CAREERS

Race, Disadvantage and Faculty Experiences in Academic Medicine

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BACKGROUND: Despite compelling reasons to draw on the contributions of under-represented minority (URM) faculty members, US medical schools lack these faculty, particularly in leadership and senior roles.

OBJECTIVE: The study's purpose was to document URM faculty perceptions and experience of the culture of academic medicine in the US and to raise awareness of obstacles to achieving the goal of having people of color in positions of leadership in academic medicine.

DESIGN: The authors conducted a qualitative interview study in 2006–2007 of faculty in five US medical schools chosen for their diverse regional and organizational attributes.

PARTICIPANTS: Using purposeful sampling of medical faculty, 96 faculty were interviewed from four different career stages (early, plateaued, leaders and left academic medicine) and diverse specialties with an oversampling of URM faculty.

APPROACH: We identified patterns and themes emergent in the coded data. Analysis was inductive and data driven.

RESULTS: Predominant themes underscored during analyses regarding the experience of URM faculty were: difficulty of cross-cultural relationships; isolation and feeling invisible; lack of mentoring, role models and social capital; disrespect, overt and covert bias/discrimination; different performance expectations related to race/ethnicity; devaluing of research on community health care and health disparities; the unfair burden of being identified with affirmative action and responsibility for diversity efforts; leadership's role in diversity goals; and financial hardship.

CONCLUSIONS: Achieving an inclusive culture for diverse medical school faculty would help meet the mission of academic medicine to train a physician and research workforce that meets the disparate needs of our multicultural society. Medical school leaders need to value the inclusion of URM faculty. Failure to fully engage the skills and insights of URM faculty impairs our ability to provide the best science, education or medical care.

INTRODUCTION

Medical schools hold a social mission to educate physicians who will care for the entire population.[1,2] Diversity among faculty enhances the ability of academic medicine to fulfill its educational, research and patient-care missions.[3] Inclusion of under-represented minority faculty members (URM) in medical schools promotes more effective health care delivery to a diverse population; improves the quality of medical education,[4] and may stimulate research attentive to the needs and concerns of minority groups.[5]

Despite these compelling reasons to draw on the perspectives and contributions of URM faculty members, there is an alarming dearth of these faculty in US medical schools and a serious paucity in leadership or senior roles[6–8] (Table 1).

Studies have shown that URM faculty are less satisfied and more likely to leave academic medicine, advance more slowly and are less likely to be in the basic sciences.[9–12,17,18] Additionally, minority faculty report experiences of ethnic harassment, biased treatment and racial "fatigue."[11,13–16] They spend more time in patient care and less in research than their non-minority colleagues. Efforts have increased the enrollment of URM medical students,[19–22] but the environment or culture for URM faculty has received much less attention.

Out of concern regarding the failure of academic medicine to adequately recruit, retain and advance diverse faculty, we formed a national collaborative, the National Initiative on Gender, Culture and Leadership in Medicine ("C - Change")[23] to engage five US medical schools in action research to facilitate culture change in academic medicine. In this partnership, we conducted an in-depth interview study of faculty to deepen our understanding of factors underlying the lack of URM faculty in the nation's medical schools.

METHODS

As part of the larger C - Change initiative, we selected five schools representing organizational characteristics of all US medical schools, [i.e., public (two)/private (three), NIH research intensive (two), primary care orientation/community orienta-

Table 1. Representation of Faculty Members of African-American/Hispanic/Latino and Native American Groups is Far Below the Demographics of These Groups In the US Population and US Medical Students.[6–8]

	US population 2000[6]	Medical students 2007[7]	All medical faculty 2007[7]	Medical faculty instructors/ assistant professors 2007[8]	Medical faculty associate/ full professors 2007[8]
African American	12.3%	6.4%	3.0%	8.0%	3.8%
Hispanic/Latino	12.5%	7.2%	4.2%	3.0%	2.2%
Native American	0.9%	0.3%	<0.1%		

tion (one)]. The sample represented all designated Association of American Medical Colleges (AAMC) regions. Sex and URM faculty demographics in these five schools were almost identical to national statistics.

