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Debra Malina, Ph.D., *Editor*

Structural Solutions for the Rarest of the Rare — Underrepresented-Minority Faculty in Medical Subspecialties

Kemi M. Doll, M.D., and Charles R. Thomas, Jr., M.D.

"I'm sure they will want to work with you because, well, you know . . . you're black."

I (K.M.D.) heard these words in 2016, at an interview for a faculty position at a highly ranked academic medical center. The "they" in question were a respected group of researchers affiliated with the institution. I was meeting with more than one senior department member, and I'd asked about research and mentorship resources at the institution.

I entered the interview proud of my accomplishments. I was bursting with enthusiasm about all the possibilities available in academic medicine and carried my detailed, color-coded 5-year plan, complete with budget projections, in my folio. But in that moment, I was reminded of the common no-win lens through which I would be viewed: my potential success was undermined by the implication that my race, not by ability, was my real qualification. And if I was not successful, I would simply validate the "diversity-hire" stereotype, proving that I never really deserved my position to begin with. As in many times that would follow in my career and those of my peers, I was reminded that people I liked, respected, and looked up to would hear such comments — and say nothing.

Such experiences are real phenomena that can affect all physician faculty from racial and ethnic minority groups that are underrepresented in medicine (URM), and they are more common and severe in specialties in which extreme underrepresentation is the norm. To reach their positions, URM faculty in highly specialized areas are often ultra-achievers who have managed to overcome both the competition involved in entering a subspecialty field and the structural racism inherent in a medical education system that perpetuates societal devaluation of people of color.[1]

This achievement often paradoxically results in significant isolation. Isolation, in turn, leads to some adaptive behaviors, including "code switching," or adjusting one's style of speech, physical appearance, behavior, and facial expressions in ways that will optimize the comfort of the (nonminority) people with whom one interacts, in exchange for fair treatment, high-quality service, and career opportunities.[2] Former President Barack Obama made an art form of this survival technique, but code switching can deplete cognitive resources, impede performance, and ultimately result in further isolation.

At the same time, URM faculty are hypervisible, both because they stand out physically and because their institutions often try to showcase them in marketing or recruitment materials in order to demonstrate the diversity of their workforce. A consequence of this hypervisibility, however, is an intensification of "stereotype threat"[3] — whereby URM faculty experience the added pressure of representing their entire community, and thus any failures carry an additional consequence of confirming negative stereotypes in the eyes of the majority, resulting in a narrow margin of error in career pursuits. For people who have defied the odds by succeeding, this narrow margin of error can create an incremental, risk-averse approach to both research and career building — a limiting strategy that can unfortunately serve as evidence of the very stereotype of limited potential that URM faculty seek to avoid.

THE FORCES AGAINST DIVERSIFICATION

The fact that medical subspecialties continue to have extremely low numbers of URM faculty[4-6] decades after national workforce-diversity efforts began indicates the extent of resistance to diver-

sification in these fields. The challenges created by this resistance are faced by URM subspecialists and can impede academic success.

The racial composition of any professional group in society is a product of racist or antiracist policies or norms, not happenstance. Cultural racism, in which the behaviors and norms of one racial group are deemed better or "more appropriate" than those of another, manifest when faculty mentors who are not self-reflective regarding their own biases and privileges perpetuate the social pressures that lead to code switching, by reacting negatively to the behaviors or language of URM faculty that deviate from the majority norms.

In addition, exposure to "counterstereotypical" successful exemplars from URM backgrounds can lead to automatic inferences that racist policies are no longer active or influential[7] — inferences that are consistent with a misguided belief that we inhabit a "postracial" ecosystem. This dynamic results in the minimization of URM faculty's concerns about and experiences with interpersonal or institutional racism.

Finally, a well-meaning desire to protect these faculty can lead mentors to hold back on critical feedback for fear of being perceived as prejudiced.[3] These influences work together to limit the professional trajectory of a URM subspecialty faculty member and the impact of their academic pursuits.

