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Running head: WHAT GETS LOST IN THE NUMBERS

**What Gets Lost in the Numbers: A Case Study of the Experiences and Perspectives  
of Black and Latino Faculty in Academic Medicine**

A Doctoral Research

Presented to

Morgridge College of Education

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Education

by

Sylk M. Sotto-Santiago

December 2016

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### Abstract

The following doctoral research examines the experiences and perceptions of underrepresented minority faculty in academic medicine through a case study approach. The study focuses on several stages as presented through a model referred to as the *faculty life cycle*. Specifically, the study addresses the socialization, mentoring, and professional development experiences of URM faculty in academic medicine. How do URM faculty experience their environment, culture, and climate in academic medicine? And what is their perception of the impact of diversity and inclusion initiatives and offices in academic medicine? This study utilizes the conceptual frameworks of Inclusive Excellence (IE) and Culturally Engaging Campus Environments (CECE). Analysis of the experiences and perspectives is accomplished through an intentional view of the organization (IE) while simultaneously examining the importance of culturally relevant environments in academic medicine (CECE).

Findings demonstrate that socialization, mentoring and faculty development are of extreme importance to URM faculty in academic medicine in ways that affect their perspectives on diversity and inclusion, organizational structures, culture and climate, and academic advancement. The findings describe a “win or lose” academic medicine culture and institutional climate plagued with challenges and misalignment with URM faculty values. Moreover, socialization into academic medicine impacts URM faculty sense of belonging and identity, and demand extraordinary self-agency and resilience. Identity as “URM faculty” is forced upon by the institution and adversely adds another layer to already complex intersectionalities. URM faculty mentoring is enriched by informal mentoring and shapes their own identities as mentors. Furthermore, URM faculty need development programs that acknowledge the differences in experience and

create spaces for networking, affirmation and accountability. Overall, these experiences relayed by URM faculty voices inform the institution and academic medicine about its environment. Conclusions and recommendations craft the next research and practical agendas in support of URM faculty in academic medicine.

*Keywords:* underrepresented minority faculty, URM, faculty of color, academic medicine, higher education, diversity, inclusion, inclusive excellence, culturally engaging campus environments, socialization, mentoring, and faculty development.

To all underrepresented minorities in higher education and academic medicine who have inspired me every day of my career and to those that will inspire the next generation.

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### Key Concepts and Definitions

*Academic Medicine* - Encompasses the traditional tripartite mission of educating the next generation of physicians and biomedical scientists, discovering causes of and cures for disease, and advancing knowledge of patient care while caring for patients (Kanter, 2008).

*AMC* - Academic Medicine Center. Also *AHC*- Academic Health Center.

*Climate* - It is necessary to distinguish between the concepts of culture and climate as the two often are conflated. Peterson and Spencer (1990) define climate as “the current common patterns of important dimensions of organizational life or its members’ perceptions of and *attitudes toward those dimensions*” (p. 7).

*Culturally Engaging Campus Environments (CECE)* - a model of college success suggests that a number of external influences shape individual influences and success among racially diverse student populations (Museus, 2014). It describes nine indicators that characterize these environments: Cultural Familiarity, Culturally Relevant Knowledge, Cultural Community Service, Cultural Validation, Meaningful Cross-Cultural Engagement, Collectivist Cultural Orientations, Humanized Educational Environments, Proactive Philosophies, and Holistic Support (Museus (2014).

*Campus Culture* - Kuh and Hall (1993) defined culture as the “collective, mutually shaping patterns of institutional history, mission, physical settings, norms, traditions, values, practices, beliefs, and assumptions to guide the behavior of individuals and groups within an institution of higher education.” (p.2)

*Diversity* - As a core value, diversity embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socio-economic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age (Association of American Medical Colleges - AAMC, 2015). Individual differences (e.g., personality, learning styles, and life experiences) and group/social differences (e.g., race/ethnicity, class, gender, gender identity, sexual orientation, country of origin, and ability as well as cultural, political, religious, or other affiliations) (Association of American Colleges and Universities - AAC&U, 2005).

*Equity* -The creation of opportunities for historically underrepresented populations to have equal access to and participate in educational programs that are capable of closing the achievement gaps (AAC&U, 2005).

*Faculty Development*- Professional development includes support for activities part of academic advancement, such as finding research funding, writing academic articles, participating in conferences and professional associations, leadership and management trainings, as well as other types of curricula (IUSM, 2015).

*Identity*- Salient characteristics with which an individual identifies.

*Inclusion* - A core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of an institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community (AAMC, 2015). The active, intentional, and ongoing engagement with diversity—in the curriculum, in the co-curriculum, and in communities (intellectual, social, cultural, geographical) with which individuals might connect—in ways that increase awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions (AAC&U, 2005).

*Inclusive Excellence* - AAC&U model of Inclusive Excellence charges an active process through which higher education institutions achieve excellence in learning, teaching, student development, institutional functioning, and engagement in local and global communities (AAC&U, 2005).

*Mentoring*- An advisory relationship. An overarching term for mentorship, coaching, advising, champion, allies, institutional navigators and agents.

*Minority* – Given the focus on academic medicine, the terms underrepresented and minority faculty (URM) emphasize African Americans (Black), Hispanic/Latino, Native Americans and Alaskan Natives, South East Asians, Pacific Islanders or other ethnic or racial group members who have been found to be underrepresented in biomedical or behavioral research nationally. This definition includes women (NIH Guide, 2004) and LGBTQ faculty. Again, these categories described are used as basic guideline while remaining cognizant of the distinctions within each group and inclusive of others. LGBTQ, refers to those who may identify their sexual orientation as lesbian, gay, bisexual, gender fluid, queer and transgender.

*Socialization*- Socialization is the process through which individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997).

*STEM* - Science, Technology, Engineering, and Mathematics fields.

*Underrepresented* (in medicine) – means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population (AAMC, 2015).

## Chapter 1. Introduction

*The increasing disadvantaged position in which URM faculty find themselves has developed through years of segregation, discrimination, tradition, culture, and elitism in academic medicine. That in turn has adversely influenced the recruitment, retention and career progress of URM faculty in medicine. (Nivet, 2010; Clark & Corcoran, 1986)*

Institutions of higher education have not kept pace with significant demographic changes in the United States. The changing demographics of the U.S. population have pulled higher education in different and complex directions (Keller, 2001). Minority groups now comprise 37% of the U.S. population and are projected to comprise 57% of the population by 2060 (U.S. Census Bureau, 2012). The total minority population will more than double, from 116.2 million to 241.3 million over this fifty-year period (U.S. Census Bureau, 2012). As defined by the U.S. Department of Health and Human Services, “A minority group is a readily identifiable subset of the U.S. population which is distinguished by racial, ethnic, and/or cultural heritage” (U.S. Department of Health and Human Services: National Institutes of Health, 2000, para. E).

The categories described below are used as basic guidelines for the purposes of this research project, which also remains cognizant of the distinctions within each group. The groups are defined as follows: American Indian or Alaskan Native: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition. Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, China, India, Japan, Korea, the Philippine Islands and Samoa. Black, not of Hispanic Origin: A person having origins in any of the Black racial groups of Africa. Hispanic: A

person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race (U.S. Department of Health and Human Services: National Institutes of Health, 2000).

As a result of the U.S. populations shifts, colleges in the United States today serve a different population of students. Enrollment statistics indicate that the percentage of American college students who are Hispanic, Asian/Pacific Islander, Black, and American Indian/Alaska Native has been increasing. From 1976 to 2012, the percentage of Hispanic students rose from 4% to 15%, the percentage of Asian/Pacific Islander students rose from 2% to 6%, the percentage of Black students rose from 10% to 15%, and the percentage of American Indian/Alaska Native students rose from 0.7% to 0.9%. During the same period, the percentage of White students fell from 84% to 60% (NCES, 2015).

Nationally, this demographic shift is identified primarily by rising Hispanic/Latino(a) college bound students, modestly declining White high school graduation numbers, a steady increase in female enrollment, and more first-generation college students (Epstein & Parrott, 2009). How colleges and universities respond to these changes, opportunities, or challenges may determine whether they will thrive or survive as centers of higher education (Bjork & Thompson, 1989). Institutions of higher education will need to develop resources to better serve the Hispanic population and educate larger numbers of first-generation, adult, and low-income students, while adjusting to a majority female student population (Epstein & Parrott, 2009). In the case of females in higher education, colleges and universities have experienced and continue to experience marked increases in female enrollment (Merchant & Omary, 2010).



Women earned 57.3% of bachelor's degrees in all fields in 2011 (NSF, 2015).

Nationally, women and minority students are greatly underrepresented in the science, technology, engineering and mathematics (STEM) fields, which ultimately also affects academic medicine. In 2011, women earned 50.4% of science and engineering bachelor's degrees. However, women's degree attainment in STEM differs by specific disciplines. Women received only 18.2% of computer sciences, and 19% of engineering and physics degrees (NSF, 2015). With the inclusion of more specific data, NSF found that in 2015 underrepresented minority women obtained 3.1% of bachelor's degrees in engineering, 6.5% of bachelor's degrees in physical sciences, 5.4% of bachelor's degrees in mathematics and statistics, 4.8% of bachelor's degrees in computer sciences, 9.7% of bachelor's degrees in biological sciences, and 14.2% of bachelor's degrees in social sciences (NSF, 2015).

However, there is strong widespread commitment regarding the need for college graduates in the STEM fields. Initiatives by the President of the United States, through the National Science Foundation (NSF) and the National Institutes of Health (NIH) serve as examples. Some of these successful programs include the S-STEM, scholarships in science, technology, engineering and mathematics, initiative by NSF, which seeks to increase the success of low-income academically talented students with demonstrated financial need who are pursuing associate, baccalaureate, or graduate degrees in science, technology, engineering, and mathematics (STEM). The program provides awards to fund scholarships, and to enhance and study effective curricular and co-curricular activities that support recruitment, retention, student success, and graduation in STEM (NSF, 2015; NIH, 2015). In addition, NSF has recognized the importance of teacher

leadership which it has sought to support programs such as the *Presidential Awards for Excellence in Mathematics and Science Teaching*, the Master Teacher Fellowship of the *Robert Noyce Teacher Scholarship Program*, and the *Math and Science Partnership* program. The ADVANCE program seeks to increase the representation and advancement of women in academic science and engineering careers, thereby contributing to the development of a more diverse science and engineering workforce. The NIH, as part of the US Department of Health and Human Services, is the nation's medical research agency formed by 27 different institutes and centers. It is the leader in federal research funding for academic medical centers. NIH offers the Science Education Initiative (SEI), which is designed to encourage students to seek careers in the biomedical, behavioral, clinical, and social sciences. In addition to an outreach component, the initiative provides educational, mentoring, and career development programs for individuals ranging from kindergarten through the post-doctoral level. (NSF, 2015; NIH, 2015).

Existing research directly links increasing racial and ethnic diversity of the student body and diversifying the faculty. The absence of diversity influences "perceptions of possibility and openness" (Smith, 2015, p. 149). Smith (2015) presents additional arguments in support of faculty diversification that are not exclusively related to student population shifts and URM faculty as role models. First, faculty diversity represents the institution's values concerning equity in hiring and retention. Secondly, diversity is central to higher education's ability to develop diversity in knowledge with diverse themes in scholarship, curriculum, pedagogy, and engagement (Smith, 2015; Milem, Chang, & Antonio, 2005). Moreover, faculty diversity is critical to relationship

building and service to communities outside of college campuses. With regards to campus leadership, URM faculty provide unique perspectives and address power inequities while also creating inclusive environments (Smith, 2015).

### **Statement of Problem**

Academic medicine is a large sector of higher education that has not been well represented in the current higher education literature. Academic medicine encompasses the traditional tripartite mission of education, clinical service, and research. This includes educating the next generation of physicians and biomedical scientists, discovering causes and cures of diseases, advancing scientific knowledge, while providing cutting-edge health care, and serving the community (Kanter, 2008).

Academic medicine is a higher education sector that is not only greatly affected by the pipeline of underrepresented minority students with interest in the science, technology, engineering and mathematics (STEM) fields, but is also a sector in which the low representation of minority faculty numbers is especially worrisome (Sotto, 2015).

The current U.S. demographic shift suggests the need for a closer look at student and faculty composition at institutions of higher education, particularly in academic medicine. Embracing diversity plays a key role in the success of minority groups around the nation. Underrepresented minority faculty in academic medicine often support non-traditional areas of scholarship, give minorities at the institution a greater voice, provide mentors for students of color, serve as role models in STEM fields, while also contributing greatly to the way diseases are studied and the care delivered to high risk and diverse population (Alger, 1999; McGee, 2012; Merchant & Omary, 2010).

Aside from the obvious need for increasing minority student participation in STEM fields and the academic medicine pipeline, research in recruitment and retention has demonstrated the barriers in participation of URM faculty in academic medicine (Bilimoria & Buch, 2008; Moody, 2004). This type of research often highlights the non-inclusive, microcosms of a mostly White-male dominated environment (as in Predominantly White Institutions-PWI) (Bilimoria & Buch, 2008; Moody, 2004). Retention is difficult to maintain due to negative experiences by URM faculty characterized by feelings of social isolation, unwelcoming environments, bias, hostility, limitation in leadership participation, lack of mentors, and racism among others (Jayakumar et al., 2009, Trower & Chait, 2002). In terms of URM faculty advancement, such as promotion, tenure, mentoring, socialization and development, studies revealed similar negative trends such as challenges in promotion and tenure attainment, unsupportive environments, stagnant careers, as well as significant attrition (Baez, 1998; Cropsey, Masho, Shiang, Sikka, Kornstein, & Hampton, 2008; Jayakumar, 2009; Mamiseishvili & Modica, 2010).

Mentoring and faculty development programs have offered an opportunity to address diversity and increased participation of URM faculty in academic medicine. Mentoring literature points out the positive effects this has on faculty development. Studies and practices in mentoring will continue to evolve in academic medicine because approaches to mentoring programs are broad and their intensity varies (Beech, 2013; Zellers, Howard, & Barcic, 2008). In addition, the literature on mentoring seems to align with that of socialization and faculty development programs in the sense that it can be positive if done well. However, insubstantial mentoring programs, lack of institutional

support, and unsuccessful faculty development programs can contribute negatively to URM faculty (Tierney & Rhoads, 1993; Daley, 2008; Guevara, 2013). Socialization of faculty plays an important role in successful promotion and tenure of any faculty member. Socialization is the process through which individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997). Tierney and Rhoads (1993) considered socialization as an important factor that could positively or negatively affect retention and promotion of faculty of color and their introduction to the academy.

The climate in which URM faculty operate in academic medicine is often summarized with a deficit-centered tone. Scholars often identify barriers, provide suggestions on comprehensive plans that may highlight lack of opportunities for a diverse community (Cora-Bramble, Zhang, & Castillo-Page, 2010; Pololi et al., 2012; Cole, Goodrich, Gritz, & Grimsby, 2009). Others contrast the deficit centered barriers scholars also introduce culturally competent or diversity conscious curricula and support institutional change through a diversity-champion leadership, such that of a chief diversity representatives (Butts, Hurd, Palermo, Delbrune, Saran, Zony & Krulwich, 2012; Reede, 1995; Wilson, 2013; Williams & Wade-Golden, 2007).

The focus on diversity has created an opportunity for roles such as those led by offices targeting Diversity and Inclusion and the leadership visibility of Chief Diversity Officers. Initiatives such as those modeled by Inclusive Excellence and cultural engagement aim to positively impact campus cultures and spread the message on diversity and inclusion. However, the literature has not been clear on measurable outcomes that can directly be tied to the success of URM faculty in academic medicine.

While diversity may often be followed by compositional diversity and associated values, communicating a holistic account of gender, race and ethnicity, inclusion and climate are not as easily evaluated.

Expansion of diversity and inclusion initiatives across campuses around the nation have also allowed for an opportunity to develop and commit to diversity and inclusion. Change in higher education takes time, and academic medicine is faced with not only with a dismal number of URM faculty, but also with research funding challenges, and delivering health care in a dynamic population while educating the next generation of physicians and scientists (Schafer, 2013).

### **Significance**

The increasing disadvantaged position in which URM faculty find themselves has developed through years of segregation, discrimination, tradition, culture, and elitism in academic medicine. That in turn has adversely influenced the recruitment, retention and career progress of URM faculty in medicine (Clark & Corcoran, 1986; Nivet, 2010)

Several studies have evaluated issues of recruitment, retention, promotion, tenure, and development; there is a definite need to delve deeper into more specific stages in the faculty life cycle, particularly in the academic medicine setting. In chapter 2, I review the literature around these stages along with general themes. More specifically, mentoring, integration, and relationships are important to the success of faculty in achieving career advancement. As such, I have chosen to focus on the experience of URM faculty through the stages of socialization, mentorship, and faculty development in academic medicine. In addition, these are key stages in academic functions of faculty affairs and professional development, my area of practice. The study contributes to research through the study of these experiences and perspectives in a higher education sector often missed in higher

education literature and one that often misses the value of higher education literature. It will also contribute to institutional policies and practices in ways that foment informed decision making in regards to opportunities and development of URM faculty.

### **Purpose of the study**

The purpose of this research is to explore the experiences of URM faculty as they specifically relate to their socialization, mentoring, and professional development within the environment of academic medicine. Special attention will be paid to the environmental factors that may present as a barrier or assist in successful career advancement. This environment will be studied through the lens of the conceptual frameworks of Inclusive Excellence (AAC&U) and Culturally Engaging Campus Environments (CECE) (Museus, 2014). Neither Inclusive Excellence nor CECE have been fully embraced or explored in academic medicine. In addition, this will be the first application of the CECE model, a student centered model, to URM faculty in medicine.

This study aims to contribute to higher education literature, but will also impact current URM faculty development practices in academic medicine as well as expanding the theoretical and conceptual frameworks utilized in academic medicine. The study is guided by three primary research questions.

### **Research Questions**

Utilizing the conceptual frameworks of Inclusive Excellence (IE) (AAC&U) and Culturally Engaging Campus Environments (CECE) (Museus, 2014), the following research questions will be addressed:

1. What are the (a) socialization, (b) mentoring, and (c) professional development experiences of URM faculty within academic medicine?

2. How do URM faculty experience academic medicine culture and environment? What is their perception of the climate at their current institution?
3. What is URM perception on the impact of diversity and inclusion initiatives and offices in academic medicine?

This research will also contribute to the following practical considerations:

1. How can the data collected inform the design of environments, practices, policies, and strategies that support Inclusive Excellence within a School of Medicine?
2. Can the Culturally Engaging Campus Environment (CECE) be adapted to assess URM faculty environments in academic medicine?

Specifically, a qualitative case study approach will provide the best understanding of the School of Medicine and the environment in which URM faculty operate.



## **Chapter 2. Literature Review and Conceptual Frameworks**

The following chapter contains a comprehensive review of the higher education and academic medicine literature relevant to the study of underrepresented minority faculty. First, the literature explores the statistical representation of underrepresented faculty in higher education while including literature on URM faculty recruitment, retention, promotion and tenure, mentoring, socialization, and professional development. The review also brings attention to faculty self-agency, resilience and sense of belonging. Second, the literature focuses on the academic medicine sector, providing context of its culture and environment while exploring the similar elements in the faculty life cycle. Third, I consider the literature on diversity and inclusion in understanding the trends and impact of related initiatives. Finally, the chapter ends with a review of the conceptual frameworks guiding this study, inclusive excellence (IE) and culturally engaging campus environments (CECE).

### **Importance of Underrepresented Minority Faculty in Higher Education**

Census data shows that minority groups constitute roughly one-third of the U.S. population (US Census Bureau, 2012). Yet, the presence of underrepresented minority faculty is less than 10 % in certain disciplines (Nelson, 2007). For example, a 2007 study showed that in disciplines such as mathematics, computer science, astronomy, and physics URM faculty constitute a little over 2 % of the faculty ranks suggesting that faculty diversity is not just a problem at the institutional level, but even more so within STEM related disciplines (Nelson, 2007).

The National Center for Education Statistics (NCES, 2011) reported that just under 20 % of the nation's professoriate consists of persons of color with Blacks/African

Americans at 7%, Hispanic at 5%, Asians at 7%, Pacific Islanders at less than 1%, and American Indian/Alaska Native also at less than 1%. More specifically, the Professor rank is comprised of 4% Black, 3% Hispanic, and 9% Asian/Pacific Islander. The Associate Professor rank is represented by 6% Black, 4% Hispanic, and 11% Asian/Pacific Islander. The greatest representation is in the ranking of Assistant Professor with 7% Black, 5% Hispanic, and 11% Asian/Pacific Islander (NCES, 2014).

The dismal numbers present two challenges: a failure to increase representation of diverse individuals at proportions equal to their representation in the general population and a lack of senior role models and mentors to support the success of diverse students and junior faculty members (Whittaker & Montgomery, 2014).

Faculty composition and diversity play a key role in the success of underrepresented minority college- students. Not only do URM faculty contribute to student diversity, but they are also likely to contribute in unique ways to what is taught, how it is taught, and what is important to learn in a diverse context (Daufin, 2001; Smith, 1989).

Faculty members teach not only through their classroom presentations, academic writing, and public speaking, but also through their actions, activities, and personal interactions within and outside the classroom. URM faculty members can play a pivotal role in role modeling, improving underrepresented groups access to higher education and race relations on campus. The benefits of faculty diversity accrue both for students and for faculty members themselves (Alger, 1999; John, Ehrenberg, & Janushek, 2004). The importance of racial diversity among faculty members may be even more valuable than student diversity in breaking down stereotypes because of the perceived authority and expertise of faculty. Moreover, early interaction with faculty

serves as anticipatory socialization process that leads students to have more meaningful interactions with faculty later in their college career, in the form of mentorship (Fuentes, Ruiz Alvarado, Barden, & DeAngelo, 2014).

According to Antonio (2002), faculty of color provide students with diverse role models and assist in providing more effective mentoring to minority students. In addition, faculty of color appear to support nontraditional areas of scholarship such as ethnically relevant research, give minorities a greater voice, and are essential to creating diverse colleges and universities (Antonio, 2002). Moreover, increasing faculty of color in the academy provides mentors, role models, and a sense of connection that students of color and junior faculty of color often lack on predominantly White campuses. Another compelling reason for securing greater faculty diversity leads to the potential that faculty of color bring toward institutional and societal transformation (Jayakumar, Howard, Allen, & Han, 2009). Given the value that URM faculty provide to students, our nation's colleges and universities, and their critical role in transformation, their recruitment and retention represent the first steps towards supporting the changing student demographic and expanding the vision of inclusive campus environments.

### **Recruitment and Retention**

Traditionally, the growth in the number of URM faculty has lagged behind the numbers of undergraduate and graduate students of color on universities and colleges (Antonio, 2003; Jayakumar et al, 2009). The recruitment of individuals from diverse groups at meaningful levels is an important first step towards faculty diversity (Taylor, Apprey, Hill, McGrann, & Wang, 2010). While the increase in numbers for URM faculty has shown some progress, there are difficulties with their recruitment. Bilimoria

and Buch (2008) reported that the typical faculty search process is non-inclusive, in that only the subset of the faculty who are part of the search committee are actively involved in all steps of the process and the composition of the average faculty search committee is also non-diverse on a variety of dimensions. When institutions search committees are microcosms of the faculty from which they are drawn, they are likely to be homogeneous in terms of gender, race, religion, and ethnicity (Bilimoria & Buch, 2008). Moreover, Moody's (2004) research suggests that the typical search committee is considerably biased and that minority faculty face an uneven field plagued with obstacles and disadvantages usually absent to White male majority faculty in predominantly White institutions.