Participant Criteria

Using purposeful and chain referral sampling,[24] we interviewed equal numbers of faculty from each school stratified by sex, race/ethnicity, department/discipline and career stage. Participants were research scientists, medical and surgical subspecialists, and generalist faculty holding doctoral degrees (84% MD/MBBS, 16% PhD) and represented 26 disciplines. The 96 faculty members interviewed in 2006–2007 represented (almost equally) four career stages: (1) early career (initial faculty appointment for 2 to 5 years), (2) "plateaued," (faculty for ≥10 years and who had not advanced as expected), (3) faculty in leadership roles such as deans, department chairs and center directors, and (4) former faculty who had left academic medicine. We oversampled women (55%) and URM. The 17% African American/Black, 4% Hispanic/Latino respondents represented 11 specialties/disciplines.

Data Collection and Analysis

A multidisciplinary research team (2 MDs, 2 PhDs) conducted in-depth, semistructured interviews—15% in person and 85% by telephone for convenience. Interviews (typically 1 h) were audio-recorded and transcribed verbatim. The interview guide (developed from pilot interviews) consisted of open-ended questions on aspirations of faculty, energizing aspects of their careers, barriers to advancement, collaboration, leadership, power, values alignment and work-family integration (Table 2). We concluded interviewing when we no longer obtained new information.

After deletion of all identifying information, transcribed data were coded and organized using Atlas.ti software. Inductive analysis [25,26] identified patterns and themes as they emerged from the coded data. The secondary analysis reported here utilized all coded data related to URM faculty and discrimination, and the entire interviews of URM faculty. We verified our findings using a consensus process. Brandeis Institutional Review Board approved the project. The example quotations illustrate themes stated repeatedly.

RESULTS

Male and female URM faculty experienced: difficulty in cross-cultural communication; feeling isolated and invisible; lack of mentoring, role models and social capital; disrespect, overt and covert bias and racism; devaluing of professional interests; being identified with affirmative action programs and diversity responsibilities; and financial hardship.

Cross-Cultural Communication

Many URM faculty described problems with conversation and relationship formation with Caucasian colleagues, e.g., *"Maybe they don't know how to talk to me because I'm an African American person."* They ascribed this to having different professional and social frames of reference. URM faculty didn't feel included and perceived that they caused Caucasians to be uncomfortable in conversing with them. This lack of connection created a barrier to collaborating with other faculty.

> It makes me feel like they're so uncomfortable. We don't have the same frames of reference. And it doesn't feel comfortable on either side of the conversation. I feel like I'm making people think about things they don't want to think about and so why bother? (URM female, plateaued)

Some described academic medicine as feeling like a foreign culture.

> So academic medicine is a foreign culture that isn't friendly to American Indians and Latinos. You're not going to attract Latinos, American Indians who have a community bent, who want to change social systems, who have a sense of family and community. It's very hard for us to fit in academic institutions, where that's about the individual. (URM male, early career)

Table 2. Interview Guide Questions

What is it about your work that energizes you?
When have you felt most successful in your work?
What's been your sense of being a part of your institution?
What has been difficult or frustrating in your work?
Can you talk about some experiences you've had related to the advancement of your own career in academic medicine?
What do you see as valued at your institution?
What does it take to get into a position of power or leadership in your school?
Is leadership something you've wanted or want for yourself?
How has power affected you/your career in academic medicine?
How do your personal values align or conflict with what you experience in academic medicine?
Why do you think there are so few women in the upper reaches of academic medicine?
What about underrepresented ethnic groups or people of color?
Tell me about the relationship between your work and family or personal life.
How are your aspirations for yourself in academic medicine being fulfilled?

Isolation

Isolation due to the scarcity of colleagues of color was cited frequently. This was especially prominent for female faculty.

> Early on, there were just no women and certainly, no faculty of color, and so you're just there by yourself. (URM female, leader)

Some URM faculty remarked that people of color need other supportive relationships from family, church or community outside medicine to survive the professional isolation.

Feeling Invisible

The sense of isolation was compounded by feeling invisible in the institution and at national professional meetings.

> What I struggled with for a long time here was my being an African-American woman, in a male, white male-dominated institution and the feeling that I was invisible. My opinion didn't matter, what I was feeling didn't matter. There were people who I passed every single day, who were chairmen of departments, and I mean, good God, after 5 years you've got to see a person... I would really hate to go to national meetings. Because I wouldn't see very many people who looked like me and even though I had met people the year before or 2 years before, they always acted as if they'd never seen me before. (URM female, plateaued)

Lack of Mentoring, Role Models and Social Capital

Many commented on the lack of support and mentoring and the paucity of URM role models in academic medicine. This was especially significant as many African American and Hispanic faculty came from backgrounds where they had little exposure to academia or the systems of higher education.

