SERVICE LEARNING:
AN INSTITUTIONAL LOGICS APPROACH

A Dissertation
Submitted to
The Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
DOCTOR OF PHILOSOPHY

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by
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August 2023

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ABSTRACT

The medical profession is in a state of social transformation. Medical education must follow suit to continue to produce physicians who can meet the demands of the ever-changing field of medicine and of the public it serves. In this study, an institutional logic framework is used in examining how the implementation of transformative pedagogy in medical education may be impeded by competing institutional logics, thereby disrupting the change process. This study proposed three questions aimed at examining and understanding the perceptions of social actors as it relates to transformational change in medical education:

1) What is the impact of institutional logics on the implementation of transformative pedagogy in medical education?

2) What are the institutional logics in medical education that may impact change, and are there any conflicts between them?

3) Is there any evidence that these conflicts, if they exist, act as a barrier or disincentive to pedagogical reform when diversity, equity, and inclusion measures are introduced?

A mixed method approach involving a two-step method of data collection and analysis was used in this study. Information from websites was used to create interview guidelines for interviews with faculty, administrators, and students at two US-based urban medical schools. By analyzing data from the websites of two US-based urban medical schools and comparing those findings to that of the perceived notions retrieved from interviews of the impact logics have on service learning, this research has shown

that understanding institutional logics aid in the implementation of transformative pedagogy by better understanding the role of competing logics.

This researcher provides three recommendations for medical schools to consider when using an institutional logics framework to enact transformational pedagogy. The first recommendation is change on the micro level (i.e., on the program level). The second recommendation relates to change on the macro level (i.e., relationship with governing bodies). And the third recommendation is related to the influence on diversity, equity, and inclusion (DEI) practices on the change process. I end with providing reasons for how examining the perceptions of the role of transformative pedagogy as a change agent in medical education can advance the field of medical sociology.

ACKNOWLEDGMENTS

Words cannot express my gratitude to my professor and chair of my committee, Dr. Matt Wray, for his invaluable patience and feedback. I also could not have undertaken this journey without my defense committee, Dr. Shanyang Zhao, Dr. Lauren Olsen, and Dr. Lucy Tuton who generously provided knowledge and expertise.

I'd like to thank my family, especially my parents Julie Burroughs and Terrence Almond, my sister, Lauren Burroughs, husband, Nicholas Wood, and my son, Finn Burroughs-Wood. Their belief in me has kept my spirits and motivation high during this process. I would also like to thank my friends for all the entertainment and emotional support, especially my dear friend Dr. Norma Alicea-Alvarez.

Lastly, I would be remiss in not mentioning my interviewees who took the time out of their days to share their experiences and stories with me. The stories they shared are the fuel for change.

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CHAPTER 1

INTRODUCTION

The medical profession is in a state of social transformation. Medical education must follow suit to continue to produce physicians who can meet the demands of the ever-changing field of medicine and of the public it serves (Faulker and McCurdy 2000; Khan, Iwai, DasGupta 2020). Institutional logics (i.e., the cultures, beliefs, ideals, and practices) upholding the medical profession were created under antiquated circumstances and now are changing to reflect new current/contemporary times. For example, changes related to policies, such as the passing of the Patient Protection and Affordable Care Act of 2010 (Kuramoto 2014) have greatly shifted not only how care is administered, but also how it is conceptualized (Timmermans and Oh 2010: S97). Terminology has also evolved with the introduction and usage of terms such as "structural violence" to describe how certain social factors (i.e., wealth, education, occupation) may put individuals and communities in harm's way (Farmer et al. 2006: e449). Studies aimed at understanding the impact of inequality, stress, and socioeconomic status have also impacted how we understand these factors and the barriers to maintaining healthy habits (House 2002:127; Thoits 2010:42; Link and Phelan 1995:87).

The Liaison Committee on Medical Education (LCME), the accrediting body for medical education, requires medical schools to institute transformative learning practices, such as service learning, not only to remain accredited but also to produce physicians ready to meet the demands of a changing world and a changing profession. The LCME (2019:26) defines service learning as "educational experiences that enable medical students to engage communities in activities that respond to community-identified

concerns and reflect on these interactions." Transformative learning (TL) practices like service learning also aid in the examination and reconstruction of past frames of reference to impact future perceptions as students pursue a career in medicine (Van Schalkwyk 2019:548). Through service learning, students may gain a greater understanding of the role social determinants of health (SDoH), defined as "the conditions in the places where people live, learn, work, worship, and play that affect their health, quality-of life-risks, and access to care" thereby challenging their own misconceptions (Centers for Disease Control and Prevention 2020). Service Learning has the potential to prepare medical students to be able to continue to meet the demands of the ever-changing field of healthcare by equipping them with the skills to be culturally competent and empathic providers.

Though transformative learning practices like service learning have the potential to continue to foster a new generation of physicians to meet the changing population, the implementation of service learning in medical school may be met with barriers that may inhibit fully transformative implementation. Barriers that may inhibit reform include the ability of the faculty to competently instruct on certain issues, curricular constraints, and shifts in patient and student demographics. For example, challenges related to the conscription, enlistment, of students into the role of teachers when issues of race and vulnerable communities are discussed in class or labs (Olson 2019:57) demonstrate an area in which faculty may lack some of the knowledge and skills. The structure of the curricula itself may make it difficult to teach such nuanced subjects (e.g., topics such as anatomy and physiology) through traditional didactic methods (Hunt et al 2011:248).

Medical school curricula are historically rigid, and the introduction of reformative measures may be met with constraints stemming from this rigidity. For example, LGBTQ+ health has been of greater focus over the past decade, and there is still difficulty adeptly adding elements related to LGBTQ+ health into the medical school curriculum due to the lack of culturally competent physicians, finding time in the curriculum, and competing institutional logics between institutions and social actors (Morris et al 2020; Roth et al 2018; Rieker 2010).

Unwritten and unspoken rules of conduct also need to be re-examined as future doctors are being trained to face a more dynamic healthcare system and a changing, graying, browning, and rainbowing society (Murphy 2016:265). Many institutions aim to introduce transformative pedagogy to facilitate change and/or expand on current practices, but due to the organization's culture, reformation is often met with multilevel external and internal challenges and resistance from various social actors that inhabit these institutions (Hallet & Ventresca 2006:215).

In my research, I aim to understand how the medical profession implements pedagogy as a part of its curricular reforms. I contend that utilizing an institutional logic framework is helpful in examining how the implementation of transformative pedagogy in medical education may be impeded by competing institutional logics. Institutional logics are the culture, beliefs, and practices that make organizations and programs who they are (Dunn and Jones 2010:114). These practices can be either overt or covert and as simple as students greeting one another when passing one another in the hallway on their way to the anatomy lab or as complex as the following of procedures by faculty and administrators during times of crises. These processes and others related to politics,

inspirations, emotions, mindsets, and psychodynamics can greatly impact how an organization or field engages in the process of reform (Marshak 2006:5). Institutional logics and the hidden curriculum share a bond. They carry rich amounts of information and practices that drive decisions, practices, and growth. Institutional logics may help guide and shape the hidden curriculum and redefine educational practices. According to Edgar Schien (2010:7), a leader in the field of organizational culture, "If we don't understand the operation of these forces (cultural forces), we become victims to them. "Unfortunately, many of these logics are so deeply embedded within the social structure of an organization, it may become quite difficult to understand their impact on the reformation process as they may seem so elemental to the organization that they elude study.

Medical training must continue to evolve to meet the challenges of today's patients, but change is neither straightforward nor simple. The importance of social factors related to race, access, and social networks and their impact on the care and wellbeing of patients is continuing to move from the periphery into the spotlight (Link & Phelan 1995; Williams & Sternthal 2010; Smith & Christakis 2008). Patients have dynamic lives that are impacted by an array of social factors and the implementation of transformative learning practices can be beneficial in understanding these changes if implemented well. Much like patients, medical schools are also dynamic and are impacted by external and internal factors, including markets, politics, faculty, and students that impact how the healthcare system works. Each of these entities has its own mission, values, and lenses that impact practice, relationships, and delivery of medical care. Medical school education and implementation of transformative learning practices

need to be explored along with institutional logics specific to the curricula. Transformative learning practices have the potential to transform medical education, but they may not be able to have their maximum, desired impact without an understanding of the institutional logics that may limit or block their deployment.

Examining these new inputs is important as they encounter current and preexisting logics because they may produce unforeseen conflicts. For example, the rise of patients' interest in using complementary and alternative medicines (CAM) such as cannabis to aid in managing chronic pain has introduced alternatives to traditional forms of medical care that have challenged the logics of some parts of medical education (Timmermans & Oh 2010: S98).

As medical education continues to engage in the practice of reformation more attention is paid to the interplay between institutional logics and change processes, which may alleviate some growing pains. My work has the potential to not only contribute to sociological knowledge at the intersection of medical and organizational sociology, but also to inform medical training and practice. My work also has the potential to aid medical schools and programs in meeting current and future challenges of transformative pedagogy. An institutional logic framework can be beneficial to curricular reformation giving a framework to examine how medical schools and the social actors that inhabit them (i.e., faculty, administrators, and students) reconcile and negotiate sometimes conflicting or competing institutional logics. My work aims to examine how uncovering the impact of these competing institutional logics may have on systematic change in medical training when transformative pedagogy is introduced, and challenges well-

established and outdated concepts related to care and practice related to traditional medicine.

The Institution of Medical Education

Three of the most influential groups that govern and dictate the course of medical education in the United States are: The American Medical Association (AMA), The Association of American Medical Colleges (AAMC); and The Liaison Committee on Medical Education (LCME). Each plays a pivotal role in directing the course of medical practice, with the AMA acting on behalf of the profession and practice of medicine; the AAMC acting on behalf medical schools and teaching hospitals; and the LCME, co-sponsored by both the AMA and AAMC, acting as the body that accredits medical education programs. Before I continue, I will give a brief background on each of these organizations.

The American Medical Association

The American Medical Association (AMA) is the professional association for physicians and medical students. Founded in 1847, AMA's mission is to promote the art and science of medicine and the betterment of public health (AMA 2022). According to the AMA, their mission is achieved by lobbying for better practices that remove obstacles from patient care, pushing the field of medicine to enact preventative measures for care, and training the next generation of doctors to tackle future health care challenges.

In effort to meet these challenges related to patient care, health equity, and medical training, the AMA has renewed their value to training and serving a diverse population. Though the AMA does not specifically address the role of service learning and community engagement on their website, its commitment to creating a diverse and

culturally competent pool of physicians is still present. Their commitment to change and challenge medical practices is twofold. The AMA sets a tone, noted in their diversity, equity, and inclusion statement that provides opportunities for growth in personal and professional development and acknowledging that they, as the lobbying body for the profession of medicine, must continue to "promote and advocate for equity and justice in our policies, products and services." (AMA 2022)

The Association of American Medical Colleges

The Association of American Medical Colleges (AAMC) is a nonprofit organization that represents medical colleges in the United States. Established in 1876, the AAMC's goal was to add regulations to medical training to create practices and standards to ensure that there was quality assurance in care once medical students graduated and became physicians (AAMC 2022). As it has grown, the AAMC's mission now focuses on transforming health care in four areas: medical education, patient care, medical research, and diversity, inclusion, and equity in health care (AAMC 2022). To meet these goals, the AAMC aims to ensure teaching hospitals and medical schools are prepared to train future physicians to meet the challenges of an ever- changing medical landscape; continue to pioneer new discoveries in the field of medical care and treatment; continue to innovate to provide optimal patient care; and partner with communities to continue to cultivate trust. (AAMC 2022)

The AAMC's website doesn't specifically address service and community engagement, however, this could be inferred from how their four goals intermingle as it relates to the preparation of physicians through having a better understanding of patient,

community collaboration, and innovation in care. The AAMC does, however, provide robust reports on how medical schools report service learning in their curriculum, as well as articles related to service learning. This is then broken down by teaching formats; what teaching tools are employed (e.g., discussions, lectures, activities) in the teaching of service learning; and what schools have made service learning a requirement. As for diversity, equity, and inclusion, the AAMC has made a commitment to create medical personnel that embodies their mission by enhancing their focus on equity and community engagement.

The Liaison Committee on Medical Education

The Liaison Committee on Medical Education (LCME), established in 1942, accredits medical education programs that lead towards an MD in the United States and Canada. Co-sponsored by both the AMA and AAMC, the LCME mission is to ensure that standards of the field are being met by assessing medical education programs "general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care" (LCME 2022). This is achieved through medical schools going through an accreditation process every eight years that requires that they be assessed on twelve different standards based on institutional infrastructure and processes, curricula, and resources for both faculty and students (LCME 2022). The LCME is also recognized by the US Department of Education and the World Federation for Medical Education (WFME).

Though there are a set of standards that must be met, each medical school is responsible for defining how these standards are met. For example, Standard 6 focuses on competencies, curricular objectives, and curricular design and has 8 different sub

standards, one being service learning/community service (standard 6.6). For this standard *"The faculty of a medical school ensure that the medical education program provides sufficient opportunities for, encourages, and supports medical student participation in service-learning and/or community service activities."* (LCME 2022). How this is carried out is totally subjective and how it is assessed is based on how the school defines it. This standard could also work in conjunction with standard 6.5 which focuses on elective opportunities. For this standard *"The faculty of a medical school ensure that the medical curriculum includes elective opportunities that supplement required learning experiences and that permit medical students to gain exposure to and expand their understanding of medical specialties, and to pursue their individual academic interests."* (LCME 2022). Service learning or community service opportunities can be displayed or executed through electives.

In effort to create a diverse pool of future physicians the LCME created standard 3 which focuses on the academic learning environment. For example, standard 3.3 looks at diversity and pipeline programs and partnerships to ensure diversity among qualified applicants into each medical school as well as faculty and staff. Currently there are 155 accredited medical degree granting institutions in the United States. Total number of applicants continues to rise each year at a steady rate of 2% (AAMC 2021). In the past ten years 170,362 students have graduated from US based medical schools, with an average of 18,929 students per year (AAMC 2021) and currently the average graduation rate of MD-only students is 95.9%. Gender wise, women graduates have been on a steady uptake since the 1980's and are beginning to match the number of male medical school graduates, the once predominant group of graduates (AAMC 2021). With such robust

numbers of students entering medical school, the practice of medicine continues to thrive. The variation of students is increasing as well, with an ever-growing number of women graduates, not to mention browning, with average rates of Black, Hispanic, Latino graduates growing at a steady rate (AAMC 2021). With these demographic changes to the profession may come challenges to norms, practices, and decorum.

Long Held Traditions Within Hierarchy of Medical Education

The profession of medicine has its own set of practices that protect and socialize students into the role of physicians. Beliefs and values that are passed down year after year from master to apprentice, through the hidden curriculum, are now being confronted with new questions around medicines, social responsibility, and social accountability (Hafferty 1998; Faulkner et al. 2000; Woolard 2006). Heteronormative practices stemming from a long history of the medical profession consisting primarily of white men in white coats that pervaded the field of medicine before the publication of Howard Becker's *Boys in White* (1961) are now being challenged. Stories told in anatomy labs over dead bodies are being brought into question, as we look at how physicians detach themselves not just from living bodies, but also from the people that will be (or are) in their care (Underman & Hirshfield 2016).

Stories shared while spending arduous hours in anatomy labs are passed down as bodies lay cold and lifeless on the tables. Cadaver stories, according to Hafferty (1988:345), aid in the detachment of concern for patients and people and how students should respond during highly emotionally charged moments. Though seen as a means of protection, these stories can act as vehicles to transmit maladaptive practices that detach

physicians from the rigors of their job in which they may have to share bad news or experience the loss of life (Underman & Hirshfield 2016; Tseng & Lin 2016:265). Students continue to be exposed to new issues and concerns in and out of the classroom and clinical setting related to conduct, social accountability, and responsibility as future physicians. Renee Fox discusses (1980:7) the role of uncertainty and how it begins to manifest itself around decision making and the ability to provide care for an ever-increasing pool of patients and illness. Though this uncertainty may wax and wane with each new exposure and experience, it is still there when students are once again confronted with changes related to power structures impacting the doctor/patient relationship and the dominance of the profession.

Eliot Freidson (1970:215) discusses the social structure of medical care and the reorganization of it and notes "we cannot solely depend on the profession itself to change and be responsible for the reorganization of care." Medical schools also can play a role in the reorganization of care. The institution where students begin to hone their craft as physicians can play a pivotal role in the reformation process. Like the profession of medicine, medical schools have their own cultures and beliefs that they impart either through their mission or vision statements or through the way they implement their curricula. These values and concepts of quality care impact the culture, perceptions, and knowledge that are transmitted through the implementation of curricula and are impacted by underlying organizational structures, values, customs that may impact the learning process (Hafferty 1998:404). The language used in these statements and how schools conduct their educational practices convey the philosophy and values that the school is built on and hopes to impart on those who attend their institution (Mills 1940:9).

Statements are presented on university websites and speeches are given by university presidents to welcome students into the halls of medical school. Each school hopes that one day students will graduate and become both a representative of their profession and their institution. Though each school is accredited by the LCME, each school institutes its curriculum in its own way, and administrative, political, and bureaucratic policies that are specific to each university shape practices and behaviors that impact the development of new physicians (Butin 2006:480). For example, faculty teach how they are taught, and administrative policies on how faculty implement and shape curriculum are a product of this and not of practices based in adult learning (Halpern & Hakel 2003:38). Many physicians may either be unaware of educational approaches or changes or if they are, may not have fully incorporated these changes into their own approach to care or in how they teach young doctors. These practices, even if they are taught, may come off clumsy or disingenuous, and this awkward approach may be transmitted to students' practice, impacting treatment and patients' ability to build trust in them. The understanding of the institutions in which they are housed may aid in how medical schools approach curriculum reform.

