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A Letter to the Editor: Under-Represented Minority Faculty in Academic Medical Centers

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It is a part of an academic center's responsibility to work with and serve the neighboring community. As our communities become more and more diverse, the need for under-represented minority (URM) faculty in academic centers is realized. It is well known that URM physicians care for URM patients.[1] Low numbers of URM faculty hinder patient care, advances in medical research, and advances in medical education.[2] To take this a step further, underrepresentation has direct effects on mentoring, recruitment, and retention of URM students.[3] This underrepresentation will trickle down to our communities as diminished resources and opportunities. There are direct implications here to the family physician as we are the ones who will likely be hardest hit with fewer and fewer resources to provide high-quality, evidence-based care.

So what specific strategies are academic institutions initiating to recruit and retain URM physicians? This is where my personal story begins. As a junior faculty member fresh out of residency, I had poor understanding of my institution's culture and the pathway to advancement. There were no formal mentoring programs to ensure my success. Interestingly enough, I was unaware of my needs as a junior faculty member until I was several years into my career and behind on publications and other scholarly work. As I found myself with substantial administrative work, committee work, and clinical demands, I learned that I had very limited time to do anything scholarly, and not only that, had little insight into how I might complete scholarly projects. My personal experience is not unlike what I have seen represented in the literature. It is well documented that minority faculty have more clinical responsibilities and committee and community work than their non-minority peers, which in many situations is not valued by the academic institution for promotion and tenure.[4] There is also evidence to show that URM faculty often leave academia after about five years and are more often held at the assistant professor rank.[4] That was my story. Burned out, tired and confused, I left academic medicine after only six years of service.

Does it have to be this way? No, it does not. Many great URM clinicians, educators, and scientists are lost due to being unable to navigate the waters of academic medicine. To think about the contributions that could have been realized for teaching, research and patient care is staggering, contributions that could have led to advances in family medicine and improved health of a community. Those contributions could have led to the encouragement of URM students to enter primary care specialties thereby helping reduce health disparities by fighting for the underserved.

Even with the challenges I faced when I entered academic medicine and when I finally learned what it would take to stay, I realized that my passion for underserved care, community outreach, and teaching students to care for underserved populations was as alive as ever. I knew that I had to figure out how to thrive in the academic

arena. The blend of patient care, teaching, and scholarship has always appealed to me and I learned by fire that I had to create for myself longevity in academic medicine—not just for me, but for my students and patients. So, after a year away, I rejoined the academic arena, this time with more insight into what would give me staying power. I knew that I would need to focus more on scholarly pursuits such as research projects and publishing. I knew that I would need to limit community and clinical work and make the work that I do in those areas scholarly. I learned that mentorship can come from outside of an institution as well as from within. I learned to network and share research interests with any potential collaborators and not limit myself to collaboration within an institution. Within the research network, I learned to integrate students to not only show them the scientific method in approaching a problem, but also the advantage of documenting work from which others can benefit. A whole year later and a whole lot wiser, I have determined that longevity in academic medicine for the URM faculty member hinges on mentorship and understanding institutional culture, leadership styles, and the need for scholarly pursuits along with faculty development. Consider this letter a call to action to academic health centers to begin and strengthen initiatives to recruit and retain URM faculty in academic medicine, for the good of students and the community.

Sincerely,

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Notes

1. Price EG, Powe NR, Kern DE, Golden SH, Wand GS, Cooper LA. Improving the diversity climate in academic medicine: faculty perceptions as a catalyst for institutional change. Acad Med. 2009 Jan; 84(1), 95–105.
2. Pololi L, Cooper LA, Carr P. Race, disadvantage and faculty experiences in academic medicine. J Gen Intern Med 2010 Aug; 25(12), 1363–1369.
3. Price EG, Gozu A, Kern DE, Powe NR, Wand GS, Golden S, Cooper LA. The role of cultural diversity climate in recruitment, promotion and retention of faculty in academic medicine. J Gen Intern Med 2005 Feb; 20(7), 565–571.
4. Palepu A, Carr P, Friedman R, Ash A, Moskowitz M. Specialty choices, compensation and career satisfaction in underrepresented minority faculty in academic medicine. Acad Med 2000 Feb; 75(2), 157–160.