> When you're the first person in your family to reach this point, you are clueless. I was not receiving any counseling at all about what the next move was... A lot of people of color don't know that. (URM female, leader)

Programs for URM students and resident were available, but faculty believed it "*pretty well peters out at the faculty level.*" Many faculty of color acknowledged that they lacked role models for themselves, but still felt responsible for serving in leadership roles and being role models for other URM faculty.

> The other reason that leadership is important for me is because you want your family, other people of color to say, "Okay, I can do this too, I can do it." Academics is not an area that people think about. (URM female, leader)

> I'm at a point in my career where I have to decide whether to stay or go, and if I go, where's the role model for the ones coming behind me? Then they have a similar experience like I did. (URM female, plateaued)

Disrespect, Prejudice, Bias and Racism

We heard numerous accounts of experiencing racist remarks and bias. Minority faculty described being stereotyped; sometimes being viewed as similar to uneducated minority patients or other people of color in service roles.

> If the majority of the patients that you're treating are African American and very poor and uneducated, and I'm African American, well, people are sometimes not able to make the distinction between some of those patients and you. (URM female, early career)

> So I showed up at the meeting last year, and one of the Division Directors asked me to take his luggage to his room...I was just puzzled. And he said, "You are at this meeting aren't you?" And then it became clear to me that he thought I was one of the organizers of the meeting. I said, "Well, yes I am at the meeting." And then he very sharply said, "Well then can you take care of this?" And I said: "Sir, I believe I'm at the meeting for the same reason you are." (URM female, leader)

Another minority physician remembered an incident as an intern.

> I was on call and one of the nurses interrupted me and said, "Oh go to room such and such, the sheets need to be changed." ...making the assumption that if I am African-American, I'm here to clean the beds. (URM female, left academic medicine)

A pervasive example of stereotyping was that colleagues and supervisors often had low or mediocre expectations of what URM faculty (or students) could accomplish.

> I have heard it from African-American students that were very interested in science, and they had teachers that said, "I don't think you really can get a PhD." (URM female early-career)

Individually, URM faculty consistently believed that they had to perform at a higher level than others in similar situations to be perceived as accomplished.

> I think you always feel like you're expected to do a mediocre job. Always. And so, you strive to be super woman. To combat the expectation that you're only going to be mediocre. (URM female, plateaued)

Others recounted instances of racism.

> I sent my resume for something and when I showed up someone said to me, "Your resume didn't look black." Can you imagine someone saying that? (URM female, senior)

> There was a night shift that I worked, the resident came down and asked me if we could hold a patient in the emergency department because it had been a busy night for the resident, and he didn't want to admit the patient. And I said "No," because the patient was an older woman on a stretcher down here in the ED, I

wanted her to go upstairs. He walked away and mumbled, "You black bitch." My boss happened to come down first thing in the morning, and I recounted the episode to him, and told him I was so angry I could have punched this guy and he says to me, "Well, you know, we don't live in the jungle." That was his response. I will never forget that. (URM female, plateaued)

Discrimination in recruitment emerged as a sub-theme. One respondent recounted her experience of discrimination by other faculty members. She pointed out the burden of dealing with discrimination for many years.

So he asked the chair to bring me on as a faculty member. And one faculty went to the Dean, and said: "Let's not bring her on. Let's wait 'till next year because we want (name), because we believe that a white, Jewish male will fit the environment better." So, sometimes you look back and wonder why you stayed. (URM female, leader)

Another Caucasian faculty explained discrimination on the basis of class. He believed that prejudice exists against non-white speech patterns.

I think that even though people may not be prejudiced against skin color, they may be prejudiced against— and I know I'm prejudiced—language patterns. It's the way I'm prejudiced against people who put their Rs in the wrong place. It's a sign of class. (Non-minority male, plateaued)

Devaluing of Professional Interests

In the departments where there was focus on research on underserved populations or community-based health care, URM faculty perceived a more favorable microenvironment for themselves. Such departments were better able to recruit URM faculty. Conversely, respondents commented on how research in communities and giving back to their communities, as well as research on minority health disparities (MHD) was less rewarded, and perceived as less weighty.

I think from all the other departments' perspective they'd say, "What's going on with them? They're doing soft research out in the community and they're not real scientists." (URM male, left academic medicine)

Minority faculty felt a sense of responsibility to their communities that often conflicted with the demands of an academic career.