Transformational Learning - Service Learning

Higher education has sought to figure out how to negotiate the competing logics of their institutions, their pedagogy, and that of the communities and various professions they serve (Taylor & Kahlke 2017). The commitment to learning has taken on new methods to continue to grow and hopes to meet patients where they are. With changes around social responsibility and social accountability in the field of medicine, medical education also is having to rethink how current and future physicians engage with

patients (Borges & Hartung 2007:1). Medical schools aim to incorporate transformative learning and pedagogy into the already packed curriculum to various degrees of success (Van Schalkwyk et al 2019; Cavanagh et al 2019). Service learning is one of the LCME standards that has students engage with communities and allow for periods of reflection in hopes to challenge misconceptions. With a greater focus on people and future patients and where they are born, live, learn, work, play, and worship, a greater understanding and rapport could be created, positively impacting medical students' ability to empathize with their patients (Diez Roux 2016; Pelletier 2016).

This type of experiential learning via service learning is a way medical students can go about constructing (or deconstructing) misconceptions. Service learning is an educational approach that combines active community participation and ongoing reflection in the hopes of addressing needs identified by the community one is serving (LCME 2019). Service-learning aids students in rediscovering their initial, altruistic reasons for studying medicine by helping medical students to fully appreciate and embody the very service ethic that underlies their chosen profession (Greenhill et.al 2018; Hunt 2011; Warshaw 2018). Service learning is unique in that it not only immerses students in communities that may be unfamiliar to them but also in that it asks them to reflect on these experiences. There is a lot to learn through this method of engagement, via its hidden curriculum. Engaging in service also invokes the need to get out of the clinical environment to gain a better understanding of the people that medical students will one day serve.

There are key components that enable service learning to yield both service outcomes and learning outcomes, a strong balance between practice and profession,

reflection, and being student-centered (Stewart & Wubbena 2014:147). Service learning needs to focus equally on the service context and the academic context. That balance is important to ensure that what is learned can be incorporated into practice. Critical reflection in service learning is important because it connects the service to specific learning outcomes. As students engage in service learning, instructors must note each student's experience because each and their background is different, therefore students' experiences should be measured by the learning that takes place and the service work accomplished (Kiely 2005; Taylor & Kahlke 2017; Swords & Kiely, 2010).

To teach students social determinants of health (SDoH) without interacting with people in their own communities and environments is difficult because there is much that can only be learned through engaging with others outside of the walls of medical school (Stewart & Wubbena 2014; Borges & Hartung 2007; Taylor & Kahlke 2017). Some challenges that may beset service learning may be related to established structures, funding, faculty and staff, relationships with community-based intuitions, and usage of terminology (Stewart & Wubbena 2014). These established structures and funding can act as constraints on service learning regarding its value, how it is incorporated in established lessons, and how to find sustainable funding for it leading to questions around how to measure its efficacy to justify its existence (Stewart & Wubbena 2014:149). The constant struggle that faculty and staff, according to Stewart and Wubbena, is to justify how service learning contributes to the mission and goals of the school, while at the same time being bombarded with outcries from patients and the medical profession itself to evolve. Relationships with community-based institutions are brought into question as students venture out into communities that they are unfamiliar with (Schnieder 2018).

Even with preparation, experiences and expectations are challenged and conflicts may emerge through conflicting inputs from conversations with community members and interaction with institutions, organizations, and communities.

Misuse of and interchangeability of terms also impact the institution of transformative practices. Service learning is often used interchangeably with community service and volunteering (Borges & Hartung 2007; Hunt et al 2011; Stewart & Wubbena 2014). Where they differ is that service learning provides the links between knowledge building, challenging preconceptions, and enabling students to apply their altruistic ideals (Meili et al 2011:60), whereas with volunteering, for example, students only engage in activities, but there are no elements built in to reflect on whom they engaged with and how it relates to their identity or profession.

Past research does not adequately inform current educational practice because today's medical school environment is different from when most of the published research was conducted regarding students engaging outside the walls of medical school (Crandall et al 2006). As evidence-based medicine continues to proliferate in the field of medicine, new measures are being created to determine if any change has occurred as students engage in service. For example, The Jefferson Scale of Empathy, an instrument developed to measure empathy in the context of health professions education and patient care, was constructed after a study of the current literature on empathy, and it employs both qualitative and quantitative methods to measure the construct (Hojat et al 2018).

Logics around values related to human concern and social factors are once again brought to the forefront as they present challenges to the profession of medicine and its dominance in care (Woolard 2006; Friedson 1970). Students' experiences and attitudes

are being addressed as they engage in service learning as new challenges emerge when the students' newfound enlightenment is confronted with the moral dispositions of faculty and administrators (Franzen 2017).

Institutional Logics

Institutional logics, according to Thornton and Ocasio (2008), are "the practices and systems made up of assumptions, beliefs and values that organizations and the individuals that inhabit them that provide meaning for conduct, organization, and how to experience what transpires within an organization". These logics are generally unspoken, but so ingrained in the system that their power is unfathomable. The ones that are "spoken" are generally found in mission and vision statements or on websites and pamphlets that aim to convey an organizations or institutions belief and value system. For example:

The University of South Alabama College of Medicines (AAMC 2021:2) mission statement is:

> As a diverse community focused on the science and practice of medicine for Alabama, the Central Gulf Coast, and beyond: We educate, We discover, We serve.

While Morehouse School of Medicine (AAMC 2021:8) mission statement is:

> Morehouse School of Medicine is dedicated to improving the health and well-being of individuals and communities; increasing the diversity of the health professional and scientific workforce; and addressing primary health-care needs through programs in education, research, and service, with emphasis on people of color and the underserved urban and rural populations in Georgia and the nation.

Each of these mission statements share a focus on their respective communities (i.e., Alabama, the Central Gulf Coast, and Georgia). While other mission statements such as Harvard Medical school (AAMC 2021:13), whose mission statement is:

> To nurture a diverse, inclusive community dedicated to alleviating suffering and improving health and well-being for all through excellence in teaching and learning, discovery and scholarship, and service and leadership.

And Drexel University School of Medicine (AAMC, 2021:25):

> Drexel University College of Medicine delivers innovative biomedical education in an environment that embraces inquiry and collaboration, founded on excellence in patient care, and based on a culture of, and respect for diversity. These principles are built upon the College's legacy of a firm commitment to meeting the healthcare needs of the communities in which we live and work.

Harvard and Drexel have less of a specific focus on their local area, but more on the concept of community health and wellbeing. Nevertheless, at the core of each of these mission statements, is to help people. How those values and beliefs are disseminated to students will vary based on how much the institution embodies these guiding principles that they have set forth.

Patricia Thorton and William Ocasio (2008) discuss the role of institutional logics and how they come into being within the confines of institutions. Thornton and Ocasio note that institutional logics latch onto the collective identities of groups, professions, and institutions creating norms, beliefs, and values (Thorton and Ocasio 2008:11; Thornton, Ocasio, & Lounsbury 2014). Medical schools, like many other institutions in higher education, are also faced with making cultures and processes function within the institutions in which they are housed (Taylor & Kahlke 2017:139). Each medical institution is embedded with its own history, bureaucratic systems that affect the interactions between the students, physicians, and hospital and the people and surrounding communities they care for. These elements are examples of broader institutional logics that may impact how medical schools not only create their social reality but also how they train future physicians.

Some more examples of observable institutional logics in medical schools are: clinical logic, academic logic, professional logic, and social justice logic. I contend that these logics encapsulate and govern the core practices, values, and beliefs of medical education (Thornton & Ocasio 1999; Dunn & Jones 2010; Ishimaru & Galloway 2020; Accreditation Council for Graduate Medical Education 2023). Clinical logic is centered on patient care and the development of clinical skills. It emphasizes experiential learning, practical training, and the application of medical knowledge to diagnose and treat patients. Clinical logic values the doctor-patient relationship, empathy, and the acquisition of clinical expertise through patient encounters. Academic logic emphasizes research, scholarship, and academic pursuits within medical schools and values the production of new knowledge, intellectual rigor, and critical thinking. It promotes faculty engagement in research, pursuing publications, and the pursuit of academic careers. The professional logic focuses on the development of professional identities and the socialization of students into the medical profession and emphasizes ethical conduct, professionalism, and the adherence to professional standards and codes of practice. Much like clinical logic, professional logic emphasizes the cultivation of empathy, patient advocacy, and the development of a sense of professional responsibility. The Social Justice logic places a strong emphasis on social justice, equity, and addressing health disparities and highlights the role of medicine in promoting societal well-being, reducing inequalities, and advocating for marginalized populations. Social justice logic encourages medical schools to incorporate community engagement, cultural competence, and social determinants of health into their curricula.

These logics do not just manifest themselves automatically, history plays an important role in the development of these logics as well as the change process. An understanding of how an institution got to where it is today aids in understanding how it may react during periods of reform and how social actors navigate and reconcile (or do not) these various institutional logics. For example, the process of sanctioning controls how individuals are chastised for actions that may go against set practices and behaviors that the institution holds dear. Sanctioning can hamper innovation and growth by fostering a mindset that may fear change because of the potential repercussions of going against the norm. Norms aren't created overnight; they take time to form and solidify. The interplay between social actors and their environments and the construction, deconstruction, and reconstruction of social realities are a part of this process. Practices and behaviors shape and give legitimacy to what transpires in an organization and greatly influence reformation. Norms are enforced by sanctioning certain behaviors that the institution has created to ensure that systems continue to hold (Horne & Mollborn 2020:48). Bureaucratization also plays a role in the process of over-reformation. John Meyer and Brian Rowan (1977:343) discuss the causal role norms play in bureaucratization and how their importance has been neglected by scholars but is very important in the creation and embedding of values in a system.

Healthcare services are now more governed by macro-level structures that are generally government and market-driven, controlling a wide range of regulatory measures that influence how care is disseminated and evaluated (Anthony et al 2014). These organizations are not doomed to fatalism or being locked in a proverbial “iron cage.” Max Weber introduced the concept of the "iron cage,” to describe such

phenomena by looking at the social organizations of organizations through bureaucratization and noting how they may be at the mercy of many competing internal factors that impact beliefs and values of the organization (DiMaggio and Powell 1983:150). Marya Besharov and Wendy Smith (2014:370) discuss the types of logic multiplicity within organizations and how at times that they may be in conflict. These logics are concerned with alignment and dealignment and related to how an organization functions and strategizes. With so many logics in play, conflict may be inevitable.

Styles and methods to care have changed as new technologies and drugs are introduced. Practitioners and their trainees are now having to reconceptualize their role in the provision and management of care (Casper & Morrison 2010). Conflict, change, and reform have come to the greater forefront of medical education as new processes, technologies, and advancements and pharmacology emerge. As conflicts emerge, researchers have begun to study how they manage potential rivalries of competing institutional logics by understanding where conflicts may arise from (Reay & Hinings 2009). Medical schools have tried to react to these changes by incorporating transformative learning pedagogy and practices to various degrees as they attempt to manage multiple and oftentimes competing logics.

Research Questions and Study Design

This research project asks three questions that examine the understanding and perceptions of social actors as it relates to transformational change in medical education: 1) What is the impact institutional logics have on the implementation of transformative pedagogy in medical education? 2) What are the institutional logics in medical education that may impact change, and are there any conflicts between them? and 3) Is there any

evidence that these conflicts, if they exist, act as a barrier or disincentive to pedagogical reform when diversity, equity, and inclusion measures are introduced? My work consisted of a two-step qualitative research project in the form of a case study approach using documents collected from websites and interviews aimed at examining the possibility of conflicting institutional logics at two medical schools. I find that the perceptions of how medical schools present themselves, how they are interpreted and embodied by those currently at the medical schools involves negotiation and renegotiation of logics related to values.

After a discussion of my research design and data collection methodology in chapter 2, chapters 3 and 4 focus on the thoughts and perceptions of the social actors (faculty, administrators, and students) in the medical schools in my study. In chapters 3 and 4, faculty, administrators, and students were asked questions related to their understanding of the mission and values of the school; the impact of service learning; and the potential impact of diversity, equity, and inclusion on reform in medical education.

Institutions such as medical schools are given life by the people that inhabit them. Medical schools are not just empty and hollow brick and mortar structures, they are complex social systems that are being made and unmade through social interactions, the agreement (and sometimes disagreement) of values, and the creation of cultures and processes. These social interactions can be as innocuous as saying "good morning" to a colleagues or peers or harmful such as yelling at colleagues and peers, which can potentially be detrimental to a work or learning environment. Values may be agreed on at one point, but that agreement can change at any time if other stakeholders enter the picture with different wants or desires or changes in the social zeitgeist, such as the Black

Lives Matter movement starting in 2013 and which gained more traction and national recognition in 2020. Cultures and processes change are also a part of this making and unmaking of medical schools that can come from internally with the changing of a dean, who may bring in new thoughts, perspectives, and people, or externally, such as when new accreditation standards are changed or updated by the LCME.

While chapter 3 focuses on responses of faculty and administrators and chapter 4 focuses on the responses of students as they grapple with questions related to institutional culture, values, and reform, chapter 5 engages the two groups in conversation. I compare and contrast comments made by faculty and administrators with those of students and see where there are areas of resonance, dissonance, and potential for growth that may aid in the reform process. Each group's unique perspective, as well as wants and desires, is of value. The desire to see the profession of medicine thrive and create a system where doctors and patients work together by creating shared understandings related to patients' lived experiences. But we must acknowledge that each stakeholder interacts with the medical education system differently and their agendas may not always align. For example, one of the students in my study would like for one of the schools to make more of a concerted effort to add more structure to service learning, but unfortunately, according to one of the administrators, the school no longer has a designated person to run service learning and therefore without the institutional support, granting this request is less than likely to happen. There is still much to gain from these interactions as we look at the desire to change and the means to which to do it and with most change processes it starts with a conversation.

I conclude by returning to my initial research question about "what impact institutional logics have on the implementation of transformative pedagogy in medical education?" Patients have complex and rich histories, but so do the medical schools that produce future physicians. The history related to practices related to how medical care is taught may impact patients' relationships with physicians and their adherence to medical care and future physicians need to be ready to meet these challenges. It is imperative to the field of medicine to be able to train medical students to meet the needs of the patients they will one day serve by skillfully incorporating transformative pedagogy. Conflicts such as competing logics in the profession of medicine, medical schools, and current pedagogy may act to stymie or even negate the changes that need to be created. My research looks to further our understanding of transformational change, benchmarks that need to be made, and methods of evaluation used to study the pitfalls, adoption, and implementation of transformational pedagogy.

CHAPTER 2

METHODOLOGY

As discussed in the previous chapter, institutional logics have been used in many arenas from economics, banking, healthcare, and others to study and examine the culture of organizations, which makes and dictates what organizations are and sometimes controls the directions that organizations take in times of change and transformation (Lounsbury and Boxenbaum 2013). Identifying and understanding the organizational dynamics, their interplay, and sometimes their clashes are key elements to understanding the change process. My work consisted of a two-step qualitative research project in the form of a case study approach aimed at examining the possibility of conflicting institutional logics at two US-based urban medical schools. I contend, with others, that a case study methodology is an ideal way of illustrating theories around organizational and structural change and helps to show how different aspects of institutional logics and individuals are related to one another as systems and domains are constructed and deconstructed (Instrup, Aarikka-Stenroos, & Adlin 2019:269; Thorton & Ocasio 2008:11; Thornton, Ocasio, & Lounsbury 2014; Yin 2018:34).

To gain a better understanding of the institutional logics that impact the medical profession as well as medical schools, I employed two methods of data collection and analysis that focused on the governing bodies of medical education and two US-based urban medical schools. Due to access to medical schools and to faculty, administrators, and students, convenience sampling proved to be the most prudent way to pursue my study of inquiry. Though I used convenience sampling in selecting the medical schools for my study, I also employed two additional criteria to enhance the selection of the

medical schools in my study. The first criteria was based on the type of medical school and the second was based on the employment of service-learning as it relates to the level of coherence, agreement, and unity within the school.

The two most prominent types of medical schools in the US are public and private. I renamed the two medical schools in my study to a) Public University Medical School (PUMS) and b) Private University Medical School (PRMS) to protect their identities and to ensure the anonymity of the interviewees in my study. A public medical school is typically funded and operated by the government or state. It receives substantial financial support from public funds, which allows it to offer lower tuition fees for in-state students compared to out-of-state students. Public medical schools often prioritize admitting residents of the state or region in which they are located. They may have a legal obligation to serve the healthcare needs of the local population. Private medical schools on the other hand often have higher tuition costs compared to public schools, regardless of a student's residency status. They have more flexibility in their admission policies and may admit students from both in-state and out-of-state backgrounds. There are also semi-private medical schools, which are medical schools that operate under a hybrid model and receive a combination of public and private funding. It may have a partial affiliation with a public institution or government but also relies on private sources for financial support. The exact characteristics and admission policies of a semi-private medical school can vary depending on the specific arrangement between the public and private entities involved.

As for the employment of service-learning, I looked at how well the medical school's various components, such as its staff, policies, and practices, are working

together towards a common purpose. I also examined each school's clarity about its mission, vision, and values, and how these principles guide its decision-making processes and actions in shaping and implementing service-learning. I contend that clarity about the mission, vision, and values of a medical school plays a crucial role in shaping service-learning outcomes and ensures that service-learning experiences are consistent with the broader objectives of the institution. Aligning service-learning with the mission and vision, students can engage in projects that contribute to the school's broader goals, such as addressing health disparities or promoting preventive care and by integrating core values, medical schools can shape service-learning outcomes that emphasize professionalism, empathy, and a patient-centered approach. Overall, clarity about the mission, vision, and values of a medical school serves as a guiding framework for designing service-learning experiences that align with institutional goals, foster meaningful community engagement, and develop well-rounded medical professionals.

