Removing Barriers to Academic Medicine for Underrepresented Minorities

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Abstract

This article discusses the program and goals that were instituted at our new community-based medical school to increase the representation of underrepresented minorities (URM) as faculty. We rely heavily on mentorship of the students for their research, and also employ community physicians for teaching and to serve as role models for the students. In addition, we collaborate with nonprofit organizations in our community, and offer pipeline programs for URM students. The combination of these programs serve to provide a pathway to academic medicine for URM students.

Introduction

Medical students who engage in public health research learn the demographics and needs of the community they serve, the role research and scholarship play in studying and treating a local community, how to engage in scholarly activities and its role in academic medicine, and the role social determinants of health play in their community's health. At our new community-based medical school, one of our areas of focus is to increase the number of medical school faculty with respect to underrepresented minorities (URM). Here we discuss what we do at our school and what others can do at their medical schools to facilitate this endeavor.

Background on Medical School Recruitment

Academic medicine historically recruits low numbers of URM faculty. In 2015, only 3% and 4% of medical school full-time faculty were African American and LatinX, respectively (Diversity in Medical Education; AAMC; 2015). The lack of URM faculty represents a missed opportunity to provide mentors for URM students (Carethers 2016) which may hinder their decision to pursue academic medicine. Increasing the presence of URM physicians in academic medicine is important to improve minority health, accelerate health disparities research, and increase the diversity of medical school admissions committees (Carethers 2016).

Minority physicians are more likely to serve minority patients, with 51% and 39% of African American and Hispanic medical school graduates, respectively, planning to practice in an underserved area compared to 23% of their white and Asian counterparts (Diversity in Medical Education; AAMC; 2015).

A major predictor of career satisfaction for faculty in academic medicine is mentorship; however, female faculty and URMs are less likely to have a mentor (Kosoko-Lasaki, Sonnino and Voytko 2006). Faculty from our community-based medical school recruited students through summer research programs, lecture announcements, and individual expressed interest. Students begin their research in the spring semester of their M1 year (1st year of medical school), completing the IRB for new projects and producing research products, such as abstract submissions, poster presentations, and manuscript publications, through their M2 and M3 years.

Our medical school relies heavily on community physicians for teaching the medical students as well as partnerships and collaborations with 29 nonprofit organizations where students are placed. These organizations provide public health research and services to the elderly, to children with cancer and their families, to the disabled, to at-risk youth from elementary school to high school, to the homeless, to the LGBTQ+ community, to disadvantaged youth, people with IV drug use/addictions, etc. Pairing up our community teaching faculty, as well as our nonprofit organization partners, with our medical students provides these students with research opportunities and mentorship. In addition, during their M4 year, our students rotate through an Academic Medicine Rotation so that they can be exposed to academic medicine in "real life" and real time and learn about what happens "behind the scenes". This rotation provides additional mentorship to the students from academic faculty. The M4 students also get opportunities to teach M1 to M3 students as well as taking the lead role of teaching by being "faculty" during this rotation. Many students become interested in academic medicine careers after they complete their four years at our medical school, and a large

percentage of these are URM students. Some comments from the students: "I am definitely entering academia after I complete my residency in family medicine"; "I want to be full time faculty at a medical school and train the next generation of doctors"; "I can see myself in a career teaching medical students".

In addition, we have several pipeline programs that recruit high school and college URM students for admission to our medical school. Many of these students are first in their family to either graduate high school, attend college, obtain a college degree, or especially attend medical school. All of these students are paired up with a mentor while in the pipeline program and also while they are in medical school.

Discussion

We arrived at our decisions on how to structure and implement our program and goals for removing barriers to academic medicine for URM in order to increase their representation as medical school faculty based on what other medical schools around the country were doing and not doing in the general sense, but nothing specific in the sense of ideas and nothing specific to one medical school. Various general elements and general ideas from different medical schools were combined to come up with our own unique program and curriculum.

Conclusion

At a new community-based medical school, we aim to create a culture of mentorship to shepherd students through research and scholarship to increase their competitiveness and preparedness for residency and beyond. This model seeks to foster the creation of

compassionate physicians who are keenly aware of their role in their social environment as well as to provide a pathway to academic medicine for URM students who may otherwise not have considered a career in academia.

References

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About the Author

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