life away from you. It blows. It cleans you out.

Roger experienced a tension between becoming a physician and honoring his own integrity. By riding a motorcycle, he saved some of himself for himself.

Jessica did not feel she was giving up some of herself to become a physician. For her, the tension in professional socialization was between her culture and the culture of medicine. She said:

This type of training . . . is not in our nature. Culturally, we are taught to listen and not ask too many questions. For some of us, direct eye contact is disrespectful. We are a quiet, yet thoughtful people. This has been the hardest part for me. I often don't have questions because I listen intently and generally understand the information or may need time to digest and can come up with questions later. This often comes across as a lack of interest or lack of intelligence.

Jessica's customary behaviors conveyed different meanings in medical school than in her home community. She had to learn new cultural cues to fit into medical school.

Kahlia was initially less critical of the professional socialization process. She came to the medical profession in her 30s and confided:

My most profound learning, to date, in my life has been learning that I needed to be a healer. Part of the issue was . . . I just never thought of myself as being good enough. It took me a real long time to accept the fact that I didn't have a choice. Whether or not I was good enough was irrelevant. That was my path.

After shifting to medicine from a degree in fine arts, Kahlia faced academic challenges. By the time she had reached her third year—the level at which Roger had analyzed the process—she was still determined to become a physician, but disappointed with the process of getting there. She had realized from the start that her greatest strengths were in working with patients, so she had eagerly anticipated her clinical experiences, hoping that at last she would perform well:

I've changed a lot since starting medical school. I lived for the day when there would be validity in my patient skills. I thought I would enjoy my third year, since I would have contact with the patients, but it has been tough. I had the delusion that my psycho-social skill would be worth something. It

ain't worth diddly squat. In medical school, they tell you that patient care is important, but on rotation one preceptor told me to watch out for evaluations that say you have good patient skills. He said, "People will read that and think you're just blowing hot air." I've been told my patient skills are stellar, but that's not worth a whole lot. The validity is on the gunners—the people with the strong differential diagnoses.

Kahlia was disappointed with what she saw as hypocrisy about patient care and sorry that she was not getting credit for her strengths. Looking at different fields of medicine as an outsider, she differentiated the socialization process as follows:

There's a persona—different disciplines acquire different personalities. In internal medicine they impress each other with complicated differential diagnoses. One of the medical students calls it "mental masturbation." They even look alike. They're all tall; they wear glasses; they're blond.

In surgery, the hierarchy is the thing. It's all about machismo. There's no team work. They're abusive to each other. I'm a team player. I'm into having a good time. The reality is they forget the patient is a person. When they're finished talking and impressing each other, you have to answer: "Will the patient take it?" and "Can they afford it?"

Kahlia disdained the pressure to become like other physicians when they failed to deal with pragmatic realities. "I don't want to play that game," she said, referring to the posturing that fostered one's career. Her vehemence belied the fact that she had begun to find fields in which she did fit. "Psychiatry loved me," she admitted. She had begun medical school with a determination to go into family practice with obstetrics and her determination had not flagged. She added, "OB-GYN loved me—loved my personality."

She had heard harsh criticism and she had met with little support, but she processed the criticism and realized that she did need to work on her differential diagnoses—her ability to think of all the alternatives that might explain a patient's symptoms. In her desire to improve, she decried evaluations she had received that were too imprecise for her to understand what was wrong with her work:

"Needs to improve knowledge base"—what does that mean? Knowledge base improves with time. Does that mean I have an average knowledge base for a fourth-year student and need to improve to be qualified for residency? Or does it mean I'm not up to standard? My scores on a scale of one to ten have varied from one to six depending on the evaluator. Why the inconsistency? I want feedback I can use—that I can incorporate into my training.

Like Jessica, Kahlia came to understand that she did not learn in the way that the other medical students learned. Commenting on the way she learned, she said:

I need a lot of patient contact. One attending talked about a program in which we would be in a clinic once a week throughout our program. I need that contact, so I can get to know the patients and their symptoms and start to see patterns.

Even though positive feedback was scarce, Kahlia gave herself credit for her own strengths:

Being able to get the story is the hard part. One case presented like drug abuse. The man looked homeless, but he said, "I have a home; I don't use drugs." He would not admit to substance abuse. Three people talked to him: the attending, the resident, and one intern. Nobody could get his story. I walked in and in five minutes he admitted, "I'm addicted to methamphetamines." Just a little med student and he spilled his guts.

I said, "I'm not here to judge you, but we have a treatment program if you're ready for it."