Recruitment of URM faculty is critical but institutions of higher education should also invest in their retention as a means for increasing diversity on college and university campuses around the nation. A study by Trower and Chait (2002) claimed that many women and persons of color are avoiding academic careers altogether or exiting academia prior to the tenure decision because both groups experience social isolation, a cold environment, bias, and hostility. The authors also speak about common concerns, which include limited opportunities for faculty to participate in departmental and institutional decision-making; excessive and "token" committee assignments; infrequent occasions to assume leadership positions or achieve an institutional presence; research that is trivialized and discounted; lack of mentors; and little guidance about the academic workplace (Trower & Chait, 2002). For example, Turner, Myers, and Creswell (1999) reported URM faculty feeling like token faculty members while expecting to handle all institutional minority issues. Moreover, URM faculty have been asked to teach a course

on race and/or gender even when their expertise may not be in that particular area. Smith (2015) refers to institutions guilty of “pigeonholing” faculty who do not emphasize diversity related content in their scholarship. Baez (2002), Villalpondo and Delgado Bernal (2002) emphasize that when there is not sufficient diversity in the overall faculty, URM faculty are seen as members of groups, instead of individuals potentially creating an environment in which institutional pressures force their engagement in diversity in stereotypical ways.

Jayakumar et al. (2009) called race and racism into question for the retention of URM faculty by creating conflicting relationships between professors of color and the predominantly White institution. Turner, Myers and Creswell (1999) also explored the challenges of retention by uncovering the hostile racial campus climate encountered by many faculty of color. According to their study, participants reported several challenges including feelings of alienation, racial and ethnic bias in their campus climates. These challenges constituted significant barriers that threatened productivity and satisfaction as faculty members in unwelcoming and unsupportive climates.

Campus climate can be defined as the current perceptions, attitudes, and expectations that define the institution (Bauer, 1998). It is a term often utilized in reference to the student experience. Campus climate research demonstrates that campus environment has a direct effect on student populations and it often defines how students feel about their educational environment (Bauer, 1998; Harper & Hurtado, 2007; Jayakumar et al, 2009; Museus, 2014). Therefore, campus climate has a direct impact on diversity and inevitably, must have also an effect on URM faculty. Thus, it is important to further study the effects of campus climate on URM faculty, especially in highly

specialized environments such as those at academic medical centers where the numbers of URM faculty are even bleaker.

### **Promotion and Tenure**

The current status of URM pipeline development and recruitment is not sufficient to create diverse and inclusive campuses. URM faculty face tangible challenges and barriers when it comes to promotion and tenure, which is a critical issue in the retention of URM faculty. Baez (1998) examines the role of individual and institutional racism in shaping their promotion and tenure process. URM faculty reported working twice as hard as their White counterparts and being held to standards higher than those for White faculty, while still being denied tenure and promotion (Baez, 1998). Similarly, another study discovered that women and URM faculty are also misinformed or lack information regarding institutional processes for promotion and tenure and experienced unsupportive work environments as they work towards this goal (Jayakumar et al. 2009; Turner, Myers & Creswell, 1999). Moreover, the overall representation and doctoral degree attainment for Black students has increased yet Black faculty are still disproportionately represented among tenured positions (Mamiseishvili & Modica, 2010). The percentage of African American/Black and Latino faculty obtaining tenure and earning promotion to full professor has stayed relatively stagnant (IPEDS, 2011). In 2009, 3.4% of college and university tenured faculty were Black, 2.6% were Hispanic and 0.5% were American Indian/Alaska Native (IPEDS, 2011).

### **Mentorship**

Mentorship has grown as a tool for all faculty in academia and is often considered a critical part of URM faculty success. There has been progress in mentorship of faculty

in higher education, especially in combination with professional and faculty development. Faculty mentoring is a dynamic reciprocal relationship for both the mentor and mentee to work closely in developing a professional and productive academic career (Dennery, 2006). The process of mentoring can be complex. Mentors provide leadership and guidance, but they should also provide prospective counseling, education, and monitoring of career progress (Dennery, 2006). Mentors should facilitate participation at meetings and critique the trainee's work, as well as provide rewards whenever possible (Dennery, 2006). A seasoned mentor enhances the likelihood of critical introductions to prospective collaborators, thereby decreasing the isolation of a vulnerable group of faculty (Dennery, 2006).

Other scholars have discovered trends toward overvaluing mentors, citing examples in which academicians have been successful without mentors and in some cases have achieved success in spite of poor mentors (Zellers, Howard, & Barcic, 2008). In addition, Zellers et al. (2008) provides examples of senior faculty members who exploit or sabotage the careers of junior colleagues under the mentoring umbrella. Currently, Responsible Conduct of Research programs at institutions not only address and establish a regulatory compliance framework, but their scope also extends to mentor and trainee responsibilities protecting graduate students and junior faculty (ORI, 2007). The mentoring literature does not demonstrate a conclusive understanding of formal faculty mentoring programs, but it generally describes mentoring relationships in higher education as positive. Zellers et al. (2008) call for a more rigorous examination of mentoring programs in relation to their effect or impact on women and marginalized groups within higher education.

**Socialization**

Socialization of faculty plays an important role very early on, upon the faculty appointment, but also in successful promotion and tenure of any faculty member. Socialization is the process through which individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997). Tierney and Rhoads (1993) consider socialization as an important factor that could positively or negatively affect their introduction to the academy, retention, and promotion of faculty of color. Tierney and Rhoads' (1993) characterize the difference in experiences due to "inadequate anticipatory socialization, weak mentoring relationships, fewer networking opportunities, divergent priorities, and additional work demands" as women and faculty of color are less encouraged to pursue graduate degrees. (Gardner, 2013, p. 7). Research by Mathis (1979) classified socialization at the beginning of career development process and explained it in two stages, at graduate school and in their early career faculty appointment. However, Tierney & Rhoads (1993) also speak of continuing socialization of faculty and their role in socializing others throughout the span of their career.

Organizational socialization is defined as a learning and adjustment process that enables an individual to assume an organizational role that fits both organizational and individual needs (Chao, 2012). As a result, organizational socialization has a significant impact on the culture of the organization. Faculty are socialized into the organization at different levels. These levels could include the institution, a school, department and even at a programmatic level. Throughout the socialization process, faculty members also engage in distinct cultures at national, professional, disciplinary, individual and



institutional levels (Clark, 1987, Tierney & Rhoads, 1994). Literature on the socialization of URM faculty is limited and at times combined with other stages in faculty development.

### **Faculty Development**

Models for faculty development generally divide them into three stages: early career (junior) faculty, mid-level faculty and senior faculty (Sorcinelli, Austin, Eddy & Beach, 2006). There is great diversity in the options and opportunities offered when it comes to faculty development. This professional development includes support for activities such as finding research funding, writing academic articles, participation in conferences and professional associations, leadership and management trainings, as well as other types of curricula (IUSM, 2015).

Women and faculty of color share a lack of supportive professional networks and acknowledge that their networks were less effective in helping them build their professional reputation. Both groups are also more involved in teaching and service activities (Tierney & Rhoads, 1993). This realization may have contributed to faculty professional development programs, which are seen as being of major importance in academia. URM faculty have the skills and knowledge to be successful, but institutions need to provide collective support in recruitment and development. Efforts are in progress but there is a great deal more to achieve in order to achieve the success desired, which is a significant increase in the number of URM faculty (Thompson, 2008).

### **Self-Agency and Resilience**

Underrepresented minority faculty face difficulties remaining in academia for similar reasons that minority students have trouble remaining in college (Campbell &

Rodriguez, 2013). Some of the reasons for minority faculty attrition include: isolation; stereotyping, racism, and lack of mentorship; financial struggles; lack of advisement and support; low institutional expectations; and institutions inadequately structured for minority faculty advancement (Campbell & Rodriguez, 2013). Campbell and Rodriguez (2013) estimate that “there is an 80% overlap of reasons for minority students’ departure from undergraduate education and reasons for minority faculty members’ difficulties remaining in academic medicine” (p. 1056).

Agency and resilience have served as concepts from which to study the individual or internal characteristics of underrepresented minority groups. Resilience is a strength and asset-based construct centered on protective or enabling factors such as competence, coping skills, and self-efficacy (Cora-Bramble, Zhang, & Castillo-Page, 2010). Cora-Bramble et al. (2010) identified spirituality, assertiveness, persistence, clarity about personal goals, and sense of humor as internal protective factors. The authors accentuated individual characteristics of minority faculty in academic medicine as “positive self-reliance, the need to work harder and prove themselves, and the use of minority excellence to overcome misunderstandings, cultural differences and preconceived ideas” (Cora-Bramble et al, 2010, p.1496). Bandura (2008) defines agency as the ability to intentionally influence one’s functioning and the course of environmental events. Self-efficacy is often used interchangeably with agency and has been described as one’s belief in one’s ability to succeed in specific situations (Bandura, 1997).

Faculty of color may seek to confront their systemic oppression through service, which significantly presents obstacles to the promotion and retention of URM faculty. This service is a form of critical agency that resists and redefines academic structures but

may also hinder faculty success (Baez, 2000). Critical agency is being practiced by “community-engaged faculty who work towards social change and social justice by redefining and collaborating across the institutional structures of which they are a part of” (Kiyama, Lee, Rhoades, 2012, p. 284). In this respect, academic medicine leadership may be encouraged to review criteria that overemphasizes research and undervalues contributions in education, administration, and community service often made and chosen by minority faculty (Fang, Moy, Colburn & Hurley, 2000)

In relation to the issue of gender in academic medicine, a study by Pololi et al. (2012) found that stereotype threat could itself contribute to a reduction in self-confidence and self-efficacy. In combination with lower self-efficacy, unconscious bias, and lack of sponsorship, stereotype threat factors may contribute to the slow pace of professional advancement for female faculty in academic medicine (Pololi et al., 2012). Similar results might be expected when considering URM faculty. Through previous literature, scholars have shown that there are intersections and commonalities between the documented experiences of women and other minority faculty (Cropsey et al, 2008; Trower & Chait, 2002; Jayakumar et al. 2009; Turner, Myers & Creswell, 1999; Tierney & Rhoads, 1993). For example in the areas of underrepresentation, these commonalities include a lack of supportive professional networks and feelings of isolation.

### **Sense of Belonging**

Hurtado and Carter (1997) referred to a sense of belonging as a student’s attachment to the campus community and the concept has expanded to consider feelings of attachment to the various communities or universities contexts (Maestas, Vaquera & Munoz Zehr, 2007). Several factors have a positive impact on sense of belonging, for

example, displaying positive behaviors toward diversity issues, socializing with different peers including those of different racial/ethnic groups than your own, and being able to make personal connections with a range of individuals who cross racial and ethnic lines (Maestas, Vaquera & Munoz Zehr, 2007).

Furthermore, Museus, Yi and Saelua (2017) indicate that campus climates and cultures might be associated with the extent to which college students feel like they belong to the community on their respective campuses. The study examined the relationship between campus environments and sense of belonging and found evidence that CECE indicators might be correlated to sense of belonging. While these examples centered on student-related literature, it is also important to make connections between sense of belonging and faculty of color. Current literature demonstrate a substantial gap around this topic and a lack of exploration of sense of belonging in academic medicine.

### **URM in Academic Medicine**

As mentioned before, academic medicine encompasses the traditional tripartite mission of educating the next generation of physicians and biomedical scientists, discovering causes of and cures for disease, and advancing knowledge of patient care while caring for patients (Kanter, 2008). In addition, academic medicine faculty advance science, engage in clinical innovation and service, foster multidisciplinary education, and nurture the next generation of scientists and health care providers (Roberts, 2013). This type of mission and environment is unique in higher education and certainly inspiring. Academic medicine provides healthcare for a disproportionate share of low-income communities while also offering cutting-edge treatments (Kohn, 2004). Nonetheless, some believe that academic medicine is being threatened by lack of leadership and

innovation along with a diminishing workforce including that of physician scientists (Straus, Straus, & Tzanetos, 2006). Academic medicine centers have made incredible contributions to medicine and society; however as large and complex systems they must respond to their changing environment and demographics. Therefore, the future of academic medicine relies on attracting the most diverse and inclusive candidates.

### **URM in Academic Medicine-by the Numbers**

A retrospective cross-sectional study from 1997 to 2008 found that Blacks, Latinos, and women are underrepresented in academic medicine (Yu, Parsa, Hassanein, Rogers & Chang, 2013). The study sought to identify trends in the academic appointments of underrepresented groups at all levels of academic medicine, including gender, race, rank and leadership positions. Over the twelve years the study found that White faculty accounted for 84.76% of professors, 88.26% of chairpersons, and 91.28% of deans. Asians represented 6.66% of professors, 3.52% of chairpersons, and 0% of deans. Blacks represented 1.25% of professors, 2.69% of chairpersons, and 4.94% of deans. Hispanics represented 2.76% of professors, 3.37% of chairpersons, and 2.91% of deans. Women represented 14.7% of professors, 9.2% of chairpersons, and 9.3% of deans (Yu et al., 2013). The study found that there was a net positive increase in the percentage of minority academic physicians. Overall, minorities and women remain grossly underrepresented in academic medicine, while Blacks showed the least progress. The study highlighted that the disparity is greatest at the highest levels (professor, chairperson, and dean) in academic medicine.

Furthermore, NCES projects that by 2019 women will represent 59% of total undergraduate and 61% of post graduate enrollment (NCES, 2015). However, women

hold only about 45% of tenure track positions, 31% of tenured positions, and 23% of college presidencies (Branch-Brioso, 2009). In academic medical centers the numbers are even more noticeable. In 2011, women represented 47% of first year enrollments, and 48% of graduates at all accredited U.S. medical schools. However, only 37% of full time medical school faculty were women (AAMC, 2012). Despite the fact that the percentage of female medical school faculty has increased over time, women remain underrepresented in the ranks of associate professor and full professor. The higher up the professorial and leadership ladder at a medical school or teaching hospital, the fewer women are present. Women account for 19% of full professors, 21% of division or sector chiefs, 13% of department chairs, and 13% of deans at AMCs (AAMC, 2012). Consequently, the current professorate is not representative of the changing demographics of the U.S. population or even higher education in general, which does not prepare the institution for the student of the future.

### **URM Academic Medicine Pipeline**

Much has been written about concerns for our scientific future and how to increase the pipeline of undergraduate and predoctoral underrepresented minorities in STEM fields. For example, the National Science Foundation (NSF) publishes reports and supports resources towards k-12 education, undergraduate and graduate degrees, post-doctoral trainees, employment and funding toward STEM fields. In 2007, the National Science Board (NSF) put forward a national action plan addressing pressing issues in STEM education in response to a failure in meeting the STEM education needs of U.S. students and implications in the workforce and U.S. economy (NSF, 2007). Specifically, “in the 21st century, scientific and technological innovations have become increasingly

important as we face the benefits and challenges of both globalization and a knowledge-based economy. To succeed in this new information-based and highly technological society, students need to develop their capabilities in STEM to levels much beyond what was considered acceptable in the past” (NSF, 2007, p. 2). A recent *Nature* article from representatives of the Association of American Universities (AAU) and the Research Corporation for Science Advancement Cottrell Scholars, a group of research-active science faculty members called for immediate changes to improve the quality of STEM education. Their article outlines examples of scholarship, best-in-class programs and practices that highlight active learning interventions shown to improve achievement for all students, particularly those with disadvantaged and ethnic minority backgrounds (Bradforth, Miller, Dichtek, Leibovich, Feig, Martin, et al. , 2015).

Success in undergraduate and graduate STEM degree attainments leads to a greater pool of candidates and subsequent recruitment of URM junior faculty in academic medicine. Therefore, issues pertaining to recruitment and retention of these students need to be overcome while also enhancing the support of senior URM faculty who will then serve as needed mentors (McGee, 2012). Development of available talent within underrepresented students who are interested in careers in biomedical research is more important than ever because of demographic trends, research manpower needs, and evidence that research teams gain problem-solving capacity by diversification (McGee, 2012). Increases in participation of URMs in biomedicine are expected to invigorate efforts directed at health and healthcare disparities among their constituent groups. According to McGee (2012), achievement of a more rapid pace of growth in participation by these students will require continued innovation and interventions of many kinds and

at many time points in the pipeline. This may include formal mentoring programs, exposure earlier on to STEM opportunities and careers, and additional tutoring programs (McGee, 2012).

URM faculty involvement is critical to the success of the student pipeline. The underrepresentation of women and minority faculty in STEM disciplines continues to be a major concern to university leaders, policy makers, and scientists. For example, the biennial report, *Women, Minorities, and Persons with Disabilities in Science and Engineering* is mandated by the Science and Engineering Equal Opportunities Act. The digest highlights key statistics drawn from a wide variety of data sources (NSF Women, Minorities and Persons with Disabilities, 2015). Data and figures in this digest are organized into topic specific areas of enrollment, degree field, occupation, employment status, and academic employment and revealed disparities amongst women, minorities and persons with disabilities.

The most disturbing trend in the graduate pipeline is that of Black males in medicine. A recent study sponsored by the Association of American Medical Colleges (AAMC) showed that “the numbers of Black male applicants and matriculants to medical school have not exceeded the 1978 numbers, a trend that has persisted over the past 35 years. In 1978, there were 1,410 Black male applicants to medical school, compared with 1,337 in 2014. For matriculants, there were 542 in 1978, compared with 515 in 2014.” (AAMC, 2015, p. 6). Diversity in academic medicine fosters service and engagement, exposure to different educational approaches, different research and scholarship interests, and cultural awareness. The relatively small number of URMs admitted to medical schools influences the institutional culture in which the relatively few successful



applicants find themselves (Bergen, 2000).

### **URM Faculty in Academic Medicine**

The number of underrepresented minorities (URM) among U.S. medical school faculty is markedly low when compared with their respective percentage of the U.S. population (Merchant & Omary, 2009). As mentioned before, the U.S. Department of Health and Human Services (DHHS) defines URMs as “racial and ethnic populations who are underrepresented in a designated health profession discipline relative to the percentage of that racial or ethnic group in the total population.” (U.S. Department of Health and Human Services: National Institutes of Health, 2000, para. E). This definition includes Black or African American, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and any Asian other than Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, or Vietnamese/Southeast Asian (DHHS, n.d.). Similarly, the Association of American Medical Colleges (AAMC) states that underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population (AAMC, 2015).

Only a small number of underrepresented faculty serve as faculty members in the nation's medical schools and this should be a significant cause for concern. URM faculty in predominately White medical schools make up only 7.3% of all faculty (Nivet, 2010). With regards to faculty appointments, women URMs are twice as underrepresented, particularly as the academic rank advances from the instructor to the professor level, and gender discrepancies occur more prominently when compared to White female faculty (Merchant & Omary, 2010). Although the percentage of White faculty has decreased, the

low percentage of Black and Hispanic faculty has not changed proportionately (Merchant & Omary, 2010). According to Nivet (2010), literature shows some progress and success in medical school URM enrollment, but much less emphasis has been achieved in diversifying the faculty and leadership of the nation's medical schools.

Minority faculty are expected to maintain top-notch research programs while at the same time shouldering the burden of all minority or diversity programs, forms of tokenism and cultural taxation that the majority scientists do not have to face (Smith, 2015). Tierney and Bensimon (1996) defined “cultural taxation” as the institutions overuse of its few faculty of color in order to portray a commitment to diversity (p. 367). Tokenism refers to a person being visible as a representative of a group, but invisible as an individual (Tierney and Bensimon, 1996). There is considerable stress in being the sole representative of a group; research shows that there is greater likelihood that the environment will trigger negative stereotype or awareness of the individual’s marginal position (Smith, 2015).

In addition, few programs teach or even discuss the social skills required to navigate the world of academic medicine or the ability to persist in an environment that feels alien and foreign (Cropsey, Masho, Shiang, Sikka, Kornstein, & Hampton, 2008). Faculty attrition, particularly among female and minority faculty, is also a serious problem in academic medical settings. The three most common reasons for leaving the institution appear to be career advancement, low salary, and departmental leadership issues (Cropsey et al., 2008). In this particular study, faculty pursued other opportunities that increased their median income. Women were significantly less likely to positively evaluate their opportunity for advancement and rate of promotion compared with their

male counterparts. The order or ranking of these reasons varied across racial and gender groups. For example, the ranking order from most important to least for women were: departmental leadership issues, professional development, low salary, and personal reasons. For men the order of reasons for attrition were: professional advancement, low salary, and lack of faculty development/mentoring (Cropsey et al., 2008). Minority faculty reasons were similar to those of women; women and minority faculty were at lower academic ranks at the time they left academic medicine. Further, harassment and discrimination were reported by a small number of those surveyed, particularly women and minority faculty. Women were more likely to report sexual harassment and gender discrimination, and minority faculty were more likely to report racial discrimination (Cropsey et al., 2008).

### **Experiences of URM Faculty in Academic Medicine**

URM faculty perceive medicine as a difficult environment (Wingard, Reznik, Daley, 2008). Many minority faculty report experiencing racial/ethnic bias in academic medicine and have lower career satisfaction than other faculty (Cohen, 1998). Despite this, minority faculty who reported experiencing racial/ethnic discrimination achieved academic productivity similar to that of other faculty (Peterson, Friedman, Ash, Franco, Carr, 2004). Even more problematic than lower career satisfaction is the fact that, programs are seeking individuals from diverse backgrounds but prefer that they behave exactly like the majority (Dennery, 2006). Dennery explains that behaving like the majority provides a zone of comfort for minority faculty: “It appears that the only way to be accepted is to truly 'fit in' by having White characteristics in a Black or brown exterior” (p. S47). Specifically, Dennery highlighted the traits that may be considered

desirable by a program (such as assertiveness, self-assuredness and speaking up frequently) are not necessarily the natural characteristics of all cultures. Furthermore, the author discovered that even differences in hairstyles and manner of dress often make the majority uncomfortable. Consequently, URM in academic medicine are compelled to fit in by projecting White characteristics in a non-White exterior.

Underrepresented minority faculty face unique obstacles that can impede their success in academic medicine. According to Cohen (1998), isolation, disproportionate obligation to serve in time-consuming committees, commitment to mentor students with complicated nonacademic problems, and participation in community service, along with a complex tangle of obstacles... that is “many subtle, largely unconscious social conventions, falling short of overt discrimination,” may explain the disparity that exists between URM and non-URM faculty in the attainment of senior faculty rank (para. 6).

URM faculty in medicine, for their part, often face added demands to tutor, mentor, remediate and encourage URM students, although the effort dedicated to such pursuits may receive little recognition from their colleagues (Bergen, 2000). Furthermore, the time required for such effort is purely extracurricular, and competes with the pursuit of other scholarly activities that are the real keys to advancement within academic medicine (Bergen, 2000). URM faculty in academic medicine report being more dissatisfied with their careers and are more likely to report wanting to leave academic medicine within five years compared to non-minority faculty (Cohen, 1998).

Although information is available documenting the hostile treatment of faculty of color in higher education, less information is available about how to counteract these negative patterns of sexism and racism (Peterson et al., 2004; Turner, Myers & Creswell,

1999; Baez, 1998). Cropsey et al. (2008) believe that the reasons for faculty attrition in their study were avoidable and amenable to possible interventions; they suggest that if institutions provide more opportunities for professional advancement, training, and mentorship, and address salary and infrastructure issues in a systematic way, retention would be improved. Further research should go deeper into understanding the environment these highly successful environments.

The existing literature suggests that supportive administrative leadership, mentorship relationships, networking, and interaction with other faculty of color are all important positive factors related to faculty persistence and success (Hassouneh, Lutz, Beckett, Junkins, & Horton, 2014). Hassouneth et al. (2014) suggest that it is important to utilize a “strengths-based lens” to view one’s own career, stay true to oneself, learn self-advocacy, and find allies. In addition, knowing the culture and rules of one’s institution, learning to protect one’s time, ensuring productivity, and being prepared to respond skillfully to racism and other systems of oppression in academe were described as useful strategies for retention of faculty of color (Hassouneth et al., 2014). However, this merely places the burden on the individual as opposed to changing the system in which faculty of color operate. No study or literature was found that addressed the individual’s burden in relation to his or her environment or system.