Structural racism, or long-standing institutional traditions and policies that result in racial inequity, affects the medical subspecialties as well. Some of its manifestations are an unwillingness to create countermeasures to mitigate inequities in federal funding for URM faculty,[8] biased grading of medical students in clerkships,[9] and differential expectations for, and value placed on, work toward diversity, equity, and inclusion on behalf of the institution.[10,11] General career-development offerings available for junior faculty in most institutions are not sufficient to address these burdens. In addition, institutional trainings on equity, diversity, and inclusion are not designed to teach URM faculty themselves how to navigate their own positions at the margins. The result is a structural underresourcing of needed support for career advancement of hyperisolated and hypervisible URM faculty.

TOOLS FOR CHANGE

We offer several tools that can be deployed at the division or department level to cultivate the retention and promotion of URM faculty in the medical and surgical subspecialties after they have been successfully recruited.

First, institutions can provide continuing education for leaders to help them prepare for URM faculty and learn how to constructively advocate on their behalf. When entering a division as the only person or one of only a few persons of their background, URM faculty members become a lightning rod for unrecognized racism within an institutional ecosystem — an enormous burden. They become the reporters on acts of implicit and explicit racism to leaders who have been at the institutions for years, unaware. Such reports are subject to disbelief and minimization, exacerbating the reporter's isolation.

Mentors and leaders can prepare themselves in several ways. They can attend high-quality, in-depth antiracist trainings (such as those offered by the Racial Equity Institute) rather than short, optional educational programs on implicit bias. They can reach out to current URM faculty in other areas of their institution to learn about the challenge a new hire is likely to face — and then actively listen to those colleagues. And they can make a clearly articulated commitment to address any personal or structural instances of bias against their new faculty member. Such a commitment includes the willingness to use their positions of power to act in response to unpleasant truths about established faculty and staff or established policies that are inequitable. Unprepared leaders are part of the problem, but they can also be tangible and powerful parts of the solution.

Second, structural support (time, funding, and expectations) can be provided for mentorship and training for new faculty members specifically for navigating isolation, hypervisibility, stereotype threat, and institutional racism. Although a growing number of such resources exist, they often have to be sought out by new hires themselves — and then are too easily subject to automatic deprioritization in light of the employee's other responsibilities and the burden of explaining these unique needs to mentors who are often

unaware of them. Institutional or department leaders can alleviate this burden by establishing the expectation that URM faculty access such resources as part of their career responsibilities, while providing both time and funding support for them to do so.

Third, departments can provide support for URM-specific local and national funding opportunities. The National Institutes of Health (NIH) has documented the inequity in the process of peer review and awarding of grants for black faculty, specifically at the R01 level.[8] It is critical for URM faculty to be able to avail themselves of nontraditional funding mechanisms, especially those created to alleviate this kind of funding inequity. These nontraditional mechanisms may require strategic and time-limited institutional investments, since they may provide lower initial reimbursement for indirect research costs, come with expectations of greater cost sharing, or rely on other costly accommodations. Institutions that make these accommodations can counterbalance the documented structural bias of the peer-review process for traditional NIH grants.

These three strategies do not represent an exhaustive list. They require the support of school deans, center directors, department chairs, and division chiefs in the form of vocal, written, and financial support. By failing to act to address the consequences of isolation for URM faculty in subspecialties, we effectively require this group to overcome disproportionate challenges once again. Taking these actions will allow URM faculty members to succeed in a way that can create a diversification engine for their entire fields. Structural solutions will allow them to fully channel their considerable resilience, dedication, and intelligence into academic endeavors that advance medical science, resulting in a better health care system and better quality of care for all patients.

Our framework of URM faculty is purposely narrow and specific. Recognizing that analogous challenges are faced by historically disadvantaged populations defined by gender, gender identity, disability, and the intersection of these categories with race and ethnicity, we encourage readers to apply and adapt our recommendations to meet the needs of other groups that remain underrepresented and undervalued in medical and surgical subspecialties. All of medicine can benefit from the currently undertapped potential that talented URM faculty can contribute to their professions and the world.

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From the Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Washington School of Medicine and Seattle Cancer Care Alliance, Seattle (K.M.D.); and the Department of Radiation Medicine, Oregon Health and Sciences University, Portland (C.R.T.).

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