Minority Medical School Faculty

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It is well documented that minority physicians, both black and Hispanic, are more likely to serve a greater number of black and Hispanic patients than other nonminority physicians.[1-3] Documented also, is the fact that minority communities are much more likely to have physician shortages and, unlike their nonminority physician colleagues, both black and Hispanic physicians tend to practice in areas where there are higher minority resident population regardless of the community income base.[4] These findings, in themselves, present a morally convincing argument and a strong compelling interest that provides legal reasoning for continuing to support and expand affirmative-action programs. Affirmative-action programs have made a positive impact in the efforts of U.S. medical schools to increase the diversity among the approximately 16,000 physicians that graduate each year. The increase of minority physicians trained in U.S. medical schools, while making significant strides, is still small compared to their natural minority representative's proportion in the U.S. population. Thus, affirmative-action and the responsibility of medical schools to train more minority physicians to more adequately serve underserved minority communities still have a long way to go and must continue.

More serious perhaps is the small number of African Americans, Hispanic Americans, and Native Americans on medical school faculties. Underrepresented minorities in faculty positions have been proportionately much lower than the number of underrepresented minority physicians practicing medicine within the United States. One continues to question why affirmative-action was largely responsible for gains made by minorities entering and graduating from medical school yet appears to have been less influential in the efforts to increase the number of minority faculty members.

The low number of black, Hispanic, and Native American medical school faculty is an issue that requires more careful study. However, the number of minority faculty that exist in such small percentages relative to their number in the population, or even relative to their total representation in medical education, may be due to several reasons other than the lack of a more significant impact by affirmative action. One reason may be that during the years when medical schools first opened their doors to underrepresented minorities, the focus was on producing physicians that would likely practice medicine in their own communities. Medical school admissions committees were looking for minorities that not only were likely to practice in minority communities but ideally were looking for those who were also interested in primary care specialties or in becoming general specialists.

In 1978, Dario Prieto[5] pointed out that the increase in minority admissions at that time was due to the goal of medical school admissions committees to shift their selection focus from a homogeneous group of students to one that is more diversified; i.e., admitting more students that are representative of our society, which includes more females and

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more members of minority groups. Admissions committees were also charged with selecting not only students with high academic credentials but also students who were expected to solve specialty and geographic distribution problems.[5] Many studies performed during the period between 1974 and 1996 document the fact that minority graduates generally opted for primary care specialties in greater percentages than nonminority and that minority physicians tend to serve minority communities more so than do nonminority physicians. According to data from the Association of American Medical Colleges (AAMC), of medical school graduates of 1995, more than 50% of the underrepresented minorities (black, Mexican American, Puerto Rican, Native American) planned to pursue careers as general specialists and indicated plans to practice in underserved areas compared to approximately 25% of the minorities that were not underrepresented. These figures are based on a total of 15,888 medical school graduates, of which 9% or 1427 were underrepresented minorities.[6]

The issue of minorities in medical education also needs to focus on the need for a diverse U.S. medical school faculty. The present existence of the small number of minority medical school faculty needs to be seriously addressed if real progress is to be made across all facets of medicine for underrepresented minorities. In 1985, there were 52,464 full-time faculty among the 127 U.S. medical schools in the country, and of these only 1444 (2.7%) were underrepresented minorities. Between Howard, Meharry, Morehouse, and the two Puerto Rican medical schools, they accounted for 460 (32%) of all minority faculty. The predominantly black schools accounted for 229 (15.85%) of the minority faculty and the University of Puerto Rico and the Universidad Central del Caribe schools of medicine accounted for 231 (15.99%).[7] Drew Medical College was not included in this analysis because the first graduating class was not until 1984. Approximately 11 years later, in 1996, there were a total of 70,082 full-time faculty (family medicine, internal medicine, pediatrics) among 125 U.S. medical schools that reported to an AAMC survey. Underrepresented minorities make up only 3.8% of all U.S. medical school faculty, excluding the predominantly minority institutions, because 90% of all black male and 13% of all black female faculty were at Howard, Meharry, and Morehouse.

The same goes for Puerto Ricans. If you exclude the medical schools in Puerto Rico, Puerto Ricans will account for only 0.7% of all Puerto Rican faculty at predominantly white medical schools, because Puerto Rican medical schools account for 53% of all male Puerto Rican faculty and 60% of all female Puerto Rican faculty. When you exclude Howard, Meharry, Morehouse and the medical schools in Puerto Rico (University of Puerto Rico and University of Central del Caribe), it becomes clear that the issue of underrepresented minority faculty among U.S. medical schools is a serious problem.

The absence of a critical mass of minority faculty, especially of blacks, Hispanics, and American Indians, has clearly denied minority role models in the medical profession to underrepresented minority students. One can only assume that lack of role models for minorities is a negative factor that has contributed to the small number of minority graduates pursuing careers in academic medicine. Another factor contributing to the dire underrepresentation of blacks and Hispanics among U.S. medical school faculties may be related to specialty choice restrictions facing minority graduates. Data has consistently shown that within the National Residency Matching Program, the rate at which minority student's match, according to their first choice, is much lower than for nonminorities. Babbott and colleagues[7] found that only 30% of the minority students matched their first choice of a residency program in 1984 and that a higher proportion of underrepresented minority students in 1985, 1986, and 1987 failed to obtain a first choice through the matching program than did other students. This suggests that underrepresented minority students find positions in primary care specialties by default rather than by choice, simply because they fail to match to the subspecialty of their choice.[4] In addition, underrepresented minorities have been less successful than other students in obtaining a match. For example, in 1987, the unmatched rate for all students was only 6% but, for underrepresented minorities, it was 12%, with Native American men experiencing an unmatched rate of 30%.[8]