### **URM Recruitment and Retention in Academic Medicine**

Recruiting and retaining minority faculty in academic medicine is important. First, it improves medical education by the awareness and appreciation of cultural differences among racial or ethnic groups (King, Dickinson, DuBose, Flack, Hellmann, & Pamies, 2004). Cultural competence in minority and nonminority providers helps

promote more effective health care delivery to a diverse patient population (King et al., 2004). In addition, from economic necessity, the health care delivery system must factor in how to increase the number of physicians who will deliver health care, as well as increase the number of physician scientists, clinical investigators, and scientists who will analyze the ailments that plague these populations (Merchant & Omary, 2010).

Second, diversity in the academic environment promotes research that is inclusive of the needs and concerns of minority groups (King et al., 2004). This research mission is carried out by physician scientists (MD), natural or basic science scientists (PhD) and the supporting cast of health care affiliates and research associates/assistants across many other fields. The more diversity in these groups, the more diversity there is in addressing health related research questions. Lastly, greater minority representation among practicing physicians improves the care delivered to minority and medically underserved groups (King et al., 2004).

While a number of complex factors across the entire academic pipeline play a significant role in the recruitment and retention of URM faculty in academic medicine, future studies should investigate how recruitment is conducted and how hiring decisions are made within this environment (Billmoria & Kuch, 2008). Moreover, it would be a disservice to launch diversity initiatives without considering structural barriers that hinder true progress.

Given the organizational structure, history and tradition embedded in academic medicine, innovative recruitment models must be introduced in order to infiltrate a highly hierarchical and structured system. Adoption of social science theory of “unconscious bias” has created an opportunity in academic medicine to explore barriers that inhibit

diversity progress across academic medicine. Unconscious bias refers to social stereotypes about certain demographics or groups of people that individuals form outside of their own conscious awareness (AAMC, 2009). Social scientists argue that most people have some degree of unconscious bias, which stems from our natural tendency to make associations to help us organize our social worlds (AAMC, 2009). A recent analysis by the Association of American Medical Colleges (AAMC, 2009) offers a literature review that shed light to the issue of unconscious bias in academic medical centers. For instance, a study by Trix and Psenka (2003) evaluated at over 300 letters of recommendation that helped medical school faculty receive their clinical and research positions as part of the recruitment process. The authors found that the letters for females were shorter, lacked skills specificity, and had terms that could foster doubt about the applicants. The authors also found that the most common semantically grouped possessive phrases referring to female and male candidates for recruitment reinforced gender representation portraying females as teachers and men as researchers and professionals (Trix & Psenka, 2003). A similar study has not been conducted for faculty of color in medicine.

Moreover, currently only 30% of funded investigators are women. Junior women faculty have fewer peer-reviewed publications than men and are more prevalent on clinician-educator tracks rather than physician- scientist tracks (Sege, Nikiel-Bub, & Selk, 2015). Scholars questioned whether the primary difference was institutional support at an early time in their careers and found that this might be the case. Upon recruitment, institutional start-up funds varied greatly, especially for applicants with PhDs. Overall, men reported significantly higher institutional start-up support with a

median of \$889,000 while women reported a median of \$350,000 (Sege, Nikiel-Bub, & Selk, 2015). Again, a similar study has not been conducted for faculty of color in medicine.

Recruitment practices and models have surfaced that emphasize diverse search committee composition, unconscious bias training, creating structured interview processes, fostering awareness that bias may be presented in recommendation letters, and that cultural differences can affect first impressions. These practices align with literature for overall faculty diversity in higher education (Moody, 2004). These practices appear to be seeing delayed implementation in academic medicine. In addition, studies have revealed that recruitment and hiring of faculty in areas that also contained a diversity requirement resulted in the most reliable recruitment of URM faculty. Specifically adding criterion in the job description such as experience working with diverse groups of students, populations, and faculty; for example, can increase the likelihood of a URM being hired. The author also suggests that this strategy is rarely utilized in science, medicine and engineering searches (Smith, 2015). Moreover, a study by Wingard et al. (2008) explores the career paths and attitudes of URM faculty and compares them to non-URM faculty at University of California San Diego. The study suggests that as academic medical centers expand their searches for URM faculty they may find competitive candidates in existing staff positions and alternative faculty tracks within their own institution.

Retention strategies are extremely important if institutions are committing to diversity and actively changing the make-up of the faculty at academic medical centers. Recruitment resources and efforts will be ineffectual if there is no systemic effort or



intentions to nurture URM talent. Improvements should be noted as academic medicine practices begin to align and adapt from practices adopted from other fields (Moody, 2004). An institution should be able to retain URM faculty and capitalize on its recruitment efforts. Retention practices in the academic medicine literature have often led to faculty development programs that integrate professional skill development and focused academic career advising with instrumental mentoring associated with an increase in the retention of URM faculty in schools of medicine (Daley, Wingard, & Reznik, 2006).

### **URM Development and Advancement in Academic Medicine**

For medical schools to be successful in retention of URM medical school faculty, faculty development programs also need to be in place. The evidence appears to be strong that these programs, along with mentoring programs increase retention, productivity, and promotion for this group of academic medicine faculty (Rodriguez, Campbell, Fogarty & Williams, 2014). A study found that there are not enough faculty development programs for minority faculty and identified several characteristics that successful faculty development programs use: effective and frequent mentoring; focused instruction on clinical, teaching, and research skills; providing regular networking opportunities; reducing administrative or clinical expectations to facilitate scholarly activities that lead to promotion and tenure; providing institutional seed money for pilot projects; and giving promotional weight to institutional service and community service (Rodriguez, Campbell, Fogarty & Williams, 2014). Community service is an example of the importance of URM faculty in addressing health disparities of the community in which the institution is located. However, URM faculty participation in these settings are

not as highly valued in the promotion and tenure process (Rodriguez, Campbell, Fogarty & Williams, 2014).

Similarly, another study identifies the “ingredients” for successful faculty development programs as clearly setting program goals and content, mentoring and coaching, providing a conducive environment, and sustaining support (Daley, Broyles, Rivera & Brennan, 2008). On the other hand, Guevara (2013) counterpoints Daley (2008), arguing that the presence of a minority faculty development program targeted at underrepresented minority faculty was not associated with greater URM faculty representation, recruitment, or promotion. Guevara (2013) found that institutions with minority faculty development programs had a similar increase in percentage of underrepresented minority faculty as institutions without minority faculty development programs. However, the intensity of the programs is what matters (Guevara, 2013). The intensity referenced by Guevara (2010) goes beyond reporting number of faculty served or rating of their experiences with a workshop. It is important to note that Guevara (2010) did not correlate this faculty development with faculty vitality and satisfaction. Some studies within academic medicine have measured the effectiveness of faculty development programs beyond participation and found that the most rigorous programs were structured part-time with fellowship style component (Palmer, 2011). This emphasis on professional development often translates to what academic medical centers measure in promotion and tenure areas: recognition as great educators, significant publications, and a healthy funding portfolio for researchers.

Mentorship of URM in academic medicine has been geared towards increasing the number of URM faculty that pursue careers in academic medicine. A multitude of

mentoring programs exist at institutions, but for the most part they follow this format and expectation, although they may now include mentoring panels (a small group of scientific mentors) and may routinely provide feedback with the goal of evaluating individual's career in the academic medicine currency of publications and funding towards promotion and tenure. These mentorship programs have been continuously growing and are expected to enhance productivity and promotion while addressing numerous barriers disproportionately experienced by URM faculty, such as diversity, competing demands, and lack of institutional support (Beech et al., 2013).

Mentoring is an integral part of the success of URM faculty, especially in academic medicine, which often follows a scientific foundation, guide or format when it comes to mentoring. Academic medicine is formed by faculty that are expected to exist in an environment that embraces clinical enterprise and duties, educational responsibilities, and where performing research is specified. This research greatly relies on federal funding such as that set forth by the National Institutes of Health and other federal entities. In this environment the Principal Investigator (PI) is usually considered the primary mentor, even as other members of the research team may monitor experiments, offer guidance, and provide feedback on research projects. In this system, the best mentors are considered advisors, coaches, counselors and supporters all at the same time (NIH OITE, 2016). A PI is an experienced scientist who guides the research, but also challenges and encourages trainees to achieve independence in their own research. The expectation is that a good mentor will help trainees and early career faculty to define research goals, and support them in this achievement. In addition to promoting the research, this PI or primary mentor should assist in developing career goals and

construct a scientific network (NIH OITE, 2016). Either as a basic scientist (STEM) or as a physician scientist, this is a model that our academic medicine faculty is accustomed to and has assimilated.

The literature is broad and mix, with multiple terms that may fit under the mentoring umbrella, while in other fields, the terms are distinctively separate from mentoring. For example, sponsors are senior-level champions who advocate for their protégés' career. Protégés build the sponsor's currency and polish their legacies. This relationship makes it especially strong and critical to career advancement (Hewlett, 2013). Champions are those individuals on your team that bring credibility, connections, and provide motivation (Weinstein, 2014). Coaches develop the capabilities of high performers (Coutu & Kauffman, 2009). The literature also encourages conducting comprehensive program evaluations and the dissemination of findings in order to determine the most successful approaches for mentoring URM faculty (Beech, 2013; Zellers, 2008). URM Faculty in academic medicine, specifically, Black and Latino groups, are less likely to be in tenured or in tenure-earning tracks compared to non-URM faculty, are concentrated in lower ranks, are paid less, and are less likely to be promoted. Tenure is important to note because it is directly associated with leadership in medicine (Campbell, Rodriguez, Brownstein, & Fisher, 2016).

The leadership provided by the department chair and the executive team appears to be an especially important factor in the departmental climate in URM and women's professional growth and advancement. The chair can improve the departmental climate for women in the sciences by encouraging collegiality, engagement, and collaboration; ensuring equity in departmental assignments, performance and pay, and discouraging

sexist behavior (Bensimon, Ward, & Sanders, 2000). Naturally, this departmental chair philosophy could transfer to equity in the treatment of URM faculty. Moreover, department chairs are the first line of leadership among their faculty, and as such should be included in climate assessments and diversity efforts. Department Chairs performed two very important functions that are critical to these efforts: they hire, retain and promote faculty; and they admit and support students and trainees (Smith, 2014). It is possible for the department chair to build-up URM faculty through a culturally engaging environment aligning with diversity and inclusion values. Historically, addressing diversity in academic medicine has not been a simple endeavor. The problem with diversity in academic medicine originates with the production of scientists who pursue a career in the natural and biological sciences (McGee, 2012). This field's complexity requires thinking and acting in new and different ways. Science and medicine are advancing in a rapidly changing society; one that struggles with ideals of equity and justice in the face of disparity, bias, and lack of access to health care (Reede, 1995). Society's values, beliefs, laws, and regulations have shaped and continue to shape the lives and actions of individuals both inside and outside of academia (Reede, 1995). Academic medicine operates within this environment. How institutional leaders recruit, retain, and advance the diversity of students, residents, fellows, faculty, and administrators will determine the ability to meet the needs of our health care system and its delivery to society. Given the faculty and student demographics of academic medicine, views should not be limited to whether the diversity must match the medical and graduate students or the demographics of the state, but must also focus on the absence of significant diversity across the whole institution. Diversity is essential; even

though it has been given more focus and urgency in recent years. It remains one of the least successful areas of institutional diversity and inclusion initiatives (Smith, 2015).

### **Academic Medicine Culture and Environment**

Climate and culture are often conflated because the terms are normally used in the context of understanding the experience of specific groups in higher education and are an important part of institutional assessments (Museus & Jayakumar, 2012). Peterson and Spencer (1990) defined climate as “the current common patterns of important dimensions of organizational life or its members’ perceptions of and attitudes toward those dimensions” (p. 7). Kuh and Hall (1993) define culture as the “collective, mutually shaping patterns of institutional history, mission, physical settings, norms, traditions, values, practices, beliefs, and assumptions to guide the behavior of individuals and groups within an institution of higher education.” (p. 2). Hurtado et al. (1998) delineates four dimensions of climate: institutional history, structural diversity, psychological climate, and behavioral climate (p. 282). In general, institutional history focuses on social identity groups and structural diversity on the composition of those groups. Psychological and behavioral climate assessments study relationships, perceptions and attitudes towards diversity, as well as this interaction within groups. The model was based on a synthesis of nearly 30 years of research on underrepresented populations in higher education. Milem et al. (2005) introduced a “fifth dimension” to the climate model that speaks specifically to the organizational structure. In this study, culture will refer to a set of perceptions and actions that apply and refer to the organization as a whole, and climate will be used in the context of the organization’s constituents and how they experience the organization through their interactions.

The complex organizational structure of academic medicine can be difficult to succinctly capture as it greatly differs from typical institutions of higher education. The organizational structure of academic medicine has been generally established in alignment with its tripartite mission of clinical, research, and education. Therefore, it is usually comprised of a medical school including other forms of allied health schools, a teaching hospital, and a physician practice group (Cole, Goodrich, Gritz, & Grimsby, 2009). Adding to the complexity, each academic medicine center operates in a unique environment with a distinctive organizational culture and structure, sometimes even different from that of its flagship institution. While some organizational structures of academic medical centers may vary, they do all exist along a model of integration under a single administrative (Dean) and governance structure (Barrett, 2008).

Beliefs and attitudes of faculty appear to be aligned with the professed missions of academic medicine, however its culture appears to be a barrier to successfully fulfilling these goals (Pololi, Krupat, Civian, Ash, & Brennan, 2012). Scholars have shown that academic medicine's culture shows a misalignment between the faculty's own values and perceived institutional values (Pololi, Kern, Carr, Conrad, & Knight, 2009). In particular, faculty perceived a lack of attention to the social mission of providing care for all people and to the community, a lack of prioritization of excellence in clinical care, a devaluing of educational roles, questionable ethical behavior among leadership or management, and the necessity for self-promoting behavior to achieve success (Pololi, Kern, Carr, Conrad, & Knight, 2009).

In addition, academic medicine's culture is one of self-promotion; faculty expressed their distaste of an environment that requires them "to brag" about themselves

and how this behavior differs from personal values of being humble and more dedicated to achieving good than to personal aggrandizement (Pololi, Kern, Carr, Conrad, & Knight, 2009). Other scholars have suggested that academic medical centers may be described as having a “conflict laden” culture, where competition and the associated struggle to remain “on top” are a way of life (Cole, Goodrich, Gritz, & Grimsby, 2009, p. 115).

The environment around compensation has been described by some faculty as a model where “You eat what you kill.” (Cole, Goodrich, Gritz, & Grimsby, 2009, p. 115). This model gives insight to a highly competitive environment that rewards aggressive approach to performance and generating one’s own salary funding. This compensation model is affected by the organizational structure and fund flow structure. For example, a faculty salary in academic medicine is not just dependent on geographic location and rank, but other factors as well (Davenport, Meyer, & Sotto, in press). Typically, compensation is comprised of a clinical component which provides the funds from clinical operations in which the faculty member sees patients, a research salary component often originating from the individual’s research funding portfolio, an educational component for their role in teaching medical students, residents and fellows, and lastly an administrative component depending on leadership positions held (Davenport, Meyer, & Sotto, in press). The characteristics of academic medicine fund flow models are unique to each institution. However, in the ideal academic medical center the education mission would be supported by tuition and fees, research mission would be supported by research grants and contracts, and its clinical mission by the health care system (AAIM, 2009). Realistically, however, this is not the environment in



which academic medical centers or academic health centers operate. Revenues and cross subsidies are often complicated to document and the lack of transparency calls into question the appropriateness and alignment of these funds (Kaiser, 2013).

Moreover, a new generation of students and faculty who seek balance across their personal and professional lives, along with the current lack of diversity in leadership influence difficult choices in the challenging environment of academic medicine. This makes it increasingly clear that there must be a renewed focus on the culture of academic medicine (Powell, Scott, Rosenblatt, Roth & Pololi, 2010).

### **The Faculty Life Cycle**

In order to provide a visual representation, I created the faculty life cycle. The cycle is used to represent the phases or stages faculty experience beginning with their recruitment and then moving through socialization, mentorship, career and professional development, retention, promotion and tenure, and ultimately career advancement. In addition, it considers P-20 education because of the difficulties in the STEM pipeline through graduate school that ultimately affects URM faculty recruitment. It also acknowledges the production of executive leaders.

A cycle representation is used because it highlights faculty progression; as new opportunities arise, perhaps at other institutions or in other capacities, it recognizes that some of these stages are continuous. This model highlights the importance of URM self-agency, resilience, and belonging, throughout their faculty status as explained earlier. It is appropriate to conclude that continuous mentoring and faculty development are critical pieces in advancement and as such they are depicted multidirectionally and in the center of the model.

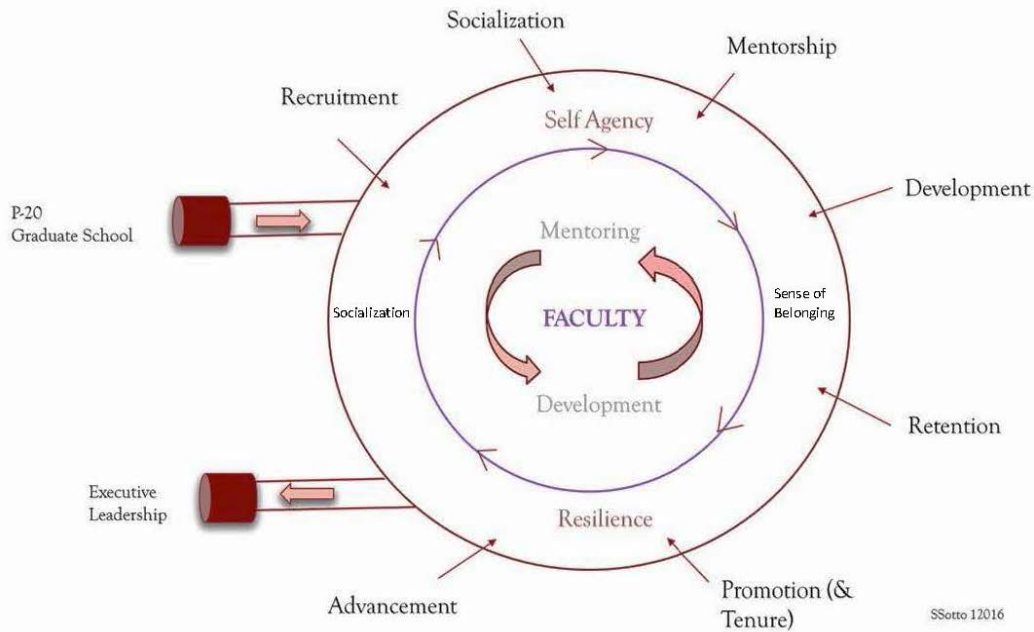


Figure 1. Faculty Life Cycle. Pictorial depiction of faculty life and career progression.

The representation of faculty life has contributed to the current focus areas of this research study. The areas of *socialization*, *mentorship* and *development* served as the context from which to study the experiences and perceptions of URM faculty in academic medicine. Socialization is the process through which individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997). Tierney and Rhoads (1993) consider socialization as an important factor that could positively or negatively affect retention and promotion of faculty of color and their introduction to the academy. This study has characterized socialization as the introduction to the institution and its constituents, as well as highlighting the importance of continuous interpersonal socialization.

Mentorship has grown as a tool for all faculty in academia and is often considered as a critical component of URM faculty success. A significant amount of progress has

been made in the area of mentorship of faculty in higher education, especially in combination with professional and faculty development. Faculty mentoring is a dynamic reciprocal relationship for both the mentor and mentee to work closely in developing a professional and productive academic career (Dennerly, 2006). The mentoring literature does not demonstrate a conclusive understanding of formal faculty mentoring programs, but it generally describes mentoring relationships in higher education as positive. Zellers et al. (2008) call for a more rigorous examination of mentoring programs in relation to their impact on women and marginalized groups within higher education.

For medical schools to be successful in retention and recruitment of minority medical school faculty, faculty development programs also need to be in place. The evidence appears to be strong that these programs along with mentoring programs increase retention, productivity, and promotion for this group of academic medicine faculty (Rodriguez, Campbell, Fogarty & Williams, 2014). The study by Rodriguez et al. (2004) found that there are not enough faculty development programs for minority faculty and identified several characteristics that successful faculty development programs use. These characteristics include effective and frequent mentoring; providing regular networking opportunities; reducing administrative or clinical expectations to facilitate scholarly activities that lead to promotion and tenure; providing institutional seed money for pilot projects; and giving promotional weight to institutional service and community service (Rodriguez, Campbell, Fogarty & Williams, 2014). All these stages in faculty life can be positively influenced by inclusive environments.

### **Diversity and Inclusion**

Taylor et al. (2010) summarize why we should care about diversity in academia

and suggests a reasonable justification, “Since women constitute almost 60% of U.S. college students, and because minorities will exceed 50% of the U.S. population before 2050, we must do a better job of preparing and hiring more persons from these groups for faculty positions in order to provide diverse role models for the nation's changing demographics” (Taylor et al., 2010, para. 2). Bollinger (2007) further argues that in our obligation to students, universities understand that to remain competitive they have to demand and deliver what future graduates “will need to know about their world and how to gain that knowledge” (para.7). A complement of classmate from diverse range of backgrounds is essential to students' training for this world, “nurturing in them an instinct to reach out instead of clinging to the comforts of what seems natural or familiar” (para. 8).

Academic medicine’s closest ally is the Association of American Medical Colleges (AAMC). This organization is comprised of 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Veterans Affairs medical centers, and more than 80 academic societies. Its mission is to serve and lead the academic medicine community to improve the health of all (AAMC, 2015). Its collaboration and influence within academic medicine centers cannot be understated and in terms of diversity and inclusion; AAMC is critical in sharing and communicating key issues, initiatives and best practices. The organization defines diversity as a core value that embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, institutions are mindful of all aspects of human differences such

as socio-economic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age (AAMC, 2015).

Inclusion is defined as a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community (AAMC, 2015). Yet, Butts, Hurd, Palermo, Delbrune, Saran, Zony and Krulwich (2012) summarize the barriers and role of institutional climate in fostering diversity in biomedical research workforce. The authors explain that leadership should regularly and publicly present a clear message in support of diversity and identify those accountable for creating a climate for diversity and inclusion. Interventions should be based on identified barriers and guided by data and information available and unique to the institution's culture. Comprehensive plans should be developed to assess issues, challenges, opportunities, and regularly monitor the impact of these interventions (Butts et al., 2012). Assessments including climate surveys and focus groups are of considerable value in building on institutional history and successes while acknowledging the importance and success of diversity efforts. Building a diverse community should be based on institutional values of diversity and inclusion that are aligned with institutional missions to support excellence (Butts et al., 2012).

There has been great emphasis in this pairing of diversity and inclusion and institutional values. Smith (2014) highlights five ways in which institutions are framing their goals towards institutionalization of the value of diversity: (1) structuring diversity as a core value of the institution; (2) linking diversity to other core values; (3) allocating

resources to support initiatives and sustainable structures; (4) creating programs that promote understanding of everyone's role in diversity issues; and (5) identifying talent that would lead to a change in inclusive leadership.

Institutions have adopted a leadership model that has now become common practice, the creation of positions such as those of Chief Diversity Officers (CDO) and Offices of Diversity and Inclusion. In practice, this position and offices serve a critical role at institutions; however, the literature clearly suggests that it does not take the place of shared values for diversity and inclusion across the institution and it is not the panacea for solving all problems related to diversity and inclusion (Smith, 2014).

CDOs are most successful in institutions in which they are perceived as a resource (Smith, 2014). CDOs elevate the visibility and credibility of the institution's diversity function, leading strategic diversity planning efforts, building new institutional diversity infrastructure, enhancing structural diversity success, informing the search process, and building new academic curricula conscious of diversity courses and initiatives (Wilson, 2013; Williams & Wade-Golden, 2007). The creation of this role and offices might provide a visible way to demonstrate commitment to diversity at the institution; however it is uncertain how effective they are in implementing diversity initiatives (Wilson, 2013). In instances of perceived ineffectiveness, research has shown that CDOs are not effective in environments where there is no clear understanding of their role, duties, and/or when the CDO is a junior person (Smith, 2014).

