Self-Reflection in Multicultural Training: Be Careful What You Ask For

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Abstract

Self-reflection in multicultural education is an important means to develop self-awareness and ultimately to change professional behavior in favor of more equitable health care to diverse populations. As conceptualized by scholars in the field of psychology, racial identity theory is critical to understanding and planning for the potentially wide range of predictable reactions to provocative activities, including those negative reactions that do not necessarily herald a flaw in programming. Careful consideration of racial identity developmental phases can also assist program planners to optimally meet the needs of individual physician trainees in their ongoing constructive professional and personal development, and in strategically mobilizing and having ready the type of institutional leadership that supports trainees' change processes.

The authors focus on white physician trainees, the largest racial group of U.S. physicians and medical students. They first explain what they mean by the terms *white* and *nonwhite*. Racial identity theory is then applied, with true case examples, to explore such issues as where the self-proclaimed "color-blind" trainee fits into this theoretical schema, and how medical educators can best serve trainees who are resistant or indifferent to discussions of racism in medicine and equity in health care delivery. Ultimately, the authors' goal is to demonstrate that engendering genuine self-reflection can substantively improve the delivery of health care to the nation's diverse population. To help achieve that goal, they emphasize what to anticipate in effecting optimal trainee education and how to create an institutional climate supportive of individual change.

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Physician training goals should include a focus on minimizing bias to reduce racial/ethnic disparities in health status and the health care experience.[1–6] *Self-reflection* is an activity used in several training models to accomplish this goal.[3,6–13] From our perspective, *self-reflection* is cultivated when trainees are given the opportunity to cognitively and emotionally process—*to reflect on*—the social, cultural, and personal meanings of events and life experiences. This definition of self-reflection is based on the premise that all individuals have consciously or subconsciously incorporated or rejected specific life values, reflex thought patterns, and relational styles. Skillfully engendered self-reflection helps physicians and physician trainees delineate and bring to a conscious (and thus intervenable) cognitive space the multiple contexts and life roles, past and present, that influence their learning and their personal and professional behavior.[3,6–13]

Little attention has been given to what learners, educators, and organizations should anticipate in attempts to engender self-reflection in multicultural medical education. Failure to anticipate the wide spectrum of reactions to multicultural education activities could potentially compromise the success of training initiatives.[5,6,9,12] The following discussion is informed both by a multidisciplinary literature and also by our extensive experiences in small- and large-group venues, exploring cultural issues in medical practice and training. The true case examples presented in this article were crafted from our experiences as well. We apply racial identity theory to argue that engendering genuine self-reflection can substantively improve the delivery of health care to the nation's diverse population, emphasizing what to anticipate in effecting optimal trainee education and how to create an institutional climate supportive of individual change.

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Planning for the Predictable

Case #1: Anticipating Backlash

> A group of medical school curriculum planners presented a highly acclaimed, provocative "unlearning racism" video in a quarter-long first year "doctoring" course. This was the only session devoted to multicultural issues. To facilitate self-reflection, small-group discussions followed the video presentation. In the postsession evaluation, and in the informal feedback received in the days that followed, many of the students strongly objected to the session, perceiving it to be "divisive" and "an attack on Whites." Other students expressed their eagerness for additional multicultural training, which they felt was conspicuously lacking in the current curriculum. Program planners were quite disappointed and perplexed by the spectrum of responses and especially by the degree of resistance to their honest attempts at engendering self-reflection on racial issues in the practice of medicine.

In their efforts to promote self-reflection, could the program planners have

anticipated the wide range of trainee responses to this instructional session? Racial identity development theory (RIDT) predicts this variability in trainee response, and can be used to assist program planners in establishing resources and follow-up activities for individual trainees at specific developmental levels.[14–21] RIDT also makes imperative an administrative and institutional support system that minimizes trainees' resistance to individual and institutional change, and maximizes and sustains trainees' development towards providing unbiased, culturally respectful, effective patient care.[3,10]

Racial Identity Development Theory

Scholars in counseling psychology are substantially ahead of medical educators in formulating and testing conceptual maps, including the whys, hows, and what-ifs pertaining to self-reflection in practitioner training.[10,14,17–21] They recognize that trainees of all racial/ethnic backgrounds are at varying levels of "readiness for the assimilation"[18, p. 77] of instruction on bias and unlearning racism.

These scholars highlight the centrality of RIDT to one's education and clinical practice in cross-cultural encounters.[14,16,17–21] In fact, Sabnani and colleagues[18] state that the "single most significant advancement in cross-cultural counseling practice and research in the last decade centers on the salience of both the client's *and* the counselor's racial identity development to the cross-cultural encounter."[18, p. 76] [Sabnani et al.'s emphasis.]