Four years before, Kahlia had promised herself she would deal with patients that way. She said,

I would have been a lousy doctor at 28. I had no sense of empathy—no sense of why people choose to abuse substances. I would have said, "Well, just can't get your s--t together!" You know, "Get a grip!" Well, I was just clueless. I fought for everything I ever got and I couldn't understand why other people couldn't fight. And then, through my late 20s and early 30s, I got beat up by society. Now . . . I can look at people and say, "Let's just move on. You have this problem. Try and deal with it in the best way you can." I'm not judgmental. This is a problem they have and we need to work on it together.

Kahlia had met a substance abuser in a clinic and treated him with the dignity she had promised herself when she started medical school.

### **Conclusion**

This study suggests some strategies for supporting American Indian and Alaska Natives in medical school. Jessica and Kahlia each indicated that the ways in which they learned were different from dominant culture medical students, which confirms that Swisher and Deyhle's (1989) insight that people learn about the world in different ways is true in medical school just as it is in elementary school.

The question for students, educators, and administrators is whether medical school accommodates diverse ways of learning that are generated by different cultures. Kahlia's concern for feedback that she could use to improve her practice could be met with more precise assessment tools. A more precise tool could streamline the time residents and attending physicians use in evaluation. It would outline categories of the skills medical students demonstrate briefly and with clarity.

The participants were conscious of the professional socialization process and, in some ways, resisted it, but they resolved many of their concerns by claiming their new identities in their own ways; that finding conflicts with Notman and Nadelson (1973), who claimed that all medical students want to develop an identity as a physician. These participants wanted to practice medicine. They did not necessarily want to develop an identity as a physician. Sievert demonstrated that he shared the goal of identifying as a physician, but Kahlia resisted identifying with other physicians unless that identity could be achieved

on her own terms. "I don't want to play that game," she stated. These results were not consistent with Broadhead (1983), Becker et al. (1961/1997), and Haas and Shaffir (1987) who concluded that medical students do eventually align themselves with the subculture of their profession.

American Indian and Alaska Native medical students were reluctant to relinquish their own identities in order to adopt a subculture that was grounded in the dominant culture. In effect, they drew the line when professional socialization came to resemble assimilation. Would it be possible for medical school to become more sensitive to cultures outside the dominant culture? If that were possible, then it would serve two purposes. The process of moving from resistance to acceptance of a professional identity might be eased for students. Furthermore, a culturally sensitive medical profession might be able to offer more culturally appropriate medical care to patients.

Family and community were very important to these participants. The expectation that medical school will be the focus of the lives of the students who are engaged in becoming physicians has a long tradition. Is it possible for medical school to shift to accommodate people who are determined to maintain healthy relationships with their families?

Dawson (1999) described how residents coped with stress by distancing themselves emotionally. Roger had referred to pompous residents; Kahlia had bemoaned a lack of respect for patient skills. Perhaps they were observing the blocking phenomenon Dawson described. Roger's and Kahlia's statements suggest that residents distance themselves from medical students as well as from patients. An environment that placed less stress on residents might serve the dual purpose of improving patient care and improving the learning environment for medical students.

Roger's final advice in our last interview was, "Tell Native people not to sell themselves short." The participants in this story have modeled American Indian and Alaska Native success. Roger described a childhood of poverty. Surviving that experience gave him confidence that strengthened his resolve in medical school. The medical students in this study found ways to become physicians that were consistent with whom they were when they started the process. They did not have to become White to become doctors.

This article has not revealed the tribal affiliation of the participants. There are so few American Indian and Alaska Native physicians that to do so would be to compromise their confidentiality. This ambiguity may lead you to wonder the next time you see an American Indian or Alaska Native physician, "Could this be Roger, whose comfort with a bucking horse auction belies his complex intellect?" Perhaps the photography in the outer office makes you wonder if it could be Kahlia, whose devotion to medicine is matched only by her love for her children. Or maybe it's Sievert, who cares so much about the birth of your baby, he's willing to pry himself out of a sound sleep. These people could be your physicians.

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### Endnotes

<sup>1</sup>We have grown so accustomed to hearing bad news that sometimes we overlook the good. While .7% of bachelors degrees granted to American Indian/Alaska Native students may sound small, that is nearly twice the proportion granted in 1976–77 when .4% of bachelor's degrees went to American Indian/Alaska Native students (NCES, 2002, Table 268.) Seven tenths of one percent (.7%) of first professional degrees that are granted go to American Indians and Alaska Natives—an increase from .3% in 1976–77 (NCES, 2002, Table 277). Since the American Indian population is .8% of the national population, both figures are almost at parity.

<sup>2</sup>I am unable to reveal from which nations the medical students came, because there are very few American Indian and Alaska Native medical students. As a result of their small numbers, stating their tribal affiliation could result in a breach of confidentiality.

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