Furthermore, Leon (2014) emphasizes the importance of equipping CDOs with the tools and resources they need to succeed. The appointment of CDOs accompanies the creation or restructuring of Offices of Diversity and Inclusion Affairs (ODIA), although

these offices' names may vary by institution. ODIAs streamline diversity related efforts and symbolize the importance of diversity around campuses. A comprehensive literature search did not yield specific studies aimed at understanding or framing the organizational structure of these offices. It will be important to evaluate the relationship between ODIAs, and the ability to empower institutional and systemic changes through initiatives, as well as satisfaction and success of the institutions' URM students, staff and faculty. A broad web search on these initiatives revealed that diversity and inclusion centered initiatives supported by ODIAs in higher education include: special funding, pipeline programs for k-12, undergraduate and graduate programs, professional development opportunities surrounding pedagogy and career advancement, multicultural events, faculty, staff and student affinity groups, as well as strategic institutional initiatives (Indiana University School of Medicine, University of Colorado Anschutz Medical Campus, University of California San Francisco School of Medicine, University of Michigan Medical School, University of Wisconsin School of Medicine and Public Health, 2015). An example of a strategic institutional initiative is a Diversity and Inclusion plan, which creates a roadmap for incorporating diversity and inclusion in all aspects of the academy. The plan directs the mission and vision of the ideal inclusive environment and in most cases acknowledges the necessary systemic changes (IUSM, 2014).

Often, diversity and inclusion plans reflect the complexity and culture of the institution, as well as institutional and individual commitments. A recent study by LePeau (2015) highlights how individuals look to "institutional documents to understand what values the institution espoused." (p. 109). Individuals described doing the diversity

and inclusion work because it aligned with the institutional mission and they formed a personal connection with the institutional mission based on that awareness (LePeau, 2015). The diversity and inclusion plan has the opportunity to engage all stakeholders not just in its development but also in its inevitable evolution.

It is important to create this plan while armed with scholarship, practice, knowledge, and support. Moreover, theoretical and conceptual frameworks provide opportunities to develop these plans in thoughtful manners. For example, Inclusive Excellence is a model that offers full integration across all aspects and stakeholders of the academic institution; leaders have the ability to adapt it based on the institutional core mission and values or the microcosm of each discipline or department.

### **Conceptual Frameworks**

#### **Inclusive Excellence**

Inclusive Excellence (IE) is designed to help colleges and universities integrate diversity, equity, and educational quality efforts into their missions and operations. Through the vision and practice of inclusive excellence, the Association of American Colleges and Universities (AAC&U) called for higher education to address diversity, inclusion, and equity. The model of Inclusive Excellence charges an active process through which higher education institutions achieve excellence in learning, teaching, student development, institutional functioning, and engagement in local and global communities (AAC&U, n.d.). One of the goals is to develop “equity-minded practitioners,” who are willing to engage in the necessary conversations and decision-making that can lead to transformational change through the principles of diversity, inclusion, equity and equity mindedness. In addition, the IE organizational change



framework looks at external environments, organizational behavior dimensions, organizational culture, scorecard and change strategy (AAC&U, 2005). These characteristics and dimensions are transferrable to multiple settings and organizations.

Inclusion is defined as the “active, intentional, and ongoing engagement with diversity in the curriculum, in the co-curriculum, and in communities (intellectual, social, cultural, geographical) with which individuals might connect—in ways that increase awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions.” (AAC&U, n.d., para. 6). It centers on diversity, individual differences (e.g., personality, learning styles, and life experiences) and group/social differences (e.g., race/ethnicity, class, gender, sexual orientation, country of origin, and ability as well as cultural, political, religious, or other affiliations) (AAC&U, n.d.).

Equity is referred to as the creation of opportunities for historically underrepresented populations to have equal access to and participate in educational programs that are capable of closing the achievement gaps in student success and completion (AAC&U, n.d.). Equity-mindedness is a demonstrated awareness of and willingness to address equity issues among institutional leaders and staff (AAC&U, n.d.). In order to strive for inclusive excellence, institutions of higher education must construct a concerted effort within the organizational systems, structures, politics, curriculum, development, resources, and culture (Williams, Berger, & McClendon, 2005).

Institutions have operationalized IE in several ways. For example, the University of San Diego drafted the 2020 Strategic Plan for Diversity and Inclusive Excellence establishing a sustainable infrastructure, offering vision and goals at the institutional level, and

operationalizing diversity and inclusive excellence. The plan manifested in a framework identifying six interconnected terrains around which inclusion and diversity are operationalized: access and recruitment of students; student success, retention, and integration; faculty, staff, and administrator access, recruitment, and development; campus culture, curricular learning, and community relationships and engagement (University of San Diego, 2015). The University of Denver operationalized IE under four overarching goals of building a diverse community, creating a supportive climate for diversity, structuring for change and serving the public good. Under each of these goals, university leaders drafted specific actions and objectives (University of Denver, 2011).

The model of inclusive excellence should also be implemented in academic medicine. Only a handful of institutions with academic medical centers have embraced the IE model thus far, including: Virginia Commonwealth, Case Western Reserve, Missouri, and Drexel among a few others. Amongst academic medical centers, Virginia Commonwealth University committed to intentionally integrating IE in all aspects to adhere to a three-dimensional model of social identity, core areas and focus groups (VCU, 2015). Drexel University has implemented the model in favor of creating four subcommittees focusing on target constituents: faculty diversity, professional staff, student diversity, and community outreach (Drexel, 2015). The low IE implementation numbers in academic medicine may demonstrate the perceived limited options in conceptual frameworks that apply in academic medicine, the complexity of developing an inclusive excellence model within medicine, but also the complexity of academic medical centers climates and cultures.

Inclusive Excellence in the context of a Department is the recognition that the

Department's success is dependent on how we value, engage and include the rich diversity of students, staff, faculty, administrators, and alumni constituents. Utilization of this conceptual framework as part of a departmental comprehensive diversity and inclusion plan will require transformation of the department that intertwines with its strategic plan, mission, vision, and values ultimately aligning and assisting the larger efforts. By making diversity and inclusion part of the strategic approach to transformational change in the department practitioners can also evaluate the department's climate in reference to cultural engagement and give URM faculty in academic medicine a forum in which the environment can be assessed and from which the ideal environment can be its ultimate goal.

As mentioned before, campus climate has a direct impact on diversity and inclusion not only for racially minoritized students, but also for URM faculty. Literature suggests that faculty who consider a positive campus climate are more likely to feel professionally supported; these meaningful patterns were also found in measures of the department climate (Settles, Cortina, Malley, Stewart, 2006). Creating a healthy campus climate (and departmental climate) is as important for faculty and staff as it is for students (Settles, Cortina, Malley, Stewart, 2006). Campus climate demands a broad focus besides what the numbers indicate regarding the presence of diverse groups (Milem, Chang, & Antonio, 2005). Vaccaro (2012) explores the campus microclimates, department or discipline specific microclimates for LGBT faculty, staff, and students concluding that complex institutions of higher education may have more than one campus climate experienced by constituents, therefore making IE buy in and implementation challenging in medicine.

### **Culturally Engaging Campus Environments**

Culturally engaging campus environments are institutional environments that reflect and are responsive to the identities of culturally diverse student populations (Museus, 2014). Research indicates that these types of college and university environments lead to more positive individual experiences and higher levels of success among diverse college students. Specifically, the Culturally Engaging Campus Environment (CECE) model of college success suggests that a number of external influences shape individual influences and success among racially diverse student populations (Museus, 2014). Museus (2014) describes nine indicators that characterize these environments: Cultural Familiarity, Culturally Relevant Knowledge, Cultural Community Service, Cultural Validation, Meaningful Cross-Cultural Engagement, Collectivist Cultural Orientations, Humanized Educational Environments, Proactive Philosophies, and Holistic Support.

Cultural familiarity suggests that the extent in which college students have the ability and opportunities to connect with faculty, staff and peers with whom they share commonalities are connected with a higher likelihood of success (Museus, 2014). Culturally relevant knowledge refers to the ability of higher education institutions to provide opportunities for students to “cultivate, sustain, and increase knowledge of their cultures and communities of origin,” and by doing so, positively impacting their success (Museus, 2014, p.210). Cultural Community Service suggests that culturally relevant community service impacts the experiences and success of racially diverse student populations (Museus, 2014). Meaningful Cross-Cultural Engagement offers and promotes many positive outcomes in college while Collectivist Cultural Orientations

create spaces that counter individualist orientations. Culturally Validating Environments positively affect success by validating the students' cultural backgrounds and identities (Museus, 2014). Humanized Educational Environments refers to environments created by caring and committed institutional agents. Lastly, Proactive Philosophies and Holistic Support provide positive vision of success among racially diverse students, and the resources and support necessary for success (Museus, 2014).

The intent of the CECE model is to provide indicators that may guide institutional action in a positive direction while stimulating discourse and a potential guiding framework for committed institutions explicit about the success of racially diverse student populations. In explaining campus environments, the model offers a tool to understand the ways in which campus environments influence the experiences and outcomes of diverse students (Museus, 2014). Recent literature explored CECE as a model to mobilize campus conversations in ways that centered specifically on Latino/a student communities and values. CECE offered a framework to underscore the importance of Latino cultural principles and the integration into institutional structures, spaces, curricula, policies, programs, practices and activities supporting the Latino/a student population (Kiyama, Museus, & Vega, 2015). It is in this purpose and application that each of the CECE indicators has a great potential to transcend this student-centered model into faculty and administrator assessment for engagement. Further research should explore the relation between three areas: URM faculty (and/or administrators), diversity and inclusion initiatives and culturally engaging environment.

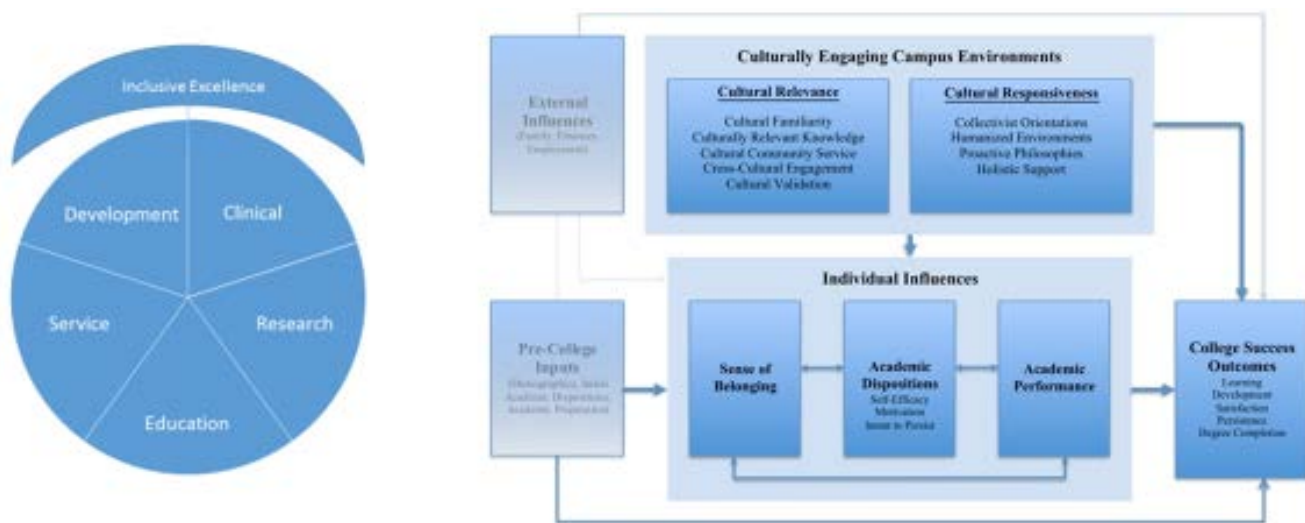


Figure 2. Inclusive Excellence in a Department of Medicine (AAC&U) and CECE (Museus, 2014)

### Dual approach

The use of both IE and CECE models as conceptual frameworks offers an opportunity to combine models that embrace diversity and emphasize the importance of inclusive environments in the success of student populations. The AAC&U argues that racially minoritized students will succeed when an inclusion framework that incorporates diversity at its core is actualized (Harris, Barone & Davis, 2015). CECE explains the ways in which campus environments shape the experiences and outcomes of diverse student populations and asserts that this culturally engaging campus environment yields positive experiences and outcomes. Both models, although originally viewed through a student-based lens have effects that are transferrable to faculty and administrative environments in academia.

The combined conceptual framework approaches URM experiences with an analytical opportunity to examine culturally relevant environments, inclusiveness and excellence within an organization. Each framework offers a unique way to focus on specific aspects. For example, Inclusive Excellence served as the foundation for studying

Midwest School of Medicine as an organization and allowed for me to explore its general environment, organizational behavior and culture in alignment with the IE framework. IE addresses several dimensions demanding a closer look at the climate and organizational behavior dimensions through a scorecard and potential change strategy (Museus, 2014; AAC&U, 2005). CECE provided another way to focus on the cultural environment and engagement for URM faculty. CECE provided the culturally relevant instrument focusing on Culturally Familiarity, Culturally Relevant Knowledge, Cultural Community Service, Cultural Validation, and Meaningful Cross-Cultural Engagement. Both frameworks, collectively, offered a more comprehensive analytical framework of the environment for URM faculty.

In relation to the pictorial depiction of the faculty life cycle, both frameworks guided the analysis of the experiences and environment of URM faculty in academic medicine through an active and intentional view of the organization (IE) while measuring the underlying characteristics (CECE) in relation to URM faculty socialization, mentorship, and professional development. As such, this study demonstrates both the analytical and practical utility of these frameworks and adaptability in addressing URM experiences. Currently, there is no literature that focuses on the experiences of URM faculty in academic medicine through the socialization, mentoring and faculty development processes. Furthermore, the complementary frameworks allow for an examination of a different population (faculty) in a new setting (academic medicine).

### **Chapter 3. Methodology**

Chapter 3 describes the research methods utilized to investigate the experiences and perceptions of URM faculty in academic medicine. First, I describe and justify the qualitative research inquiry and case study design. I then outline setting selection, participant recruitment, ethical considerations, data collection, analysis, reporting, and trustworthiness considerations. The chapter ends with potential limitations of the study and bias as a researcher.

#### **Qualitative Research Design: Case Study**

Given the limited higher education research focused on academic medicine and the importance of studies that focused on the experience of URM faculty in this sector, this study's research approach needed to provide URM faculty in medicine a voice, a way to freely express their experiences and describe their environment. These experiences and perspectives are best understood through qualitative inquiry. The selection of this methodology was a result of careful consideration of the research questions (p. 71). Questions such as "What" and "How" are being used as a way to study specific stages of URM faculty's life cycle. The research questions in this study are open-ended which supports this research approach:

1. What are the (a) socialization, (b) mentoring, and (c) professional development experiences of URM faculty within academic medicine?
2. How do URM faculty experience academic medicine culture and environment? What is their perception of the climate at their current institution?



3. What is their perception on the impact of diversity and inclusion initiatives and offices in academic medicine?

Hence, a quantitative approach could not adequately describe, relay nor interpret these experiences. Framing the research questions qualitatively was used to better understand any phenomenon that we know very little about and to gain more in-depth knowledge or perspective on already known phenomena (Strauss & Corbin, 1990). Qualitative research employs different philosophical assumptions, strategies of inquiry, and methods of data collection, analysis and interpretation (Creswell, 2009). The focus of this study was learning the meaning participants hold regarding their faculty experience. The qualitative researcher interprets what is seen, heard and understood. This must be considered in light of the researcher's background, history, context and prior understanding. In addition, the researcher endeavors to develop a complex picture of the problem or issue by reporting multiple perspectives and identifying multiple factors involved (Creswell, 2009). Moreover, qualitative research is often conducted in the field because it allows direct interaction with the people being studied in their context. Researchers collect data by examining documents, observing behavior or interviewing participants, among many other qualitative instruments. Multiple sources of data are preferred over a single source which requires the researcher to review all data, analyze and organize it into categories or themes that cut across all sources (Creswell, 2009). Given all these characteristics, a qualitative research design was most appropriate for the purposes of the study.

Among numerous qualitative research methodologies, a single case study design was selected. A single case study is used to generate an in-depth, multi-faceted

understanding of a complex issue in its real-life context (Creswell, 2009). The research is conducted through “detailed, in-depth data collection involving multiple sources of information” which “reports a case description and case themes” (Creswell, 2013b, p. 97). Multiple data collection and analysis methods are adopted to further develop and understand the case, shaped by context and emergent data (Stake, 1995). By utilizing a single case study design, this study concentrated on answering the research questions on the bound space and institutional context of Midwest School of Medicine (MSOM)<sup>1</sup>.

Within this single case study design, subunits of analysis were incorporated to add opportunities for meaningful analysis and enhancing insights (Yin, 2014). A critical step in the design process and conducting the single case study is defining and operationalizing these subunits of analysis (Yin, 2014). Subunit examples may often suggest outcomes, programs, projects and individual or groups as subunits (Yin, 2014). For this design, I selected the processes of socialization, mentoring, and faculty development. I believe that by focusing on the processes rather than specific initiatives, programs or projects, I was able to examine specific critical areas of the URM faculty life cycle (see Figure 1). Figure 3 represents these subunits of analysis.

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<sup>1</sup> All names of participants, departments, and institutions have been assigned a pseudonym.

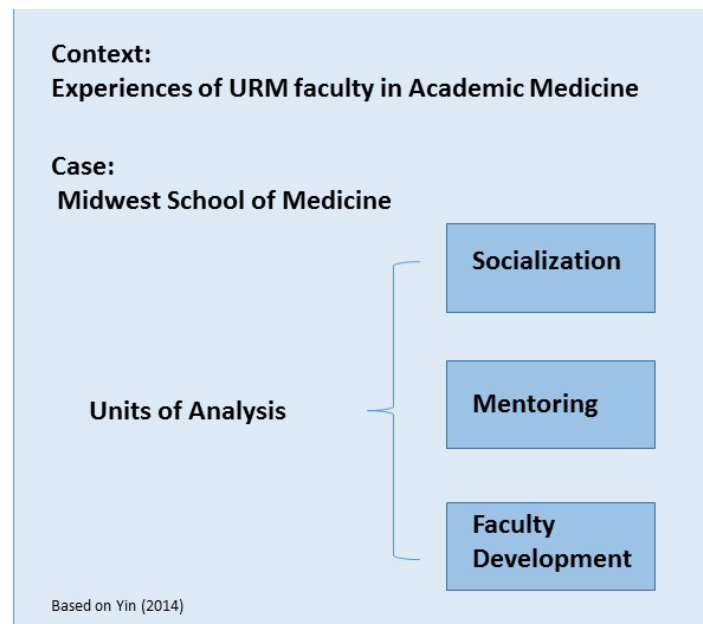


Figure 3. Case study design based on Yin (2014)

Furthermore, the case study allowed for multiple sources of information and data to be collected and analyzed (Creswell, 2009). The following sources were utilized and gathered in phases: interviews, collection of artifacts and texts, and participant journaling. These phases will be explained in the data collection section. These data constitute critical sources in understanding, describing and analyzing this specific case at Midwest School of Medicine.

### Research Setting

This case study was conducted at Midwest School of Medicine (MSOM) in the Midwest region of the United States. Midwest School of Medicine is currently one of the largest schools of medicine in the country and considered a national leader in medical research and education. Similar to other academic medical centers, it is comprised of more than 60 academic departments and specialty divisions across multiple campuses statewide along with strong clinical partnerships with the state's most advanced hospitals

and physician networks. MSOM's mission is to advance health in the state by promoting innovation and excellence in education, research and patient care. It also focuses on the value of respect for individuals who are affiliated with, or come in contact with, Midwest School of Medicine: staff, students, residents, fellows, faculty, staff, partners, communities, patients and families. MSOM believes in integrity that embraces the very highest standards of ethical behavior. The institution states that they value diversity and appreciate all individuals.

MSOM was founded in early 1900s and is currently comprised of several medical campuses across the state. It has a considerable research funding portfolio of several hundred million dollars in research. According to MSOM, both women and people of color remain underrepresented at the institution, in the same manner these groups remain underrepresented in academic medicine. A core diversity emphasis of the institution is to advance women and underrepresented minorities in medicine and science. In alignment with the AAMC and inclusiveness, MSOM is mindful of all race, ethnicity, language, nationality, age, sex, gender identity, sexual orientation, religion, work styles, character traits, wealth, educational advantage, disabilities, rural learners, first generation learners, and those from groups traditionally underrepresented in medicine.

The diversity definition and group emphasis closely mirrors the demographics of this Midwest state. With a population of about 7 million, Whites are about 80.3% of the population, Blacks or African American comprise 9.6%, Hispanic or Latino, 6.6%, American Indian and Alaska Native 0.4%, Native Hawaiian and Other Pacific Islander 0.1%, two or more races 1.9%, and Asian 2.0%. Women comprise 50% of the population (US Census, 2016). The LGBT population is estimated at a 3.7% (MAP,

2016). Currently, URM faculty represent an estimated 5% of its full time faculty, 9% of affiliate faculty, and 6% of those are part-time. The institution's URM student population is about 10% (MSOM, 2016).

### **Selection, Sampling, and Recruitment**

The selection of MSOM was based on multiple factors. First, MSOM is one of the oldest and largest schools of medicine in the country, which provides for a larger number of potential participants, rich history and institutional context. Secondly, its composition of URM faculty closely mirrors national data at an estimated 6%.

Nationally, URM faculty in predominately White medical schools make up only 7.3% of all faculty (Nivet, 2010). Lastly, its position as a state institution of higher education and an academic medicine center offers intensity and wealth of rich knowledge of the experiences of URM. In addition, this status as an AMC provides future opportunities for comparison studies that look closely at this group of institutions.

The target population for the study was URM faculty. However, recruitment resulted in a majority Black and Latino faculty participants. The selection criteria for potential participants was tenured and non-tenured URM and female faculty who hold the rank of Assistant, Associate, and/or Full Professor. At MSOM about 68% of full time-regular faculty are men and 32% women<sup>2</sup>. The faculty sample allowed for all medical specialties, basic and behavioral science faculty. Given that there is no rule for sample size in a qualitative case study research and that this sample size depends on the aim of the study and what is possible given the time and resources available (Patton,

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<sup>2</sup> Excludes affiliates and part time faculty. However, it is important to note that 70% of the part time and affiliate faculty are women.

2002), the sample of faculty consisted of nine faculty members from the participant institution. Each participant has been given the following pseudonyms: Rosana, Jessika, Henok, Alberto, Francisco, Evelio, Blair, Elizabeth, and Abigail.

Table 1

*Participant Sample*

Gender		Race/Ethnicity		Faculty Rank	
Male	4	Black	4	Assistant Professor	4
		Latino	4	Associate Professor	3
Female	5	White	1	Professor	2

Due to the confidentiality promised to participants, additional demographic details about each participant may risk identification. However, it is important to note that other intersectionalities were represented in this study, such as sexual orientation; but the majority of participants focused on their racial/ethnic identities. One participant (Abigail) in particular, a White female Associate Professor, shared experiences that focused significantly on parenthood and work/life integration issues that create barriers and challenges for clinicians and physician scientists. Because the themes represented in this particular participant's experience differed from the remaining 8 participants. I have chosen to highlight issues surrounding parenthood and work-life integration challenges in future analysis and reports. Thus the current focus of this research study is on URM (Black and Latino) faculty experiences.

I used purposeful sampling of participants to identify those that have firsthand knowledge and experience of the phenomenon of inquiry, in this case their experience as

URM faculty (Creswell, 2008; Merriam, 2009). The study's recruitment was through an email announcement sent by the School of Medicine Office of Diversity/Multicultural Affairs. Interested participants were asked to contact me directly.