It's important that we're out in the community actually caring for patients, giving back to our community. I know that my closest colleagues who are African-American definitely feel that way. They felt that they couldn't do that within the confines of academic medicine. (Non-minority male, left academic medicine)

Additionally, issues of tokenism and "window dressing" were voiced. Some faculty suggested that URM faculty are "*just a*

pawn to be used by the institution" to show that the institution is attending to URM recruitment or doing something about MHD.

The minorities see academia as an environment that they can potentially thrive in and they get played. They become the representative in that it shows that the institution is doing something about health disparities and they get used, and they also don't wind up in the decision-making circles. (Non-minority male, plateaued)

Burden of Affirmative Action Programs and Representing One's Own Race

Compounding tokenism, faculty spoke of the stigmata of having participated in affirmative action programs or programs specifically targeting MHD, thus being simultaneously benefited and disadvantaged. URM perceived that others thought they had *"got there because they were Black."*

You almost feel that you have to do better than anybody else to prove that you are where you are because you deserve it. I was very lucky and I got my R01 very quickly and I got a very, very good score. I was really proud of that. I worked very hard on that grant. And a colleague of mine, he looked at me and said, "I'm convinced that these things are decided based on ethnicity." (URM female, leader)

Often URM faculty were asked to provide service and committee work to promote diversity. They felt conflicted in the realization that this service on behalf of URM detracted from personal scholarship and an individual need to advance in the system.

They told me the only reason I got the job was because I was Black. And when I came into the Dean's office, there was talk of: "We don't have an Office of Minority Affairs (OMA) here." Every time they start talking about an OMA they start looking at me. And I said, "If I'm good enough to be the Dean of Minority Students, I'm good enough to be the Dean of all the students." (URM female, plateaued)

A dilemma for many faculty was how to manage concurrent efforts to take care of other people of color, as well as to advance professionally to be accomplished role models.

Responsibilities of Leadership

Many faculty commented on the pivotal role of leaders with respect to diversity and the scarcity of people of color in leadership roles in medical schools. Leaders were perceived as not valuing diversity and needing to make a firm commitment to diversity goals if to acheive real change. Leaders tolerated unacceptable behavior or even racism (e.g., see Racism section). Interviewees believed that leaders rarely selected people of color for leadership positions as doing so would detract from their sense of comfort interacting with people like themselves.

It has to be something that leaders prioritize. When everything else is equal, you have to step up to the plate

and choose the person who does bring diversity. So you need leaders who are willing to stand for it. (URM male, senior)

Some commented that having more URM faculty in positions of leadership would dispel stereotypic myths and create greater exposure to minority excellence on an individual basis.

An intern on my teaching service said to me "I really enjoyed working with you. I truly respect the way that you take care of patients and I want to try to mimic the way I take care of patients after you." He was a non-minority young man and I thought that was incredibly important for me to be in a position to have somebody like him say that. But you have to have the commitment from schools, from hospitals, from administrators to find the people to be in those [leadership] positions and I think it has a huge calming effect on society in general. (URM male, early career)

URM faculty reported that they usually have to be the one to notice and comment on inequity and that this responsibility is not assumed by majority leaders. Some commented that when URM faculty assume administrative leadership, it's at the expense of advancing their own scholarship. On the other hand, having an URM in a leadership role gives the clear message about commitment to achieving diversity.

Some drew a contrast between African-American, and Asian or Middle Eastern faculty. perceiving that the latter groups often came from educated and privileged families who were more familiar with academic pursuits and hierarchies:

I think Asian and Middle Eastern men have been accepted much more than African-American men, and that reflects who's going to medical school. Second and third generation people from Pakistani, Indian and Iranian families. They're well trained and they're very hard workers, and excellent clinicians and teachers—so no issues there. But I think that gives the institution the feeling that they're ethnically diverse, but with all due respect, these are "WASPs" with brown skin. They're more similar in their behavior to the white Anglo-Saxon Protestant model than a Brooklyn Jew, for instance, who's noisy and loud. (Non-minority female, leader)

This white woman shows a nascent understanding of a certain way one has to act in order to be accepted, i.e., similarly to a white male. Asian and Middle-Eastern faculty with more privileged backgrounds may more easily adapt to expected behavior patterns and consequently advance more frequently than URM faculty.

Financial Hardship

A persistent interview theme was the financial sacrifice perceived by choosing a career in academic medicine.

