



Growing up in a medically underserved rural area led me to shape my personal strength as well as my academic purpose. In my home, there was no primary healthcare available within the community because it took hours to drive to reach hospitals. I personally observed the effects of socioeconomic, transportation, and provider shortages translated into avoidable pain, especially in older inhabitants and low-income families. These experiences at an early age left me with an intense sense of responsibility and an obligation to deal with structural health inequities. During my undergraduate studies, I have volunteered in a local community health outreach program, where I have been working with patients seeking insurance coverage enrollment and preventive care services. My engagement with people in a disadvantaged position in the system helped me strengthen the belief that health disparities are not a clinical issue, but rather a social and policy issue. My graduate training further refined this perspective. In the course of researching healthcare access among rural communities, I realized that quantitative data would not be an adequate source of information to explain the lived experiences of marginalized populations. This understanding prompted me to use qualitative interviews in my practice, whereby the members of the community can express themselves using their own words. The process enabled me to establish a research identity that is based on a sense of empathy, ethical involvement, and community-based scholarship. Outside the academic field, I have attempted to increase involvement in academic spaces through mentoring first-generation college students on health-related career paths. It was through my experience in academic systems where there was no previous history in my family that I learned about this hidden curriculum that usually restricts one to higher education levels. Mentoring students with a similar background has helped me enhance my belief in

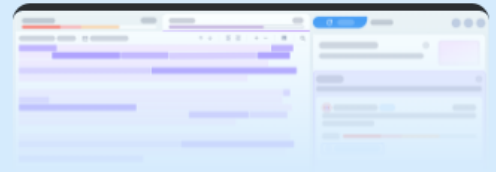
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