Tatum defines racial identity development as "the process of defining for oneself the personal significance and social meaning of belonging to a particular racial group."[18, p. 16] Other dimensions of the literature on RIDT highlight the distinctiveness of this process based on group differences in power, including the allocation of resources, and in majority and minority status.[15–17,19,21,22] RIDT also encompasses how and to what extent an individual comes to identify with a racial group based on a common cultural heritage or sociopolitical history. Further, RIDT includes the process through which an individual comes to function or dysfunction psychologically to maintain a cohesive, positive sense of self within a social hierarchy that is critically important for one's status and life chances in society, but to some extent beyond one's control.[14,19,23,24] Finally, racial identity development occurs as an ongoing, albeit often subconscious, psychological task throughout one's life.[19–21]

For three reasons, in this article we have limited our discussion to the implications of RIDT for white practitioners and trainees only. First, as mentioned, whites make up the largest proportion of physicians and medical students in the United States.[25–28] Second, presenting the RIDT of both white and *minority** physician trainees would make this discussion unavoidably lengthy when neither of these broad categories should receive short shrift. Both discussions are certainly critical for optimizing the multicultural training of all physicians.

The third and perhaps most important reason to focus here on the white trainee has to do with the meaning of *whiteness* as a well-delineated social concept.[19,22,23,29–33] Indeed, whiteness as a social construction and reality has very real and profound, daily implications for how all individuals conduct themselves within the multifaceted experience of wellness and illness in the U.S. health experience, be it as sick patients, well patients, clinicians, researchers, hospital staff, or others.[1,2,15,26–28,34–43] Appreciating the differing sociopolitical experiences of minority peoples in the United States, many scholars describe a general process of racial identity development that is shared by the U.S. minority, or persons of color, and a *separate* process shared by whites.[14,15,18–21] While U.S. medicine is most familiar with the study and researching of minority populations, for decades, many scholars in fields such as psychology, sociology, history, and women's studies have detailed this U.S. social phenomenon of whiteness as an entity that also needs to be studied and deconstructed.[19,22,23,29–33]

Admittedly, this is a novel and perhaps controversial concept for many medical educators. And this is not to say that there is a monolithic "white" U.S. experience, or that the experiences of the Irish American, the Portuguese American, or others are not distinct ethnically.[22,31,44] However, like a fish pondering the invisible water in which it swims, it is challenging but necessary to intellectually grasp how the ubiquitous nature of a "white" U.S. identity holds profound health status, institutional, and relational implications for us in medicine. In fact, the dominant aspect of white America is faithfully reproduced as an organizing and stratifying concept within the dysfunctional racial hierarchy that defines certain other realms of the U.S. experience (i.e., housing segregation and inequalities in educational achievement, employment opportunities, and economic status).

Finally, we specifically refer to *racial* and not *ethnic* identity development for the historical and current significance of race, again, as an organizing social concept in U.S. life. For instance, the police officer is not accused of ethnic profiling in unfairly targeting black men, even though the ethnicities of these targeted men may be Nigerian, or fifth-generation African American from South Carolina, or Puerto Rican, et cetera. Rather, it is *race*, the phenotype that has come to have social meaning and often subconscious significance in our society, that triggers our attitudes and behaviors. It is recognized that, in the earlier part of the 20th century, the British worker was favored over the Irish worker, who was favored over the Italian or Greek worker in the U.S. labor market, and so on down the line in the historical ethnic hierarchy of the labor market. Still, today, when any of these white ethnics step into a room, it can have different meaning for the employment consequences and relational experiences of the person identified as being of the Asian race, for example, whether that latter person is Korean, Japanese, or from another Asian group.[23,27,28,35,44,45] These racial consequences are in fact consistent with an abundance of hard data from the medical literature, currently defining a national initiative to eliminate racial disparities in health status and in

*The word *minority* is deliberately used here as a term that connotes the power imbalances and lesser social status experienced by people of color as "minor" citizens over the entirety of this country's history.[22,23,44–46] It is not used in a numerical sense, since whites no longer represent the numerical majority in many cities where resident physicians and medical students train.

clinical encounters and resource allocation.[1,2,27,28,36–43]

The notions of *whiteness* and *race versus ethnicity* are complex and fascinating concepts whose full discussion is beyond the scope of this article. We hope they soon find a more prominent place in the discourse concerning multicultural medical education and the elimination of health disparities. For now, it is most important that the reader appreciate that we are sensitive to the complexity of these social concepts and terms before we move on to the discussion of self-reflection in the context of white racial identity development.