### **Ethical Considerations**

Prior to initiating the study, Institutional Review Boards (IRB) approvals were obtained from Midwest School of Medicine and University of Denver. As mentioned, potential faculty participants received notification announcing the study directly from the School of Medicine Office of Diversity/Multicultural Affairs. The announcement described the study purpose, addressed the fact that participation was voluntary, explained how data would be collected and disseminated, and informed the potential participants that there were no anticipated harms from participation in the study and that information shared would not impact their employment at MSOM. Willing participants were asked to contact me directly. A letter of informed consent was distributed to interested faculty participants via email and again at a scheduled meeting. All participants reviewed the letter of informed consent prior to starting the study process and signed as agreement to participate.

Participants were informed that they could end their participation in the study at any time. They also had an opportunity to self-select the interview settings for the interview. To further protect the confidentiality of participants, MSOM was not informed of faculty members that volunteered to participate in the study. Additional identifiable and demographic information was collected, however, in order to protect participant confidentiality I have chosen not to include descriptors of sexual orientation, citizenship or national origin, medical specialty, and department. Pseudonyms of participants

interviewed and dates of the interviews were recorded along with field notes. All materials were kept in a locked file. To further protect confidentiality the researcher stored journals, audiotapes, and transcriptions separately from the consent forms. Transcriptions of the interviews did not include any identifying data.

### **Data Collection**

Data collection for this study was guided by three main research questions: What are the (a) socialization, (b) mentoring, and (c) professional development experiences of URM faculty within academic medicine? How do URM faculty experience academic medicine? What is their perception of the climate at their current institution? What is their perception on the impact of diversity and inclusion initiatives and offices in academic medicine?

By adopting a case study approach, the study was bound by MSOM as its setting and centered on the experiences of URM faculty in academic medicine with socialization, mentorship and faculty development as subunits of analysis. The best approach in data collection is one that allows for multiple sources of data, in this case I utilized: collection of texts and artifacts, interviews, and participant journaling (Yin, 2014). Each of these sources represented a different phase in this study.

#### **Phase 1: Collection of texts and artifacts**

Researchers may learn about a bounded system by collecting and studying artifact materials set forth by institutions such as policies and initiatives (Creswell, 2013). In this case, as the data collection was initiated, research on artifacts associated with diversity and inclusion data and school and departmental strategic plans, were reviewed. This



included a collection of diversity and inclusion strategic plan drafts, summary and progress reports, as well as, documents relating to institutional mission, vision and values. The data ranged within the last ten years. These documents were generally available online, through the departments and institution's public site and intranet. Each of the sources provided a wealth of information making for a diverse approach critical to the study of the experiences of URM faculty in academic medicine and the study of organizational structures that support diversity and inclusion.

This data was organized and analyzed per the adaptation of the Inclusive Excellence organizational change framework. More details about this adaptation is discussed in the next section explaining the operationalization of conceptual frameworks during data analysis.

### **Phase 2: Interview 1**

The second phase of data collection consisted of semi-structured interviews with URM faculty. These interviews focused on participants' decision to explore the faculty path, their recruitment to an AMC, experiences with their socialization, mentorship, professional development, and their perspectives on the culture and climate of the institution (see Appendix A). These semi-structured interviews were designed to obtain descriptions of the life of the interviewee and explore the ways in which participants experienced and understood their world in their own words (Kvale, 2007). The goal of these semi-structured interviews was to gather data and develop a personal relationship with participants, allowing for an open dialogue. The interview took about an hour to conduct and was scheduled in person. Only one participant, Elizabeth, chose to interview

via phone, given her work at a satellite campus. Interviews took place at the participant's preferred location including cafes and institutional offices.

It is important to reiterate that both, interview 1 and 2, as well as participant journaling, were informed by IE and CECE frameworks. Specifically, interview 1 asked questions related to the faculty member's path to the academy, their experiences integrating into academic medicine (socialization), mentoring, and faculty development (Appendix A). The IE conceptual framework provided the foundation from which to consider and reflect about faculty responses in a holistic way. This holistic approach considered the organizational structure, which was reviewed through the IE organizational change framework, and the principles of diversity, equity, and inclusion.

### **Phase 3: Participant Journaling**

The third phase of the data collection process intended to provide participants with a journaling and reflection opportunity. Participant writing is a method of inquiry that can serve the interests of participants and researchers alike: it attends to the well-being of research participants whilst providing social scientists with access to rich qualitative data (Hayman, Wilkes & Jackson, 2012). Journaling refers to the process of participants sharing thoughts, ideas, feelings and experiences through writing and/or other media. And for researchers, journaling offers an opportunity to record participant experiences in their natural contexts (Hayman, Wilkes & Jackson, 2012).

Participants were given the option to journal through hand written memos, voice memos or electronically to record reflections of the first interview topics and other prompts related to diversity and inclusion initiatives and office functions in the context of serving URM faculty (see Appendix B). They were given a period of two to three weeks

to work on the journals and return them. The goal was for participants to be able to reflect and as such, some accommodations had to be made based on participant preference. Three participants chose to journal their thoughts while other participants chose an additional interview to accomplish the same task. Hence, journaling for some participants served as a useful tool for reflection and expression, but others expressed time commitment difficulties that precluded them from accomplishing this. These participants also spoke of their comfort with the researcher in discussing the topics that were planned for this session.

#### **Phase 4: Interview 2**

Upon analysis of interview one and review of journaling or journal conversations, themes were identified that helped inform part of this second interview. This interview was meant to follow up on any themes or gaps in the information gathered in the first and second phase. In addition, the focus of this interview was on Cultural Relevance indicators of cultural familiarity, culturally relevant knowledge, cultural community service, cross-cultural engagement, and cultural validation (Museus, 2014). These five indicators are the first construct of the CECE model and as such it is important to understand their potential relation to URM faculty (See Appendix C).

Some participants chose to extend this time to process their journal responses or conversations with me depending on the complexities of their participation and work-life responsibilities. The interview took between an hour and hour and thirty minutes to conduct. Again, one participant (Elizabeth) chose to participate via phone based on her location. More information on the operationalization of these frameworks follows. A total of 18 interviews were completed with the nine participants.

### **Data analysis**

Creswell (2008) addressed analysis in qualitative research as the formation of answers to research questions through description of data obtained and the generation of themes. For qualitative studies this involves a constant interplay between the two stages of data collection and analysis (Corbin & Strauss, 2015). Operationalization of the frameworks provided the foundation for data organization and data analysis. As such, data analysis was initiated concurrently with data collection, following the same phases as outlined earlier. As previously described this data was organized and analyzed per the adaptation of the IE organizational change and CECE frameworks. These frameworks facilitated the identification of ideas, themes, and possible relationships.

A high quality analysis attends to all the evidence of data sources, considers all alternative explanations, addresses the most significant aspects of the case study, and uses the researcher's expert knowledge (Yin, 2014). The resulting data organization was done as described in Merriam (2009) which encompassed looking at the transcriptions and creating categories that were: responsive to the research purpose, exhaustive, and conceptually congruent.

After each interview, I began to categorize themes in the context of this study. Yin (2014) proposes an analytical case study strategy that searches for patterns, insights, or concepts that seem promising. Other strategies discussed includes putting information into different arrays; making a matrix of categories and placing the evidence into each category; creating data displays for examining the data; tabulating the frequency of different events; and putting information in chronological order or some other temporal scheme (Yin, 2014).

Interviews were transcribed verbatim and coding of interviews and journals were based on identification of themes in the current literature, which are depicted by the faculty life cycle and the literature review from chapter two. These initial themes included micro and macro aggressions, unconscious bias, feelings of isolation, disproportionate commitment to service and minority students, agency, resilience, persistence, and cultural taxation. I also allowed for inductive analysis that demonstrated gaps in the literature and those that might be directly related to MSOM as the case study. For example, these emerging themes included not only socialization, mentoring and faculty development, but also themes such as minority faculty identity, cultural relevance, organizational structures and hierarchy, and sense of belonging.

Some modes of analyzing interviews involved coding, condensation, and interpretation of meaning. Coding “involves attaching one or more keywords to a text segment in order to permit identification of a statement, whereas the categorization entails a more systematic conceptualization of a statement” (Kvale, 2007, p. 105). In categorization, long interview statements were reduced to simpler categories. Further, the meaning condensation compressed statements into the main point, and rephrased them into fewer words (Kvale, 2007).

First, I sought to simply identify themes. Even though some codes could initially be somewhat repetitive, I did not rearrange these until the initial coding process was done. At this step, I started to look for close relationships amongst codes and reviewed quote segments that could also be interpreted under several themes. For example the umbrella code: “D&I” for Diversity and Inclusion gave rise to other broad categories, such as: “Leadership and organizational structure”, “Meaning Broadening”, “Supportive

Communities”, “Faculty vs. Students”, “ Minorities vs. Women”, “PhD vs. MD”, and “Microaggressions: Inter-Intra-Group”. Furthermore, the subcode of “leadership and organizational structure and hierarchy” which included statements around the importance of this type of office was compressed under its parent (umbrella) code, D & I for Diversity and Inclusion. Another example is that of the umbrella code of “identity” which had subcodes that were ultimately compressed in the discussion, inter-intra group microaggressions and perseverance and resilience. A full list of codes is available under Appendix (E). A total of nine parent codes were documented, as well as fourteen subcodes. Under these fourteen codes, seven additional subcodes were compressed.

The use of a computer assisted qualitative data analysis software proved to be critical in this process. QSR International’s NVivo 11 Software was used. The efficiencies afforded by this software included managing the data while allowing for an increased focus on examining the meaning of what was documented through the interview process. The software also assisted in linking the data to developing patterns and research questions (Bazeley & Jackson, 2013). Special attention was given to those themes that spoke of the experiences and perspectives on socialization, mentoring, and faculty development.

Table 2

*Coding example*

<b>Diversity and Inclusion</b>		<b>NVivo Code: "D &amp; I"</b>
	<b>Quote/Evidence</b>	<b>Participant</b>
Subcodes: "Leadership and organizational structure"	"if you wanted to give them power, you give them power."... "I did think that that person needed to be like just under the dean, that office needs to be just under the dean. Because the problem is, if you have another filter, what is their objective? What is their agenda? Agenda may not be the same as the office of diversity/multicultural affairs. And so whatever they want to do, if it's filtered through, may never get to the dean."	Evelio
"Meaning Broadening"	"The diversity now has a different meaning. And since it has a different meaning, there is a different structure to diversity. It is very different than many people would expect."  "We have broadened it so much. I think that Hispanic is always left to the side and ignored. I think part of it because we don't understand it. It is more difficult for people to understand because it's so diverse the group itself. Now, the inclusion has gone to include more gender related issues, which makes the thing fine but again I think it leaves us behind (Latinos)"	Evelio  Henok
"Supportive Communities",	"But that kind of relationship building that you start from day one, that community, yeah we don't have that. From medical student on there's just not that sense of community."	Blair
"Faculty vs. Students",	"There's always something for the medical students and you can sort of clam on to that if you want, but there's never really been a minority faculty group, or you didn't quite know who to reach out"	Blair
"Minorities vs. Women"	"Men now get it for women, but men and women still don't get it for faculty of color."	Henok
"PhD vs. MD"	"Also being part of basic science and the medical school regardless if I'm	Henok

	minority or not that's just not valued. There is no value for that aspect of the University culture”	
“Microaggressions: Inter-Intra-Minority Group”.	“In the first couple of years that I went, it was good, but it felt very African-American only. There would be a few Hispanic students there. It almost like they came because they didn't know that they weren't supposed to come kind of thing.”	Blair

**Operationalizing the frameworks**

Academic medicine’s complex environment is unique and often forces operation in a silo focused on scientific innovation and clinical approach. Because of its very mission and commitment to innovation in all facets, there is an opportunity for diversification and incorporation of conceptual and theoretical frameworks from other disciplines. As a practitioner, I have used these frameworks to understand the experiences of URM faculty in academic medicine with a practice-based outcome of developing a strategic plan that includes a focus on diversity and inclusion, in order to prove URM climate and culture.

The dimensions of IE organizational change framework demand a closer look at external environments, organizational behavior dimensions, organizational culture, scorecard and change strategy (AAC&U, 2005). In the table below I have summarized each element, definition, and component as they were analyzed and the purposes of this study.



Table 3

*Adaptation of Inclusive Excellence organizational change scorecard*

Elements	Definition	Components	Faculty life cycle			
External Environment	Environmental forces that drive and constrain implementation of diversity and inclusion offices, initiatives, and programs	Shifting Demographics Societal Inequities Workforce Needs  Political and Legal Dynamics in the state	How each element affects each subunit.  <table border="1" data-bbox="1135 499 1354 667"> <tr><td>Socialization</td></tr> <tr><td>Mentoring</td></tr> <tr><td>Development</td></tr> </table>	Socialization	Mentoring	Development
Socialization						
Mentoring						
Development						
Organizational Behavior Dimensions	Multiple vantage points that must be used to shift the informal and formal environmental dynamics toward inclusive excellence.	Systemic Bureaucratic – Office/Organizational/Departmental and Leadership Structure	<table border="1" data-bbox="1135 779 1354 947"> <tr><td>Socialization</td></tr> <tr><td>Mentoring</td></tr> <tr><td>Development</td></tr> </table>	Socialization	Mentoring	Development
Socialization						
Mentoring						
Development						
Organizational Culture	Dynamics that define higher education and that must be navigated to achieve inclusive excellence.	Mission Vision Values Traditions Norms  (Spoken and unspoken)	<table border="1" data-bbox="1135 1094 1354 1262"> <tr><td>Socialization</td></tr> <tr><td>Mentoring</td></tr> <tr><td>Development</td></tr> </table>	Socialization	Mentoring	Development
Socialization						
Mentoring						
Development						
IE Scorecard	Understanding inclusive excellence that extends and adapts work on diversity and dimensions of the campus climate.	Access and Equity Diversity in the Formal and Informal Campus Climate	<table border="1" data-bbox="1135 1335 1354 1503"> <tr><td>Socialization</td></tr> <tr><td>Mentoring</td></tr> <tr><td>Development</td></tr> </table>	Socialization	Mentoring	Development
Socialization						
Mentoring						
Development						
Inclusive Excellence Change Strategy	Fluid institutional strategy to make inclusive excellence a core capability of the organization.	Senior Leadership Vision and Buy-In Capacity Building Leveraging Resources	<table border="1" data-bbox="1135 1650 1354 1818"> <tr><td>Socialization</td></tr> <tr><td>Mentoring</td></tr> <tr><td>Development</td></tr> </table>	Socialization	Mentoring	Development
Socialization						
Mentoring						
Development						

During data analysis, this Inclusive Excellence scorecard was used to organize and code the information under each area and subunit. I used this approach for initial coding in my deductive analysis phase. Deductive reasoning works from the more general information to the more specific terms (Trochim, 2006). This scorecard was critical in demonstrating how each element under this Inclusive Excellence organizational framework may influence each subunit of socialization, mentoring, and faculty development for URM faculty.

For example, the scorecard element of Inclusive Excellence Change Strategy is defined as fluid institutional strategy to make inclusive excellence a core capability of the organization and included components regarding senior leadership vision and buy-in capacity building, and leveraging resources. Collection and examination of organizational documents revealed the existence of an MSOM diversity strategic plan. This plan's goals were reviewed and aspects directly relevant to faculty were organized in the scorecard and evaluated for their relation to either socialization, mentoring, or faculty development. Specifically, the existent MSOM school wide diversity plan was considered part of the IE Change Strategy. Each goal such as "increase the diversity in leadership positions throughout" was analyzed as a function and may be achievable through faculty professional development (Table 3).

Table 4

*IE Change Strategy*

Elements	Definition	Components	Faculty life cycle
Inclusive Excellence Change Strategy	Fluid institutional strategy to make inclusive excellence a core capability of the organization.	Senior Leadership Vision and Buy-In Capacity Building Leveraging Resources	Socialization
			Mentoring
			Development
Document	Goals	Stage in cycle	
Diversity Plan	To create a culture where all individuals feel included, valued, and respected	Inclusion	All
	To increase diversity in leadership positions throughout the School of Medicine	Diversity	Development
	Increase the recruitment, advancement, and vitality of underrepresented minority faculty members.	Diversity and Inclusion	Development
	to be at the forefront of developing policies, programs, and resources that improve recruitment, education, retention, professional development, mentoring,		Mentoring Development

The CECE model was proposed as an important tool for institutional leaders to better understand the ways in which the campus environment “influences the experiences and outcomes of their diverse students” (Museus, 2014, p. 219). Although, student centered, the model’s potential applicability in faculty populations is promising. Therefore, as part of this research, CECE’s culturally relevant elements were applied to a new sample population- URM faculty and a new setting- academic medicine. In order to

evaluate CECE within this group, the following items or constructs were utilized: cultural familiarity, culturally relevant knowledge, and cultural community service (See Appendix C). The results explored the cultural environment and engagement of the participants while revealing the critical points during socialization, mentoring, and faculty development. In utilizing these specific indicators my goal was to study if and how a culturally engaging environment of academic medicine was important to the faculty and which items were experienced by URM faculty in their academic medicine environment. In similar approach to the IE scorecard discussed earlier, I used this approach for initial coding in my deductive analysis phase.

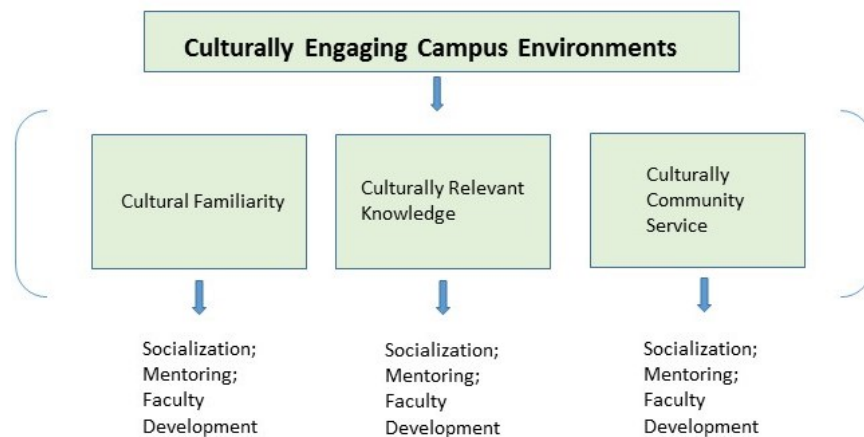


Figure 4. Adaptation of CECE for URM Faculty during Faculty Life Cycle

Analysis of CECE indicators were critical in understanding the importance of culturally relevant environments and analyzing the viability of CECE as a framework for faculty in this sector of academic medicine. I used the CECE framework to inform notes and information gathering. For example, based on this interview and participants' answers, quotes were organized under each indicator and evaluated for their relation to socialization, mentoring and/or faculty development. In addition, participants were asked if these notions of familiarity, knowledge and service were important to them. All eight

participants indicated these are of significant importance. As a more specific example, when a participant (Elizabeth) stated during the cultural familiarity questions that: “we don't get together outside of work but when we see each other there's that bond, we know we've had, three, you know similar experience or something” the quote was classified under socialization. Under cultural community service, Elizabeth made the following reference: “So one thing I really look at my position as Ministry, it is not just that I'm going in everyday to fulfill a pay check but I'm there to hopefully interact and have a permanent impact on others.” This quote was also classified under socialization.

Table 5

*CECE Scorecard Example*

<b>Participant</b>	<b>CECE Scorecard</b>			
Are these aspects important to you?		<b>Socialization</b>	<b>Mentoring</b>	<b>Faculty Development</b>
*Important		#of quotes related to:	#of quotes related to:	#of quotes related to:
	<b>Cultural Familiarity interview Questions 1-3</b>	3	1	
	<b>Culturally Relevant Knowledge interview Question 4</b>			1
	<b>Cultural Community Service interview Questions 5-6</b>	1		

Moreover, Yin (2014) offers several analytical techniques towards case study evidence, including the logic model. Yin (2014) discusses logic models in conjunction with illustrative purposes, which aligned with my faculty cycle depiction and allowed for a more visual data analysis process. In this case, I utilized the following logic model as a way to track socialization, mentoring and faculty development as events to link themes and responses affecting these events. My logic model established institutional culture

and climate as the foundation and possible determinant in the experiences of faculty throughout their different stages; cultural relevance and diversity and inclusive environment are also elements that intertwine with these experiences.

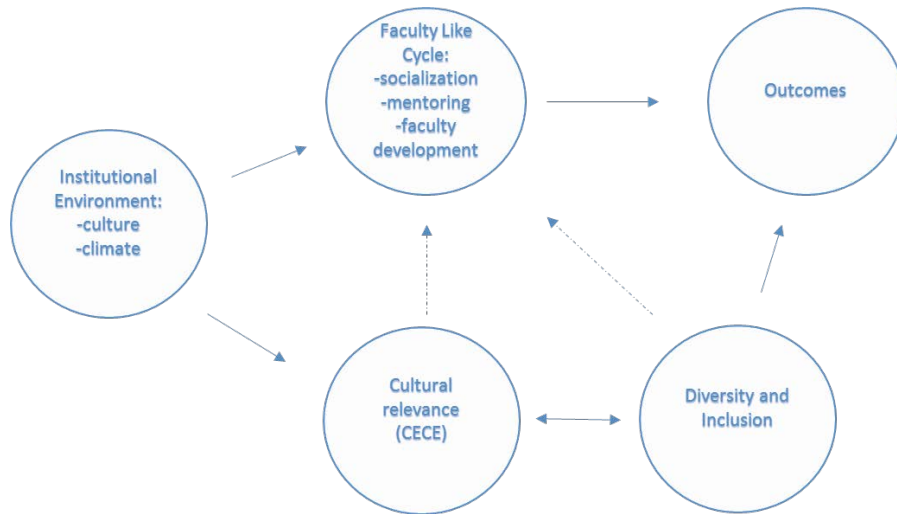


Figure 5. Logic Model

Both IE and CECE frameworks guided the analysis of the experiences and environment of URM faculty in academic medicine through an active and intentional view of the organization (IE) while studying the underlying culturally relevant characteristics of the environment (CECE) in relation to URM faculty socialization, mentorship and professional development.

The data analysis also contributed to important practical considerations: How does the data gathered inform the design of environments, practices, policies and strategies that support inclusive excellence within a School of Medicine? Can the Culturally Engaging Campus Environment (CECE) student-focused model be adapted to assess faculty environments in academic medicine? These implications will be discussed under findings. The analyzed data contributed to formulation of a case overview for MSOM.

### **Case Study Reporting**

According to Yin (2014), the case study reporting phase creates great demands on a researcher. It does not follow a stereotypical form and may include textual and non-textual forms. This aspect of case study reporting is an appealing way to report this doctoral research. Because of the different stakeholders in academic medicine and the different audience within the institution, a flexible way of reporting that includes academic and business-like approach offers the best presentation. Although this doctoral research project fulfills an academic requirement, its praxis component demands the communication of terms and results between higher education scholarship and academic medicine jargon. Although academic medicine is an area within higher education, its specialization and culture demands flexibility in the way terms are explained (and vice versa). The case study itself serves as communication device, raises awareness, provides insight and suggests courses of actions (Yin, 2014). More specifically, the case study communicates research-based information to a variety of individuals in a way that goes beyond a research report. The findings and recommendations based on this study will be presented to the leadership of MSOM and made available to other constituent groups as determined by this leadership. This includes a written report or presentation.

### **Trustworthiness**

Lincoln and Guba (1985) suggested that trustworthiness of a qualitative research study is critical in evaluating its merits. Trustworthiness involves establishing: credibility, defined as confidence in the findings; transferability, demonstrating some applicability; dependability which shows consistency; and confirmability that the

findings are shaped by participants (Stake, 2005). This trustworthiness can only be established through thorough data collection and analysis processes (Stake, 2005).