Between 1984 and 1988, the rates at which underrepresented minority students were not matched with a residency position was alarming. In 1984, 17.7% of the minority students were not matched compared to only 6% for all students. In subsequent years, this rate went down slightly and went back up to 12.3% in 1988.[9]

The need to provide more access for minority

students to careers in academic medicine has been echoed by many leaders in the minority community to increase the number of role models and to provide more equitable fulfillment of career aspirations among underrepresented minority physicians.[10]

It is unlikely that opportunities for underrepresented minorities to pursue careers in academic medicine will be expanded. Currently, of the approximately 16,000 medical school graduates, about 9% are underrepresented minorities compared to about 7% 10 years ago for about the same number of total graduates. More precisely, of 16,318 medical school graduates in 1984 through 1985, 7.5% were underrepresented minorities. This number increased in 1994 through 1995 when, out of 15,888 total graduates, 9.0% were underrepresented minorities. Very few of the graduating minorities are pursuing academic careers. According to AAMC data, of 81,448 medical school faculty in 1995 and, excluding the predominantly black and Puerto Rican schools, only 1476 (2.4%) were underrepresented minorities.[11] If we compare the percentage of underrepresented minority graduates for 1994 through 1995 (9.0%) with the percentage of minority faculty for the same year (2.4%, excluding the minority schools), one can see that only a few underrepresented minorities are pursuing careers in academic medicine.

Other factors likely to influence or contribute to perhaps an even smaller number of minorities pursuing careers in academic medicine are recent findings and reports that the U. S. is currently experiencing an oversupply of physicians. This oversupply has not been felt in rural areas or in minority and disadvantaged communities. Thus, our nation is experiencing a geographic maldistribution of a physician workforce that is not culturally competent. There are 684,000 physicians nationwide and, according to the New York Times (3/9/97), "there is a growing consensus within the medical world that the nation faces a huge doctor glut, mainly of specialists." If the physician surplus is made up mainly of specialists, we know that few are minorities as documented by the matching statistics. One could reason that, because of physician oversupply, a larger number specialists might begin to seek academic careers thereby making the number of faculty positions even more competitive, especially for underrepresented minorities.

Trends indicate that minority graduates historically tend to choose "traditional programs" because they are more likely to obtain their first or second choice. However, because they fail to pursue more prestigious programs that offer more research opportunities and that lead to faculty positions, the representation of minorities among U.S. medical school faculties is not likely to improve significantly. The AAMC Graduate Questionnaire, which is administered to all graduating medical students each year, has consistently shown that a high percentage of minority graduates indicate an interest in teaching or research. However, when one looks at the actual number of medical school faculty, minorities are in fact drastically underrepresented, indicating that the interests of underrepresented minorities to pursue careers in teaching or research are not being fulfilled or that their choices are unrealistic. For example, in 1982, 15.9% of minority graduates indicated an interest in academic medicine and research, but a few years later, following their residency training, the number of minority faculty at U.S. medical schools, not counting the predominantly black and Puerto Rican Schools, was only 2.7%, and for 1995, it was 3.8%.[11] These data indicate that, although a significant number of minority graduates were interested in academic medicine, the encouragement or the opportunities for them to pursue the types of programs that lead to faculty positions were not readily available. The AAMC Group on Student Affairs, Minority Affairs Section, set up to advise the AAMC on minority students issues, recognized these problems and began to address them as early as 1978. The 1978 report of the AAMC Task Force on Minority Student Opportunities in Medicine recognized the challenges that minorities were facing in graduate medical education and made the following recommendations:

1. Encourage medical schools and teaching hospitals to establish a more affirmative approach to informing, counseling, and recruiting minority students for residency positions.
2. Develop a mechanism to assist program directors and department chairmen at academic medical centers and teaching hospitals in the identification of potential candidates for housestaff and faculty positions.
3. Encourage foundations and the federal government to continue to provide financial support for extramural clinical elective clerkships, thus actively supporting those for minority career development.

4. Work with foundations to provide more graduate fellowships for minorities interested in academic medicine.[12]

More recently, the 1999 AAMC Task Force on Cultural Competency has been in deliberation with Liaison Committee on Medical Education (LCME) regarding the development of cultural competency as an accreditation standard.[13] Physicians responsible for providing quality, cost-effective medicine in the twenty first century will need to be competent in recognizing the influence of a person's cultural background on health. This will become increasingly important, because the projected population for the next century indicates that the majority of citizens seeking medical care will be of ethnic backgrounds other than white. The need for minority medical faculty has never been greater.

CONCLUSION

It is probably fair to say that, although some of the above recommended activities have been instituted to some degree, reiterating the need for these same recommendations today is probably still appropriate, timely, and relevant if further increases in the number of minority faculty are to be realized. In addition, the fairly small numbers of underrepresented minorities among the classes of predominantly white medical schools make it imperative that medical students and residents be exposed to more minority role models. Without a significant increase in minority faculty, the concept of the importance of role models for underrepresented minorities will fail to develop fully and will continue to have minimal impact or influence on the decision of minority graduates to pursue academic careers.

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