I compiled and examined public documents found on their respective websites and developed a small number of research propositions about conflicting institutional logics. Documents collected included organizational history, mission statements, vision statements, any information related to service learning, and diversity, equity, and inclusion statements. These documents carry ideological commitments and motives of the institutions that I examined to better understand the role that language may also play in conflict between logics and cultures (Mills 1940; Yin 2018:115). Though each organization is different, there is much to learn from the examination of each organization. For example, each organization must follow the same standards for accreditation, but the way they implement them varies. Another example is how they

comprise themselves and conduct processes. We can look at which positions or structures that they may employ and see where they may differ from one another and the underlying reasons why they may differ. The ability to recognize and to categorize patterns and logics associated with language gleaned from documents (Weber, Patel, Heinz 2013) is a crucial element to my research. For example, Silva and Figueiredo (2017) has researched institutional logic approaches in organizational sustainability, looking at socially constructed action, intentions via organizational practices and documents. Document analysis as a method of analysis for studying artifacts, such as websites and literature, is ideal for researching and examining language and its impact on culture.

Document Analysis

My methods are also apt for investigating metrics that individuals and medical schools may use to denote change. Medical schools are inhabited by people, and logics continue to be shaped by their presence (Zilber 2013:146). Knowing what these metrics are, how they can be used as markers, and how these findings can create meaning will be important for investigating the effects of transformative pedagogy (Reay & Jones 2016; Mills 1940; McGee 1980). As a researcher this enhances my methodology by allowing me to collect and analyze that include accounts of recurring action statements and interactions in relation to social actors and shifting social contexts.

As higher education continues to grow and adapt to social changes, qualitative document analysis as an approach to capturing institutional logics in higher education has continued to gain ground among researchers. Like Warshaw and Upton (2018:77), I employed a method of data collection and document analysis using publicly available

documents from each organization's websites. These documents (e.g., statements, plans, descriptions, and press releases) served as examples of where and how institutional logics may present themselves. Document analysis can be beneficial in better understanding the allocation of resources and missions set forth by institutions (Warshaw and Upton, 2018). As Warshaw and Upton applied the theory of institutional logics in their research in higher education they note (2018:71) "that qualitative document analysis is particularly helpful in indicating: 1) something of the underlying thought processes by which policy is formed; 2) perceived sources of legitimacy, often as the direct audience(s) to whom documents are addressed; 3) universities' assessment of key constituents' preferences; 4) where statements reflect established organizational values and where they speak to external constituencies; and 5) change over time."

In my research, I focused on the data collected from three primary governing bodies of medical education: The American Medical Association (AMA), Association of American Medical Colleges (AAMC), and the Liaison Committee on Medical Education (LCME) and two medical schools. To better understand what shapes their culture and the impact their respective cultures have on the creation of transformative learning practices I focused on the mission statement of each institution as well as four additional parts: history; service learning and community engagement; and diversity, equity, and inclusion.

I used Hafferty's work as a guide and explored mission statements of U.S LCME-accredited Medical Schools (MS) stated/implemented to better understand linkages between the mission statements of these schools in my research (Hafferty, Grbic, Hafferty, 2019). Like Hafferty, I used a similar methodology in my work wherein I

conducted web searches and web reviews of mission statements, diversity, equity, and inclusion statements, organizational histories, and any and all information related to service learning from each entity. Going beyond the work of Hafferty, the scope of my work is a more holistic look at MSs, as I considered other social forces and other social actors in my research. In his research, Hafferty concluded that moving beyond a simple frequency count would be important in better understanding the linkages between medical schools. I aimed to address the role that an institution's history and statements regarding service learning/community-based learning, as well as diversity, equity, and inclusion have on transformative learning practices, and therefore to create a more holistic understanding of these statements I homed in on service learning in my interviews.

In my research on governing bodies, organizational groups that have the authority to exercise governance over an organization or a profession, I examined how each body presents itself and looked at common themes and categories that emerge in my analysis of each group. For example, the Liaison Committee on Medical Education (LCME) (2019) is the accrediting body for educational programs at medical schools in the United States and creates the guidelines to which medical schools adhere to and on which they are evaluated. The history of an organization contains information on how the organization came into being, what it has done, and why it has adopted what measures it uses to justify its existence. This history is also important in the creation of the mission and the direction of the organization. I selected service learning and community engagement as another part to explore because of how it acts as a vehicle for transformational learning, learning that takes place outside of the confines of the

institution itself. In addition to my three focused areas of research (impact of institutional logics, what institutional logics in medical may impact conflicts, and evidence of conflicts/barriers) I discovered it was pivotal to include diversity, equity, and inclusion (DEI) as an additional final focus due to its continued presence in the information that I had been reviewing.

In my analysis, I discuss how each of these four areas informs practice, the practices that each institution employs, and what themes and categories emerged from my research. Each governing body's web page was reviewed and saved using the main web page for the starting point of my search. Unlike Hafferty, I used ad hoc rules if either one of the focus areas was not easily identified or if it had several sub links that went more in depth about that particular area.

Each web page related to each respective organization was extensively reviewed. I specifically looked at mission and vision statements as they were presented online. To get a sense of the organization's history, I looked at how the history of each organization was presented and any other information that pertained to its founding. For information pertaining to service learning and community-based work I looked to see where they were explicitly stated on their respective web pages. Information related to diversity, equity, and inclusion was taken from the DEI statements from the organization. All work that appeared in text was present on the websites as of March 1, 2022. I used ATLAS.ti, a qualitative data analysis software, in my analysis. Each web page was converted into standard text and was uploaded into data analysis software. Once inputted, I used the software to locate and identify similar language and themes that were used across each of the organizations to identify common variables, themes, as well as the frequency of their

being mentioned. I contend that the roles of these governing bodies in the shaping of medical education is important to understanding how these institutional logics may be made and unmade as well as the impacts of other structural constraints stemming from bureaucracy (Perrow 1970:51). For example, Rob Stone (1991) in his work in methodological bracketing, purported that the usage of context analysis is valuable in linking the context of data that is associated with meaning to better understand the relationship to the environment in which that meaning was constructed. Stone goes one step further stating that there should be a strategy, which he calls *strategic context analysis* to provide the "missing institutional link" (Stone 1991:676) between ideation (what is wanted or vision) and reality (possibility of actualization). In his work, Stone uses examples such as the usage of strategic context analysis to mitigate some limitations of just depending on visible pattern recognition in document analysis when trying to unlock meaning and connection between logics. Through examination of these documents, I aimed to discover where potential conflicts may emerge between institutional logics.

I used pattern deducing and pattern matching (using reasoning to determine a pattern to see whether a logic is in use) in my analysis as I attempted to capture institutional logics exposed through sentiments, statements, and other forms of language used on the websites I scoured from the governing bodies of medical education and the two schools in my study to deduce referential meaning (Reay & Jones 2016:2). Yesim Kurt (2021) used a similar method and analyzed institutional logic and legitimacy literature in his research that she obtained from online posts, press releases, and news about the airport. Kurt also used descriptive content analysis as a data analysis method in

his research and noted how her research findings were enriched by the usage of direct quotations, obtained from websites and quotes from posts, which she used as a method to increase trustworthiness in qualitative research (Kurt 2021:3).

Noting the occurrence and frequencies of certain words and phrases as well as their placements on websites and in documents can aid in unearthing covert logics related to meaning and influence (Mills 1940). Pattern-matching to the ideal types of logics that these institutions want to embody may aid in seeing where conflicts may arise between desired goals of the institution and their ability to actualize in their current environment. Similar interpretative analytical methods have been used by Patricia Thornton and William Ocasio (2008) to understand the meaning that students and faculty may invest in their course of actions as they negotiate and reconcile competing logics. Michael McGee's work on ideographs, which contain ideological commitments and values that medical schools aim to uphold, will also be beneficial as I look at the differences between each institution and compare the usage of their ideographs (McGee 1980:8).

Conflicts that were identified aided in the next level of inquiry as I looked at the impact that they have on the individuals who inhabit these institutions and eventually their role in the change process. Like in the vein of inhabited institutions, I aimed to bring people back into the fold because people are a part of the creation of social realities (Hallet and Ventresca 2006:215). I took an iterative approach in refining my interview protocol to find effective and productive ways to ask students and faculty questions regarding if and how they experience, negotiate, and attempt to resolve conflicts between competing logics. Varpio et. al. (2017) used a similar method of analysis in exploring the institutional logics common across health professions education scholarship units

(HPESUs), an organizational structure in which a group of people is engaged in health professions education scholarship, and how these logics influence the organization and activities of these entities. Like Varpio et al.'s work, ten students were interviewed on Zoom using transcription. Transcriptions were reviewed and spot checked to ensure the accuracy of the transcription. The transcriptions were fed into ATLAS.ti for analysis. Each web page was converted into standard text and was uploaded into data analysis software. Once inputted, I used ATLAS.ti to locate and identify similar language that was used across each of the organizations to identify common variables, themes, as well as frequency.

Conducting Interviews

Using the information that was collected, I constructed and administered an interview protocol. Interviews with students and faculty acted as my second form of data as I attempted to understand the logics that may not be verbalized through the documents that were collected from websites. Thirty interviews were conducted altogether - five faculty/administrators and ten students from each respective school were interviewed to look for evidence that supports or does not support the research propositions I presented. Interviews can portray the actions of social actors within each organization and to ascertain the linkage between the role of institutional logics and the implementation of transformative learning practices. I developed a series of interview questions that targeted potential conflicts looking at 3 areas: mission of the school; implementation of service learning, and impact of diversity, equity, and inclusion on learning. Examples of research questions were: *a) What is the mission of your school?; b) Do you believe that your*

school embodies that mission? If so, why? If not, why not?; c) How is service learning implemented? And how are discussions related to diversity, equity, and inclusion appearing in your medical training? Though questions for faculty, administrators, and students may have some similarities, they will be slightly altered based on the audience. I contend that these interviews can capture phenomena related to institutional logics and the perceptions of the influence of those logics by students and faculty. Interviews were useful for this type of study because respondents were able to share a great deal of information in a manner that unearths unspoken logics that the interviewee may not even be aware of themselves (Weiss, 1994:3). Though, at times, interviewees may respond to questions and possibly conflate organizational practices with institutional logics (ILs), the two are not the same. Organizational practices are more specific and focus on micro-level practices and on individual level and group level processes, while organizational logics are broader and more dynamic and focus on macro-level processes associated with the underlying sets of values, beliefs, assumptions, and rules that guide organizational behavior and change. Organizational practices encompass the tangible actions, processes, and procedures that are followed by individuals and groups in their day-to-day work. Institutional logics on the other hand are more abstract and encompass the collective social and cultural norms that shape the actions and practices of organizations.

First-year students were excluded from this study because they are very much still in the transition period between undergraduate school and medical school or from a career to medical school and they generally are trying to get their bearings of being in medical school. This was also thought to be too much of a strain or pressure and first-year students would be able to describe or have a great deal of experience of being a

medical student. Third-year students were excluded from my study because they are in the clinical phase and therefore fully devoted to clinical work in the hospital and practice setting. And fourth-year students were excluded from the study because they may be too far removed from the process of service learning/transformational pedagogy implementation and may be more focused on the transition out of medical school and into residency programs. As each medical school has freedom as to when they implement service learning into their curriculum, it is not guaranteed that all student participants will have engaged in service learning yet, and this is a focus of exploration in my study.

I used snowball sampling and convenience sampling in my interview-based research. These strategies enabled me to reach the desired number of participants. I used snowball sampling because it gave me access to the population of focus in my study (Biernacki and Waldorf 1981). Convenience sampling paired well with snowball sampling in getting the desired number of participants for my study, and it also assisted with finding some differences in thoughts and opinions. For example, though faculty, administrators, and students identified in my research occupied the same schools, it provided me with the convenience of snowball sampling to create enough variation. The limitations to snowball sampling revolved around variations of values and culture. Snowball sampling may tend to connect me with people who have the same or close to the same opinions on the subject matter potentially lowering variation of logics identified due to relationships or shared lenses and therefore, convenience sampling may aid in creating more of that variation in examining perceptions of institutional logics and where conflicts may emerge.

Faculty was not involved in the selection process of students in my research due to potential influence of responses. Faculty might select students that they believe will give the "right" answer thereby influencing students' responses. There was no demographic (i.e., age, race, sex) component in my sampling. Though demographics such as age, race, and gender may have some impact on responses it makes it difficult to ascertain how much of this variation impacts responses made by students.

Due to the constraints stemming from the COVID-19/SARS COV2 pandemic, interviews were conducted virtually. Inclusion criteria for this study include faculty, administrators, and medical students who have just completed the first year of medical school. Students must also be able to provide verbal consent to participate in the study. Interviews occurred over the span of 6 months and were conducted on zoom. Interviews were transcribed using Zoom's transcription feature and then reviewed for accuracy. Transcriptions were then imported into ATLAS.ti for analysis. Interviews were analyzed looking at how faculty and administrators understand the mission of the school; their understanding of transformative learning; and the perceived impact of DEI on institutional culture and transformative learning. Participants had to confirm that they meet inclusion criteria when they receive the initial recruitment email. I will personally conduct all interviews and analyze the data. A consent protocol was created for students who opt in to be interviewed. Data was de-identified to ensure anonymity in responses from participants. Questions were open-ended and interviews were transcribed with permission from the interviewee. Interviews would last 30-45 minutes. To screen for eligibility, participants were asked if they recently completed their first year of medical school. The consent process took place before students engaged in the study. Consent

protocol was read to each potential interviewee. Throughout the study participants were made aware that they could withdraw from the study at any point. My dissertation work was built off my research and was submitted to Temple University Institutional Review Board (IRB) for approval and therefore was deemed IRB exempt because it had been submitted through IRB in the past two years and had gotten exempt status then.

Conclusion

A case study methodology enables advancement in this arena of study by allowing for the generation of new ways to conceptualize how we understand the role of covert practices generated by institutional logics during times of change that later may be tested by other methods. The documents that I used were useful in examining the impact of what happens when institutional logics are in conflict, the impact they may have on social actors, and how this impacts the implementation of transformative pedagogy. Documentation related to institutional structure, mission, leadership, how they define and describe service learning, and their relationship with their respective communities, were suitable for my research.

These documents were important in understanding the messaging of the respective organizations and schools to get a sense of the values that they are trying to convey. These documents compared with the data that I collected from interviews enhanced the validity of my coding. This also aided in seeing where there is resonance and dissonance between perceptions of how logics are preserved, and how objectives and values and strategies are being implemented and perceived. The alignment (or misalignment) between what is perceived as acceptance/adoption of transformative

pedagogy (such as service learning) in medical education versus practices that may, in turn, be counterproductive to goals set by the profession, the institution, and the curriculum is crucial to understanding the role of institutional logics. Lastly, this also served to add further information to the logics of the profession itself may play in this process of transformation and perhaps a basis for future exploration.

CHAPTER 3

FACULTY AND ADMINISTRATORS

Introduction

Ten medical school faculty and administrators (five from each school) participated in my study. Faculty and administrators, as well as the schools, were renamed to ensure confidentiality (n=10). Of my interviewees from Public University Medical School (PUMS), four of my interviewees identified as female (n=4) and one identified as male (n=1). For race, four participants identified as White, and one identified as Latino. All participants have been employed at the Private University Medical School (PRMS) for various amounts of time with the shortest tenure being one year and the longest being over fifteen years. Of my interviewees at PRMS, three of my interviewees identified as female (n=3) and two identified as male (n=2). For race, three participants identified as White, one identified as Black, and one identified as Latino. All participants have been employed at the PRMS for various amounts of time with the shortest tenure being four years and the longest also being over fifteen years. Participants were not asked if they switched roles during any point of their career at their respective universities.

Interviews occurred over the span of 6 months and were conducted on Zoom. Interviews were transcribed using Zoom's transcription feature and then reviewed for accuracy. Transcriptions were then imported into ATLAS.ti for analysis. Interviews were analyzed looking at how faculty and administrators understand the mission of the school; their understanding of transformative learning; and the perceived impact of DEI on institutional culture and transformative learning.

In this section I look at faculty and administrator responses to the questions from the interviews that were conducted. Discussion points were broken down into 3 areas: 1) mission, 2) service learning, and 3) diversity, equity, and inclusion. Based on responses provided by interviewees, themes emerged. Examples are provided of where these themes emerged as they relate to institutional logics and transformational learning.

From my interviews, I found considerable variation in responses from faculty and staff from PRMS faculty and administrators, as well as students, which I will address in the following chapter, and less variation in responses from PUMS faculty, administrators, and students. Despite the smallness of my sample, it clearly brought to light how shared cultures and understandings are pivotal to execution of transformative practices in medical education as I will demonstrate in this section. What is much less clear, given the scale of my sample, is how change is measured and what is the actual impact of the inclusion of these transformative practices. Despite this, the rich detail of the qualitative interview data yields 2 important insights: change takes time and a concerted effort. The final part of this section is devoted to questions about the impact of DEI on the change process. As I previously noted in the preceding chapter, there has been a greater interest in DEI and has permeated many in medical education.

Mission

To get a better understanding of the mission of each of the schools, faculty and administrator members were asked questions related to the core values of the school and their potential impact on service learning. There is much to be learned in the mission statement and how it is interpreted by the social actors who engage with it (Hafferty 1998). Much of the underlying values, structures, and cultures are encapsulated in these

short statements and function within the institutions they operate in (Taylor & Kahlke 2017). In my research I intentionally asked questions related to the core values before asking participants about the exact mission of the school. This is done in an effort to get a clearer answer that is not primed by the verbiage that is in the mission statement.

