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PERSPECTIVE

#Me_Who Anatomy of Scholastic, Leadership, and Social Isolation of Underrepresented Minority Women in Academic Medicine

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"The thing to do, it seems to me, is to prepare yourself so you can be a rainbow in somebody else's cloud. Somebody who may not look like you…"
—Maya Angelou (1928–2014)

In academic medicine, underrepresented minority women physician-scientists (URMWP)* are uncommon, particularly in leadership positions. Data from the American Association of Medical Colleges show that among internal medicine chairs, 12 are Asian men, 10 are black (9 men, 1 woman), 7 are Hispanic (5 men, 2 women), and 137 are white (116 men, 21 women). In the top 40 ranked cardiology programs, there are no female cardiology chiefs, whereas there are at least 10 Asian, 2 black, 1 Hispanic, and 24 white men, respectively. There are more URMWP than URM men, yet URMWP are less likely to be professors and occupy leadership positions in academia. Specifically, among US medical school faculty, relative proportions at assistant, associate, and full professor levels according to race/ethnicity and sex have remained essentially unchanged over the past 20 years. Information from the American Association of Medical Colleges shows that only 11%, 9%, 11%, and 24% of Asian, black, Hispanic, and white women, respectively, are full professors compared with 21%, 18%, 19%, and 36% of Asian, black, Hispanic, and white men, respectively. In addition, although there are representative proportions of women and Asians at the lowest faculty levels, they have not equitably progressed in academic medicine, likely reflecting discrimination and structural/organizational barriers that are also applicable to black and Hispanic women.[1]

HOW ARE URMWP WOMEN DIFFERENT FROM NON-URMWP AND URM MEN?

URMWP are isolated because of a lack of critical mass by both sex and race/ethnicity. Women and URM represent only 15% and 2% to 4% of cardiologists, respectively.[2] The subsequent isolation impedes the social engagement necessary for academic and personal success. Drivers of this isolation include but are not limited to lack of racial/ethnic diversity, racial/ethnic discrimination from patients and families, bias from superiors and colleagues, hypervigilance from stereotype threat, reactions to tokenism, and, in some cases, misguided promotion of only 1 URM as being successful. For URMWP, these experiences are further amplified by social environments, wherein the attractiveness of URM women as mates is devalued, a circumstance that promotes lack of shared social experience with non-URM women and successful men of any race/ethnicity.

Similar to URM men, URMWP are more frequently faced with insufficient family resources/wealth to help manage family-work conflicts such as child care, elder care, and multigenerational financial dependence and to promote retention in academic

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medicine careers that have relatively lengthy training with lower financial yield. As in society at large, particularly in the case of black women, service as the breadwinner can have major personal and career implications. For specialties such as cardiology, delayed personal and professional goals arguably have the harshest impact at the intersection of race/ethnicity and sex, where inattentiveness to URMWP needs remains endemic. In addition, frequently cited barriers to advancement and accomplishment for URM include fewer publications and grants, lack of mentorship and sponsorship, and lack of leadership opportunities.[3,4] Thus, at the foundational levels, URMWP face numerous adverse experiences that are exacerbated by inadequate social or emotional support within their professional and personal environments that can result in poor well-being and attrition.

MOVING FROM ZEAL TO INCLUSION AND PROFESSIONAL SUCCESS

As *diversity* has served as a politically correct word in academic medicine for the past few decades, so does *inclusion* in present day. However, beyond the statement that diversity and inclusion be incorporated into the mission of organizations, an authentic approach to the latter is paramount to ensure sustainable professional satisfaction and success for URM faculty at present and to ultimately build an academic pipeline that reflects equity. The Figure outlines specific approaches aimed at recruitment, retention, and attainment of senior leadership for URM. Authenticity in approach requires both grassroots and orchestrated processes and programs.

First, from the grassroots angle, it cannot be assumed that "rising tides will float all boats." Hence, URM from across the academic life course must be included in discussion and programming efforts. Because specific vulnerabilities shift and are age-sensitive, an accurate assessment of climate is best understood and acted on along career life-course coordinates.

Second, opportunities should be created to encourage hybrid careers that interdigitate academics with private practice. This can lead to better alignment of