White Racial Identity Development: Implications for Multicultural Training

Social scientists have postulated that trainees at different stages of their racial identity development will be "differentially primed"[18, p. 84] and thus react differently to multicultural training experiences.[14,17–19] Thus, it is critical that educators be aware of *the variety of developmental stages that can coexist within a single audience*, such as among the individuals of a medical school class or residency program. Appreciating this schema allows educators to anticipate, to forewarn others, and to develop a plan to manage the range of predictable reactions, such as those that occurred in Case #1. In fact, the potential for these reactions, including resistance and backlash, should be clearly articulated to organizational leaders, program staff, trainees, and other stakeholders *before the educational activity takes place.* This proactive and preemptive approach facilitates the program's progress, preventing it from being hamstrung by the misinterpretation of predictable emotions or by fear of the apparent premature failure of the program.[6,14,15,17]

In the description of white racial identity development (Figure 1) adapted from Sabnani and others,[14,15,17–19] the developmental stages are not numbered, so as to emphasize that the following process is not necessarily linear.[14,19,20]

The preencounter, or precontact, stage

The *preencounter,* or *precontact,* stage, described by Sabnani et al.[18] is labeled by Dreachslin[15] as simply *naiveté.* This stage characterizes the self-ascribed "colorblind" white individual, who professes that color does not matter in his or her perceptions of and interactions with people. It is possible that such an individual has not had occasion to think in a sustained and meaningful way about how the U.S. experience, and the experience of U.S. medicine, might differ in profound ways for those who are, for example, nonwhite, non-English-speaking, or in nontraditional families. The trainee in this stage may have trouble acknowledging how white, European-U.S. culture dominates U.S. medicine and its educational institutions, and that other individuals—nonwhite physicians, patients, and others—may do much work to fit in practically and/or emotionally with what such culture-bound interactions require of them.[15,34–36]