So they are seen as not just the breadwinners for their household, but for the greater family at large. There's a sense of responsibility not only to give back to the community, but also to earn a higher wage to help out

the extended family. (Non-minority male, left academic medicine)

Slowness of Change

The history of segregation and slavery in the US is still a part of many people's consciousness. Several faculty highlighted the slowness of realizing the full positive outcomes of legislation resulting from the civil rights movement. *"I'm just disappointed with the progress of our country."*

I mean it's your normal change process, establishing the value of the differing person or persons and eventually change occurs. It's the same process that we went through with integration. That wasn't overnight either. And we're still struggling with it in academic medicine. (Non-minority male, senior)

DISCUSSION

URM faculty bring knowledge and experience of different backgrounds and world views to medical schools. Our findings suggest that these valuable attributes and abilities, instead of being perceived and received as beneficial, are often responded to as untoward contributions and become barriers to acceptance in the systems of academic medicine.

Isolation and feeling like an outsider resulted from a combination of barriers to communication and relationship formation with majority faculty; scarcity of faculty of color; and lack of role models. Lack of family instrumental support and social capital combined with education-related debt added to the burden of trying to advance professionally. Faculty experienced disrespect, discrimination, racism and a devaluing of their professional interests in community service and MHD. Women faculty commented on the double disadvantage of gender and minority status.

URM faculty experience social as well as professional discrimination and may feel justifiably angry. The "tokenism" and "window dressing" they describe pertains to at least three concepts: a lack of authenticity among institutional leaders in efforts to include minorities; the burden of having to represent one's entire race; and being on the receiving end of special programs and assumptions that the achievements of people of color are due to special favors rather than merit. Faculty ascribe a pivotal role to leadership in combating discrimination and achieving diverse faculties. Many leaders lack the experience of having different types of people in leadership roles, and it may seem risky to put power in the hands of less experienced people. Most URM faculty come from non-affluent families (in contrast to many white majority students) and incur substantial debt during training. URM physicians supported their households and often their extended families. The combination of this and dedication to their communities contributed to URM leaving academic medicine.

While published research on diversity in medical school faculty report on a single school,[18] on URM physicians in practice[15] and some national recommendations,[27] this paper's contribution is in-depth data on the experience of URM medical faculty from diverse subspecialties, collected from five disparate schools in different US regions. While we have

focused on URM faculty, other faculty of color may contend with many of the same disadvantages. The findings on relational barriers align with our study results in non-minority faculty.[28] Limitations of the study are those inherent in qualitative studies with relatively small numbers of participants: selection or sampling bias, potential for response bias and the subjective nature of analytic strategy. Even so, qualitative studies singularly allow voicing of perceptions of individuals who voluntarily share such information. We found the themes to be consistent and highly congruent for faculty of varying rank, discipline and sex across the five schools.

McIntosh observed that people who benefit most (in the short term) from privilege systems are mostly unaware of and blind to the existence of privilege systems. This preserves the myths of moral and managerial meritocracy.[29] This likely occurs because the exposure of bias is often painful and disturbing, particularly among individuals who explicitly hold egalitarian and humanitarian views. Having inherited unconscious biases that are manifested unintentionally in interpersonal interactions, these individuals may feel guilty about their own advantage (acquired typically without effort or consent on their part) and its role in keeping others disadvantaged. Through elucidation of URM faculty experiences, we hope to raise awareness among health professionals, educators, administrators and policy-makers of obstacles to achieving the goal of having URM faculty as leaders in academic medicine.

Medical schools and their policies need to reward service and research on community-based health care and MHD, similarly to other accomplishments and research if this work is to be shouldered by a broader set of faculty. Health disparities in the US are among the highest in the developed world, and reducing them is a major health priority.[30–32] Successful strategies to reduce disparities must address the physician workforce.[27,33] We propose that having more URM faculty in senior and leadership roles in medical schools will support training a more diverse physician population and increase the cultural awareness and skills of all physicians-in-training and biomedical scientists. These factors will contribute to a greater capacity to care for underserved groups and to better elucidate the causes of and solutions to health disparities. Failure to fully engage the skills and insights of URM faculty means that we don't have the best science and the best medical care that we could have. We agree that medical schools and their leadership should be evaluated on the extent to which their graduates meet the health needs of the nation.[33–35] Achieving a diverse medical school faculty would help meet the institutional mission of academic medicine to train a physician and research workforce that meets the needs of our multicultural society.

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