When faculty and administrators at PUMS were asked "what did they believe the core values of PUMS were?" all respondents stated that the core values of PUMS are related to student learning and academics. For example, Glenn (all respondents in this research are pseudonyms) stated that the core values of PUMS were to provide a quality education that prepares future practitioners. While Bob stated "that there is an emphasis on being a good clinician and how to connect to patients. This course and foundations of patient care really help shape these future physicians. There is also a huge emphasis on service. My office is an example of that, and it has been built into the curriculum for close to 30 years." Three of the respondents (Glenn, Perry, and Laverne) also noted how PUMS has a sense of community and is a collegial environment. Glenn stated that "PUMS builds a strong sense of community within and outside of the school." Perry noted that it is a very collegial environment, and everyone looks out for one another. While Laverne stated that "there is a mutual respect between administrators, faculty, students, and the administration."

When faculty and administrators at PRMS were asked "what do you believe the core values of PRMS are?" all respondents stated "community". Three respondents also stated education and training are also part of the core values of PRMS. Other responses were related to diversity, professionalism, and research. For example, Margaret stated "when you compliment clinical learning with what is going on in the community it helps

strengthen it." Walter stated that "service to the community shows student passion and is student driven." Sherry and Charles had some caveats to their answers regarding "community." Sherry stated that "community actions are important, but we (PRMS) have not figured out how to do it effectively or even to manage it." Charles added to their response about "community" adding "if the community knew about the message that PRMS has, then we could 'move the needle'. Residents don't truly know the mission of PRMS and don't see the distinguishing points of the school."

Logics related to values and purpose are reflected in the identity and purpose of the medical profession. Clinical and academic logics in addition to professional logics are the most prominent in the responses that were given. These collective logics shape much of the day-to-day practices and norms behind why the learning is occurring and its overall purpose to continue the longevity of the profession itself (Thorton & Ocasio 2008). Based on the responses and examples provided from the faculty and administrator of PUMS, there appears to be more of a shared understanding of values related to the profession and less variation in their responses compared to those of PRMS faculty and administrators. Though "community" was stated by all respondents the term was used in a more nebulous way and the variation lied in previous responses made by both faculty and administrators. With this much variation occurring in responses we can look to the communication or dissemination of said values in the mission statement in order to better understand where this variation may have occurred (Mills 1940).

The mission statement was recited to faculty and administrators. Faculty and administrators were asked "if it [the mission statement] makes a strong declaration about its purpose and values?" and "are the purpose and values reflected in the medical training

that students receive?" As with the previous question related to core values, we will see that there is more variation in responses from PRMS faculty and administrators than those at PUMS. These variations may stem from norms that are presented in the structure of the school as well as external and internal drivers (Meyer & Rowan 1977). All respondents agreed that the mission statement made a strong declaration about the purpose and values of PUMS and that they were reflected in the medical training that students were receiving and agreed that they were aligned with the training students were receiving. For example, Glenn stated "yes" from their experience because they sit in on a lot of live sessions. While Carla also replied "yes" and that when they are looking at their courses, they are cognizant of the way they expose students to good care. The mission statement was recited to faculty and administrators at PRMS and the same question was asked about the mission statement making a strong declaration about its purpose and values and are they reflected in the medical training that students are receiving. Though all respondents responded "yes", their responses were less definitive and had caveats to some of their responses and when asked "do they align with the medical training students were receiving", responses were mixed as well. For example, two respondents said "yes," with Walter stating "yes, there are so many faculty and educational leaders that are invested in the mission." While Carla responded "no," noting that they are trying and that they would be just as critical about any other institution.

As we continue to drill down the connection between the impact of these values and the mission, faculty and administrators were then asked "how do they think that the school's mission and core values shaped service learning?" These questions were asked to further address what norms that may come in conflict with the values that they hold to

be important (Horne & Mollborn 2020). Though faculty and administrators at PUMS presented their answers differently, they were all in agreement that the school's mission and core values greatly shaped service learning. For example, Glenn stated that PUMS's commitment to making the health advocacy practicum a required course reflects mission and commitment. Glenn also noted that support for other programs like the health outreach project, as well as other opportunities outside the practicum shows their commitment. Bob stated that "they (PUMS) see that it's important to provide service and learn from others." Perry noted that PUMS wants students to be compassionate and this is done by guiding them through coaching and having conversations and being a social support. Perry continued by stating that they "are preparing students for the importance of that human connection." Carla stated that "PUMS is very invested in service learning and that is reflected in the way students do it." Noting examples such as students' exposure in student run clinics, that aim to work in partnership with the community to provide health services to individuals who have limited or no access to care, and the ability to grow it however they like. Laverne had a more nuanced and expansive answer stating that "they (the school's mission and core values) inform and motivate those that are involved in community care and that only a small number of faculty that really embrace it." Carla continued by stating that "those values motivate those who are very interested."

When faculty and administrators at PRMS asked "how do they think that school's mission and core values shaped service learning?" respondents had various responses noting that there was a disconnect between what is published on the website versus what is actually happening at the school and that there is room for improvement. For example, Ben stated "there is an unspoken mission and core values. There is disconnect between

what's published and what's out there, as well as what is acted upon and translates to actual activity. They expanded on their response by saying "the stated core value and mission aren't nearly the actions and aren't represented in the core values. There is a disconnect between what's actually happening and what they do." Margaret stated that "it (PRMS) has great potential and not at capacity for what they could be doing." Margaret continued with saying "there are conversations about what to do about service learning, but nothing is happening. It (service learning) is off the table and has gone back to more volunteerism and less rigorous service learning." Margaret closed with "you go on the website, and you see stuff, but not being done," noting the student symposium as an example. Sherry stated that "PRMS, in general, being situated where it is, recognizes that service is important in a high poverty area and that a lot can be given back, but figuring out how to serve the community in a culturally competent way is harder. Sherry continues by saying that "I guess it does, but on paper, I don't think it's been given the resources or priority that it deserves. That includes consistent administrator or importance in the curriculum."

Walter and Charles noted that there also is room for improvement. Walter stated that "it is a way of exposing students to social determinants of health that they can't experience in the hospital." They remind students that being in the hospital is not the norm and that it is important to the person in the community to that in the hospital to show that they are the same person the things are related and combined and see the care." Walter finishes by stating that "it is important to understand the larger context of people's lives, if done well." Charles stated "There is room for improvement. Service learning isn't extremely restrictive. We are training students, but also giving them the opportunity to be

at sites alongside community leaders to develop something new. Charles finished by saying that "it needs to be flexible because the needs of the community changes."

At both institutions the drive for change is ever-present in the people that embody these schools. There is understanding of the values and needs of the profession, as faculty and administrators at both schools noted, but as we see from my interviews, that manifests itself differently in the institution itself. As with previous responses clinical and professional logics are present, but we begin to see a social justice logic emerge. We begin to see faculty and administrators navigate these logics, but as we see in these interviews, they aren't always reconciled. Over the years, there have been calls to reform medical education (Irby et. al 2010; Matathia & Tello 2020), but there has been less of a call to look at the cultures of the institutions who are responsible for providing medical education and training. Medical schools still struggle with reconciling logics related clinical knowledge, professional logic, and logics related to social justice. In my work we see that the medical schools themselves are pivotal in this process and the people and institutions must work in concert if there is going to be change in medical education. In this next section we look at how this impacts service learning.

Service Learning

As the field of medicine aims to be more socially responsible (Borges & Hartung 2007), I look at the potential impact of transformative learning in medical education and the perceived purpose of service learning in my work. When asked questions regarding the purpose of service learning, faculty and administrators at PUMS responded positively noting that it aids in students' understanding of others through exposure to different communities and individuals from other backgrounds. For example, Perry responded

"Working with communities and understanding their needs of the community from day one of medical school is important and it goes beyond just working with standardized patients" and Carla responded "exposing students to other backgrounds and individuals they may not have interacted with in the past is crucial. It is important for students to go out in the community, and I encourage students to volunteer across campuses."

When PRMS faculty were asked questions regarding the purpose of service learning, respondents responded positively noting that service-learning aids in connecting with communities to learn about others and build empathy, and also noted the importance of exposure to other communities and people. In discussing learning about others, Ben stated "it is important for students to think about the community and ask "what do we see when out in the lived environment?"; How much do you learn going to and leaving the site?" Ben continued with saying "students need to engage with people, see what happens. How they engage with health, power balance, learning from them. Ben ended with saying "people and communities matter" and that they "learn so much more in doing it. Students are able to reflect, but with initiated conversation and asking the question "why do they do it?" Connecting the dots." They noted that the context pieces are missing and there is a need for conversations, and post assessment, beyond just a reflection.

Margaret and Sherry echoed these sentiments with Margaret stating that "it gives students the ability to interact with communities and not be distant," and with Sherry stating "it (service learning) provides students the chance to have an opportunity to observe and interact with people from a different background than themselves." Walter added "the students have these interpersonal connections and are able to see what are

some of the challenges community members face. They see another side of people. Being in communities can get another perspective beyond statistics." Charles stated "you can teach it, but different it is when you actually meet someone living it. It personalizes it. In medicine so much is depersonalized. Charles closed with "a lot of students come to PRMS because of this because they are drawn to working with the community and hopefully community benefits form."

Regarding exposure, Sherry responded "students get a sense of environmental and system factors that they aren't aware of and how they manifest in people's daily lives and impact health outcomes." Charles added - To give the opportunities for students to be in communities." Walter responded "being embedded in a community and given exposure to communities they would care for well help them understand the circumstances that led them to the needs that they have. The intention to expose students to these topics on a personal level." Margaret adds "this (service learning) is a great opportunity to engage with the community at the same time with the hope of learning about what communities encounter that isn't clinical. Margaret continued by stating "participatory experience is very valuable! If done correctly people can understand issues that people are facing in the community sensitively and comprehensively if done correctly with the right balance of being in the community and reflecting on them." Ben adds "getting students out of the hospital and clinics into the community is key! They quote one of their colleagues, Lyle Beaver, stating "the primary role of a family physician is to know that health happens before they come into the clinic and after they leave." About building empathy, Walter responded "engaging in service-learning leads towards empathy and motivation to

advocate and change circumstances through political or social avenues and to help understand social determinants' health on a one-on-one level.

The value and the purpose of service learning is agreed upon by faculty and administrators at both institutions. The challenge lies in how to implement and measure its impact. This is not uncommon. According to Taylor & Kahlke (2017) the implementation of service learning still alludes most higher education institutions including medical schools. To get a better understanding of the role service-learning plays in medical training, faculty and administrator members were asked questions related to the institution, execution, and impact of service learning. Faculty and administrators were first asked "how is service learning initiated at their respective schools?"

As with previous questions, faculty and administrators at PUMS responded the same to this question stating that service learning is built into the curriculum and is a required course. It is a core course for all first- and second-year students at PUMS. The course focuses on the cultivation of relationships with communities and providing students with a better understanding of the underlying social factors that impact health. Each respondent continued on noting different aspects of the curriculum ranging from the implementation to the autonomy of the students in the course. For example, Glenn stated that "for part of the course, 1st year students have presentations, readings, reflections, discussions, and engage in 24 - 32 hours of a practicum at community site." Bob added "that students take the lead when it comes to selecting their sites." All respondents also added that there are multiple ways for students to engage in community work outside of the curriculum such as being a part of the health outreach program, student run interest

groups, etc. Carla also noted that there is an administrative hub that helps keep continuity as student projects grow.

Based on the responses of the faculty and administrators, there also appears to be a shared understanding of what the purpose, implementation, and impact of service learning is at PUMS. Respondents noted student exposure as an important aspect in the learning process. It is also important to note that this shared understanding is more than likely related to the fact that service learning is already embedded within the curriculum, thereby potentially giving it more legitimacy. The legitimizing of service learning as a course has provided greater influence in the change process by providing structure and weight to the work that transpires within the course thereby making it a stronger component of the culture of the school (Horne & Mollborn 2020).

Based on the responses of the faculty and administrator at PRMS there also appears to be a shared understanding of the purpose and the potential impact of service learning, but not when it comes to understanding of how it is implemented at the school to the point that some respondents stated that it has devolved. Logics related to the core function and purpose of service learning were present, but those logics come into conflict due to the somewhat fragmented implementation. There is no shared vision or understanding, and as previously stated, this could stem from the misalignment of mission and its connection to transformative learning. Unlike at PUMS, service learning is unmoored at PRMS and is not legitimized by a course, which inhibits the change process. Without social structure to reinforce or connect the work to the mission, service learning does not have the support systems needed to thrive.

For example, when asked at PRMS "how is service learning initiated at your school?" responses from faculty and administrators varied and leaned towards uncertainty. Two respondents were "unsure" on how service learning was initiated, with the other three respondents adding that service learning was "broken", in other places, scattered, and student led. Margaret and Walter noted that they were unsure how service learning was initiated. Margaret stated that they are "not sure the best way to answer that." They noted that there was a general understanding and service learning was once instituted. Margaret continued by saying that "for a lot of students without a ton of experience with communities of color and students with housing security it (service learning) can be beneficial if given the tools to interpret it. It's a marriage of being a physician advocate and understanding the community. Margaret ended with saying "some (students) didn't like it because it made them feel uncomfortable," but hopefully it helped them. Margaret was also not sure if it's currently required, and that it went from required to optional and believed that was due to some feedback from students. Walter echoed these sentiments adding that it (service learning) was not as prevalent as it once was.

Ben stated, "currently it (service learning) is broken in terms of initiation." They continued with saying "I wouldn't truly call it service learning. It is now defined as students finding opportunity under the guise of "service learning." It feels like we are throwing people into places, and, over time, it has been narrowed down and is not well understood by the administration leading it or students who are doing it, but this is not unique to PRMS." Margaret noted that one of the departments at the school has taken service learning over and that they have meetings with first year students that have

interest in service learning and explain projects for students to get involved with. Margaret also noted that students can do external community-based interdisciplinary learning experiences. Margaret also noted the community board from Student Government Organization (SGO), who has a mission to help students get involved in communities and understand issues. Margaret ended with saying that "there is a strand in the curriculum about social determinants of health and even though it is not directly service learning it helps them (students) understand community and SES issues that affect people's health and the importance of cultural humility and issue of racism. Charles also echoed Margaret's statements by saying "students share interest with professors at school," and that there are service opportunities and clubs, and student groups.

As we see, implementation and legitimizing service learning is important in its being embedded into the culture of the medical school, but change takes time, and bureaucratization could play a role in this process, both supporting and hindering it (Meyer & Rowan 1977). The next question addresses how service learning has changed over time at each medical school. We look at how service learning and its importance has been reconceptualized over time.

When asked questions about the evolution of service learning, faculty and administrators at PUMS agreed that the service learning at PUMS has evolved overtime. Each respondent shared a different reason for why service learning has evolved at PUMS. Glenn stated that even though the medical program just expanded to a new campus last year, that service has been a priority. Glenn's point speaks to how the reproduction of experiences, structures, and processes are made easier by the legitimization of service learning via a course (Hafferty 2019). Glenn also stated that the types of organizational

partners continue to expand based on the needs of the community. Bob noted several changes to how originally the program had two different tracks, one traditional, wherein students spent 16 hours in the community. The second track, which was originally 10 weeks then 7 weeks, students could go anywhere in the country to do service. Bob also noted that the medical school curriculum changed about 5 years ago and became the course. When it changed it, added a second-year component but became unrealistic due to time constraints. Perry noted how the program has built on itself due to student interest stating, "spin-off projects have happened and that students are starting to understand social determinants of health in new ways." Carla noted how COVID impacted how service learning was done and that "students had to react to figure out how to continue service work and that in some ways the pandemic has given students the ability to streamline and reassess programs to better facilitate clinics and help with continuity." And Laverne noted that service learning has increased, stating that "recognition is better" and "seeing it (service learning) as a much more accepted activity."

When asked if service learning has evolved overtime at PRMS, three respondents stated "no" and two of those respondents actually said that it has actually "de-evolved" over time. The other two respondents did not have an answer for the questions. Ben stated that "when I first started there, it was more aligned with tradition, but now it is a "check box" approach." Ben continued by saying that "it has lost its mission and ultimate understanding of what it is, why it is, and why it is a requirement. It has de-evolved, not understanding its importance of impact." Ben ended with saying "from what I hear from students, they don't understand what they get out of it, and I don't blame the students because it is unclear why they do it." Margaret also said that service learning has de-

evolved over time and “at a time there was a strong commitment to integrate service learning into curriculum, but it requires resources that weren't there.” They continued by saying “when I was there it was abandoned instead of explored. People aren't sure how to define it and then COVID had an impact. Also, race and diversity in medical training also had an impact on how to implement service learning.” Margaret reflected on a story about a service-related event a few years back and how it was replaced by talks about issues of race and other things related to LGBTQ issues. Charles noted how service learning was not “strategically organized” and didn’t allow students to reflect on it more.

As we see that service learning has taken two very different paths at each medical school. Service learning at PUMS has improved overtime, becoming more enmeshed and shaped by the school's culture, while service learning at PRMS has de-evolved overtime. This could be attributed to a myriad of reasons stemming from oversight or institutional logics being unable to connect to the mission of the school despite talks about “community” being highlighted by faculty and administration (Thornton, Ocasio, & Lounsbury 2014). The next question regarding the implementation of service learning may shed some light on how service learning has changed.

When asked questions regarding the implementation of service learning at PUMS, all respondents noted that it is a required course and that it is a part of their curriculum. Though there are other opportunities for students to engage and volunteer such as student clinics, student groups, and community based interprofessional learning experiences, the primary vehicle for service learning is through the curriculum. All respondents also noted that the service-learning curriculum has evolved over time. Respondents replied with states like: “we’ve expanded to a new campus, and it is clear that service is a priority;”

"the service-learning curriculum has built on itself based on student interest"; and "it has changed a lot, the medical school curriculum changed about 5 years ago and then became the community health course." Respondents at PRMS were asked "how do they engage students in service learning since it is not graded." Four of the responses were less than positive or unsure, and one respondent did not answer. Ben stated that "it's thrown as a requirement that they need to do, but it is a checkbox, but as we move towards a competency-based curriculum, it needs to be more than a checkbox. Ben continued on with saying "when it comes to administration, it is not any easy thing to do. It gets brushed to the side" Ben ended with "perception is reality. Since it's not graded, it becomes a checkbox, and not built as something is important, and without the emphasis behind it then it is not valued, and it doesn't matter."