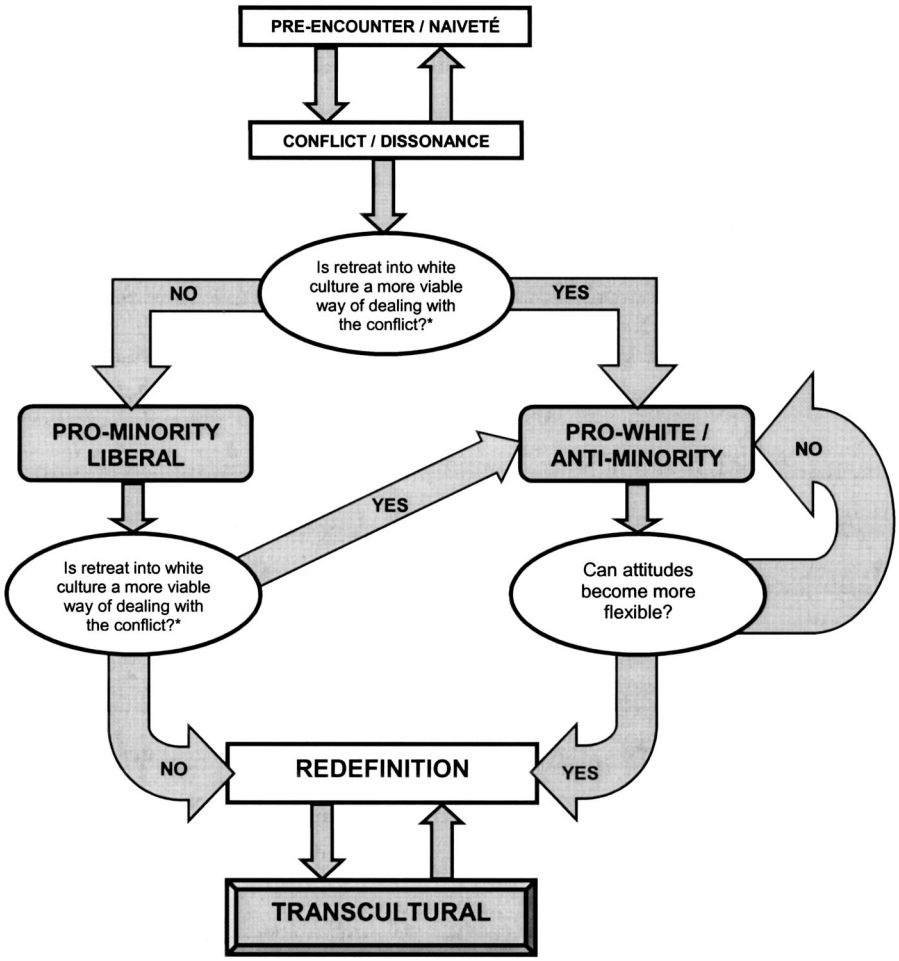

Figure 1 White racial identity development. The figure shows the process—not necessarily linear—of racial identity development that can, ideally, occur for white trainees. The process is dependent upon (1) the response of institutional leaders, including the public statement of new employment standards vis-à-vis culture and difference; (2) opportunities for sustained self-reflection; (3) opportunities for sustained cross-cultural dialogue; (4) the prevailing institutional ethos; (5) the presence of positive white role models; and (6) the clear articulation of the centrality of multiculturalism to excellent, effective doctoring. (Adapted from Sabnani H, Ponterotto J, et al. White racial identity development and cross-cultural counselor training: a stage model. Counsel Psychol. 1991;19:76–102, with permission.)

The preencounter trainee requires facts about suboptimal health status and health care allocation for people of color, and facts about differences in the measured quality of care for people of color. Such disparate measures of quality include patient satisfaction, access to services, physician communication, and other important components of the health care experience.[1,2,35–43] This trainee also needs current facts about the existence of racism and the ongoing patterns of exclusion in America, and how this can make the daily lives and health care encounters of whites different from those of nonwhites. The clearly

delineated clinical implications of continuing in a state of ignorance or naiveté should be discussed. The following case illustrates this principle.

Case #2: These Are Just Stories to Me

> Following a presentation on the impact of racism on the health and development of African-American children, a white male physician stated sincerely to the presenter, "I hear what you're saying, and believe that there is racism. But I can't quite shake the sense that these are just stories to me. They are so far removed from my own experience that I don't know how to act on this information." In response, the presenter communicated the story of an African-American mother who had, from her perspective, received a firm and disrespectful reprimand from a medical student and attending physician who were treating her son for an asthma exacerbation. Though this mother took meticulous care of her severely asthmatic son (e.g., no hospitalizations in over five years), she was alarmed and humiliated that these two young practitioners were so stern in their criticism of her decision to wait out the night to bring him in. The medical student also suspiciously eyed and asked the ten-year-old patient about a scar on his thorax, a scar obtained during the course of a PDA ligation performed when the patient was a mechanically ventilated premature infant. Was this a sign of previous physical abuse? He did not ask the mother about the scar, and apparently had not seen this piece of neonatal history in the patient's thick chart. The mother's past experience and learned distrust of this medical institution was so great, that for weeks after the encounter, her initial response to every phone call and every ring of her door bell was to think that Child Protective Services was coming to take her child away from her. She was a nervous wreck. On the other hand, when approached by the child's primary pediatrician, neither of the practitioners involved remembered the case as significant. The presenter suggested to the white physician, who was also a public health student, that it was surely worthwhile to develop a sensitivity whereby, ideally, he would at least recognize when he had engaged in such a cultural disconnect in communication—a disconnect that was unappreciated and quickly forgotten by the clinicians in this example, while holding profound, health-stealing implications for the mother, though ironically already forgotten by the clinicians. In a collegial manner, the presenter invited the preencounter trainee to seriously commit himself to an ongoing program of multicultural education to heighten his cultural sensitivity and thereby reduce the likelihood of similarly offending and harming his patients or their family members. He was reminded of his responsibility as a physician to "first, do no harm."

The conflict, or dissonance, stage

Any substantive exposure to the present-day reality of U.S. racism has the potential to catapult trainees into the white racial identity stage that Sabnani et al.[18] entitle *conflict* and Dreachslin and Hunt[15] term *dissonance*: Guilt, anger, anxiety, and other emotions may follow (1) the realization of racism and the systematic exclusion of people of color, and (2) the realization of the privilege white people experience in not having to daily acknowledge or prove the unjust exclusion faced by many people of color.[14,16,17,19]

Substantial psychic pain, loss, and instability can be engendered or uncovered when whites squarely face the reality of racism and the myth of U.S. meritocracy, the latter constituting an illusion perpetuated to explain the socioeconomic stratification of U.S. society.[13,14,16–18,22] This angst can be magnified as physicians and physician trainees simultaneously confront parallel, institutional case examples of unequal or disrespectful treatment delivered by their professional peers to disenfranchised patients and families.[13,14,17–19]

