Prioritizing Equity and Diversity in Academic Medicine Faculty Recruitment and Retention
Antonette A. Ajayi, MD, MPH; Fatima Rodriguez, MD, MPH; Vinicio de Jesus Perez, MD

URM Physician Recruitment and Retention Challenges

Underrepresented in medicine (URM) groups remain disproportionately low in the medical workforce compared with their numbers in the US population. The URM groups included women, those with disabilities, and African Americans, Hispanics, Asian Americans, Native Americans, and Alaska Natives. Despite hefty efforts over several decades by many institutions, the government, accreditation bodies, and advocacy groups alike, there has been limited success in the recruitment and retention of a diverse medical workforce. There is an unmet need to increase the presence of URM groups in the medical workforce that has become more urgent in light of recent national events and the COVID-19 pandemic.

There are several challenges to the recruitment and retention of URM individuals that affect the evolution of diversity in the medical workforce. These include: first, the persistence of discrimination in the work environment where URM individuals experience microaggressions, implicit and/or explicit biases that make them feel devalued and like perpetual outsiders within their institution. Second is the strain of the “minority tax” on URM individuals in efforts to achieve diversity where URM faculty are disproportionately asked to participate in time-consuming, poorly compensated institutional efforts such as engagement in committees, advisory boards, community service, and mentorship of minority students/trainees. Third, lack of mentorship, which could serve as an avenue for feeling connected, supported, and having a sense of belonging to an institution. Fourth are the limited opportunities for academic promotion and career advancement—it has been well established that URM faculty are promoted at lower rates than their White counterparts and are less likely to hold senior faculty and leadership positions. Finally, the financial burden of pursuing a medical career can be overwhelming; URM individuals who come from low socioeconomic backgrounds often acquire more debt throughout their medical training, and this burden is further exacerbated by disparities in compensation.

Strategies to Increase URM Representation in the Medical Workforce

Herein we offer some strategies to increase URM representation in the medical workforce. These are also summarized in the Table along with potential effects of the pandemic.

Address Bias and Discrimination in the Workplace

Institutions must make a pledge to carry out an honest and transparent assessment of the philosophies and attitudes behind discriminatory practices that sidetrack URM individuals from enjoying academic career success and recognition as valued members of the medical community. Any effort to increase URM representation is doomed to fail unless institutions are willing to invest in establishing an infrastructure of respect and inclusion. As part of their continuing medical education, members of the medical community should be required to participate in implicit bias workshops. Several studies have shown that taking the Implicit Association Test (IAT) can help clinicians improve interactions with coworkers and patients by helping recognize how subconscious beliefs and

Open Access. This is an open access article distributed under the terms of the CC-BY License.
Implementation of bystander training and how to address witnessed discriminatory actions.3 Against biases and discrimination, even when unintentional. The latter can be accomplished with the implementation of bystander training and how to address witnessed discriminatory actions.3

Minority Tax
Minority tax refers to extra responsibilities placed on minority faculty by their departments or divisions in the name of efforts to achieve diversity. In many cases, URM individuals are frequently asked to participate in efforts to achieve diversity, inclusion, and equity; however, these efforts usually do not result in additional compensation for time spent. Institutions should reward this time spent by URM faculty with either financial incentives or by recognizing these contributions as essential to their promotion. By establishing financial transparency and equity, institutions demonstrate their respect for URM faculty and will likely provide more incentive to remain in academia. In addition, encouraging nonminority groups to engage in and participate in diversity and inclusion efforts can potentially decrease the tax on those in URM groups.

Table. Summary of Barriers to URM Recruitment and Retention and Some Potential Strategies to Address the Barriers and Factors Related to COVID-19 That Effect Attaining and Sustaining Diversity in Medicine