This study was transcribed utilizing two services, one for those interviews conducted in English and another for those in Spanish in an effort to maintain consistency and reliability. Participants were offered the opportunity to review interview summaries. This provided participants with the ability to review, revise or add information to clarify their own statements. This step aligned with confirmability and the practice of participant checking, which is the practice of seeking feedback and checking the accuracy of the researcher's interpretations of the experience of the participant (Ely, Friedman, & Gardner, 1991). Participant checking assists the researcher in the process of establishing credibility and confirmability. Lincoln and Guba (1985) support triangulation as a technique for establishing credibility and confirmability. Triangulation is an important tool in this project as it encourages the corroboration of research findings through multiple sources, such as interviews, journals and institutional documents (Yin, 2014).

Trustworthiness and validity are intertwined. Validity rests on the researcher continually checking, questioning and interpreting the findings (Kvale, 2007). In validating, a researcher must play devil's advocate to his or her own findings and integrate validation in every stage of the construction of knowledge (Kvale, 2007).

### **Expert Advisory Panel**

This study relied on frameworks that centered in the social sciences and higher education. An expert advisory panel was formed in order to further the study and solidify its application, confirm its relevance to academic medicine, and ensure



trustworthiness. The expert advisory panel offered an opportunity to engage in conversations about the conceptual frameworks of IE and CECE, as well as, gather feedback regarding the study's findings. The panel was formed to gather specialized input and opinion within the academic medicine field.

The expert advisory panel consisted of seven executive leaders in academic medicine representing several institutions, prominent academic medicine professional organizations, and several facets of academic medicine. In addition, four of these panel members identify as underrepresented minority faculty. Panel members agreed to review a six-page summary of the study findings and discussion. Individual phone and in-person conversations were scheduled in which experts added value to this research by discussing questions and providing feedback. These conversations were significant in several aspects. First, experts confirmed the need for innovative ideas and creative frameworks that could significantly impact the diversity, equity, and inclusion work that is conducted in academic medicine. Secondly, in sharing these findings, experts were able to acknowledge the gaps in practice and recognized a lack of literature in reference to specific topics addressed by my study. These gaps were especially noticeable in the study of faculty socialization, sense of belonging, identity formation, climate, and URM faculty development. Experts contributed ways in which these topics could be complemented with current literature in the future. For example, how CECE could be complemented specifically with Milem, Chang and Antonio (2005) and Pololi's C Change Faculty Survey (2006) in studying academic medicine climate. Lastly, experts not only shared their own experiences within academic medicine, but

were also able to reflect on these findings in ways that confirmed the importance of this work.

### **Positionality Statement**

An important part of conducting qualitative research is to understand the researcher's perspective and how this perspective may influence the study. It is essential for me to reveal my perceived bias on this topic. I do not intend to delve deep into personal stories of resilience but there are particular aspects that are important and helped shaped this research agenda. First of all, I was born and raised in Puerto Rico. Secondly, I attended college in the United States as a STEM (Chemistry) major, and lastly, in addition to my administrative functions I hold a faculty appointment at an academic medicine center. In the context of this study, I identify as Puerto Rican and Latina, also considered by my current institution as URM faculty.

I did not grow up in Puerto Rico in a family or educational environment in which we talked about educational limitations. My sister and I were never told we would not be able to accomplish or achieve any success by virtue of being a female, even in a machismo society. I now realized that we had a feminist champion in our mother. In high school, when I applied to a STEM oriented residential/boarding public school, there was no discussion about the lack of women in STEM fields. My path to college was an expected event, even though my single mother did not attend college. As I entered college in Puerto Rico, first as a pre-med and chemistry major, my classes as well as my professors and instructors seemed gender balanced. When I received a perfect score in my first Chemistry test, my professor did not indicate that the field needed more female Chemists. This was my reality until I transferred to study in the United States.

My undergraduate experience changed into one that did not have any connections to professors in my program or most of my peers because of the lack of Black or Latinos in the program, dismal number of females in the program and in the professoriate. I did not have a true role model or mentors. In addition, there were language and cultural barriers that in retrospect may have also prevented me from fully engaging in the college experience. In fact, the most lasting college connections I experienced were made with international students and exchange students. Outside of this group of international and exchange students, I did not experience a supportive community, and when I graduated, it was truly a story of persistence and resilience. I was not going back to Puerto Rico defeated nor would I let this undergraduate experience stop me or hold me back. This is a common story still today; the dismal numbers of females and minority students in STEM and in many educational settings.

I do not know why these two college experiences were dramatically different, especially when the education system in Puerto Rico has been shaped by the United States, and by virtue of being a U.S. territory. Perhaps, the difference was a feminist foundation within my family and perhaps the numbers of females in the natural sciences was greater at University of Puerto Rico-Mayaguez, which is known as the science and engineering school of the University of Puerto Rico system. What it is clear to me now is that my undergraduate college experience in the main land lacked support, role models, a sense of belonging, a community, and lack of knowledge of what I needed.

As I continued into my professional career, I found my professional home in academic medicine from my first position as a chemist/biochemist in an academic medicine center through my progression to the position of an executive administrative

leader and faculty position today. Sixteen years ago, I entered a unique sector in higher education, which was probably one of the most exciting to me. Every day I go to an institution devoted to health, research, education and service. My scientific curiosity is fulfilled by the constant presence and knowledge share of biomedical research, the education of medical and graduate students who are the next generation of physicians and scientists, the clinical care and kind of innovation that saves and improves lives.

Throughout the years URM faculty in academic medicine have always inspired me. The stories that I have heard and encountered, the experiences that have been shared, and the friends that have been made are the most impactful reasons to perform this doctoral research. The number of underrepresented minorities in academic medicine is quite dismal, yet we are constantly struggling to impact the very pipeline that emphasizes STEM, the pipeline that leads to careers in academic medicine, the pipeline that takes care of vulnerable and disadvantaged populations. The presence of URM faculty in higher education has an impact on where students see their place in the future and also the environment and health of our communities.

Although it might be challenging to separate this identity from my participants, as practitioner and researcher I believe that this position opens opportunities to relate to participants in extraordinary and meaningful ways.

### **Limitations**

There are several limitations to this study. First, a bounded single case study was justified earlier as the best approach for this study based on the research questions and institutional context. However, the bounded nature of this study may be deemed by some as restrictive. Although it provides the ability to better explore the application of the

conceptual frameworks and the ability to look at multiple data sources, its results may not present an opportunity to argue similar experiences across all AMCs.

A second limitation is the potential broadness of underrepresented minority faculty participants. Specifically, this study is not focused on a particular group. Given my broad interest and the limited number of URM faculty in academic medicine, I chose a liberal approach to its definition. As described in the key concepts section, for the purposes of this research and given its focus on academic medicine, the terms underrepresented and minority faculty emphasize African Americans (Black), Hispanic/Latino, Native Americans and Alaskan Natives, South East Asians, Pacific Islanders or other ethnic or racial group members who have been found to be underrepresented in biomedical or behavioral research nationally (NIH Guide, 2004). The definition also included women and LGBTQ faculty. However, as recruitment ended, the majority of study participants were Black and Latino. While their experiences shared commonalities, we cannot assume that the experiences of Native Americans, Pacific Islanders, and Southeast Asian faculty would be shared in the same way.

Lastly, this also resulted in a selection bias. In statistics, a sampling bias is a bias in which a sample is collected in such a way that some participants from the targeted population are less likely to be included than others. In most qualitative research, it may seem impossible to study all instances of a phenomenon depending on the subject of one's research. The situation places limitation in the selection of a certain proportion as the sample of study (Oppong, 2013).

However, the strengths of this study outweigh these limitations. First, it expands the current higher education literature to academic medicine. Second, it is the first study

to apply IE and CECE in academic medicine. Third, it is the first study to introduce socialization, mentoring, and faculty development as three separate stages in faculty life cycle the first to link these to academic medicine culture, climate, diversity and inclusion. By utilizing a qualitative research methodology to understand the experiences of URM faculty in academic medicine, I offer in my findings new insights and implications for studying and enhancing these experiences.

#### **Chapter 4. Findings**

The benefits of increasing diversity in academic medicine are not understated. For example, health disparities continue to persist among racial and ethnic minority populations plagued by poorer access to care than their White counterparts (AAMC, 2016). Those living in rural areas of the U.S. are less likely to receive preventative care and experience language barriers (AAMC, 2016). The LGBTQ community is likely to experience discrimination in healthcare settings, face insurance-based barriers and is less likely to have a recurring source of care (AAMC, 2016). A diverse physician workforce is a key component of healthcare delivery.

Data presented by the AAMC Facts and Figures 2014 report echoes research that underrepresented physicians are significantly more likely to practice primary care and more likely to practice in impoverished areas and areas designated as medically underserved. With regard to STEM fields, diversity of ideas, perspectives, and backgrounds are key ingredients of good science. Yet those pursuing science degrees at the highest levels are disproportionately White and Asian American; this is not because of a lack of interest by underrepresented minorities (HHMI, 2016). There is an obvious need for increasing minority student participation in STEM fields and the academic medicine pipeline, but research in URM faculty recruitment and retention has demonstrated barriers in academic medicine (Bilimoria & Buch, 2008; Moody, 2004). Academic medicine is depicted as a non-inclusive, microcosms of a mostly White-male dominated environment (Bilimoria & Buch, 2008; Moody, 2004).

In chapter two I presented literature that provided evidence that there is considerable amount of work to do in support of URM faculty in academic medicine.

Only a small number of URMs serve as faculty members in the nation's medical schools; in predominately White medical schools they make up only 7.3% of all faculty (Nivet, 2010). Women URMs are twice as underrepresented and although the percentage of White faculty has decreased, the low percentage of Black and Latino faculty has not changed proportionately (Merchant & Omary, 2010). According to Nivet (2010), current literature offers limited emphasis and progress in diversifying the faculty and leadership of the nation's medical schools.

In this case study of MSOM, I examined the experiences and perceptions of underrepresented minority faculty in academic medicine. The study focused on the socialization, mentoring, and faculty development stages as presented through a model referred to as the *faculty life cycle*. In chapter 4 I share and summarize their experiences and perspectives as they relate to three primary stages of the faculty life cycle: socialization, mentoring, and faculty development. Findings revealed a close link between these stages and academic medicine culture and climate, as well as diversity and inclusion in this setting. While this research represents a case study of one institution, the study reaffirms the current environment for URM faculty in academia while also bringing forward new themes worth investigating further.

### **Research Questions and Findings**

The research questions guiding this study are: What are the a) socialization, b) mentoring, and c) professional development experiences of URM faculty within academic medicine? How do URM faculty perceive academic medicine culture and institutional climate? How do URM faculty perceive diversity and inclusion initiatives and offices in academic medicine? I have organized the findings to reflect each of the



subareas of socialization, mentoring, and professional development experiences of URM faculty. Moreover, additional themes are introduced: academic medicine culture and climate, diversity and inclusion, and a Latino faculty narrative. This specific faculty narrative was a result of explicit experiences shared by participants of this group, which added some complexity to the IE principle of inclusion. I begin with the subarea of socialization.

### **Socialization**

Socialization plays an important role in the advancement of any faculty member. It is the process through which individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997). Faculty socialization serves as the beginning of a long faculty life cycle and it has been characterized as of fundamental importance (Tierney, 1997). Socialization is the start of their faculty career, a reflection of what they have accomplished and a first glance to what they are setting out to achieve. It is also the first look at their environment and predicting their success in such culture and climate. Faculty are socialized into the institution in many ways, often including a standard few hours or a week of faculty orientation, onboarding, and bureaucratic processes. Often this process ignores the importance of organizational socialization, the process by which employees transition from the outside to fully participating in the organization (Feldman, 1976).

Participants in this study often initiated the conversation around socialization from a school and departmental experience. These experiences were naturally the standard checkmarks of contracts and benefits but quickly progressed into a need for more desirable processes that would have ultimately signaled not only a welcoming

environment, but also one which indicated that they were valued recruits. Some participants simply wished for proper introduction to their colleagues in the departments, for the ability to know where resources were located, and for a contact that could answer their questions. As one participant (Blair) mentioned, academic medicine does not look kindly at people who are not strong enough, by which she also meant resourceful and independent. Participants shared several values related to their socialization experiences.

### **Organizational socialization**

First, participants revealed that socialization into academia was done poorly and deserves closer attention by institutional leaders. Participants spoke about experiences that questioned the organizational socialization process into the institution, which included poor recruitment processes, orientation programs, and on-boarding practices. Onboarding practices failed to adjust new members to the social and performance aspects of their jobs quickly and smoothly nor did they learn the attitudes, knowledge, skills, and behaviors required to function effectively within the organization (SHRM, 2016). For example:

Henok: I did not feel welcome. The first day I got in I went to the office of the department chair and she looked at me and said, "Who are you?" I had to say, "I am your new faculty".

This could also be understood in relation to a difficult climate and as an indication of an unwelcoming academic space. In business, such process and experience in organizational socialization is described as a "sink or swim" mentality. It is where the onus of socializing into a new work environment is on the new hire or member (Ciciora, 2010). Rosana's experience highlights this onus.

Rosana: I just kind of started...it was our on-boarding, it was not a good process, and I think it's still the same. I just came and I kind of worked out when my clinic days would be, and the administrative assistants, they kind of helped me get my password and set me up with all this stuff I have to do. It was just like, "Okay, here's your laptop, just go for it. Go. Do you." ... Maybe I know some things, but I don't know. It was very...I had to figure it all out, and just kind of find people and ask people stuff. So, yeah. No, it was not a good process.

This type of organizational approach does not fare well, but for URM faculty it went a step further. It added to a list of experiences that would be internalized not entirely as the organization's flaws, but potentially an indicator of their worth as URMs to the institution and an indicator of the culture they would encounter. Rosana provided an example in which she is part of an MSOM fellowship with a White female at a similar faculty rank. In her example, she speaks about an opportunity that was offered to the White female but not her. Rosana self-identifies as a Black woman. In fact, Rosana was not aware about this opportunity until her counterpart forwarded her the opportunity via email, along with the email thread.

I'm a fellow with another person and I find out in email, the person asks me if I wanted to do something that was offered to her. We are both supposed to be the same. In the email they often go like we always get these spots, would you like to do it, you should do it, at least get one. And when she (fellowship leader) send it, she didn't get it, and she didn't see that. The other fellow was like: "Oh, would you like to do this? I just don't have time for this and I'm not interested in this." It kind of burns a little bit more too. I'm like well, I am really interested in that

and I want to do all the stuff and she's like whatever and so it's like you know what do you do with that, what are you supposed to do, you can't really say anything, you figure out some creative way of navigating that situation without offending anyone. So it's just that...[shakes her head in disapproval].

This is the risk of poor organizational socialization, one which shapes the individual by transmitting a message of the existing culture (Tierney & Bensimon, 1996).

Elizabeth: Here I feel like that those are the people [White] that I come in contact with... So, I do not think there is much reaching out and saying, "Hey, you are new to the area. Have you around, show you a little bit about the area even in terms of like medical care.

The ways in which poor organizational socialization is internalized can vary. In Elizabeth's example there is a sense that this internalization was related to race, hence questioning the organization and socialization processes, as well as, demonstrating a glimpse of what could be understood as an unwelcoming racial climate.

### **Socialization: a way to belonging and relationship building**

Secondly, participants expressed the importance of socialization with other URM faculty as part of a welcoming process that intertwined with belonging and connectedness. The next level of socialization was the process of building relationships and connecting with other URM faculty. Participants relied on socialization opportunities to build relationships with colleagues and the institution. The findings indicate a considerable burden placed on new URM faculty to find other URM faculty on their own. Colleagues exert more influence on a new hire's socialization with a majority

of what they learn about the organization coming from interactions with others (Ciciora, 2010).

Blair: If you're trying to entice somebody to come, you want them to feel welcomed. You want them to see somebody like themselves, even if they're from a different department or whatever...

Blair highlights the importance of what is referred to in the CECE model as cultural familiarity, opportunities to connect with others with whom they share commonalities (Museus, 2014). Because of the limited number of URM's, Blair's statement suggest that interactions with other faculty of color are positive factors that influence faculty socialization, along with persistence and success (Hassouneth et al., 2014). This parallel finding supports cultural familiarity as an important aspect and one that translates to the faculty experience.

Jessika: I think the way that that really happened for me was that there was a critical mass of African-American folks predominantly women in our department and those folks really kind of helped me to kinda network to their group of friends...So, that's sort of been the primary sort of community that I have ultimately kinda found a home with.

Consider socialization not only in the context of recruitment, but retention and advancement of URM faculty in academic medicine. In Rosana's experience, the process of relationship building was critical.

There aren't very many around...so it's scary and intimidating and it makes you uncomfortable and if you don't have someone to reach out to you and to pull you in and make you feel welcome and a part of it and it gets you into the process, you

know it's kind of like you are standing watching people running around and you don't understand how to get in there with them and you are on the sideline, if someone doesn't pull you in and tell you to walk this way then why would you stay if you feel like you are on the outside all the time and you feel ineffective. And you don't really understand what you are supposed to be doing. Why stay? That's a really hard way to exist and be comfortable with. It doesn't make you feel good about yourself. I don't think.

Henok also described the importance of socialization and connecting individuals. Unfortunately, this appeared to not be the normal experience for other participants. Even in Henok's comment there is a tone of surprise in recalling his experience walking with another participant (Francisco):

Every time I walk with him. He is actually very good introducing you to people. Sometimes you walk with other people, and they say "Hi" to somebody. You stand there, and they have their little conversation, and then keep going. He actually introduces you.

It is evident that these introductions are important for new faculty, but it also automatically increases the professional network of URM faculty. This influences their socialization and eventual sense of belonging. As mentioned in chapter 2, sense of belonging is an individual's sense of identification in relation to a group within the college community (Hurtado & Carter, 1990) and speaks of relationship building and interactions that makes individuals part of something greater (Baumeister & Leary, 1995). Although sense of belonging has been explored in relation to the student interactions by Hurtado and Carter (1990) and Museus and Maramba (2011) among

others, academic medicine literature has not explored at any lengths sense of belonging of faculty and more specifically, URM faculty. These findings demonstrate that sense of belonging is as important to URM faculty and its development starts at the socialization phase.

### **Socialization and Identity**

Faculty member social identities play a role both in everyday life and socialization. In this study, participants self-identified as Black and Latino faculty and spoke about these identities in ways that reinforced links between their experiences in academia and these identities. However, as they shifted to speak of the institution and recalling their career, they mostly referred to their identity as “minority faculty.” When I followed this identity question, they often spoke about how they perceived colleagues in their immediate environments as cognizant of their identity as Black or Latino but when speaking about the institution and its leadership they perceived they were not seen as Black or Latino but as minority faculty. For example, I asked Rosana to self-identify for the purposes of the study:

That’s an interesting question. Identity is interesting. I had an interesting upbringing. But at this point I identify with being Black for the most part like at work, I’m Black and when I walk down the street I’m Black. But in my family I’m not, I’m biracial.

In reference to the institution:

Probably minority faculty because a lot of people don’t know what I am usually. They wonder.

In this way, the institution may force individuals to not only identify themselves

based on their race or ethnicity, but also a parallel URM faculty identity in which they are not only considering their experiences from a particular lens but constantly evaluating the experiences of URM as a group in search for commonalities. Alberto self-identified as Latino. His experiences centered on being a Latino male in academic medicine, however, in a few instances also referred to his sexual orientation. When I asked for clarity, he said the following:

*Soy minoría porque soy Latino. Soy minoría porque soy gay... Soy minoría, punto, porque ya no me identifico yo soy Latino, yo me agrupo.*

[I am a minority because I am Latino. I am a minority because I am gay...I am a minority period, because I no longer just identify as Latino, I identify with the group.]

This was indicated with clear awareness of a collective identity as URM faculty but also not a “natural” identity but an identity forced by institutions.

Evelio: So I, so when I see you (the interviewer), only thing I can tell that you have a little bronze color to you. I don't know who you are, I don't know what you are, I couldn't care less, right. And that's why I don't even ask because I don't make assumptions. They (School of Medicine leadership) do. So again they cannot (stop their bias and assumptions). And that's why they will not be able to understand the importance of us being together but also keeping this, having our separate identity, because to them we are all one.

Evelio statement is also important because it suggests that the organization has a “one size fits all” mentality for URM faculty rather than pursuing an understanding of the nuances that each race or ethnicity brings and provides. Each participant was able to self-



identify, but recognized that their collective identity and power at the institution was as “URM faculty.” At the school level, participants felt that they are a collective group, mostly numbers, while in their immediate departments and environments, colleagues may see them as they identify, Black or Latino (i.e. Black Assistant Professor).

Participants knew that the identity as URM faculty is artificially created and institutionally driven. They know that these experiences as a group cannot normally be generalized. Two participants (Blair and Henok) commented not only about the diversity amongst the Latino faculty community, but also about the rapport and connection built with URM students. For example, Blair commented about the potential difference between a White Latino faculty experience and that of Brown or Black Latino faculty. She also commented about the differences in social classes and backgrounds within these groups and the impact or effect it has while working with most URM students.

Blair: I identify myself as Hispanic, Mexican-American, and I guess that's how the institution...I mean if they put me on that little vest, I'd have Hispanic next to it, I guess. But I don't know that they use it in any way. Every now and again, I'll get an email from a student or something, and I don't know quite how they got me, found my name... I don't even know that one of the guys is a minority affairs guy...what's his name, X<sup>3</sup>? Yes. I never knew he existed until he ran for that position. As much as I like him, and he's a great guy, he's from X. I think he grew up with money in X, so his ability to kind of relate to that young Hispanic kid whose moving here from Los Angeles- {facial expression of disapproval}

Interviewer: Is it a little bit different?

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<sup>3</sup> X has been replaced to protect confidentiality of individuals and departments.

Blair: Yeah. And you don't have to be identical, but I think you have to have some understanding of kind of what they might be going through so you can anticipate it before it happens.

Identity formation and exploration does not stop as faculty members. Rhoades (2007) states a lack of sufficient case studies to facilitate an understanding about the experiences of those working in higher education. In addition to this concept of professional identity, these findings indicate that URM faculty also go through their own identity formation as “minority” faculty. Socialization into the institution may result in a new intersection in identities, that as URM faculty.

Inclusive excellence demands a socialization process that is inclusive not only in its on-boarding practices, but that also considers socialization as the introduction to diverse and inclusive institutional environments. Inclusive excellence can create an academic medicine culture and climate that advances inclusion and therefore eases socialization. In ideal conditions, ease of socialization, inclusive socialization, may be the factor that leads to inclusive excellent environments. In an inclusive excellent environment, identity formation may be simply development of our identity as members of the organization, accepted for who we are. An inclusive excellent environment would not force identities we do not already claim or force grouping as a source of power and social capital.

Consideration of CECE indicators are equally important, especially considering the emphasis that participants showed in relation to culturally relevant environments and familiarity that could also ease their socialization process. The socialization process seemed to associate more directly with indicators of cultural familiarity and culturally

relevant knowledge. Specifically, in the context of URM faculty, Hassouneth et al (2014) suggested that interactions with other faculty of color are important positive factors that influence faculty persistence and success. This finding supports cultural familiarity as an important aspect and one that translates to the faculty experience.

Rosana: Yes, it is. It is very important. Just in your micro environment of your department, when people, realities are so different, it can be a barrier to just kind of being engaged with people and having a community and family or getting invited to dinner, or any of those things that you can feel excluded and there's lots of stuff that talks about people being isolated and that's a dissatisfaction, and also people, there's a lot of psychology that goes into kind of your own thoughts about what you're doing and how you're being perceived, just all that stuff, if you're isolated in a vacuum then your reality is distorted as well. So it's important to come on a group and it's more challenging to do that in a way that everybody is different from you. So it is really really important because there's some things, a lot of work things you can't talk about on things they don't understand, whatever. So it is very important to have people to come to talk about.

Given academic medicine's URM faculty dismal numbers, cultural familiarity could be challenging. Building a community of other URM faculty might be limited in academic medicine and as such it was critical to understand the importance of this indicator to URM faculty.