Ideally then, instructional encounters, whether in a large group or other setting, would be followed by safe arenas wherein trainees can explore the new realities they are being exposed to or that previously held latent or hidden sites in their subconscious minds. Small-group discussions in confidential and emotionally safe group environments can serve well the needs of trainees in the preencounter and/or conflict stages. As Pinderhughes states, "When it is safe to be vulnerable, to admit ignorance, and there is expectation that the information needed will be offered helpfully, people can learn from one another."[17, p. 104]

Alternately, conflict/dissonance white trainees who are confronted with the reality and sting of racism can deal with the sense of conflict by suppressing the experience or denying the validity of the facts presented, sometimes moving quickly from the conflict stage "back" to a functional preencounter stage. However, with an ongoing small-group experience, skillfully and compassionately facilitated, and ideally coupled with an institutional or peer culture that engenders dialogue, there can be sustained opportunity for trainees' self-exploration and self-reflection with an assurance that it would be both safe and productive to manage one's psychic pain. Trainees should not be allowed to continually hide behind the highly lauded facade of being a "colorblind" practitioner.[14,17,19]

Many U.S. whites do not see themselves as racial beings within a stratified social context, though they may readily view "minorities" as such.[11,13,17,29,33,44–46] Sociologist Troy Duster termed this lack of self-awareness, combined with the tradition of being the "studier" and not the "studied," as "the unexamined privilege of the unnamed."[47] Perhaps this is why it seems that the most common stage of white ethnic identity development from which trainees will offer vigorous resistance—even to the point of collectively mobilizing a backlash against a multicultural training initiative—is the conflict (or dissonance) stage.[15,18] (We have assumed here that group leaders are skilled facilitators who are nonconfrontational in their style and do not pit one racial or cultural group against another.)

It is imperative to recognize that comments such as, "This presentation was antiwhite," "I felt like you were white-male bashing," or "I am being attacked" may not reflect a low quality or poorly planned program activity. Rather, the instructional approach may have been so well-implemented and so exactly what trainees needed to become more culturally aware, respectful, and effective clinicians that many were moved from the preencounter (or naiveté) stage to the conflict stage. It is critical that program planners continually and with each session anticipate this *success,* and warn others, especially institutional leaders who support the multicultural initiative, that these dissenting comments will be forthcoming as an expected and planned-for result of the program. (Of course, there is no guarantee that such vigilance and prework will completely prevent some degree of institutional crisis, as a multicultural initiative is an invitation to challenge, on a basic level, the way an organization conducts "business as usual."[15])

Such preparation before the predictably provocative multicultural activity did not

happen in Case #1, and the voices of dissonance won the ear of the medical school dean and department administrators. It is perhaps more difficult to undo the damage of unanticipated but predictable backlash than it is to plan for it, to have in place constructive support for trainees' natural reactions, and to forewarn influential stakeholders. In fact, as Kai et al. astutely point out:

> a difficulty with evaluation in the context of learning to value diversity is that short-term evaluation of learners' experience may be negative. This is because of the potential emotional impact that occurs when participants' fundamental assumptions, attitudes and prejudices are challenged. . . . Equally, a short-term evaluation that is very positive may simply reflect a failure to challenge learners.[6, p. 622]

As illustrated in Figure 1, white trainees can move from the conflict stage to several different stages, dependent upon

- how well institutional leaders are prepared to respond with explicit support for the program and with serial, public, and clearly stated professional and employment standards of patient care that incorporate multicultural principles;
- what opportunities are available for trainees' sustained self-confrontation, and self-reflection;
- what opportunities are available for ongoing, substantive dialogue on racial or cultural difference;
- what the prevailing institutional ethos is that firmly validates or alternately delegitimizes efforts to provide improved, culturally respectful care;
- whether white role models are accessible as examples of the value and possibility of continually engaging in such courageous and sustained self-reflection and personal transformation; and
- how clearly and repeatedly program planners and institutional leaders articulate the centrality of this topic to excellent doctoring.

The following case illustrates how constructive and progressive white racial identity development can be engendered and facilitated, or obstructed and disabled, by such factors.