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Issues</th>
<th>Factors related to COVID-19 potentially exacerbating issues</th>
<th>Strategies to address barriers and issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination in the work environment</td>
<td>Institutional or systemic structures that are unsupportive and/or noninclusive of URM individuals (eg, experiences of explicit and implicit biases, microaggressions)</td>
<td>• Worsening sense of isolation and lack of belonging in the absence of social work gatherings and personal interactions&lt;br&gt;• Impersonal nuances of virtual interactions (eg, telemedicine, recruitment interviews) propagating implicit biases</td>
<td>• Education/training&lt;br&gt;• Implicit bias testing and training&lt;br&gt;• Bystander training on how to address witnessed discriminatory acts&lt;br&gt;• Effects of discrimination, biases, and microaggressions&lt;br&gt;• Diversity the work environment&lt;br&gt;• Recruitment and retention of URM individuals has to be consistent from medical students to leadership roles with the goal that the pipeline is reflective of the general population at all stages</td>
</tr>
<tr>
<td>Minority tax</td>
<td>Burden of participation and/or extra responsibilities placed on URM faculty in efforts to enhance and/or support workforce diversity at the expense of career development activities (eg, diversity and inclusion committee membership, recruitment, mentorship)</td>
<td>• Black Lives Matter movement&lt;br&gt;• Disproportionate effect of the pandemic on communities of color (eg, Black or African American, Hispanic or Latinx, American Indian or Alaska Native)</td>
<td>• Compensate a team of people to design, implement, and evaluate diversity and inclusion efforts&lt;br&gt;• Broadening the scope of academic activities that are considered productive to include all diversity and inclusion efforts&lt;br&gt;• Encouraging nonminority groups to engage in and participate in diversity and inclusion efforts</td>
</tr>
<tr>
<td>Lack of mentorship for URM faculty</td>
<td>Incomplete pipeline resulting in insufficient mentorship networks to support URM as they progress from medical school into residency and fellowship training</td>
<td>• Fewer regular and spontaneous one-on-one meetings with mentors&lt;br&gt;• Prioritizing clinical duties over scholarly work (eg, presenting at professional meetings, developing research portfolio)</td>
<td>• Create mentorship opportunities that span outside of one’s own department and institution&lt;br&gt;• Support attendance at professional meetings or skill development workshops/programs&lt;br&gt;• Develop networking platforms by professional societies to connect URM individuals nationwide with mentors and peers that share similar interests&lt;br&gt;• Development of programs that allow for mentorship outside of one’s own department (eg, leadership education in advancing diversity program at Stanford)</td>
</tr>
<tr>
<td>Academic promotion and career advancement</td>
<td>Promotion disparities: URM faculty are promoted at lower rates than their White counterparts and are less likely to hold senior faculty and leadership positions</td>
<td>• Hiring freezes in the light of financial losses incurred with shutdowns&lt;br&gt;• Dwindling job opportunities forcing graduates to seek career opportunities in the private sector&lt;br&gt;• Shifting landscape of research careers due to the need to care for children at home</td>
<td>• Conduct evaluations to promotion processes at institutions to identify and address any URM promotion issues that may exist&lt;br&gt;• Broadening the scope of activities that are considered productive&lt;br&gt;• Programs that support URM representation in the medical sciences (eg, Harold Amos Medical Faculty Development Program) and promote networking opportunities (eg, Keystone Fellowship Program)</td>
</tr>
<tr>
<td>Financial burden</td>
<td>URM individuals are more likely to incur debt during training, making lower salaries less attractive (eg, additional subspecialty training, research, or academic careers)</td>
<td>• Physical, emotional, and financial task of having to care for sick family members or those affected in other ways (eg, loss of employment, evictions)</td>
<td>• Establish financial transparency and equity for URM trainees and faculty&lt;br&gt;• Provide financial support to offset the cost of medical training (eg, grants, scholarships) and fellowship interview travel costs.&lt;br&gt;• Secure bridge funds and seed grants to support faculty whose productivity may have been affected by the pandemic</td>
</tr>
</tbody>
</table>

Abbreviation: URM, underrepresented in medicine.
Promote a Culture of Mentorship for URM Faculty

Studies surveying URM individuals have shown that URM participants viewed mentorship and involvement in faculty developmental programs as a crucial aspect to their success and job satisfaction.\textsuperscript{2,7} Mentorship is essential and should not be limited just to opportunities within one's own department or institution, especially when there may be a lack of individuals to serve this role. To fill the gap, professional societies should provide networking platforms to connect URM individuals nationwide with mentors and peers who share similar interests. In addition, development of institution-wide programs such as the Leadership Education in Advancing Diversity (LEAD) program at Stanford School of Medicine Graduate Medical Education allows for mentorship opportunities where trainees can connect and collaborate with mentors outside of their departments.