### **Mentoring**

As mentioned in chapter 2, mentoring literature is mostly positive and will continue to evolve in academic medicine because approaches to mentoring programs are

broad and their intensity varies (Beech, 2013; Zellers, Howard, & Barcic, 2008).

Participants spoke about mentoring programs in ways that recognized the positive impact and importance of mentors, while indicating a need for more meaningful and thoughtful approaches. They also described their identities as mentors themselves.

Overall participants appeared to be happy with their current mentoring relationships, although they spoke about the limited local institutional network and could easily recall ineffective mentoring experiences. Jessika spoke of mentoring in terms of accountability, and cited that she needed someone who would believe in her abilities: “I just needed like faith, and the focus and the accountability with mentorship is the one that works really well for me.”

For Evelio, mentoring was more than fulfilling a research agenda or mission.

Dr. X, he truly took me under his wing and he helped me out a lot. Now, again, we are not your traditional academic programs where there was such a huge focus on research. But we did do some research but it was more about the mission of education, more of the mission of service. That was his forte. So he was very helpful. There was a couple of other faculty members in department of X who also talked to me and they guided me. And so, I was lucky where I did have multiple people to talk to and multiple people who offered their help very early, that I was able to utilize.

For one participant, Alberto, good mentors meant acceptance.

*Y después que me ofrecieron la posición de faculty ellos, los dos fueron mentores para mí. Y me dijeron lo que tienes que hacer y me empezaron a dar cargos administrativos que eran para mí. Eran basados en mi personalidad y en mis*

*intereses. Entonces, y... yo creo que si hay tres personas que... a las cuales les tengo que agradecer... es el neonatologist que me dijo sé tú... It's ok to be gay. Y estas dos personas. Porque por ellos dos yo creo que estoy donde estoy. Yo creo que mi carrera no hubiese... hubiese sido un poco más lenta. Y mi vida personal no hubiese sido tan... tan increíble como lo es ahora. Me hubiese demorado más en llegar a donde estoy ahora.*

[After they offered me the faculty position, both of them became my mentors.

They told me what to do, they prepared me for administrative positions that were for me. They were based on my personality and my own interests. And so... I think there are three individuals to whom I have to thank. One is the neonatologist who told me to be myself... It's ok to be gay. And the other two individuals. I think I am here because of the two of them. I don't think my professional career would be where it is right now. It would've had a slower progress. It would've taken longer to be where I am today.]

For others, the positive implications for effective mentoring in their scholarship are clear.

Jessika: For my fellowship I had like two primary mentors I met with every week like they you know like it was maybe more of a hand holding model. I needed that intellectual community. I needed the w.i.p.s. Wips being the work in progress. I needed you know those regular points of contact with somebody saying like you know okay did you get those 6 pages written, is that article out, just being accountable on that level with someone and saying next time I see you in two weeks this this and this has to be done. And I feel like that totally changed the game for me. I probably pulled together 12 manuscripts in 18 months.

For the majority of participants, a good number of mentors were not at the same institution. In addition, there were elements of self-agency and resilience that arose in mentoring discussions.

### **Mentoring, self-agency and resilience**

In regards to self-agency and resilience, all participants had to find their own mentors, either because the mentoring that they were set up with at the institution was inadequate for their career stage or because the important element of rapport was missing. Rosana said:

You had to find mentors, and that's what people advised. They were always like: "Well you need to find mentors from multiple places," and they can do different things for you. So I was like, okay."

Francisco emphasizes resilience in mentoring:

*Creo que es importante que los (URMS) de cualquier trasfondo étnico, racial o cultural, sepamos que hay que sobreponer lo que no hay... hay que identificarlo, pero hay que sobreponerte. Que no sea ese necesariamente un factor que te venza. Que te venza, sino que algo para catapultarte y seguir adelante. Y yo te voy a ser sincero, que con el tiempo he logrado crear relaciones colegiales en mi unidad o mi departamento con consistencia, con persistencia... Pero toma tiempo. Tomó tiempo. En mi experiencia como ahora hay otros a los que estoy viendo crecer en lo mismo (que yo crecí). Que están experimentando lo mismo. Pero ellos tienen un mentor (yo), ellos tienen donde venir, ellos tienen con quien hablar.*

[I think it is important that URMs of any racial, ethnic, or cultural background, know that we have to overcome, we can identify (negative instances) but we have to overcome them. We can't let it defeat us, but catapult us, to keep moving forward. I will be sincere, with time I have been able to build collegial relationships in my unit, in my department with consistency and persistence...But it takes time. It took time. In my experience, like now, there are others (professionally) growing up in the same (departmental) environment I did. Experiencing the same, but they have a mentor (me). They have someone to go to, somewhere to go, someone to talk to.]

Participants also referred to the existing mentoring relationships at other spaces including professional organizations, which may be in part because of the lack of senior URM faculty present at the institution. In addition, these professional networks appear to provide spaces that feel more comfortable and provide opportunities to seek and receive mentoring in areas that were not available at their own institutions.

Rosana: I did stuff with American Medical Women's Associations. So then, I got involved in AMWA, that was actually what totally change around everything and got me on track. So, I got involved in AMWA, and it was kind of like finding your people. I was very comfortable with the women, and all the people in AMWA. They would say, "Rosana, I want you to do this." I don't know why I needed that, and then I'd say, "Okay, yeah. Let's do it." Do this. I want you to do this. I don't know why I needed direct instruction, but I did. Then once I got started doing things, and I started seeing things here, and I was like, "Oh, well that's the same thing, I could have done it right here on campus." And even now,

I'll stumble upon things. I looked through the different things that we have, and I'd go, "Gosh, why didn't I do that before. That would have been really nice. I should have just signed up for that." Or something...

This type of experience may also influence their own approaches to mentoring others. Participants often referred to their own mentoring approach at times significantly different from the type of mentoring they experienced and received in the past. For example, I asked Blair about her mentoring approach:

It's hard because I don't know that I see myself as a mentor. I think I see myself more as a guide, and a shoulder, and a sounding box. Because as a mentor, I'm personally involved with somebody's career path, and I don't know that I am that involved with their career path as much as I'm involved with their life. My goal is to keep physicians practicing, keep people doing what they want to do, and find ways to help them do that, and to not feel bad about what they're doing. There's a potential shortage of 96000 doctors over the next few years, maybe part of that is because a lot of the docs aren't being doctors anymore, they're unhappy with what they're doing, or they're burning out, or for whatever the reasons. So if there's a way that I can help them each find satisfaction in what they're doing and being successful, then we'll have more people.

This quote is particularly important because it also indicates the importance of mentoring individuals in a holistic approach. In this instance, Blair thought about mentoring not just in terms of advising for a career path, but ushering the individual through their life and in fulfillment of their passions for this profession.

Furthermore, I asked Blair if she felt this was the way she was mentored:



No. Especially after medical school, I would get it, but it wouldn't necessarily fit. Here's an example, sitting at my chair in X early in my career, and I said...We're talking about where I'm going, what I'm doing and he's like, "Blair, if you're going to be successful, you have to pick one thing." I just kind of looked at him dumbfounded, because he was a hematologist-oncologist, he was a chair, he'd been in research and all that kind of stuff. I said, "Well Doug, I do general medicine." I'm doing general medicine that means that I like everything, how do I pick one thing?

Blair did speak fondly of a faculty member who was not assigned to her as a mentor, but someone who showed interest and provided emotional support.

He was a psychiatrist, X was, and so I think that you wouldn't have to go to him if there was a problem, he just saw you in the hall and knew. And so, it was a way of sort of, I guess, getting me through and for that additional support all the way, that I didn't have to wait 'till there was a problem, I didn't have to go seek out somebody because somebody was seeking me. And I think I really appreciated that because I wouldn't have known how to do it otherwise. Because of that experience, I think I do try to reach out to people kind of above and beyond.

Participants spoke about mentoring in a way that acknowledges the importance of mentors in their career development and at all stages of their career. More specifically, participants like Henok spoke about themselves as “collectors” of mentors.

We just need successful people. It doesn't really matter. You just need successful people. People that have come through that process. People that have

publications. People that have research. People that are good at what they do. It doesn't really matter. And as I say, mentors come in different flavors.

Participants defined mentoring broadly and challenged the one mentor notion. The concept of finding one individual with all the right characteristics is seen as fiction. For URM faculty the concept of a mentor is used as an umbrella term when it is actually referring to other roles: sponsors, champions, coaches, and institutional navigator as defined in chapter 2.

Francisco: I've had mentors that helped get confidence in assertiveness about clinical practice and learning the ropes. I had another one that was more for negotiation, and the other was more for what to do, how to accomplish things in academia, he was more academic, what to develop, how to meet needs, to whom should I talk to. That was the person that introduced me to everyone in the School.

The more people on your team and the more encouragement one receives, the greater URM faculty are supported in their journey.

Francisco: I probably have two or three mentors that have been equally successful. One was more like a clinician. You know, help me gain a confidence and assertiveness in the clinical process, of you know, seeing patients, running the practice and knowing the practice. Then there was another one for more like a negotiation in... navigation practically... to be honest. And the other mentor was more about what to do, you know, how to accomplish things in my academic department... more academic oriented about what to develop, how to meet

leaders, to whom to talk to, that was the person who introduced me to everyone in this school.

It is important to highlight that one of the roles referred to by Francisco and others was that of an institutional navigator. As participants talked about the institution and mentoring practices, there was a sense that in terms of the URM faculty experience, the person is also an integral part of their navigation of the academic medicine space and a major part of achieving a sense of belonging and an unspoken trust that someone will tell them who to go to for institutional advice, someone that would reveal unspoken procedures and policies, communicate who are the key players and stakeholders in the mix, and most importantly advise on the political interactions with colleagues and leaders. It appears to be the only role that truly resides at the institution. This role suggests that as we rethink mentoring programs, we should focus on this important role.

Museus and Neville (2012) refer to this person as an institutional agent and describe her/him as positively influencing the individual's success and provide them with access to the social capital. Although, Museus and Neville's (2012) study was minority student-centered, this case study demonstrates that a similar definition is warranted when it comes to URM faculty. The common characteristics of these agents include: sharing common ground, providing holistic support, humanizing the education experience (in this case, the URM faculty experience), and providing proactive support (Museus & Neville, 2012).

Mentoring is an integral part of the success of URM faculty, especially in academic medicine, which often follows a scientific formulation when it comes to mentoring (NIH OITE, 2016). Academic medicine research greatly relies on federal

funding such as that set forth by the National Institutes of Health and other federal entities. In this environment the Principal Investigator (PI) is usually considered the primary mentor, even as other members of the research team may monitor experiments, offer guidance, and provide feedback on research projects. Either as a basic scientist (STEM) or as a physician scientist, this is a model that our academic medicine faculty is accustomed to and has assimilated. A multitude of mentoring programs exist at institutions, but for the most part they follow this format and expectation. The problem for URM faculty is that mentors are hard to find and the ones that they currently have at the institution provide feedback with the goal of evaluating the individual's career in the currency of publications and funding, nothing else.

Henok described a deficiency that we often see in the basic sciences and academic medicine. Mentoring is said to be critical in the promotion and tenure process, but is it really mentoring? Or is it an evaluation of one's career up to that point with limited guidance for moving forward.

I think it was meant to be mentoring but, it's something that I encounter a lot of in this academic setting, what was supposed to be mentoring gets confused with an evaluation, right? And it's more of a get me with this committee to justify their existence ... as opposed to what can we do to help you do what you need to do.

It was clear that regardless of the rank of these participants, even the most experienced professor still used mentoring relationships for guidance in difficult situations. This was critical in their advancement through academic medicine and navigating the institution.

### **Informal mentoring and mentoring identity**

It also appears that formal mentoring has been labeled and structured within the institution in ways that come with great responsibility; these structures have inadvertently pushed URM faculty to focus on informal mentoring relationships that are perceived less valuable in the academic currency.

Blair: Oh yeah. I'd like to think of it as an informal mentor, because if I'm an official mentor, then it's a lot more paperwork. So, informal mentoring, yes, plenty.

The “paperwork” Blair mentioned refers to the tracking and monitoring of mentoring meetings, mentee individualized career plans, and career evaluations. These often constitute or become part of a formal mentoring program. However, informal mentoring was sometimes more critical in a sense that spoke about the individuals that participants had reached out to and spoke about these participants’ relationships in performing their own mentoring.

Henok: I like doing it (informal mentoring) a lot, but it's you know not as if it's interesting because it is not the type of thing that is evaluated or ...I don't know if it's appreciated. It's definitely not something that we are evaluated on. Like for an instance you know, in my CV I may have it but for MSOM, there's nowhere to put it.

Each of the participants referred to informal mentoring in positive ways. Keeping in mind the broadness of what participants considered the mentoring umbrella, informal mentoring was not only something that they reached out to, but something they were willing to do.

For URM faculty, informal mentoring is heightened. As faculty members at MSOM they must formally mentor over 1400 students of all races, creeds and orientations, but at times the number of URM medical and graduate students may exceed the number of URM faculty. For example, at MSOM African American/Black matriculants exceeds 100. However, in its Department of Internal Medicine, there are only 11 African American/Black faculty members. When URM medical, graduate, and trainees reach out to URM faculty it often tends to be an informal mentoring relationship because they may have already formal mentors assigned to them. In addition, URM peer mentoring also tends to be informal because of the same limiting numbers.

URM faculty support of informal mentoring demonstrates a strong commitment to the next generation of trainees and new faculty. It also demonstrates their strong commitment to service to others and the institution. They mentor throughout all aspects of a mentee's life, not just on career progression and advice. There might be also an element of "paying it forward," in which URM faculty may deem this also part of their responsibility, identity, and duty as URM faculty.

Henok: The problem is that's for our personal satisfaction, but it is one of the areas they are going to give you the tools to be promoted and be noticed within the institution? That's the issue. I think that's where the mentoring comes in. If you are interested in service, how can you utilize that service and make that service in a way that it can actually get you promoted?

Unfortunately, this is a ghost commitment; it is not documented in relation to how many individuals participants informally mentor, time and effort. The departmental evaluation process is absent of recognition and appreciation. More specifically, MSOM's

promotion and tenure criteria does not request this information and lacks an opportunity to report it in other formats.

Jessika: People of color, that is well documented and just get it, but to the point of I think if they are ways to actually reward in a real way around promotion and tenure doing that work of advising and mentoring, doing that work of community service and community engagement, doing that work. If those things were things that could be counted toward promotion it would just create better alignment but a lot of that feels like free service that you're giving away that isn't going to ultimately translate or be accounted for in the equation when they're looking at the number of publications the real productivity measures.

Also, participants spoke about their own relationship with mentoring. Only a few participants spoke about mentoring others with confidence, and even the most experienced Associate or Full Professors spoke about it in ways that were not just evaluative or career guidance, but contributing to the whole individual. Approaches to mentoring vary greatly, from one to one assignment to mentoring panels, from departmentally or school structured. Bottom line, mentoring programs must be developed for individuals based on their needs, which a constant evolution based on the rapport between mentors and mentees.

In order to apply inclusive excellence into mentoring frameworks, we have to start by speaking about the individual as a whole, not just about their career. There is so much that affects an individual's career progress, barriers are not just about writing blocks or funding gaps and so an inclusive approach to mentoring may allow for an approach desired by most URM faculty and one that allows individuals to have honest

conversations and valuable relationships passed the curriculum vitae evaluation. It is also an opportunity for inclusiveness in the mentoring approach.

One to one URM mentoring is not possible in the majority of academic medicine centers, therefore inclusive excellence would champion cross-cultural mentoring in ways that demonstrate the value of diversity of experiences and thought. In addition, inclusive excellence would reward mentoring, informal and formal, in ways that recognize this valuable contribution to the academy. While changing promotion and tenure criteria can be a substantial challenge, it would be easy to first acknowledge this contribution in the faculty annual evaluation process. This immediately changes the message of what is valued within a particular department. The department community is where URM faculty spend most of their time. If we build the departments with an inclusive excellence foundation, chances are that faculty vitality will increase and job satisfaction will shortly follow.

### **Faculty Development**

Faculty development includes support for activities such as finding research funding, writing academic articles, participation in conferences and professional associations, leadership and management trainings, as well as other types of curricula (IUSOM, 2015). URM faculty have the skills and knowledge to be successful, but institutions need to provide collective support in recruitment and not forget about URM development. (Thompson, 2008).

The majority of participants in this study obtained their faculty development through professional organizations or equivalent networks, however, spoke positively



about the institution's offerings and the work the institution does as faculty developers. They also expressed interest and attendance at development opportunities that applied to their current career standing. However, some participants also referred to these opportunities as majority or dominant group centric and not one that directly speaks to URM faculty experiences and at times counters their experiences or cultural backgrounds. The literature suggests that URM faculty promotion and advancement barriers are due to limited access to role models and networks that support their faculty development and failure in understanding the unique demands, pressures and environment places upon women and faculty of color (Tuitt, 2010). This is a consideration for participants in this study since they have expressed the lack of a critical mass of URM mentors and role models at the institution, as well as, the need for URM tailored faculty development.

One particular quote by a participant also summarized the successful efforts made in the faculty development and advancement of women in academic medicine. This progress has been greatly advanced through faculty development initiatives at national levels through key organizations. It has also been further developed in regional and localized settings. While we continue to make and achieve great strides for women in the academy, we have not been able to achieve the same level for URM faculty. The quote from Henok: "Men now get it for women, but men and women still don't get it for faculty of color" is representative of this sentiment. URM faculty from minority racial/ethnic backgrounds continue to feel "left behind" when it comes to diversity initiatives and faculty advancement.

**URM tailored faculty development**

Participants expressed the importance of faculty development programs and highlighted the need for distinction in what URM faculty need. Participants wanted to encourage fellow URM faculty to attend as many faculty development opportunities as possible and also charge the institutional leadership with creating programs that were tailored towards URMs. For example:

Blair: I think the information is useful across the board, but what's missing is that individual touch. Because the one thing that we're really afraid of saying out loud in front of other people is, "Am I really good enough?" And that's something that you just not going to get to when you're in a defined faculty development program. When you take off the morning and you go listen to people say, "Okay, you need more writing, here's how you write a grant," all of that is helpful. But what I think I found is the most helpful was somebody kind of sitting me down and go and, "You are smart. Screw what those other folks say."

Evelio seconded this sentiment:

It was informative in terms of what the policies are, how to navigate through the system and navigate in terms of, for promotion. But they could not relate, since they were the majority, of how a minority orchestrates through our challenges... There should be some things with minority. There should be an organized pathway or system for faculty that should be based upon the generic everyone else. But there needs to be some other added focus for minorities and that minority is based upon race, based upon sex. There needs to be some little added things, opportunities are very different and the challenges we go through,

are very different...I do think it is very important for someone to get to their comfort level, their comfort zone. And for me, I would've been more comfortable if there was more people like me.

Tailored minority faculty development is challenging because there needs to be a component that admits that URM faculty experiences are different than the majority, along with acknowledgment by the institution that faculty diversity is concerning and it is time to dedicate more resources to this goal. As URM faculty doubt the diversity commitment, which will be further discussed in later sections, URM faculty are reminded of MSOM's priorities which may not include them. When participants contemplated what MSOM specifically offered for URM faculty in terms of their development, Jessika stated: "I don't think it's like from neglect, I just think that it may not even be... It's just not in the forefront."

When Sorcinelli, Austin, Eddy and Beach (2006) wrote about creating the future of faculty development, they focused on three areas: the changing professoriate, increasingly diverse student body, and the changing paradigm of teaching, learning, and scholarly pursuits. In their work, the changing professoriate included expanded faculty roles, finding balance, and the needs of new faculty, non-tenure and part time faculty. Unfortunately, there is a lack of tailored faculty development even in the faculty developers' community.

URM faculty attended events offered by MSOM faculty developers, but that was not necessarily a space where they felt comfortable or that even realized that there were more complex identities at stake. Jessika specifically speaks about these complexities and tailoring opportunities.

I was just really mindful of the ways, of the additional complexities that come as sort of being a woman of color and the ways some of the issues are very much the same, and some of them aren't. And I think that that notion of just slight sort of tailoring of tools and resources, I guess at first I wouldn't expect for people to be aware of it, the necessity even, but it is a felt absence in some settings.

Based on URM faculty perspectives, URM faculty development programs might also require and benefit from the presence of senior URM faculty that could contribute to the process, which is difficult considering that these numbers are already limited. By virtue of their seniority and presence, senior URM faculty, immediately present a notion of possibility. The presence of senior URM faculty opens a range of possibilities for early-career URM faculty, someone to look up to, someone that was able to achieve the next faculty rank, and someone with whom they may share similar experiences and operates in the same environment, someone that “made it.” URM faculty development programs have great potential for contributing to more than promotion and tenure, but as networking, relationship building, accountability, and affirmation spaces.

### **Faculty development as networking, accountability and affirmation spaces**

Participants in this study spoke about their own development either through the institution or through their professional organizations. This speaks about resourcefulness with regards to not finding what they need at their local institution, but reaching out to external opportunities that would fulfill their development and participating in programs to address perceived weaknesses or provide opportunities for skill and leadership development. In addition, external faculty development programs offered additional

networking opportunities with other URMs in the field; URM numbers that are often not available at individual institutions.

Jessika: So it has been a place to make great...and I guess networking. It feels like not a sufficient enough term, because it's really been this place to really develop relationships and to also gain some degree of sort of I think like notoriety, some grounds and invitation come out of that and I think connections with people across institutions and things.

The notion of URM faculty development is also combined with a space for accountability. As part of targeted development opportunities through a professional organization, URM faculty have been able to keep in touch with other URM faculty nationwide. In lieu of a robust institutional network, URM faculty have been able to hold each other accountable throughout their career progress. They spoke about this type of program as an eye-opener in that it affirmed their realities and differences in their experiences. They could connect what was happening at that moment and able to identify challenging situations. This has increased their professional network, but has also created prospects for holding each other accountable, sharing opportunities, and creating champions nationwide.

Rosana: Even if someone tells you that there's a program, I thought that it wasn't for me, or something, or that I wasn't qualified, or was much fit for some other people. When am I ready for it? Am I ready now? When do you do this? When are you ready for these programs? Yeah, that's the thing, this is for me to do now.

Rosana was able to find this space in her professional organization. By having this space for networking, relationship building, and accountability, she was able to recognize opportunities at her own institution and at other organizations. She was able to realize that there was a place for her development.

A few participants recognized that there was a critical mass of people with a shared commitment and concerns around advancing URM faculty (and trainees) at their institution. Jessika spoke of the need for synergies and opportunities for convening the URM talent, and for the relational piece that affirms “you're not the only one here with those passions, interests, and concerns.” Faculty development seems to provide an additional space for networking but also a space where URM faculty can feel affirmation, especially when surrounded by other URM talent.

Tuitt et al (2010, p.240) proposed inclusive practices in six tenants: highlighting unique cultural characteristics as an asset to the institution, awareness of unique experiences and challenges, ensuring support and resources, committing to diversity and excellence, paying attention to URM culture and climate, and serving as allies. For example, Henok not only wants his cultural background to be highlighted, but he would like his work to be recognized as an asset to the institution:

In terms of the value. It's this idea that when I look at my CV, it is hard not to say, "Damn, this guy is good." I know of a lot of universities that would just kill to have somebody with my background, being as successful. To see that they're not even trying to highlight it. It's just odd to me. That I get this huge grant, and I tell the news, whatever. They don't even get back to me. I don't think they are even thinking about...regardless of whether I'm a minority.

Furthermore, Henok noted two common requests institutions make of URM faculty: special committees and pictures. In efforts to demonstrate a commitment to diversity and inclusion, URM faculty feel they are only remembered in these two instances.