Case #3: A New Day, A New Way

> Not long after the commencement of a multicultural training initiative, a white attending physician "taught" two white interns in a very objective and unapologetic manner how he decided whether or not to perform corrective, cosmetic surgery on a patient's injury. His decision was based on the patient's race and his perception of the norm of physical unattractiveness of members of this race. "If this were my daughter, I'd do it. And this patient is cute. And to be black and cute is really something unusual. So, I'd repair this patient." When one of the interns approached program planners, deeply disturbed at how this attending's teaching contradicted the imperatives of the program, a member of the hospital administration—and not program planners—spoke directly to this faculty member about how such teaching and practice would no longer be tolerated. Interestingly, when asked about the incident, the other white resident shrugged and said, "I just blew off that comment. Other residents warned me not to take him too seriously."

From program planners' experience with the first white intern, she had been brought from the preencounter stage to the conflict stage of her racial identity development by several earlier multicultural presentations. This opportunity presented her with an actual experience of racism, which caused her to grapple with the question of what kind of physician she was going to be. She found encouraging and accessible cross-cultural relationships through the program staff. She witnessed first hand the commitment of the administration to positive change on behalf of excellent patient care. She took advantage of the voluntary small-group experiences, which followed large-group multicultural sessions, to safely and honestly engage in self-reflection and to engage in cross-cultural and race-related dialogue. And, in both large- and small-group activities, she had a visible community of white role models she could identify with, which helped to counter the social isolation she might have faced in confronting what Tatum refers to as the "culture of silence" and empowered her to take a stand for excellent and equitable patient care.[19, p. 196] Thus, in the context of white racial identity theory, multicultural training activities became not just informative (i.e., a one-way transmission of cultural facts and interviewing techniques) but *transformative* for this individual, enabling her development into a more culturally self-aware, caring clinician and effective institutional advocate.

In an instructive twist on this case, the other white intern, to our knowledge, did not embrace this change process. His stymied progress, however passive and subconscious a process it might have been, is perhaps an example of the insidious nature of complacency and satisfaction with the social and institutional status quo.[13,19,29,48] In a powerful example of the "culture of silence," this second intern, bolstered by the advice of his senior residents (i.e., the prevailing institutional ethos) was poised to leave untouched the dysfunctional fabric of patient care and residency education he had personally witnessed. Such complacency may contribute to the differential allocation of health care services illustrated both in this case and potentially played out every day on a much more widespread level in the daily practice of U.S. medicine.[38,39,42]

The prowhite/antiminority state; the prominority liberal stage

From the conflict stage, white trainees may move either to the prowhite/antiminority or the prominority/liberal stage (see Figure 1). In the former stage, trainees may become staunchly defensive, angry, or unkind in their new or reawakened realization of racism or other inequities and of their potential role in and/or benefit from such a system.[13,15–17] In Tatum's words, "The societal pressures to accept the status quo may lead. . . to a reshaping of the person's belief system to be more congruent with an acceptance of racism. The guilt and anxiety associated with [the conflict stage] may be redirected in the form of fear and anger directed toward people of color . . . who are now blamed as the source of discomfort."[14, p. 15] Such trainees may dig in their heels and resist multicultural educational activities, if they show up at all. They can also proactively or passively collude with others to dismantle a multicultural training program, facilitate its failure, or obstruct personal or institutional changes that might come from it. Continued opportunities for self-confrontation and self-reflection, clinical case examples of culturally incompetent care, and sustained contact with the culturally different are important to encourage this trainee's development toward that of a culturally effective and respectful physician. Chief among the

factors mentioned above is the clear message from institutional leaders (e.g., those who write dean's letters and thus influence trainees' future in tangible ways) that multiculturalism, respect for others, and continuing educational activities that encourage such are now defining the professional and employment standards of the institution, as well as the criteria for career advancement and rewards.[15,39,40,48,49] This message from deans and teaching faculty can be unapologetic and forthright, appealing to our best nature and desire for reputations as fine professionals and good physicians. Such a message does not have to be coercive or antagonistic to be effective. For instance, an institutional leader can be asked to introduce a multicultural education session and then *remain* in the auditorium for the duration of the presentation. This simple, yet powerful act of leadership communicates how valuable it is to have access to this training, not previously available to physicians of earlier generations. For prowhite/antiminority trainees who are flexible enough, constructive progress can be enabled by such measures. However, some physicians and trainees will remain entrenched in this stage indefinitely. Perhaps the most that can be hoped for with these individuals is that they will be convinced, by the unequivocal and fair actions of institutional leaders, in the context of due process, that discriminatory behavior, conduct, or clinical decision making will not be tolerated.