Margaret stated that they "couldn't speak to this question." Margaret continued with saying "students who are into it commit to it, but those numbers are small. It's not mandatory because some faculty wanted to figure out how to better integrate it into the curriculum, but it hasn't happened." Margaret ended by saying that "recently a faculty member did talk with students about service learning 2.0 and how students in another program within the medical school do get an experience." Sherry and Charles echoed some of these sentiments stated by Margaret who said "the value was not appreciated by most students and there were lots of complaints about it." They continued by saying "those that were not service oriented, they missed the point." Charles also noted that their role is to facilitate conversation in reflection and that "at one point there was once check-ins with students, but no longer."

In my initial research I aimed to delve into what the core philosophy is of service learning and into the incorporation of medical education. One of things that we are seeing is the importance of curriculum design in the transformation process. Though faculty and administrators may at times conflate organizational practices and logics by focusing on more of the day-to-day practices, there is still much to be learned from their responses especially where it relates to coherence and consistency and how that is maintained. For example, the curriculum represents the expression of educational values and culture as it relates to practices (Prideaux 2003). The curriculum acts as a template on how knowledge will be administered, who is doing it, and what students will learn. According to Prideaux (2003) "The curriculum must be in a form that can be communicated to those associated with the learning institution, should be open to critique, and should be able to be readily transformed into practice." Service learning at PUMS has a set curriculum and plan and this plan allows for the dissemination of the values and logics, specifically those related to professional and clinical logics, of the institution. PRMS on the other hand, lacks coherence and consistency. It has no core plan or artifacts, like a curriculum, to latch on to and is creating much of the conflict impacting transformational change and the growth of service learning.

Though implementation varied at both medical schools, the hope that service learning could be a catalyst for change still exists. When faculty and administrators at PUMS were asked "if the goals of service learning are realistic and achievable," 4 out of 5 responded that they do believe that the goals set forth in their service-learning curriculum are realistic and achievable, with the 5th person responding that they were not sure but do see the value in service learning. For example, respondent one stated that

"Yes, I've seen students learn many new things about individuals and communities by working with service organizations. Some students have opened minds, some have faced new challenges, some are finding issues in the community that they never knew existed. Bob stated "Yes, because I've seen and talked to students that have been deeply moved and changed due to encounters; not just a potential patient, but people."

When faculty and administrators at PRMS were asked the same question "if the goals of service learning are realistic and achievable," all respondents responded that they do believe that the goals of service learning are realistic and achievable with three respondents noting that "if done correctly" noting changes need to be made to the curriculum; two respondents also noting "if properly resourced." Ben, with respect to service learning being done "correctly," stated "it is doable to do service learning correctly, it's just a matter of doing it correctly and wanting to do it correctly." Ben continued by saying that "it's a checkbox from senior level," ending with "though they might not agree with it but that's what they see." Walter stated that "they can't think of a better way to do it as an educator." Walter continued by saying that "they are lofty goals. Just a few hours in the community is not going to have a student to have an epiphany. If we are going to do it needs to be more structured and time in service to the community." Walter ended with saying that they are "not sure the advocacy curriculum is that overlaid with them. If it is tied better together it could achieve this goal."

Regarding "resources," Margaret prefaced her statement by telling a story about a previous place that they were employed, noting that it was funding for them to do it (service) and also helped residents explain what was going on. Margaret stated that "it is achievable if people are willing to put resources into it. This is where public health and

community workers could have a key role in laying groundwork. Margaret continued by saying that “without that it's just spotted stuff, but it is achievable with resources.”

Sherry and Charles noted how the individual students impact service-learning. Sherry stated “yes, I believe context is important in making the experience valuable. Students may see it, but not appreciate what they are seeing.” Charles echoed some of the same sentiments stating that “it depends on the student and if the student wants to learn. There has to be a desire to reflect on them.” Charles ended by stating that “yes, it is effective.”

For service learning to yield the desirable outcomes there needs to be a strong balance between the desires of the institution and that of the profession (Stewart & Wubbena 2014). Both are socially constructed by those who inhabit them, but external factors and support systems may be put into practice for them to thrive. As we see with PUMS, norms are being created and their mission is to be embodied, whereas with PRMS these norms are in flux and are more so ideas and harder to build on and achieve. In the last section we look at the influence DEI may have on this process of change. Institutional logics cut across medical schools and shape practices and norms. These logics adapt to new circumstances, as well as changes in the environment, but I contend that when they are constantly in flux, they become more disconnected from the missions and values of the school because they never have time to adhere to them. In the next section I examine and discuss logics related to social justice and how they may influence change.

Diversity, Equity, Inclusion

Diversity, equity, and inclusion (DEI) has continued to have a greater impact on medical training over the past few years, especially when it comes to service learning. In medical education, practices and processes related to DEI are associated with a social justice logic due to its strong emphasis on equity (in and out of the profession) and addressing disparities in healthcare and practice. The Association of American Medical Colleges (AAMC) for example, has created a framework for addressing and eliminating racism at the AAMC and in academic medicine. They have identified pillars related to their work, the academic medical community, as well as non-academic communities (The Association of American Medical Colleges, 2022). In this section I look at responses related to DEI and its impact on medical training at each medical school.

When PUMS faculty and administrators were asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given to students, all respondents responded "yes." Glenn noted that it has targeted areas, such as faculty reviewing curriculum and the review, reflection, and integration on more current issues. Bob stated that "it is emphasized in every single course that is run." They continue on with saying that "we have a vibrant diversity, equity, and inclusion office that does a lot when it comes to mandatory trainings. They met with students a lot and listened to them and made changes based on what the students said." Perry echoed what Glenn and Bob said noting that they see it in the course, and they have seen students reach out to figure out ways to make it better and the office makes sure that everyone is heard. Laverne also noted the trainings that are offered and discussed how there is even great curricular awareness and inclusion, however, she noted, even though DEI issues are in the curriculum, there are still not a lot of hours spent on it.

When PRMS faculty and administrators were asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given, three respondents responded "yes," with one respondent responding "yes and no" and the other responding "unsure." Margaret, Walter, and Sherry responded "yes." Margaret focuses on the changing landscape of medicine stating "You can open up any medical literature and see change is occurring. I think, in regard to implementing DEI, it will make changes, but will take time, but the landscape is changing." Margaret noted how they are seeing more people of color in more settings but were worried about the corporatization of the university and that this could be the latest trend. Margaret raised the following questions: "how can we capitalize on it (DEI)? Is it about branding and creating an image, or will it address the issues?" Margaret ended with noting concerns of some colleagues referring to students as "customers instead of learners," raising a final question: "Are we challenging people or just making it a commodity?" Though Ben replied with "yes and no" in their response, they also spoke to the landscape of medicine by stating "the system (medicine) may not fully value DEI and until we make broader changes, it may not be what it needs to be."

Walter and Sherry also spoke about the changing landscape of medicine, but also talked about the role of students in this change process. Walter stated "our students have been in front of diversity issues and the AAMC have been asking "how did they do it?" Walter continued by stating "students have organized very well to put pressure where pressure is needed to support URM (underrepresented minority) students and the recruitment of faculty. They have a comprehensive agenda and plans and have helped move the school along." Sherry added "students are much more embolden and

administration is much more inclined to hear wherein in the past they might have been much more hesitant." Sherry shared an example of students wanting to spend money on black owned businesses.

Ben and Charles were less clear on whether DEI has had an impact, with both responding with a "yes and no." As with respondents Walter and Sherry they noted the role of students in the change process by stating "it (DEI) is showing up because students are demanding it and asking for it; but in leadership it's still concepts that people at the top are making decisions the way to do it, it and it's not in their toolbox to do it." They continue you on with saying "we moved so fast without having the mentors, spaces, and people to connect, and making the change to have a culture who respects DEI." They followed with the question "are we doing harm by letting them (new students) come in by not doing what we said we would do?" Ben ended with stating "though there are more things there, it is not always clearly thought out or as it should be. Some things may not be done well or potentially done fast and could cause harm." Charles echoed with "not sure if it is in their (PRMS) capacity but could eventually be" noting the new initiative that has community members interview incoming students.

Medical schools are inhabited by people, and logics continue to be shaped by their presence and with the inclusion of DEI so shifts the social context (Zilber 2013). DEI offices were created at both schools in the past few years, but like many other medical schools, their increased power and interest were spurred by the murder of George Floyd in 2020 (Association of American Medical Colleges 2022). Nonetheless, the social justice logic has influenced DEI initiatives and has become more influential. It has legitimized structural and curricular changes in medical education (including service

learning and community engagement) and on the social sphere of their respective schools. For example, offices have been created staffed by DEI professionals and reports are being collected by entities, such as the AAMC, that measure progress made in this area. As we see, the impact is being felt within the school. Faculty and administrators, to varying extents, are generally not practitioners in service learning and have varying levels of understanding of adult learning and the implementation of curriculum (Halpern & Hakel 2003). We now focus on the conversations related to DEI that are had by faculty and administrators as it relates to changes in medical education.

When faculty and administrators at PUMS were asked if their colleagues talk about issues related to DEI, all but one respondent, respondent "yes," and the one who did not noted that it was because they did not have contact with a lot of faculty. When asked "how," Glenn noted that his colleagues talk about issues related to DEI as it relates to health outreach sites, specifically noting the LGBT and Hispanic Centers. Bob noted that it shows up so much in what they teach and their focus on how they do research, specifically stating that "they look through a lens of understanding." Perry noted that they learn from other colleagues, stating that "they talk like passionate advocates, very respectful and meaningful." Carla noted that they are very aware, stating that "they ask more questions to make it a better experience for community members."

When faculty and administrators at PRMS were asked if their colleagues talk about issues related to DEI, all responded "yes." When asked "how" Ben noted that they spoke to other faculty when they arrived, and those conversations were not there but are now. Walter, Sherry, and Charles spoke to faculty training and representation, with Walter noting faculty development on DEI and classes for faculty, as well as

administrators, must take, and Sherry and Charles speaking more towards the continued diversification of faculty and voices. Charles notes that more conversations have opened and there needs to be more inclusion. Charles ended by asking the questions: "When thinking about DEI we need to ask "what is the goal? Are we creating a pipeline? Are students from that area?"

Based on the responses of the faculty and administrator at PUMS there appears to be a shared understanding among all respondents of the impact of DEI on the medical training their students are receiving. This could be attributed to conversations that are being had between colleagues as they work to adhere to the current requirements, changes, and trends in medical training. Logics such as clinical, professional, and social justice that present themselves are more aligned in culture, but there is no definite way to know if it stems from that of the school or that of the culture of medicine. Based on the responses of faculty and administrators at PRMS there again appears to be less of a shared understanding amongst all respondents if measures related to DEI are showing up in medical school training. This is in spite of the fact that respondents agreed that their colleagues are talking about issues related to DEI. This may impact transformative learning practices (i.e., service learning) in a negative way. Much of the conversations that were had with respondents regarding service learning spoke to "exposure" and "getting to know other people." I contend that this is tied to the DEI practices and the logics, or rather the new logics, that are influenced by DEI and impacting learning.

CHAPTER 4

STUDENTS

Introduction

Twenty first year medical students (ten from each school) participated in my study. Like faculty and administrators, students were renamed to ensure confidentiality (n=20). Of my interviewees from PUMS, six identified as female (n=6) and four identified as male (n=4). For race, four interviewees identified as White, two identified as Black, two identified as Asian, and two identified as Latino. Of my interviewees at PRMS, six identified as female (n=6) and four identified as male (n=4). For race, five interviewees identified as White, two identified as Black, two identified as Latino, and one identified as Asian. All interviewees have also completed at least one semester of medical school.

Due to the volume of interviews, interviews occurred over the span of 8 months and were conducted on Zoom. Interviews were transcribed using Zoom's transcription feature and then reviewed for accuracy. Transcriptions were then imported into ATLAS.ti for analysis. Interviews were analyzed looking at students' understanding of the mission of their respective schools; their understanding of transformative learning (e.g., service learning); and the perceived impact of DEI on institutional culture and transformative learning.

In this chapter I look at students' responses to the questions from the interviews that were conducted. As with the previous chapter on faculty and administrators, discussion points were broken down into 3 areas: 1) mission, 2) service learning, and 3) diversity, equity, and inclusion. Based on responses provided by interviewees, themes

emerged. Examples are provided of where these themes emerged as they relate to institutional logics and transformational learning.

My interviews revealed less variation in responses from students at PRMS related to the topic areas as they are in conversation with one another. There is a great deal of unsteadiness when it comes to service learning, which I will address in this chapter. As with the faculty and administrators, there is less variation in responses from PUMS students. This clearly brought to light how shared cultures and understandings are pivotal to execution of transformative practices in medical education as I will demonstrate in this section. What is much less clear, given the scale of my sample, is how change is measured and what is the actual impact of the inclusion of these transformative practices especially when the population changes every year bringing new students with varied thoughts, feelings, and agendas. Despite this, the rich detail of the qualitative interview data yields important insights: as stability, coherence, and consistency in medical educational training are recognized as pivotal factors. The final part of this section is devoted to questions about the impact of diversity, equity, and inclusion initiatives (DEI) on the change process. As I noted in the preceding chapter, there has been a growing interest in DEI and has permeated many aspects of medical education. My findings shed some light on its impact in two medical schools.

Mission

To get a better understanding of how students interpret the mission of each of the schools, students were asked questions related to the core values of the school and their potential impact on service learning. As I stated in the previous chapter, there is much to be learned in the mission statement and as well as how it is interpreted by the social

actors (Hafferty 1998). Much of the underlying values, structures, and cultures are encapsulated in these short statements and function within the institutions they operate in (Taylor & Kahlke 2017). In my research I intentionally asked questions related to the core values before asking participants about the exact mission of the school. This was done in an effort to get a candid answer that is not primed by the verbiage that is in the mission statement.

When students at PUMS were asked "what do you believe the core values of PUMS are?," the majority of students noted that the core values of PUMS were related to "community" and "service. For example, Elliot responded "diversity is one of the tenets that is most important to me as well as community service." Chris and Sonja echoed Elliot's response by listing "community," as well as "diversity" and "inclusivity" as to what the core values of PUMS are. Howie also echoed these sentiments, and added the purpose being also related to "culturally competent and diverse doctors that understand the barriers that patients face in the future." There was one outlier, with John noting that the core values are more associated with "money" and though they believe the school does try, that's PUMS major core value.

When students at PRMS were asked "what do you believe the core values of PRMS are?" all students stated "community," with five students also noting "training" as a core value. Examples of responses related to "community" were "...community within and outside of the school" (Gloria) and "...family and community oriented, meaning among the student body and the way students operate" (John). Stanley also spoke of how "community" as a core value of PRMS and added "I'm struggling with how it (core values) is embodied within the school." Stanley continued with stating "but on the day to

day, it (PRMS) feels community-oriented to students, but as a student myself I often ask myself 'is this exploitative or is it helping the community."

Half of students interviewed also noted "training" as one of the core values of PRMS. Examples of this were from statements such as "training effective physicians to effectively work with the community" (Justin) and "having a spirit of leadership by allowing students to express themselves and create projects and new paths in medicine" (Andy). John shared similar sentiments by stating "honing more on why you need to know these skills and not just the test and making sure physicians are being prepared to work with communities."

There is a norm shift occurring in the field of medical education to better value the role of service in medical education (Stewart & Wubbena 2014; Meili, Fuller, Lydiate 2011). Though norms are not values, they can, according to Horne and Mollborn (2020) become internalized and become a part of one's value system and have important connections to culture. As we see in the responses from students at both schools, the common theme that emerged regarding "core values" was around "community," though the word is not used in either of the schools' mission statements but can be found in one of PUMS's guiding principles. Their responses are related to clinical and professional logics and somewhat to academic logic as it relates to general academic pursuit. Despite the small sample size, there was an obvious pattern of seeing that "community" is a value that students care about and as we will see in the following responses, has an impact on logics related to culture and the shifting of said culture to meet the current trend in medical education towards service.

After the mission statement was recited to students at PUMS, students were then asked "if it makes a strong declaration about its purpose and values and are they reflected in the medical training that they are receiving?" All students, except for one, agreed that the mission statement made a strong declaration about the purpose and values of PUMS and that they were reflected in the medical training that they were receiving. For example, Katie stated "Yes, I believe it does, we have way more medical knowledge than before." Katie continued by stating "some older doctors may have some bumps in teaching, but they try to learn." Katie concluded with "everything is not executed perfectly, but they (faculty) are trying." Denise echoed some of Katie's sentiments, again, acknowledging that the school is trying to increase diversity, but still lacking. They stated "they (PUMS) are trying, but it still needs work." Other aspects of the mission statement that emerged from students' responses revolved around research. For example, Chris and Drew spoke about how "huge" the school is on research, noting opportunities for collaboration and the ability for students to contribute and Howie stated that the "research is about the same as most schools and they do more in the research aspect."

After the mission statement was recited to students at PRMS, students were asked "if it makes a strong declaration about its purpose and values and are they reflected in the medical training that students receive," all but one student responded "yes." There were caveats to some responses. For example, Catherine stated "They declare it and that's what pulled me here, but being a part of every facet that they do needs work. It's all about intentionality." Students spoke of measures that the school could take to strengthen relationships with communities, such as having a community board and having community members be a part of their community service board. Students also noted that

having community members in the admissions process was a step forward. Other responses related to the mission also focused on the theme of "community." For example, Gloria stated "Yes, if you want to get research or work more with the community, there are different avenues that students can seek out." Gloria continued "but I wish there were more, and I wish they were baked more into the curriculum." Clara also responded "PRMS is making strides to bettering itself and embodying its community by having a more diverse group of students."