Ensure Equity in Academic Promotion and Career Advancement

Although eliminating systemic racial injustices in the medical system and prioritizing URM faculty mentorship is a start, there are other aspects in sustaining the recruitment and retention of URM trainees and faculty. Existing promotion disparities that disproportionately affect URM individuals make career development and advancement rather challenging. Institutions should consider conducting evaluations of promotion processes to identify and address any URM promotion issues that may exist. As already mentioned, broadening the scope of activities that are considered productive can help with career advancement, particularly for URM individuals who are heavily involved in diversity and inclusion efforts. There should also be dedicated funding mechanisms to support URM group representation in the medical sciences such as the Harold Amos Medical Faculty Development Program and the Keystone Fellowship Program provide awardees with networking opportunities, formal training, and mentorship from recognized URM academic leaders. Development of similar programs could help URM individuals find a supportive community to assist in their career development and provide more opportunities to apply for faculty jobs outside their home institution.\textsuperscript{7}

Reduce/Eliminate Medical Education–Related Financial Burden

As mentioned previously, the financial burden of medical training can effect the decision down the line to remain in academic medicine. To address this early on in training, instituting financial support to offset the cost of medical school can be helpful for URM individuals with financial insecurities. A debt-free medical education model would help attract a greater pool of minority candidates to apply to medical school and commit to completing the requirements for a degree. Other options include financial incentives such as federal grants and scholarships from donations throughout medical school, residency and fellowship. It is important to note that financial support through some of these avenues can be limited by Graduate Medical Education and human resources policies. In light of the financial crisis that could follow COVID-19, access to grants and philanthropic gifts will become a considerable limiting factor in promoting recruitment and maintenance of URM faculty in academia. Institutions should make efforts to secure bridge funds and seed grants to support faculty members whose productivity might have been affected by the pandemic. By increasing the representation of minority physicians, institutions will be creating a diverse community of mentors and role models that will continue to attract talented minority professionals and become a vital part of the institutional culture.

Conclusions

Increasing URM representation in the academic medical workforce is essential to ensure excellence in patient care, research, and education. Although there has been progress in increasing URM recruitment, efforts need to include overcoming barriers that URM trainees experience and implementing strategies that are aimed at retention to strengthen the pipeline. These historical
institutional barriers not only prevent the growth of URM representation in the medical workforce, but they transfer to the delivery of health care and outcomes for minority and vulnerable patients. In the setting of the COVID-19 pandemic that has spotlighted these disparities, now more than ever, we are obligated to establish a diverse workforce that is sustainable to eliminate health care disparities and improve health outcomes for all patients.

ARTICLE INFORMATION
Open Access: This is an open access article distributed under the terms of the CC-BY License. © 2021 Ajayi AA et al. JAMA Health Forum.

Corresponding Author: Vinicio de Jesus Perez, MD, Division of Pulmonary and Critical Care Medicine, Stanford University Medical Center, 300 Pasteur Dr, Grant S140B, Stanford, CA 94305 (vdejesus@stanford.edu).

Author Affiliations: Division of Pulmonary, Allergy and Critical Care Medicine, Department of Medicine, Stanford University School of Medicine, Stanford, California (Ajayi, de Jesus Perez); Division of Cardiovascular Medicine, Department of Medicine, Stanford University School of Medicine, Stanford, California (Rodriguez).

Conflict of Interest Disclosures: Dr Rodriguez reported consulting fees from NovoNordisk Event adjudication and Novartis Advisory board, and personal fees from HealthPals Advisor outside the submitted work. No other disclosures were reported.

Additional Contributions: We thank the following individuals for their expertise and assistance in the writing of this Viewpoint article: Etsemaye P. Agonafer, MD, MPH, MS, Kaiser Permanente Bernard J. Tyson School of Medicine; and Wendy Caceres, MD, Tamara Dunn, MD, and Iris C. Gibbs, MD; all at Stanford University. They were not compensated.

REFERENCES