At the extreme, trainees operating at the prominority/liberal stage of white racial identity development may exhibit an almost missionary zeal to identify and acknowledge racism within daily U.S. life and U.S. medicine.[13–15,17–19] They often seek or need validation from people of color, and, subconsciously or otherwise, may insist on people of color congratulating them on their liberalism. People of color, in turn, may grow weary of or unwilling to "take care of" or constantly validate the white trainee's explicit, albeit naive and superficial, identification with the minority experience in the United States. For instance, Tatum[19] relays this sentiment and the need for white people in this stage to ideally continue on in their own racial identity development:

> "Yes, there is fear," one White woman writes, "the fear of speaking is overwhelming. I do not feel, for me, that is the fear of rejection from people of my race, but anger and disdain from people of color. The ones who I am fighting for." In my response to this woman's comment, I explain that she needs to fight for herself, not for people of color. After all, she has been damaged by the cycle of racism, too, though perhaps this is less obvious. If she speaks because she needs to speak, perhaps then it would be less important whether the people of color are appreciative of her comments.[19, p. 194]

Again, to move from this stage, white trainees need what others at other developmental stages need, though perhaps in a bit more deep, intensified, and personalized way: white role models; the institutional leadership and ethos that value, encourage, and publicly call for this personal and professional development in its employees; and an identified, ideally diverse "community of dialogue" with those of similar values and yearnings. A case from a small-group experience illustrates this.

Case #4: Confronting Privilege

> A white male resident, in the prominority stage, was proud of his "progressive" character. He attributed his "enlightened" disposition to the fact that his parents were social scientists, and that he had traveled extensively in developing countries. He asserted that he understood the "minority" experience in America because he had experienced it as a "minority," the only white person, in at least one extended stay in a developing Asian country. The white male facilitator, an attending physician, challenged this resident by repeatedly and gently asking: "But what was your *privilege,* despite the fact that you were a numerical minority?" pointing out that the trainee had both the social mobility and financial freedom to leave his "minority" experience at any point it became too burdensome for him. The presence of a white male role model, of validated professional status to this resident, was important for seemingly moving this resident from his self-ascribed status as a "gift" to minority communities to apparently being a respectful partner newly confronting his own privilege in the United States. With this deepened level of self-awareness via skillfully and compassionately facilitated self-confrontation, it was theoretically easier, from what facilitators observed, for this trainee to more honestly work through the issue of power imbalances that potentially exist for each of us in every clinical encounter.

The redefinition, or integration, stage

The *redefinition,* or *integration,* stage of white racial identity development is marked by intense introspection and self-exploration.[14,15] Trainees understand further their position of relative privilege in society, and they are actively trying to discern, as Dreachslin and Hunt[15] put it, "What does it mean to be White and nonracist?"

Case #5: Restless Introspection

> Two African-American infants were admitted to the hospital with new onset seizures of unclear etiology. No history of drug use or physical abuse was elicited from either family. Among other tests, the patients both received toxicology screens and skeletal surveys to rule out old fractures that might be indicative of previous physical abuse. A Social Services representative placed one of the infants on a "Police Hold" (where the patient cannot be taken from the hospital by the parents or anyone else for up to five days) because the parents objected to the length of the stay and the extent of the tests. No cause for the seizures in either infant could be found, no further seizures were observed in the hospital, and the infants were both released to their families following their workups. Within a week of their release, a white Eastern-European toddler, a recent refugee to America with her parents, was admitted through the hospital emergency room for extensive bruising over one buttock. Both emergency room and inpatient admitting residents declined to involve Social Services because of their independent assessments that "These parents would not abuse their child." However, in consultation, the chief of pediatric orthopedics suggested that the injury looked as if someone had "kicked the child right in the butt." He was so concerned about an underlying fracture that he strongly recommended a CT scan to rule out a femur or hip fracture. A Social Services consult and subsequent "Police Hold" was obtained when the family wanted to leave the hospital before the workup was complete. One white senior resident, herself firmly in the integration stage of her racial identity development, lamented the fact that she had subconsciously felt so differently about the white parents' potential for child abuse, compared to the potential of the African-American parents. She was painfully and explicitly aware that there was no objective reason to have felt so disparately about these three scenarios. She shared these feelings with a close, African-American friend (a resident physician at the same hospital), hoping that she would be able to clearly see and negotiate her bias in the future, before she

> acted upon it. In constructively processing this incident, it was also her sincere desire to be in the future a better example to junior residents of an unbiased physician who provides high-quality, compassionate, and equitable care to all patients.