The student that responded "no" (John) stated that this was the only time they had ever heard it, however, John did agree with the part of the mission statement that focused on "education." John responded with "(PRMS) is excellent in education and patient care." John noted that this is exemplified by events and hearing from people, like a dean. Lastly, John noted that PRMS uses resources well to help students and make students feel like they are heard and that the school is adaptable to make changes.

There is alignment between students' responses prior to having the mission read to them and after the mission was read to them, however, students begin to give caveats to their responses, especially students from PRMS. I contend that these breaking downs or "caveats" begin to emerge when normative expectations are challenged (Horne & Mollborn 2020) when the mission was recited to them. As I previously stated, though norms are not values, norms can become a part of the value system and therefore can become part of the overarching logics that are created and embodied in an institution. When competing (and potentially contradictory) logics are presented, challenges (as well as conflict) that may stability and change begin to emerge. Prior comments are expanded upon to reveal richer data, as we see in the responses above. This is a part of the

institutional change process (Thornton, Ocasio, Lounsbury 2014). In the following questions, we will see how students respond to questions regarding the influence of these values as it relates to service learning.

When PUMS students were asked "how do they think that school's mission and core values shaped service learning?" students had various responses, but all agreed that the school's mission and core values greatly shaped service learning. Most responses were related to what was learned through their courses. For example, Elliot noted the purpose of the community health course and its goal to get students out and participating. The community health course is a core course in the first and second years of medical school, focused on learning about social determinants of health, health disparities and trauma-responsive care. The major focus of the course is a community-based experience, through which students learn from the lived experiences of their community partners and develop and apply basic health coaching and health advocacy skills.

PUMS students also noted that the practicum gives students the ability to read through a list of different partner organizations giving them the diversity and agency in choosing a site and clientele to work with. Other students referred to the community health course when discussing what they thought the mission and core values that shaped service learning with Sonja stating that "they (mission and core values) put a huge emphasis on service learning, and it helps us learn the more human side of medicine." Chris and Cole echoed Sonja's sentiments with Chris also using their class on patient care as an example and how they are being trained to be more "reflective in activities they are engaged in" and Cole noting how these experiences "really do try to connect students throughout the city that help medically underserved communities."

When PRMS students were asked "how do they think that school's mission and core values shaped service learning?" students had various responses. Students spoke highly about the value of service learning and themes emerged around "learning about communities" and "opportunities." Justin stated "they go hand in hand. We have to know the people they are treating, and service-based learning helps facilitate that." Libby echoed these sentiments stating, "A lot of this is about service learning and this is a great place for service learning." Regarding "opportunities," students spoke about how the school provides them with the opportunity to engage in some form of community-based work or service learning. For example, "it shapes it by encouraging students to do more community-based service learning and projects where students have a direct connection to people" (Arnold). Arnold also noted that there is monetary support from the community service board wherein students can get money to start new projects and students are encouraged to start new projects.

Though students responded fairly well about how the schools' mission and values shaped service learning, Stanley shared that this wasn't entirely true. He referenced the influence of a strand in the curriculum that focuses on race and medicine and another degree program at the medical school. Stanley also stated "if you aren't in the strand on race and medicine or a part of the other degree program at the medical school, then students aren't primed." They continued by saying that "it (the connection between the mission, core values, and service learning) needs to be more explicit. There is a disconnect between mission and service learning because it is not presented in a good way."

Students at both medical schools agreed that the mission of each medical school

helped shape service learning. The biggest difference came to the execution of service learning, which I will speak more about in the following section. Service learning is a course at PUMS, while at PRMS, service learning is not centrally run. Service learning is more legitimized at PUMS, and this legitimacy provides it with more structure and influence as well as the ability to better embody and align with the mission of the school. This legitimacy grants it other beneficial transformative properties related to techniques, policies, and functions and lessens conflicts when it comes to employed and embodied (Meyer and Rowan 1977). Loose couplings, according to Meyer and Rowan (1977), continue to create structural gaps and inefficient conflicts that may hamper change and transformation. In this next section we learn more about students' perceptions of service learning as it relates to the mission of their respective schools.

Service Learning

Service learning is one of the standards that medical schools must meet to remain accredited (Liaison Committee on Medical Education 2020). The LCME (2019:26) defines service learning as "educational experiences that enable medical students to engage communities in activities that respond to community-identified concerns and reflect on these interactions." Service learning is defined somewhat nebulously so that medical schools have the ability in a way that takes in account their respective resources and institutional cultures. In this section I examine the way students perceive the purpose of service learning, how it is instituted, and how it impacts, and if the ideals of service learning are achievable.

When students at PUMS were asked questions regarding the purpose of service learning, students responded positively with points related to “exposure to different

people" and skills that "aren't learned in clinical rotations." For example, in regard to exposure to different people, Elliot responded "you learn about people's past experiences." Elliot continued by "I want to be able to understand those lived experiences because intentionality changes how they perform and engage with those experiences. There is a dynamic interplay between who you are and who you are working with." Lucy had a similar response with saying "it puts you into real world scenarios." Lucy segues into skills that aren't learned in clinical rotations by stating "in the classroom you do simulated sessions, but this (service learning) puts you in scenarios where you are presented with the most difficult obstacles." Some other comments related to "skills that weren't learned in clinical rotation" were "it is a means of socializing students in the context of the preclinical part of education by training students to be more comfortable in a clinical setting" (Lucy). Drew echoed Lucy's sentiments and added "it's not just learning about diseases but how to apply it and we learn this by helping out in non-clinical ways." Drew ended with "we are keeping that service spirit alive."

When asked questions regarding the purpose of service learning, students responded positively. Themes that emerged were around "learning skills" and "exposure." Examples related to "learning skills" emerged in all but one of the interviews. For example, Justin stated "it helps keep it applicable that I am working with people. It helps build interpersonal and listening skills." Justin goes further with saying "other skills like making eye contact and the ability to effectively treat a patient and have a meaningful conversation." Gloria echoed Justin's sentiments and added "it helps in developing people skills by helping you communicate with people in the community but also showing gaps in care that communities have."

The learning of skills related to the theme of "exposure" emerged in seven of the interviews. For example, Gloria also stated "there are things that you could learn in the classroom but not really, service learning helps you see things in a practical way." Catherine shared similar remarks to Gloria stating, "we can see patients in their everyday environment and potentially be able to foster a relationship." Catherine continued with "it gives us exposure to someone that we may take care of one day. It humanizes people." Arnold also shared "by doing or giving your time for free you should be learning things that you won't learn in a classroom setting. There is a difference between theory and practice." Lastly, John shared "it allows us to gain skills that can only be learned from experience, like language and pattern recognition."

From the responses students see great value in service learning with the common theme that emerged as "exposure." Exposure can shape experiences, which is one of the key components of service learning. Though oftentimes "exposure" and "experience" are used synonymously, I contend, unlike exposure, experience has a greater level of intentionality behind it giving the space for learning to occur. Physicians are exposed to a myriad of things every day that they walk into a hospital or clinic, but it is their experiences that will enable them to meet the day-to-day challenges that will confront as they move further in their career by reflecting and learning from what they have experienced (Myers & Pronovost 2017). Again, clinical and professional logics emerge, and to a lesser extent academic logic, present themselves in the responses. Students see the value in this exposure and how these experiences can benefit them as physicians. They see the value of training in unfamiliar settings. Students learn that context matters and how training and learning in these unfamiliar settings creates skills related to

resilience and problem solving (Greenhill et. al 2018; Van Schalkkwyk et. al. 2019; Cavanagh et. al 2019). Transformative learning practices, like service learning, are valuable and valued. In this next section we ask students about the implementation of service learning. Though students see the value in service learning, these questions are geared towards how it is actually executed and actualized as it relates to their training.

When students at PUMS were asked "how is service learning initiated at your school," all students responded the same stating that service learning is built into the curriculum and is a required course in community health. The question "how are students engaged in service learning since it is not graded" was therefore omitted since service learning is already a part of the curriculum and is mandatory. Though students did not go into too much depth about the community health course, a third of students identified other opportunities outside of the community health course to engage in. For example, students have the ability to engage in volunteering with the PUMS's student run clinic, which provides free clinics in the vicinity of the school in hopes of providing access and opportunities to underserved communities.

When students at PRMS were asked "how is service learning initiated at your school?" responses varied. A theme that emerged was around having the ability to engage in community related opportunities, but there did not appear to be organized service learning, with three students explicitly stating that service learning is not a requirement. Activities that were brought up during interviews varied as well. For example, Stanley stated "there are a few different projects such as outreach at a local church and the medical science sessions at a local high school." Clara spoke to the service-learning groups that have emerged at the school over years, stating "there used to be a requirement

(service learning) for the school, but there is no longer a requirement. “Clara continued by stating “students do their own projects or ask school for money to execute projects. There are service-learning groups that have ongoing projects, but it’s all very individual. No requirement on how students do it.” Libby shared similar remarks, stating “there are activities that students participate in and also different classes you can take. I took an elective on urban communities and got to meet and learn about people in the neighborhood where the school is located.” Then ended with “there are also National Societies and club level stuff that students get involved with as well.”

Again, we see from the responses that when students were asked about how service learning was instituted at their respective schools, students from PUMS were in alignment, citing their community health course, while students at PRMS referenced different ways students could get involved with service learning. A student at PRMS made a comment referring to funding and how it is related to the execution of service learning. This also speaks to a logic that has only mildly presented itself, market logic. The market logic emphasizes more of the market-driven aspects of education related to efficiency, financial sustainability, and cost-effectiveness. This somewhat speaks to Stewart and Wubbena (2014) points on how funding can act as a constraint on the execution of service learning and its purported value, however, in this case, the student mentions that funding can be found in other places if students have a project of interest. This could be misinterpreted as giving value to goals of service learning. In actuality it is an inefficient means and only aids in the learning process for self-selected individuals who would like to do unguided community-engagement. In previous statements students mentioned how “community” was something that both schools valued, however, when it

comes to acting on that PUMS has placed more resources into service learning, which can be perceived as a vehicle to exemplify this value. This speaks to the conflicts that emerge in the responses from students from PRMS. Lastly, I speak to the achievability of service learning. As I have noted, PUMS has a robust centralized program with guided support systems wherein PRMS is more student-driven with less guidance and fewer support systems.

When students at PUMS were asked "if the goals of service learning are realistic and achievable" all students responded favorably, noting the "utility" of service learning, specifically highlighting exposure, and the implementation and structure of service learning. With respect to "exposure," Denise responded "the benefits and success and are useful to learn." They continued on by stating "This is really great exposure. It helps mold "self." Regarding structure and implementation, Drew stated "yes, because of how it is structured in the curriculum" and Cole stated "yes, they are because we learn more there" (referring to the community).

When students at PRMS were asked "if the goals of service learning are realistic and achievable," only half of students responded to this question. Of those who did respond, three responded "no" and two responded "yes" with the caveat "if done correctly." Those that responded "no" pointed out that the school did not have the proper reinforcements to achieve these goals, noting the implementation of service learning and support systems. For example, Stanley stated "no, because you aren't obligated to do service learning, just the people are interested in." Stanley continued by stating "it (service learning) doesn't capture the people that may need to put in the work." Libby echoed Stanley's sentiments by adding "there is no reflective space for students after they

do the events. Nothing is done before or after." The two students that responded "yes" with Clara stating "they are, but the only way you can do it is by going in with the mindset that they are going to be committed to it and not a little side project." Arnold shared similar sentiments by stating "service learning needs to be continuous because the more time you spend the more you learn. They continue with "building relationships with people takes time."

One of the key elements of service learning is that it needs to focus on the service and the academic context, and this balance is crucial, along with reflection, to ensure what is learned through this exposure so that it can be incorporated into practice. Again, the most prevalent logics that are presented are that of clinical and professional, but we see that social justice begins to have a more prominent influence. Though students at both institutions noted the utility and benefit of service learning, students at PRMS responses were mixed, with many leaning towards "no" when presented with the question "are the goals of service-learning realistic or achievable." These answers may stem from the lack of fidelity regarding the execution of service learning at PUMS, and this lack of fidelity may negatively impact service learning's ability to impact transformative learning.

What PRMS is doing is not uncommon. Service learning is oftentimes used interchangeably with terms like community service, volunteering, and civic engagement (Borges and Hartung 2007; Stewart and Wubbena 2014). This is not to say that students who do engage in practices that are related to service learning aren't receiving some benefits or being impacted in some way by the exposure that they receive by engaging with others in non-clinical, community-based settings. However, the misuse of the term "service learning" does not fulfill the goal of service learning and only mildly meets the

standards as presented by the LCME for a select few students who opt into do community-engagement, which generally student led with little to no guidance and varied impact on the student as well as the community in which they are engaging. Also, these students who are attracted to do some kind of service-related work may already have the proclivity to engage in service.

Diversity, Equity, Inclusion

In recent years, DEI has gained significant traction in society, prompting medical schools to incorporate DEI statements on their websites and integrate them into training programs. In my research I note that there has been a renewed interest in diversity, equity, and inclusion and this renewed interest has an impact on transformative learning and medical education. Conflicts emerge when values are challenged. Using an institutional logics framework, we can examine how the articulation and realization of values lead to questions and potential conflicts. The introduction of new factors, such as diversity, equity, and inclusion can further contribute to conflicts. The last series of questions asked students about the influence of DEI on their medical training and the extent to which faculty and peers engage in discussions about DEI. As with faculty and administrators the more prominent logic that presents itself is that of social justice, however clinical and professional logics are also present. Also, though students often will share some tangible organizational and process and actions in their responses, a focus on more abstract assumptions, behaviors, and beliefs gives a greater insight into how they navigate and reconcile logics.

When students at PUMS were asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given, all students

responded “yes.” Students spoke to how diversity, equity, and inclusion efforts are being introduced and the reasoning behind its (DEI) increased inclusion. In regard to efforts that are being introduced four students noted curricular ways, such as in one of their courses that focuses on the caring for patients and individuals from the DEI Office holding dual sessions with students, wherein, as Katie stated “people from the DEI office come in and talk to and make themselves available to talk more.” Two students also mentioned a task force that focuses on anti-racism measures at the school as another example of DEI efforts at PUMS. The taskforce is composed of stakeholders from the PUMS community (i.e., faculty, staff, students, and alumni), whose goal is to weave anti-racism into the very fabric of PUMS by dismantling systemic racism and fostering equity, inclusion, and justice.

In discussing the reasoning behind the inclusion of DEI efforts, seven students noted the perceived intentions of the school and the role that students play in the proliferation of this ideology. John and Howie pointed to the role that the AAMC has played with John stating that “the AAMC has a big impact on why talks about diversity should be more in our medical training. “Chris noted that “it (DEI) is making our departments more robust.” Elliot echoed Chris’ sentiments by stating “yes, they (PUMS) try their best to talk about issues and chunk it up and incorporate different aspects of it (DEI) into our training.” Regarding the role students play, six students expressed that students do have a role in the proliferation of ideology related to DEI specifically noting how feedback is given and received. For example, Denise stated “I feel like I can give feedback, especially when it comes to interactions with the community.” Cole responded similarly adding “the student population is asking for more included in their education.”

Cole continued and stated “there sometimes that the resources that are given to students are sometimes lacking, but students have again made big pushes to provide additional resources and the faculty has been positively responsive.”

When asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given, all students responded “yes.” The common theme was related to the curriculum, specifically regarding execution and usage of materials in courses. For example, seven students mentioned the course focused on the history of race in medicine that is a part of the strand that addresses race and medicine. At PRMS, strands were designed to focus and connect similar areas of focus throughout various courses that are being taught. The role of the Office of Diversity, Equity, and Inclusion was also mentioned as well by three students, alluding to it being a driver for change.

Examples of themes related to curriculum, specifically related to courses were “Yeah, definitely within the race and medicine course. That was the big one (Stanley). Other examples were “yeah I think for sure I think in our doctoring classes” (Justin) and “Oh, absolutely. Yeah. Like not for us, everything is (Ernest). Ernest continued with, “when we start a new block. They always give us a lecture, or whatever on like, but where they basically review the lectures for any, any information that is not scientifically proven. So certain people tolerate pain more than others. Or if you're learning about specific body systems, certain calculations that they use and constants that they like, numbers that they will use.” In regard to the execution of and usage of materials in courses they cited readings that they had to complete. Four students referenced the book used in the race and medicine course addressing the impact of race on education; two

students referenced the book on race and culture; while one student referenced the book the hidden cost of racism.

One student also spoke of the efforts made in increasing the pipeline of students of color through the creation of a medical school readiness program. Clara stated" I mean when I think of diversity and inclusion, I think of all of those things like the curriculum. But then also I've noticed, and this is a part of the reason why I decided to look at PRMS was because it seemed like they had a very diverse student population at the medical school level but, like medical school, is already a like medicine is a profession that's like predominantly white, and so there are more white students in the class, but I feel like here they've made a very conscious effort to like increase the number of non-white students, and it's very visible the effort that they've made."

Though the role of the Office of Diversity, Equity, and Inclusion was only mentioned by three students, it is worth mentioning because of the perceived influence on change. For example, Catherine states "yeah, like they get. It's not just black, Black Latinx or um POC. It's all students who are interested (referring to the Diversity Council). But we get to have conversations around it (race), and then um, we do have our Diversity Office." Catherine continues by stating "so I feel like overall, think we have the system. We still have a lot of navigating we have to do, but we have different tiers of where we can go, and it exists." Stanley echoed similarly with "I don't know I've never really been in an area that wasn't very diverse so last year, my post-bac class not being the most diverse, I was very out of place. But I think even just walking through the halls here, you see there's it's not like what I pictured you know, a typical medical school but I don't think it's a picture temple to feel it. It's just there's people, there's just so many

different people here and the Office I don't want to say um but, like the Office of Diversity, Equity, and Inclusion, I think were a huge presence during our orientation week they came to speak to us so many times." Stanley closes with "I think Dr. X read something in the morning and afternoon sessions. It's from that office you know so they really have a dedication to diversity."