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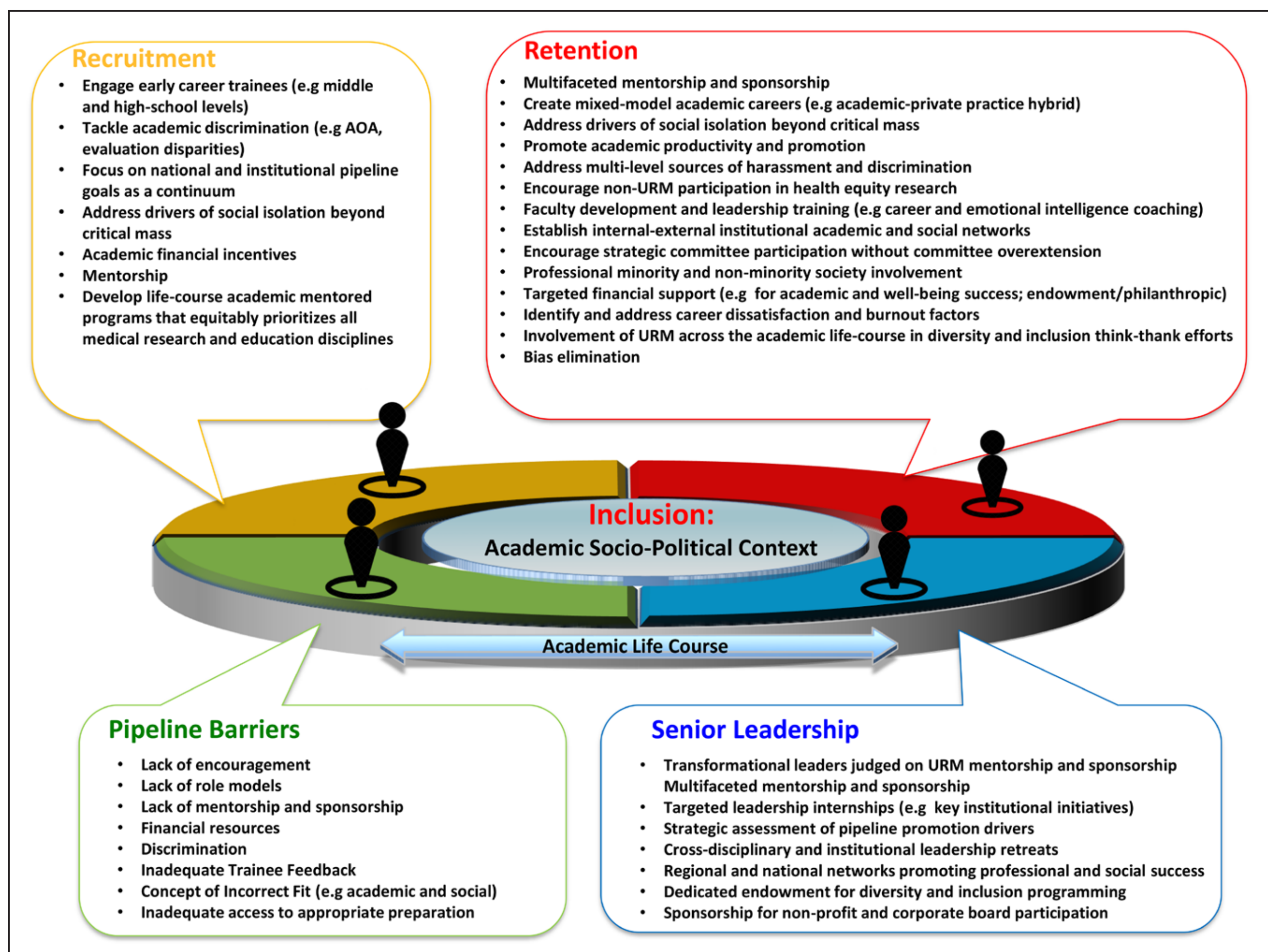

Figure. Academic medicine and underrepresented minorities.
Perspective about specific approaches for recruitment, retention, and attainment of senior leadership for underrepresented minorities.

career goals of many URM faculty who are often pulled between passion or obligation for providing clinical care at the community level, which arguably has positive health benefits to both providers and patients, and an interest in academic endeavors.[5] The current model that isolates academia from practice fails the needs of patients, providers, and communities. For URMWP in subspecialty disciplines such as cardiology, a mixed model might be particularly attractive because it could allow more flexibility related to financial and promotion and tenure pressures in light of the disproportionate burdens faced by women related to work-family conflict across the life course.

Third, at the institutional and organizational levels, leaders must be required to champion diversity and inclusion. Indeed, measurement of a leader's success should include their authentic effect on these indices. For example, organizational leaders should be evaluated on the breadth and depth of their mentorship and sponsorship portfolio.

Fourth, besides obvious diversity in numbers and inclusion related to race/ethnicity and sex, additional focus should be in the arena of faculty scholarly pursuits. Although funding research that targets health equity is extremely important, so is building a non-URM investigator pipeline interested in solutions to health equity problems. At present, URM disproportionately perform disparities research, and greater diversity is needed in this base of investigators. Great need exists for the establishment of programs that promote organized early exposure to the breadth of medical research, including population-based, community, public health, and education innovation at the medical student and clinician-trainee levels. At present, academic institutions and related entities preferentially nurture and promote basic scientists as academic leaders.

Fifth, authenticity around bias from patients and their families, as well as from colleagues, requires training and identification, as well as measurement of the impact of instituted programs on institutional climate and especially on professional and personal work-related URM satisfaction. For URMWP, because professional and social isolation within academic environments can have similar effects on accomplishment, the deconstruction of personal reasons for potential attrition should become a significant area of knowledge accumulation.[3,4]

Sixth, establishment and maintenance of a successful URM academic medicine pipeline requires the creation and nurturing of formal and informal regional and national peer affinity networks that promote professional and social support among URM and with non-URM. Minority and nonminority professional organizations can help to serve a critical role in this regard. In addition, because climate beyond the walls of academic institutions also influences retention, institutions need to understand their local environment as they seek to promote diversity and inclusion. Nonfaculty institutional hiring policies help to create the social fabric of the communities in which they reside because medical centers typically serve as major employers in their respective communities.

Because diversity funding in academia tends to center on research grants and, to a lesser extent, on mentorship, diversity funding must also target URM faculty well-being, including personal factors that promote attrition such as finances. For example, funding to facilitate additional educational needs as well as key personal needs such as home ownership might be needed to assist the attainment of personal and familial intergenerational goals.

In conclusion, URM, and especially URMWP, are faced with walking a tight rope in academic medicine that requires expertise and excellence in both clinical and scholarly domains, typically with insufficient academic support, social capital, and attainment of senior leadership roles that would turn their zeal and commitment into progress. Solutions to the challenges that URMWP face require an inclusive ecosystem where academic institutions serve as core drivers of change through partnerships in their communities to enhance the professional and social climate, at the national level with professional organizations, and with federal entities and private funders that are committed to nurturing a diverse healthcare workforce dedicated to the provision of outstanding medical care for all communities.

*Underrepresented minority refers to black, Hispanic/Latin, Alaska Native, Native Hawaiian, other Pacific Islander, and American Indian.

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Disclosures

None.

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