What Tervalon and colleagues[48] term a "community of dialogue," both consisting of and nurtured by institutional members, is critical here, not simply to transmit relevant sociocultural information about patients, but to provide a diverse, institutional network of accessible, encouraging relationships wherein trainees who have the courage to undergo such self-confrontation are supported.[49,50] Ideally, the racially and ethnically diverse members of this learning community, this community of dialogue, would not immediately dismiss the redefinition/integration trainee above as maliciously racist; rather, they would provide the trainee with timely and honest feedback and support, affirming a committed relationship that builds and does not destroy, and that is reciprocally available to each member when—not if—it is needed. Education scholar Sonia Nieto offers insight especially applicable to this awkward stage of redefinition/integration: "What is needed in the process of developing a healthy White identity is neither a narcissistic preoccupation with Whiteness nor a guilt-ridden journey that results only in immobilization. What is needed, in a word, is hope."[51, p. xiv]

The transcendent, or transcultural, stage

Lastly, the stage multicultural trainers idealize as the eventual goal for all trainees, especially in the context of lifelong learning, is termed the *transcendent,* or *transcultural,* stage.[14,15,18,19] The white transcultural trainee assumes a highly constructive role in challenging herself or himself and others to the highest standard of equitable, culturally respectful, and effective care, and to integrity in personal relationships with institutional colleagues and community members. The intense and restless introspection that characterizes the redefinition stage is no longer operant. This person, Dreachslin and Hunt state, "does not need to defend, glorify, or rescue themselves or other Whites. Institutional exclusion of others is observed and challenged in constructive ways, and the integrity of others who are different is no longer denied or questioned."[15, p.50] Such was true in the following scenario that occurred during a small-group discussion session.

Case #6: Teaching One Another

> A white resident shared his experience of being caught in the middle of a difficult situation, where the inpatient nursing staff claimed to hear an African-American mother spanking her child in one of the hospital rooms. The nursing staff called for a Social Services consultation, over the objection of the attending physician. The resident was asked by the nursing staff to inform the parents of the consultation. The resident reflected on his ambivalence regarding the situation, and how he eventually leaned in support of the consultation, saying, "We get specialist consults for other pediatric conditions, why is this so different?" Another white resident, operating most frequently as a transcultural trainee, very calmly and supportively pointed out, "We have heard of the history of how the African-American community has been treated by the hospital, and we see what happens in society. I don't think we need to pretend that those things never happened and are not part of the reality that people bring to their encounters with us. It makes sense that people might have suspicion that we're essentially calling the police when we call for a Social Services consult for something like this."

This transcultural resident was able to delineate, in a nonthreatening but challenging way to her fellow resident, how one's experience of having a Social Services Consult requested by one's health care providers might hold profoundly different meaning for individuals, depending on, among other things, one's past cultural or racial experiences or perceptions. To avoid overburdening transcultural trainees as positive examples for their peers in small-group and other settings, program leaders can provide (1) opportunities for shared leadership, (2) activities in which substantive cross-cultural dialogue and relationships can be developed and sustained, (3) support to counter potential social isolation and/or ostracism by other whites, and (4) emotionally safe arenas where trainees can interact and observe white role models.[18]

A caution

The stages of this model of racial identity development, described above, should not be conceptualized as part of a necessarily linear process.[15,19,20] A national, local or institutional event can push individuals "forward" or "backward" to different places in their development. For instance, an event such as the acquittal of the four Los Angeles Police Department officers in the initial Rodney King beating trial can throw even the transcultural trainee into a place of despair, distrust, disgust, and/or isolation, as he or she is hopefully only temporarily drained of hope that the enduring racial stratification and tensions of the United States can be resolved over time. Stereotyping or conceptually locking people into a static developmental phase can thus be counterproductive and strategically unwise, especially since the ideally ongoing self-reflective and self-confrontational training process will lend an intensely dynamic quality to this process of continual self-definition and recreation.

Toward Institutional and Individual Transformation

The application of racial identity theory to multicultural initiatives that seek to engender self-reflection has the potential to go far beyond increasing cultural knowledge or improving the interviewing technique in cross-cultural clinical encounters. Such physician training initiatives can be truly transformative for both the individual trainee and the institution. As conceptualized by scholars in the field of psychology, racial identity theory is critical to understanding and planning for the potentially wide range of predictable reactions to provocative activities, including those negative reactions that do not necessarily herald a flaw in programming. Careful consideration of racial identity development can also assist program planners to optimally meet the needs of individual physician trainees in their ongoing constructive professional and personal development, and in strategically mobilizing and having ready the type of institutional leadership that supports trainees' change processes. In multidimensional and synergistic fashion, medical educators can enhance efforts already made in physician training toward the urgent goal of more equitable and culturally effective health care.

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