From the responses we learned that curricula measures are being enacted to discuss and engage students in conversations around diversity, equity, and inclusion at both schools. Students from both schools acknowledged the impact of DEI on their current medical training, particularly on the curriculum. This makes sense because diversity is mentioned in both schools' missions. As I mentioned previously, social zeitgeist has also changed. Again, I use the death of George Floyd as an inflection point of where change began to occur. This differs from previous responses, specifically looking at PRMS, wherein service learning was not as supported or embedded in the program. However, students throughout the interview, specifically looking at PRMS, the influence of DEI has had on their medical training. The next series of questions are related perceptions of faculty members and how they discuss DEI followed how students perceive how their peers discuss DEI. As noted in this section, students and faculty are engaging in conversation and creating intentional change, but how does that look when we look at them as separate units?

When students at PUMS were asked if their professors talk about issues related to DEI, all students responded "yes" with 3 students adding the caveat "but not all." The students pointed to instances in which they have heard professors either directly talk about DEI or DEI related topics in their courses and/or how they have incorporated it into

lectures. For example, Sonja responded “I see it in my course that focuses on patient care, but not really in my more science classes.” Lucy shared a similar response stating, “they talk about it more and more, for example my professor was talking about rashes and gave examples how it may appear on people with different skin colors.” Howie shared similar instances wherein one of their courses a professor compared them to different nervous systems and specifically showed them one of a black woman, and later engaged them in discussion. Denise discussed another instance where a discussion on discrepancies of how race may play a role and impact services that are provided and noted that there was some uncomfortably on the lecturers and some of the students’ part, during the discussion.

When students at PRMS were asked if their professors talk about issues related to DEI, five students responded “yes,” two responded “no,” and three were “unsure.” For students that responded “yes” the common themes were around the capacity in which faculty discuss DEI related efforts within the courses they are taking. For example, Clara stated “so when you're asking like, Oh, is it noticeable that there's a shift? I'm like, yes, because the largest, the most like, I guess, visible or easily identifiable thing is like skin color. So, all the time more in blocks and more. I'm learning about this. They're like. Oh, and they'll try to show pictures like, and this is what it will look like on somebody with white skin, and this is what it will look like on somebody with black skin so like they try to. They try to do that.” Andy responded similarly with “thought professors taught really well last year, but you know I've ever had one Professor who really pushed us on patient first language and using pronouns, gendered language, like how to say their name and

ways to address issues. I see professors making the same effort. They concluded with, "not seeing it as much as I'd wish, but they try to have good inclusion."

For students who replied "no," they also referred to the capacity in which faculty discuss DEI related efforts within the courses they are taking but noted that they did not see discussions around DEI in the academic portion of classes. Gloria stated "I would say, not so much in like the academic portion and I don't even know what like if academic is the right word, but it's not all academic, but like if I'm learning about the kidneys." Gloria added "like we're not learning so much, but they are doing a better job at showing like different skin tones, different skin colors and like what a rash or like a specific finding might look like on someone with lighter skin versus darker skin." Libby echoed Gloria's sentiments and also noted the efforts being shown, but very class dependent. students that responded that they were "unsure" had similar responses, citing nuance, much like students who responded "no." For example, Catherine stated "I think someone in our Diversity Office is doing referencing work. I think Dr. H is one of the leads on it, and they review all the lectures." they concluded with "I don't get to actively see that, but I know that it's happening."

From what I gleaned from responses from all students from both medical schools, conversations are being had between faculty and administrators about DEI but to varying degrees. Two takeaways are that some of this engagement is context based, looking at the class the students are taking and what is being taught, and the other is that there is so much variety in faculty and administrators. As Greenhill et. al (2018) notes "context matters in the transformational learning process" as does time. Many faculty and administrators have been employed by their respective universities and have been

working for years in the field. As I mentioned previously "exposure can shape experiences" and for many faculty members and administrators this is the first time that not only they have grappled with these issues, but also had to employ them creating a sense of uncomfortableness and coming off as "clunky." In this final part, we asked students the same question, but about how their peers talk about issues related to DEI.

When students at PUMS were asked if other students talk about issues related to DEI, all students responded "yes," except one who did not respond. Themes that emerged from the students who did respond were related to the changing curriculum and student comfort in talking about DEI related topics. Elliot noted how the curriculum was structured focusing on how questions are asked by their peers. John, Drew, Sonja, and Howie shared similar sentiments, for example John stated "because some of the lectures may be old and use outdated language and terms, students speak out and some changes have been made" and Howie stated "peers are talking about and are largely happy with how they conduct their DEI in some of their courses." Though students agreed that students are talking about DEI related topics, the perception of the comfortability of some of their peers talking about these topics varied. Six out of ten students noted some trepidation in some of their peers when discussing DEI related topics. For example, Drew stated "though everyone has some baseline exposure due to courses; everyone is on a different level with it and has different ability to talk about issues." Another example comes from Katie who stated "talking about issues that may cause friction but could talk about peers while they are learning."

When asked if other students talk about issues related to DEI, all students responded "yes" and common themes that emerged were around students' level of

comfort in conversing around topics related to DEI. The majority of students responded that it varies, but that students are still engaging in conversation. For example, Stanley reflected on a moment from a talk previously in the semester related to DEI that stuck with them. The line from that moment that stuck with them was “people are dying every single day that we don't get to see.” She continued, “so you may not want to be here. You may not want to talk about it, but people are dying on your watch, and you choose not to, you know, be better.” Stanley then stated “I think that was really hard for some people in their first year in my school. It was just coming in, and it's like, Yeah, if you don't know how to give closely confident care if you're not thinking about the social determinants of how you're part of the problem. Um, but the conversations are happening. I think people are reflecting.” Libby shared similar sentiments, but also noting the level of comfort and ability to engage in conversations differ between friend groups and in class. Libby stated “I think that I'm amongst the people like amongst friend groups, I think it does.” Libby continues with “In a room or in like a small group with mixed races and, like everyone has like a very different background, I think that people are really afraid to speak up. So, I think that in those instances it doesn't get brought up, but I would say, like amongst close friends like I have had a lot of those kinds of discussions so it's a like, yes.”

Again, all respondents agreed that conversations related to DEI are happening among their peer groups, with the common theme emerging around students' comfortability with talking about DEI related issues. This isn’t uncommon. Oftentimes it is assumed how a person holds and acquires knowledge, which is not always the same. These “epistemological assumptions” can foster judgment from others and create uncomfortable situations that can hamper discussion and inhibit change (King 2000). One

thing we also see is how students are engaging in conversation. Several students at PUMS reference the curricula and courses, whereas students at PRMS did not. This speaks to how conversations are being had and what social elements and logics are being moored related to culture. The role of the curriculum is ever present in the change process at PUMS and less so at PRMS throughout this process.

In the next chapter, I turn to a consideration of where all the stakeholders sit with the fundings that were brought forward. To do this, I bring together the responses of the faculty and administrators with those of the students and engage them in conversation. I aim to showcase where there is resonance, dissonance, and areas for growth from their responses. How the logics that are unearthed are perceived by the different parties and those perceptions may influence and impact practice.

CHAPTER 5

FACULTY, ADMINISTRATORS, AND STUDENTS: A CONVERSATION

Introduction

My study examined the impact of institutional logics on the implementation of transformative learning at two US-based urban medical schools (PUMS and PRMS). My study had thirty participants in total: ten faculty and administrators (n=10) and twenty first year medical students (n=20). Of that thirty, five faculty and administrators and 10 medical students from each school were interviewed. Again, medical schools, faculty, administrators, and students were renamed to provide a measure of confidentiality. As is common in qualitative interview-based research, I used a combination of convenience sampling and snowball sampling to reach my desired sample size. Due to COVID-19, I conducted all thirty interviews via Zoom over the span of 6-8 months in 2022. Questions were geared toward faculty, administrators, and students' understanding of the mission of their respective schools; their understanding of transformative learning (e.g., service learning); and their perceived impact of DEI on institutional culture and transformative learning. Questions were relatively unchanged for both faculty and administrators and for students, with a few variations to better address the subjects being interviewed. Once all interviews were transcribed using Zoom's transcription feature, they were then reviewed for accuracy before being inputted into ATLAS.ti for analysis.

In the two preceding chapters I reviewed and analyzed responses made by faculty and administrators and students as it relates to the impact of their respective school's mission on implementing service learning and the potential effects of DEI on reform in medical education. Each group brought a unique perspective to the questions presented and the logics that presented themselves were related to clinical, academic, professional,

and social justice logics. For example, faculty and administrators selected different core values when asked "what did they believe the core values of their respective schools were" with faculty and administrators from PUMS focusing more globally by citing "student" learning and "academics" as core value; PRMS interviewees citing service as a core value; and students at both schools also citing "community" as a core value.

Though the response by faculty and administrators at PUMS may appear to be different on the surface, they are actually aligned and exemplifying why service learning is actualizing at PUMS but from different perspectives. In this chapter I bring together the responses of the faculty and administrators and those of the students together and engage them in conversation in hopes to see where there is resonance, dissonance, and areas for growth. As in the preceding chapters, my discussion is broken down into three areas: 1) mission; 2) service learning; and 3) diversity, equity, and inclusion.

Mission

To get a better understanding of the mission of each of the schools, faculty and administrators and students were asked questions related to the core values of the school and their potential impact on service learning. Again, mission statements encapsulate and share the schools' values, purpose, and goals in a concise manner. They address why they exist, what they want to achieve, and what guides their decisions and behaviors over time. The mission of an organization plays a large role in defining and shaping clinical and professional institutional logics that impact the culture of the institution, their ideals, and practices. The following questions were asked to faculty and administrators and students about the core values of the school and their potential impact on service

learning. I will compare and contrast the comments made by students and faculty at each medical school and then build off my findings.

When posed the question "what do believe the core values of PUMS are," faculty and administrators stated that the core values of PUMS are related to student learning and academics, while the majority of students noted that the core values of PUMS were related to "community" and "service." On the surface there may appear to be some disconnect between responses made by faculty and administrators and that of students when asked what they believed the core values of PUMS were, however this is not entirely true. Faculty and administrators focused on more of the "how" in their initial responses, but as we saw in responses from Glenn who noted that PUMS has a sense of community inside and outside of the school and Laverne noting how PUMS is a collegial and respectful community for everyone including faculty, administrators, and students. This is the start of a common thread that will emerge in the following response by students and faculty at PUMS as it relates the values of the school and service learning.

When faculty and administrators at PRMS were asked the same question about the core values of PRMS, all respondents stated "community," with three respondents also stating education and training are also part of the core values of PRMS. While students at PRMS, when asked the same question, they all stated "community," with five students also noting "training" as a core value. However, admins, Sherry and Charles had some caveats to their answers regarding "community." With Sherry stating that "community actions are important, but we (PRMS) have not figured out how to do it effectively or even to manage it." And Charles added "if the community knew about the message that PRMS has, then we could "move the needle." Student Stanley shared

similar remarks saying "I'm struggling with how it (core values) is embodied within the school." These instances are important to note because this is where conflict begins to emerge. As I mentioned in previous chapters, when assumptions are put into question, ideas, and values are challenged and clinical and professional logics related, as well as academics, begin to surface and come into conflict. In this next series of questions, we see that start to take more form.

The mission statement was recited to faculty and administrators. Faculty and administrators at PUMS were asked "if it makes a strong declaration about its purpose and values and are they reflected in the medical training that students receive?" All respondents agreed that the mission statement made a strong declaration about the purpose and values of PUMS and that they were reflected in the medical training that students were receiving and also agreed that they were aligned with the training students were receiving. After the mission statement was also recited to students at PUMS and the same question regarding their medical training was proposed. All students, except for one, agreed that the mission statement made a strong declaration about the purpose and values of PUMS and that they were reflected in the medical training that they were receiving.

The mission statement was recited to faculty and administrators at PRMS, and the same questions was asked about the mission statement making a strong declaration about its purpose and values and are they reflected in the medical training that students are receiving. Though all respondents responded "yes," their responses were less definitive and had caveats to some of their responses and when asked "do they align with the medical training students were receiving," responses were mixed as well. The mission

statement was also recited to students at PRMS regarding the mission statement and all but one student responded "yes," but, like with faculty and administrators, there were caveats to some of their responses.

There are variations in the responses between those of the PUMS faculty and administrators and students and that of PRMS faculty and administrators and students. Again, we see there is agreement between all interviews from PUMS. I contend that this agreement comes from the alignment between the mission of the school and the measures it has taken to ensure that this mission is an actual part of its culture. There is no pretense or guesswork like there is at PRMS. As we have seen, there are formal structures in place (i.e., the community health course) that are an example of how the mission is grounded in practice (Meyer and Rowan 1977). This is very important in the transformational learning process. Service learning is structured in a way that students don't just volunteer but engage in a series of learning processes that include reflection and discussion (Stewart and Wubbena 2014; Borges and Hartung 2007; Meili, Fuller, and Lydiate 2011). This process of understanding what logics are present is somewhat akin to how service learning is done and how service-learning shapes experiences and thinking.

When faculty and administrators were then asked "how do they think that school's mission and core values shaped service learning?" Though faculty and administrators at PUMS presented their answers differently, they were all in agreement that the school's mission and core values greatly shaped service learning. When PUMS students were asked the same question, they also had various responses, but again they were all in agreement that the school's mission and core values greatly shaped service learning. With both groups, responses were related to their courses.

When faculty and administrators at PRMS asked "how do they think their school's mission and core values shaped service learning?" respondents had various responses noting that there was a disconnect between what is published on the website versus what is actually happening at the school and that there is room for improvement. When PRMS students were asked the same question, they spoke highly about the value of service learning and themes emerged around "learning about communities" and "opportunities."

The impetus of this paper was to address the changing needs of medical training and to do this I aimed to address how the logics and values of the school impact the reform process. At the heart of these values and concepts that the schools hold impact quality care to future patients. We see here that the culture, perceptions, and knowledge that are transmitted through the implementation of curricula are impacted by underlying organizational structures, values, customs that impact the learning process (Hafferty 1998). I contend that service learning needs to focus on both the service and academic context if it is going to be incorporated into practice. One of the principles of transformative learning is to teach for long term retention. The ability to retrieve this knowledge, these skills that were achieved through exposure to experience is done through reflection, re-interpretation, and embodying what is learned through practice (Halpern & Hakel 2003; King 2000). Halpern and Hakel (2003) take these notions one step further and also discusses the transferring of said skills to others which is important to the continued flourish of change in medical education. In the next section I further address how these logics impact service learning and its ability to be an agent of change.

Service Learning

When asked questions regarding the purpose of service learning, faculty and administrators and students at PUMS responded positively noting that it aids in students' understanding of others through exposure to different communities and individuals from other backgrounds. When students at PUMS were asked the same question regarding the purpose of service learning, students responded positively with points related to "exposure to different people" and skills that "aren't learned in clinical rotations." When asked questions regarding the purpose of service learning, faculty and administrators and students at PRMS positively. They noted that service-learning aids in connecting with communities to learn about others and build empathy, and also noted the importance of exposure to other communities and people. Students also added that they were learning important skills that will aid them in their future practices from this exposure.

Overall, both groups see the value in service learning. They see service learning as a curricular tool to aid in their growth in practice. The importance of service learning, or rather the importance of learning about others has emerged through concepts such as social determinants of health, the conditions in the places where people live, learn, work, worship, and play that affect their health, quality-of life-risks, and access to care by having misconceived notions challenged (The Centers for Disease Control and Prevention 2020) being introduced into the curriculum. There is also the added value of experience which is important. One of the benefits of service learning, as mentioned by faculty at both institutions, is what happens when people are exposed to new things. Transformative learning practices like service-learning aid in the examination and reconstruction of past frames of reference to impact future perceptions as students pursue

a career in medicine (Van Schalkwyk 2019:548). Again, though the value of service learning is there, the "how to do it" is a different question.

As I noted in previous chapters, faculty and administrators and students at PUMS responded the same to the question regarding "how is service learning initiated at your school?" with faculty administrators and students stating that service learning is built into the curriculum and is a required community health course. However, when faculty and administrators at PRMS were asked "how is service learning initiated at your school?" responses faculty and administrators varied and leaned towards uncertainty. When students at PRMS were asked the same question, responses also varied. Activities for engagement and volunteering were brought up during interviews, but these varied as well. A theme that emerged was around having the ability to engage in community related opportunities, there did not appear to be organized service learning, again with three students explicitly stating that service learning is not a requirement.

Service learning is not volunteering. Service learning provides the links between knowledge building, challenging preconceptions, and enabling students to apply their altruistic ideals (Meili et al 2011:60). Service learning is also not easy to employ. It as a vehicle of change and reform must be valued and supported. It must be championed by someone who cares and must not just sit in just one silo but must cut across to other parts of the curriculum (Playford et. al 2017). Oddly enough, the latter does exist at PRMS, with being a part of blocks and faculty engaging more in conversation about, which we will address in the next section. But again, that's only one part of it. For service learning to achieve its desired effect it needs more.

When faculty and administrators and students at PUMS were asked "if the goals of service learning are realistic and achievable," all said "yes." For faculty and administrators, 4 out of 5 responded that they do believe that the goals set forth in their service-learning curriculum are realistic and achievable, with one person responding that they were not sure but do see the value in service learning. As for students, again they all responded favorably, but noted the "utility" of service learning, specifically the role of exposure, and the implementation and structure of service learning.

There was much more of a schism in responses between faculty and administrators and students at PRMS when the question "if the goals of service learning are realistic and achievable." When faculty and administrators at PRMS were asked the same question, all respondents responded that they do believe that the goals of service learning are realistic and achievable with three respondents noting that if done correctly and changes needed to be made to the curriculum. Two respondents also noted that it would also need to be properly resourced. When students at PRMS were asked the same question, only half responded and of those that did respond three responded "no" and two responded "yes" with the same caveat that some faculty and administrators made "if done correctly." Those that responded "no" pointed out that the school did not have the proper reinforcements to achieve these goals, noting the implementation of service learning and support systems.

Faculty and administrators were also asked how service learning has changed over time at their respective schools. We look at how service learning and its importance has been reconceptualized over time. PUMS faculty and administrators agreed that the service learning at PUMS has evolved overtime. Each respondent shared a different

reason for why service learning has evolved at PUMS citing the curriculum, partners, and how it is an institution on the organizational level. When the same question was posed to faculty and administrators at PRMS three respondents stated "no" and two of those respondents actually said that it has actually "de-evolved" over time noting that it was less centralized and that no one was overseeing it.

There is a sense of optimism that exists in the faculty and administrators at PRMS that does not seem to exist with the students. The institutional logic perspective provides us some insight into where these contractions emerge (Besharov and Smith 2014; Thornton and Ocasio 2008). Though an organization may have the capacity to embody two different sets of similar logics (Besharov and Smith 2014), this is clearly not the case with PRMS and most certainly not the case with PUMS who is only embodying one set of logics when related to their service-related mission. According to Besharov and Smith there are four types of Logic Multiplicity within an organization: Contested organizations, which have a have multiple logics with low compatibility and high centrality; Estranged organizations, which have low compatibility and low centrality; Aligned organizations, which have multiple logics with high compatibility and high centrality; and Dominant organizations, which have multiple logics, that have high compatibility and low centrality. Based on my findings, regarding service learning, PUMS is an aligned organization and PRMS is an estranged organization. PUMS has adequately displayed that it is an aligned organization with little to no conflict due to its alignment of mission, strategy, and core structures and practices for service learning. PRMS is more of an estranged organization with low compatibility between social actors

and process and low centrality of service learning. This is just one usage of an institutional logic framework to examine an organization.

Moving forward we look to other factors that have impacted logics in the past few years. Again, I cite the death of George Floyd as an inflection point for change. His death brought about social movements related to race and institutional change since the likes of the Rodney King beating in 1992 or the Civil Rights movement of the 1960s. George Floyd's death struck a match. There needed to be change on multiple levels, especially in the field of medicine. As we have seen, change does not come easy, especially on an institutional level.

Diversity, Equity, Inclusion

When PUMS faculty and administrators and students were asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given to students, all respondents responded "yes." Students also spoke about how diversity, equity, and inclusion efforts are being introduced and the reasoning behind its (DEI) increased inclusion. When PRMS faculty and administrators and students were asked if measures related to diversity, equity, and inclusion are showing up in the medical training that is being given, three respondents responded "yes," with one respondent responding "yes and no" and the other responding "unsure" and all students "yes." The common theme among both groups was related to the curriculum, specifically regarding execution and usage of materials in courses.

There is effort being made at both schools as it relates to measures related to diversity, equity, and inclusion measures being instituted. From my findings, PUMS seems to be working more in concert in regard to DEI measures, again, this can be

attributed to the alignment of mission and practice, whereas that doesn't exist as much at PRMS. Despite their being less cohesive at PRMS, they have a robust DEI office and are making changes not only at a curricular level but on an institutional level as well. One student also spoke of the efforts made in increasing the pipeline of students of color through the creation of a medical school readiness program while other students referenced the inclusion of reading material to gain better understanding of the impact of race on medicine. Unfortunately, it doesn't link to service learning at any level and neither faculty, administrators, nor students raised this disconnect. Another bonus that both schools have is dialogue happening on the institutional level due to changes in the way that the AAMC and AMA discuss issues around race and an increased emphasis on culture and diversity have also impacted whom, for what, and how training is focused and disseminated.

When PUMS faculty and administrators were asked if their colleagues talked about issues related to DEI, all but one respondent, respondent "yes" and one person that did not, noted that it was because they did not have contact with a lot of faculty. When students at PUMS were asked if their professors talked about issues related to DEI, all students responded "yes" with 3 students adding the caveat "but not all." The students pointed to instances in which they have heard professors either directly talk about DEI or DEI related topics in their courses and/or how they have incorporated it into lectures. When PRMS faculty and administrators were asked if their colleagues talk about issues related to DEI, all responded "yes." When students at PRMS were asked if their professors talk about issues related to DEI, five students responded "yes," two responded "no," and three were "unsure." For students that responded "yes" the common themes

were around the capacity in which faculty discuss DEI related efforts within the courses they are taking. For students who replied "no," they also referred to the capacity in which faculty discuss DEI related efforts within the courses they are taking but noted that they did not see discussions around DEI in the academic portion of classes.

Again, there are efforts being made, but the perception of these efforts vary based on how individuals view said efforts. Heteronormative practices have comprised medical practice since its inception. There is a long history of the medical profession primarily consisting of white men in white coats (Becker 1961). Though these notions are now being challenged more, it still takes time to break. Eliot Freidson (1970:215) notes "we cannot solely depend on the profession itself to change and be responsible for the reorganization of care." We must also depend on the schools and those that inhabit them. The social interactions not just in service learning, but on an institutional level continue to be interpreted and modify the negotiation and renegotiation of logics to move an organization forward (Hallet and Ventresca 2006). All stakeholders have a hand in this, not just faculty and administrators. The conversations and discussions that students have amongst themselves are just as important.

CHAPTER 6

CONCLUSION

For my research I used an institutional logic framework in examining how the implementation of transformative pedagogy in medical education may be impeded by competing institutional logics. This research project proposed three questions that examine the understanding and perceptions of social actors as it relates to transformational change in medical education:

1) What is the impact institutional logics have on the implementation of transformative pedagogy in medical education?

2) What are the institutional logics in medical education that may impact change, and are there any conflicts between them?

3) Is there any evidence that these conflicts, if they exist, act as a barrier or disincentive to pedagogical reform when diversity, equity, and inclusion measures are introduced?

Institutional logics are found in the culture, beliefs, and practices that make organizations and programs what they are. These logics guide the interactions between social actors and the institution, as well as guide the behaviors of faculty, administrators, and student behavior and practice. Institutional logics should not be conflated with organizational practices. Institutional logics and organizational practices are two concepts that pertain to the ways in which organizations operate and make sense of their environment. While they are related, they represent different aspects of organizational behavior. They differ in several key aspects that include scope; level of analysis; change; and consistency. Organizational practices refer to the specific routines and behaviors

within an organization, while institutional logics represent the broader underlying values and norms that shape organizational behavior. Organizational practices are more specific, stable, and focused on the micro-level, while institutional logics are broader, dynamic, and operate at the macro-level.

By analyzing websites of two US-based urban medical schools and comparing those findings to that of the perceived notions retrieved from interviews of what impact logics have on service learning, this research has shown that understanding institutional logics aid in the implementation of transformative pedagogy by better understanding the role of competing logics. Medical schools, like most organizations, have multiple logics (clinical, professional, academic, and social justice) within their schools and oftentimes these logics may come into conflict. My research shows that institutional logics that may impact change are related to compatibility (consistent and reinforced goals) and centrality (value and relevant to function). Though the service-learning standard that each school must follow is the same, the way they interpret is vastly different and it shows in the responses of faculty, administrators, and students.

When it came to PUMS, it took on the attributes of an aligned organization wherein the service learning was consistent through the creation of a community health course which not only reinforced the goals of the school, but that of the American Medical Association (AMA), Association of American Medical Colleges (AAMC), and the Liaison Committee on Medical Education (LCME) to create a more prepared and culturally competent workforce set to meet the changing face of medicine. PUMS also showed that it valued service learning through not only a robust online presence, but also

through supportive measures and initiatives that reflected the goals, values, and mission of the school.

When it came to PRMS, it took on the attributes of an estranged organization wherein service learning was more akin to optional volunteering and inconsistently executed. Though this wasn't to say that some students weren't learning skills and competencies in learning how to work with a diverse population. PRMS did embed some practices into their blocks, supplied students with funds for service projects, and employed some service learning-like measures in another degree program at the medical school, but on the whole, it is haphazardly done, inconsistent, and does not reinforce the goals of service learning. From my findings, participants see value in service learning, however that is seen on an individual level and not on an organizational level and therefore perceived to have little to relevance on the function of the organization, despite it being a standard that must be met for accreditation.

As we see from my findings, these conflicts do exist when multiple logics of an organization are not working in concert and act as barriers to pedagogical reform. Even with the additional push of diversity, equity, and inclusion (DEI) measures from changes in the social and societal level, these conflicts prevent medical schools from moving in an efficient manner to bring about change. However, movement is still taking place, albeit at different speeds.

Again, this call for reform has been taking place for some time (Irby, Cooke, O'Brien 2010). Articles continue to be published on why we need to look closer at the mission of school and how a school's mission drives the change process. For example, Bina Valsangkar (2015) raised the question "do medical school mission statements align

with the nation's health care needs?" noting if these needs are not a part of the school's mission the likelihood of them being actualized in student education and training is very little. Most recently, the AAMC (2023) started a pilot to examine a small cohort of medical school mission statements because they are seeing not only how valuable these statements are, but prospective students' values and goals are connected with their past and future experiences as they aspire to become medical providers.

Throughout my research I gathered text from the fields of sociology, medicine, medical education, education, business, and organizational development to aid me in my research. I found using an array of perspectives from a variety of texts was crucial to examine and to address the complexities that underpin the medical education system. Much like the physician who uses an array of skills in the clinic that they learned via service learning and clinical rotations, we as practitioners must use an array of skills to bring about reform in medical education. In some ways we should see service learning as another rotation that will aid future physicians.

Institutional logics are made up of the assumptions and beliefs of the social actors that embody these entities and the language used in statements, either on the website or spoken, convey the philosophy and values of each school. The responses shared by students from my study illuminate the interplay between institutional logics and transformative learning and how an institutional logic framework helped guide this. An institutional logic framework enables us to examine the decision-making choices that impact change. Values, standards, and standard ways of operating strongly determine the outcome of introducing transformative pedagogy. We see that choices are not made entirely by what is presented (i.e., service-learning standard), but by the socially

constructed institution made by the social actors that inhabit them. By understanding what the medical school aims to achieve, medical schools can set specific goals for students' knowledge, skills, and attitudes. Service-learning outcomes can then be designed to address these objectives, ensuring that students acquire the desired competencies while serving the community.

I recommend three things for medical schools to consider when using this framework to enact transformational pedagogy. The first recommendation relates to change on the micro level (i.e., on the program level). The second recommendation relates to change on the macro level (i.e., relationship with governing bodies). And the third recommendation is related to the influence on DEI practices on the change process.

On a micro institutional level, an institutional logic framework can pay dividends especially during periods of higher-than-normal turnover. Cohorts of students come and go every year, that is what school is, but oftentimes it is not acknowledged when faculty and administrators leave, and new ones enter. There is the occasional email that may mark their exit or entrance but does not acknowledge that these individuals could have been extremely impactful in changing the social structure of the organization, especially those individuals in high level positions. Though in a relatively fast paced environment that onesies enmeshed in, one does not have the opportunity or time to take a step and reflect on what has transpired, but faculty, administrators, and even students can increase awareness of these cultural or norm shifts that may occur from these shifting social actors and how that impacts their respective medical school ecosystems.

On a macro level an institutional logic framework can enable us to examine the potential impact of when new standards, practices, etc. are introduced through

accreditation. Institutional logics can be used to explain why and how leaders respond to external pressures for change on the university level. By having a greater understanding of how these changes connect with values and functions of the school and how to consistently employ and reinforce them to meet their intended goals. Though, even by understanding these goals, challenges can still appear. Accreditors may be influenced by policymakers and transnational movements (i.e., death of George Floyd and Black Lives Matter). These movements impact policy and standards that medical schools must follow. For example, in a recent article by Stanley Goldfarb (2023), speaks to this point by giving an example of new standards introduced by the LCME around DEI and how some state schools may struggle to adhere to these standards due to being out of sync with certain state laws. This speaks to my third recommendation related to DEI and the change process in medical education.

Lastly, an institutional logic framework can be used to better understand the influence of DEI practices on the change process. In a study done in 2008, Michael Bastedo used an institutional logic framework to look at social actors in higher education as it relates to policy making. Bastedo looked at the differences between institutional logics (values and expectations) and national perspectives and national movements underscoring the difference between logics, which are embedded in an organization, and temporal circumstances that tangentially impact change. Bastedo points to how an institutional logic framework can be helpful in identifying the drivers for change. I take this one step further by recommending not only should medical schools look for the drivers of change, but how they can either bolster or harm actual transformative learning.

Building a rapport with someone helps unearth hidden thoughts, feelings, or questions that may be important to the provision of care. Socialization is important throughout the medical education experience, but understanding the complexity of medical education is crucial to aiding the field to continue to meet the needs of the times. The findings from my research will advance knowledge in the field of medical sociology by examining the perceptions of the role of transformative pedagogy as a change agent in medical education. My research highlights the differences between meaningful versus performative change in medical education as it relates to service learning and opens the door to what I dub as "service-learning oriented medical education." Service-learning oriented medical education is an approach to medical education that combines traditional classroom learning with community service experiences. It integrates hands-on service in the community with the academic curriculum, allowing medical students to apply their knowledge and skills to real-world situations while addressing the needs of underserved populations.

A service-learning oriented medical education has six key features and benefits that revolve around: respectful and reflective engagement with communities; practical application of knowledge; greater interprofessional collaboration; enhanced empathy and patient-centered care; a better understanding of how to work with communities on addressing health disparities; and professional development that upholds the ideals of medicine.

1) Respectful and reflective engagement with communities: encouraging medical students to actively and respectfully engage with communities and individuals who may face barriers to healthcare access. By working directly with these

populations, students gain a deeper understanding of the social determinants of health and the challenges faced by marginalized groups.

2) Practical application of knowledge: providing opportunities for students to apply their medical knowledge and clinical skills in real-world settings. These guided, hands-on experiences enhance medical students' understanding of the healthcare system and allows them to develop practical skills that are essential for their future medical practice.
3) Interprofessional collaboration: this involves collaborative efforts with professionals from various disciplines, such as nursing, social work, and public health. This interdisciplinary approach fosters teamwork, communication, and a better understanding of the roles and contributions of different healthcare professionals.
4) Enhanced empathy and patient-centered care: creating and fostering experiences that can promote empathy and a patient-centered approach to care. By interacting with individuals from diverse backgrounds, students gain insights into their unique circumstances, which can improve their ability to provide compassionate and patient-centered care.
5) Addressing health disparities: service-learning oriented medical education often focuses on addressing health disparities and promoting health equity. By working in underserved communities, students will gain firsthand exposure to the social and economic factors that contribute to health disparities and learn how to advocate for equitable healthcare.

6) Personal and professional development: Service-learning experiences can contribute to personal and professional growth by fostering self-reflection, critical thinking, and problem-solving skills. Students also develop a sense of social responsibility and a commitment to lifelong learning and service.

Overall, service-learning oriented medical education provides a valuable opportunity for medical students to connect their academic knowledge with real-world experiences and make a positive impact in underserved communities. It promotes a holistic approach to healthcare education and helps develop well-rounded and socially conscious physicians.

Limitations

My research also enables the reader to gain a deeper perspective and understanding of covert practices and institutional logics that may either impede or aid in changes to medical school training and curricula when transformative pedagogy and learning practices are introduced. My research also shows how social movements related to diversity, equity, and inclusion may also impact the change process on a micro and macro level. Despite this, there are four limitations to my study that I believe are important to note: 1) the sample size of medical schools; 2) the sample size of faculty, administrators, and students; 3) the influence of past experiences on perceptions and engagement; 4) the time frame of the study. There are currently 155 MD granting programs in the United States (Liaison Committee on Medical Education 2019). Though my methods are sound and reproducible, one of the limitations in my study is that I am only sampling a small number of medical schools in the United States. This case study will not be able to capture all the nuances that emerge when looking at the interplay

between the institutions and how they carry out service learning, but it will provide a lens through which to view other medical schools.

Another limitation to my study is the number of participants that are being sampled, as well as the ability to ascertain how much of their past experiences impact how they perceive service learning as a vehicle for reform. Much like the institutions in my study, faculty, administrators, and students also have their own values and belief systems, and experiences that impact their perceptions as well as relationships to the institutions they inhabit. Race, gender, and other demographic factors also impact how students may perceive the impact of engaging in service, especially in vulnerable communities and with marginalized populations.

The time frame of my study is also a limitation. As a case study this is only a snapshot of competing logics in medical education when introducing transformative pedagogy. Internal factors around faculty and an increased emphasis on culture and diversity have also impacted whom, for what, and how training is focused and disseminated. This study can capture that moment in question and become a benchmark as we evaluate the impact of transformative pedagogy during a time of transformation. A longitudinal study may lend itself to seeing greater change as students' progress but may not adequately capture the moment. Another limitation stemming from this is related to time. The ability to work with multiple cohorts of second-year students to see if these logics continue to pervade the system or not would be a worthwhile endeavor that is outside the scope of this project.

These limitations should be taken into consideration because they may have some impact on the study, the degree to which their impact varies and does not take away from

the study as it stands. The medical schools that I have selected vary greatly in their mission, vision, and stature and are examples of the variety of medical schools that are present in the United States. Though the sample may not capture all the nuances related to the varied lenses students bring to their training, it does give insight into how future practitioners view the changes being made to their medical training. Because change is not static, this study aids in creating a benchmark study which may be useful for future researchers to gauge if perceptions and practices change as it relates to implementing transformative learning in medical education, and if so, how.

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