We can say, "Hey, look." We don't have to say it but, "Look, we have a diverse faculty." It's like when I was in X; every freaking year, I would be called for pictures for the catalog. I said, "No, I'm not going to do it." We don't have more faculty of color. "I'm not going to do it." I'm not going to be your token. That's the only time they remember you. "Oh, we need somebody at the diversity counsel HR says that this committee has to be diverse. That's the only time that they look for you. It is the same thing with women.

In support of URM faculty development, URM faculty highlighted the importance of having a space with individuals sharing similar backgrounds, or cultural familiarity as CECE indicates. URM faculty development spaces encouraged participants to share experiences, perspectives, and ideas centered on individuals' cultural identities, while strengthening diversity with cross-cultural work.

URM faculty experiences are contained within a similar environment, the culture of academic medicine and institutional climates. It was important to ask participants their perceptions about that culture and climate.

### **Academic medicine culture and institutional climate**

As mentioned in Chapter 3, Kuh and Hall (1993) define culture as the "collective, mutually shaping patterns of institutional history, mission, physical settings, norms, traditions, values, practices, beliefs, and assumptions to guide the behavior of individuals and groups within an institution of higher education..." (p.2). Academic medicine has

been described as a culture of self-promotion, a culture of “bragging,” “conflict laden,” and “you eat what you kill” (Pololi, Kern, Carr, Conrad, & Knight, 2009, p.51; Cole, Goodrich, Gritz, & Grimsby, 2009, p. 115, p. 117). Participants described this culture of self-promotion and bragging as being completely counterintuitive and found being assertive often challenging. Participants also described academic medicine as a “win or lose system”.

Henok:” Win or lose system and everything is set up that way, it's a winner or lose which is very sort of the old White dominated system in many ways, right?”

This was described as a culture that requires double the strength, that is unequal, and where one has to prove himself or herself on a daily basis, not just to colleagues, leaders, and students, but to patients as well. Blair’s statement resembles an environment of survival:

I am hoping I'm doing it (teaching) on the nurturing side of things but I'm not always sure. There's the do one, see one, teach one that you have to man up all the way down. You should be able to handle it. I don't know that we look kindly on people that aren't strong enough.

Rosana agrees with this experience, but her statement poses the notion that equality is different than equity and a diverse environment can still not lead to equality nor equity.

There is not a lot in academics to create equality. We bring people in and we say oh they are here but we don't understand what underrepresented people need to be on equal footing and so from my experience at least I feel that I am often maybe



catching up or trying to be on equal footing ...it isn't equal you know. There is a lot of things that you're missing or you're not being you know that you have deal with. You have to deal with everyone's bias. And you have to deal with all the stuff that people don't even know that they are doing. So it's challenging to even talk about that with people if they don't know if they are doing something that's detrimental to you.

Participants like Elizabeth reaffirm beliefs that others in this environment might see URM faculty through a lens of inferior performance. For URM physicians, and physician-scientists this pressure is not only from the institution, but also from the patients they serve.

I would tell them is just like you had to work hard to get where you are now, there are still just as many people looking at you like you are incompetent and you are going to learn that sometimes it is hard to prove yourself. So either you are a better physician than everyone else around you that is not a minority because you tend to be that much better at what you do in order to gain respect.

Thus far, URM faculty have described the academic medicine culture and climate as a "win or lose" system, an environment in which you have to be stronger by an unspoken standard, and one in which URM faculty performance is perceived as inferior. In this research, I aimed to study and voice the experiences and perspectives of URM faculty in academic medicine and their message is clear. Academic medicine may not be a welcoming environment for URM faculty, but coupled with institutional climates that do not support URM faculty, the results are dissatisfaction, emotionally and psychologically draining.

In regards to the institutional climate, participants spoke of an ideal space to be, to mesh clinical, education, and research with no expressed desire to go into private practice or industry. Overall, there were mixed views, those expressing possibly silver linings in the environment mixed with hesitation.

Jessika: Well now that I understand it I think it's a place where you can kind of where you can always learn and grow and get better. But it is also a place that you have to navigate and delicately and you kind of have to set aside some of your experiences and the way that you exist like your reality has to be a little bit set to the side because it isn't the reality of the most of the people that you work with so you have to understand that. And you have to learn how to be successful in spite of that.

When pressed about this, I could see participants delve into the ideals that academic medicine long held, focusing on educating the next generation of physicians and scientists, long-established mission of scientific research and discovery, improving the health of the public and retaining the obligation to facilitate and support the mission of social responsibility (Ramsey & Miller, 2009). The sentiment of scientific discovery and teaching is expressed in the following quotes.

Francisco: *Mi sueño de toda mi vida, enseñar. Me encanta aprender y enseñar.*

[My dream has been to teach. I greatly enjoy learning and teaching.]

Evelio: The thing that I knew I would miss in the private sector, was teaching because I enjoy teaching.

Henok: So, from the very beginning of getting my undergrad degree I wanted to do research. I wanted to do research independently and ask the basic questions

that I was interested in. So, it was never really a choice for me. I really wanted to do the sort of have the freedom to do research I wanted as opposed to what's commercially viable.

Jessica spoke about academic medicine in the social justice context, and she may have been more explicit about her answer than others, but they all were committed to these values one way or another.

It's interesting when you ask earlier about how I came to do that work, they number one, two and three driver of what might motivate me is about social justice and issues around sort of health and disparity and the impact of race and class and culture on health and race, on health and disparities and things. It's all of that stuff. It's not apparent, but it's at the center of what I do, within my sort of conceptual framework, I feel like that shared decision making is both a mechanism and an intervention toward that goal of actually sort of minimizing those gaps. And so, when I sort of step back in terms of like big picture, like what I wanna be accomplishing in the world, I wanted to be like... A safer place for Black woman and girls, not just exclusively that, but that sort of I want to be doing work that is actually having impact. And I think that that's become the question mark with regard to trajectory, is whether or not the incremental change and impact that you can have in academic settings is one that is going to kind of afford me the ability to do that work in the most meaningful or effective way. So, I think that that's...

However, these conversations are framed within the context of the vehicle that facilitates, the tripartite mission consisting of education, research, and clinical service.

However, there is a culture misalignment between the faculty's values and institution. URM faculty perceive a lack of attention to the social mission of providing care for all people and to the community (Pololi, Kern, Carr, Conrad, & Knight, 2009). I believe this represents the dichotomy in the participants' message; a belief in what academic medicine portrays in contrast to their reality of its culture and perhaps immediate climate. For one participant, Jessika, the difference was between academic medicine culture and the institution's climate: I think they (values) aligned with those that academic medicine professes, but I'm not sure that they aligned with this institution's. Peterson and Spencer (1990) defined climate as "the current common patterns of important dimensions of organizational life or its members' perceptions of and attitudes toward those dimensions" (p. 7). Some participants described their climate with mixed terms of "isolation" and "dissatisfaction." However, most individuals were comfortable in their immediate departmental environments.

Participants' views on the climate also acknowledged the geographic location of the state and institution, describing it as a conservative state while pointing out that the institution's staff also represented these views in contrast with a more liberal faculty and leadership. One participant mentioned a couple of examples in which he challenged views about Trayvon Martin's <sup>4</sup>case and Black Lives Matter related events while also using these opportunities to educate those involved about what these events meant to him as a Black male.

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<sup>4</sup> Trayvon Benjamin Martin (February 5, 1995 – February 26, 2012) was an African American teenager from Miami Gardens, Florida, who, at 17 years old, was fatally shot by George Zimmerman, a neighborhood watch volunteer, in Sanford, Florida. <http://www.cnn.com/2013/06/05/us/trayvon-martin-shooting-fast-facts/>

Evelio: Some see me as this Black guy, right? And that's the issue of how the institution evaluates you because I think that we all bring to the table our history, whether good or bad. And I think that there are some who in administration or whatever or colleagues, whatever, see me differently, sometimes based upon their background but also just how I carry myself. So, one of my colleagues, senior colleagues for that matter, is very vocal in terms about how physicians should look in terms of their dress, which is respectable, everyone has a different viewpoint. But at a meeting, made a comment about people wearing sweats and hoodies. I wear sweats and hoodies. I made a comment at the meeting based upon what that person said. And I know when there is some things that we should try to implement in terms of what's the acceptable dress code, my comment was, this is a cultural thing. In my culture, sweats and hoodies is acceptable based upon how I grew up and so on and so forth. And especially with the issue of Black men in hoodies, I purposely like to wear my hoodies, so people can look at me and then think we are all something. So for me, sometimes I make statements that's not viewed very well by some and that's why I think how I am, how people view me varies based upon my statement that I'm trying to make.

In reference to another event:

I think society is fit to judge every one of us. And I think, unfortunately they judge without getting to know what a person is all about. So, I make statements purposely so that society can see, oh, that's different. I didn't expect that. So there is a period of time that I used to wear Timberland's all the time. And I was known as the surgeon with Timberland's and my patient's knew me, my private

patient's they will see me and if I wasn't wearing my Timberland like what's wrong with your Timberlands? But the Timberlands was the expression based upon where I came from. I'm from the inner city, the hip-hop community of New York, City. Not too many people were happy about me but it was a step.

Evelio's actions are examples of resilience and it manifests through the use of attire as a means to bring social justice awareness and firmly establishes his identity as a Black man. Resiliency manifests in his ability to multitask, problem solve, take responsibility for actions and make a difference in the world around him (Jean-Marie & Lloyd-Jones, 2011).

Another participant spoke about the lack of space for faculty, especially URM faculty, to process and discuss these events, including the Orlando club shooting.

Jessika: Yeah. I mean, I don't think that we currently have that in the landscape and I think that that's part of what were my thoughts have been is wanting somewhere to sort of voice, you know, frustration and heartache. I mean, it's all of that, you know, and I think because there's so many spaces where you're not, like I said, the sense of I will speak for myself the sense of like... you don't want to be perceived as angry or playing the race card or always talking about race, you know [chuckles]. It's like... but that's my reality! Like these things that keep happening to people who look like me or my brothers like that is impacting my ability to navigate my interactions with all of you. So, [chuckles]....so I think that, but yeah, I don't think we have that. I think it would be a helpful thing.

This particular interview happened a few days after the events surrounding the Orlando shooting<sup>5</sup>. Jessika's transcript may note [chuckles], but this conversation and her voice can only be described as disbelief and frustration.

Although these events are not happening at the institution, it is hard to see how they could be separated from the institution's climate because this is the space in which all sides coexist. It is hard for URMs to be in spaces in which they are experiencing a different society and in which they are not be able to speak about it in the space in which they spent most of their time at work.

There is a clear discrepancy between the culture that participants hope to be in, the culture they experience, and the climates they navigate. Academic medicine is not shaped by one particular climate, and MSOM is no different. The tripartite mission happens in three different spaces. Clinical enterprise is located within health systems, impacted by interactions with multiple groups including patients, allied health professionals, health system leadership, and learners (medical students, residents, fellows, etc.). The research and education missions often happen in academic and medical spaces, although the interactions again take place with a diverse group of individuals.

A common thread was the perception that the micro and macro aggressions URM faculty experience in these spaces are often unintentional.

Evelio: They don't understand why. I know this is a horrendous example, but I don't care. But they will never understand why... why is it when I'm in a meeting they're always serving fried chicken? Or when you're at a meeting, they're serving tacos.

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<sup>5</sup> On June 12, 2016, Omar Mateen, a 29-year-old security guard, killed 49 people and wounded 53 others in a terrorist attack/hate crime inside Pulse, a gay nightclub in Orlando, Florida, United. <http://www.cnn.com/2016/06/12/us/orlando-nightclub-shooting/>

Jessika: Because that's where the token piece I think is a rub, because it feels like are you being used to their devices...and I think that that also comes with the degree of guardedness or uncertainty as to whether or not I will behave.

Evelio: It's the situation, but you still have to be careful. I don't think that there is a plan to keep us down, but I do think that we may not have as much opportunities as others.

While this might be a tool to process their experiences in this climate, or part of a process to give others the benefit of the doubt, it does bear the question: When it is no longer unintentional a form of justification? In addition, I believe Evelio's use of the phrase "to keep us down" begins to question structural barriers that exist in academic medicine culture or within the institution's climate. While the leadership may not be purposely "keeping them down", structural barriers embedded in the organizational structural and hierarchy of the institution.

Current scholarship asserts that diverse and inclusive climates provide academic medicine centers (AMCs) with a much-needed capacity to thrive as institutions of higher education and achieve the goal of improving health for all communities. As such, it is critical to perform culture and climate assessments focused on diversity and inclusion in these settings (Castillo-Page, Schoolcraft, Milem, & O'Brien, 2012). This dissertation presents a qualitative overview of the culture and climate at MSOM and academic medicine for URM faculty. The next section tackles diversity and inclusion perspectives among URM faculty.

### **Diversity and Inclusion**



According to AAMC, diversity embodies inclusiveness, mutual respect, and multiple perspectives, and serves as a catalyst for change resulting in health equity. Inclusion is defined as the creation of a climate that fosters belonging, respect, and value for all, and encourages engagement and connection throughout the institution and community. Dodson (2009) points out that diversity and “diversity work” means any activity that encourages inclusiveness. This approach is celebrated, but was also questioned by participants that firmly believe in diversity as the way to inclusiveness and challenge societal views. For example, Evelio expressed:

I'm very proud and happy of Obama. It was the best thing, but also the worst thing because of the mentality now has been everything is equal. And at the end of that mentality is that there does not need to be something different or this added thing for us, or this other program.

Evelio's point is worth noting in two respects. First, he suggests that during the time President Barack Obama presided there was a sense from the White majority that we had made incredible progress towards equality. Evelio knew that President Obama's elections were not a sign of equality in the U.S. From Evelio's perspective this was disingenuous and it may have contributed to a different approach or vision for diversity efforts. Second, this interview was conducted in the summer of 2016. As a practitioner in academic medicine, the presidential election of November 8, 2016 has alerted faculty, staff, students and administrators at campuses everywhere that we need to work even harder to achieve equality.

### **Evolution of diversity meaning**

A few participants, especially Henok and Evelio, both senior ranked professors, emphasized how the definition of diversity has broadened in ways that may continue to create barriers for the advancement of racial/ethnic minorities. As Henok expressed: “We have broadened it so much. I think that Hispanic is always left to the side and ignored.” Evelio added: “The diversity now has a different meaning. And since it has a different meaning, there is a different structure to diversity. It is very different than many people would expect.” Henok presented a more explicit view of what this expectation might be: “Well, I think to be honest, it's because of tradition and what being minority meant 10-15 years ago, which I think is the model that we are operating is that it's African American. So I think that's still there to big extent, that idea”.

Participants discussed that the broadness in diversity successfully moves the diversity needle, highlighting much needed progress in areas such as those addressing LGBTQ issues, and religious and spiritual competence and awareness. Participants looked positively at all levels of accomplishments while also perhaps concerned that this progress may project an overrated or false sense of accomplishment by the institution.

Alberto: The mentality of why diversity and inclusion is important is changing. People are realizing, based on studies and experiences, that diversity and inclusion is important in healthcare, not only for patients but also for students and faculty. I think that there is a strong workforce driving many initiatives that I think will see great results in the very near future.

Blair: There are some good ideas coming out now and appreciate that there is work going on now where there was little to none before, but without any real power.

However, for a couple of participants, racial/ethnic issues keep being “pushed to the side”:

Henok: It's very clear that right now the focus is on transgender issues and that's what the focus is there, right? So, I don't think that that's a bad thing. I think it's a new thing but again that's just lack of leadership that can't do that all these things (at once).

Henok went on to say:

Now the inclusion has gone to this whole gender thing, which make the thing fine but again I think it is left ... (racial/ethnic issues) moved to the side.

It is important to recall another quote mentioned earlier by Henok which can also apply in this diversity context: “Men now get it for women, but men and women still don't get it for faculty of color.” This sentiment might be an underlying sentiment for other participants of this study, as they spoke about opportunities that were targeted for women as in AMWA and Women in Medicine and Science programs.

After all, the institution may sense that diversity issues have been conquered when racially and ethnically diverse faculty feel that their circumstances are still not at the forefront or level of progress they would want. Black and Latino faculty suggested that this broadness in diversity may highlight progress in areas such as those addressing LGBTQ issues but should not be conflated with the advancement of racial/ethnic faculty minorities. It is important to highlight that the intersectionalities of race and ethnicity

with other identities uniquely affect the experiences of faculty of color. However, it seems evident that URM faculty perspectives indicate that there is an institutional focus on the collective group while not giving individual attention to other sub-groups within the diversity umbrella. While these collective initiatives are important, institutions need concurrent efforts.

Jessika: It would be really helpful to kind of create some intentional spaces...I'm recalling more are from a model around LGBTQ kind of conversations. So I think that there's a lot of room to think about creative spaces for transparent dialogues about race and culture and in those kinds we look about it.

It appeared to be that participant's expectations were that these conversations should be sponsored or facilitated by diversity professionals. The next section presents URM faculty perspectives on MSOM's Diversity/Multicultural Affairs Office and similar offices.

### **Perspective on Diversity/Multicultural Affairs Office**

Participants recognized the importance of diversity/multicultural affairs offices in academic medicine, higher education institutions, and the healthcare systems they are part of. As students and early career faculty they were more likely to utilize the resources provided by this type of department. As it stands in the context of this particular office at the participating institution, messages seem to be mixed. Participants speak of a lack of clear mission and vision, often agreeing that the focus of this office is students. They also often referred to the possibilities and impact the office could have on the faculty experience. A few participants were aware of diversity and inclusion that targeted

faculty. For example, participants were aware of a few initiatives: the mandate for departments within the school of medicine to create their own departmental diversity driven strategic plans, monetary recruitment incentive for URM faculty, and an expansion of offerings for physician-faculty workforce centered on patient care and cultural competence.

However, the majority of participants expect more from faculty initiatives.

Blair: “What we don’t have is someone reaching down to help out. For example, the faculty do reach out to the students and residents and put them on their abstracts<sup>6</sup>... but what about other faculty? ... At some point, we do need more than another webinar, we need more tangible things.”

In general, participants’ perspectives on diversity and inclusion initiatives at MSOM can be summarized twofold: (1) as a general lack of awareness of these institutional initiatives and (2) as not faculty-centered. They spoke about the Multicultural Affairs office’s lack of power, recognized their own mixed expectations of their mission, and organizational structures that reaffirmed diversity as “secondary” priority.

Evelio: My vision of the office diversity or the diversity council or all these diversity names or whatever, if you wanted to give them power, you give them power. And the way to give them power is to give them the monetary resources, but more importantly you give them the power to influence change, to influence what the president’s address. That’s how you empower them. So until those things are done, what’s gonna happen? Diversity will talk about some stuff, we’ll

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<sup>6</sup> “abstracts” was used by the participant in reference to conference, publications, posters, and other forms of scholarship.

have a meeting here and there, we'll be in vision council, type thing, talk about how unfair this stuff is, and so on and so forth, but the way things happened continues to fester. So the other thing, you know, ours, like, if you're gonna have a diversity council or whatever, well then it should be nice when someone does something that we think is unfair, they're the ones who pass judgment. We don't have that.

Diversity/Multicultural Affairs Offices validate students' experiences, serve as springboard for students' engagement, create a sense of community, facilitate identity development, provide a service to underrepresented students and they perform community outreach while expanding the definitions of diversity and multiculturalism (Patton, 2008). To date, the literature on the impact of these academic medicine offices on underrepresented minority faculty is limited. There appears to be a gap between institutional intention and implementation of practical initiatives aiming to promote a diverse academic environment (Page, Page & Wright, 2011).

Participants in this study had mixed expectations of their Diversity/Multicultural Office. Participants were asked to provide their perspective on the goal and mission of this office at MSOM and in general in academic medicine. Elizabeth stated: "I think that sometimes you can just get lost in the numbers" as she referred to support networks for minorities in academia.

As evidenced in the next quote, these discussions countered the established mission of MSOM's diversity/multicultural affairs office, which centers on the education of cultural competence and creating inclusive campus environment.

Although they recognized positive changes in leadership, overall direction, and a need to assist underrepresented minority students, they also expected an emphasis on diversification of the faculty, validation of their experiences, networking, and champions. As Evelio expressed:

It could be a function because again so like if you have a student or faculty or whoever who has an issue, who do we go to? We don't go to diversity, we don't go to office of faculty...we don't go anywhere. And so that's why as I'm saying, the office or whatever, they don't really help faculty, okay, because one, they have no power to help faculty and they can't change how my (White) colleagues, what they do or what is said, they have no influence towards any of that stuff.

In a national study, the top three initiatives supported by diversity programs were outreach to racial and ethnic minorities in the community, recruitment of racial and ethnic minority faculty, and retention efforts (Page, Castillo-Page, & Wright, 2011). While MSOM's Office might be modeled after this national trend, it is not clear that faculty perceived their mission and practices as such or an asset or resource to URM faculty.

### *Organizational Structure*

MSOM's Office of Diversity/Multicultural affairs at the case institution does not report directly to the Dean. Although the office leaders hold Assistant and Associate Deanships positions, the office itself reports to another sub office within the Dean's suite. Participants noted the message of this particular reporting line and office structure. Specifically, participants wondered about, and in some instances questioned this and highlighted a message equating this structure with a lack of commitment to diversity and inclusion.

Participants saw a conflict in its reporting structure and were adamant that it should be directly under the Dean of the School of Medicine. The current structure permeated a sense of lack of power by the Office to initiate, develop and enforce decisions, practices and programs. Evelio and Francisco had definite opinions about the current structure. Evelio: “We don't need, we should not have a filter before it gets to the Dean if this was important.”

*Francisco: La barrera que yo creo que existe, pero es más a nivel de ejecutivo, político dentro de la institución es el hecho de que diversity no reporta directo al Decano. Yo creo que lo ideal, porque le daría más poder ejecutivo al Decano de Diversidad sería que estuviera directamente bajo la oficina del decano.*

[The biggest barrier that exists I think it is at the Executive level, politically, the diversity office does not report to the Dean. I think, ideally, it would change the executive power of the office and the Diversity Dean will be directly under (reporting) to the Dean.]

Hobby and Stewart (2015) support an office that is no more than one person away from the CEO, in this case the school of medicine Dean. The main consideration is that the institution's diversity plan needs to align with the vision of the leadership and without this alignment the initiatives may lack the appearance of executive leadership support and endorsement. In order to maximize return on diversity initiatives, responsibility and accountability must reside where there is utmost commitment, maximum visibility, and an entire institution communication and support approach (Hobby & Stewart, 2015).

MSOM's Diversity/Multicultural Office administrators are seen positively and participants have a high regard for them. However, they also recognize limited resources



in the office's staffing model in the scope of the size of the institution and the number of programs and initiatives they would like to see. In this case a lack of power resonated with the participants.

Evelio: If diversity was an important component of the administration, let's put it like that, they can do things very differently.... It really comes down to leadership. If diversity was a main component or an important component, things could be enforced. So the things that should be or could be done if diversity was a major issue, then it could be mandated from the power, from administration.

Blair: (As mentioned) here are some good ideas coming out now and appreciate that there is work going on now where there was little to none before, but without any real power, it is an office in name only rather an organization that can make recommendations, but not real change. Seems more like a window dressing. We have the same few people over and over again being involved without enough outreach.

Participants spoke in very hopeful terms about the future of this office. In a sense, participants seem pleased with some of the changes that have been observed, in terms of its leadership and talented group of individuals that now commit to this work. Participants also recognized the burden of one office. This one office is charged with a lot of responsibility and also impacted by the institution's culture and climates, and yet perceived as the diversity driver.

Alberto: The office of diversity affairs is doing a great job in leading the efforts for recruitment and promotion. I now see leaders using these offices as a resource I think that these centers need to set the tone and the expectations and develop

initiatives that will improve the culture in our school. These efforts need to have the support of school leaders and set clear expectations. These centers need to identify areas of weaknesses and work with school leaders to make improvements. One office can't change the culture and how the school looks, but has to set the tone and school leaders need to be behind these efforts.

It would be hard not to see the value of an inclusive excellence framework in the establishment of diversity/multicultural offices and initiatives in academic medicine. Inclusive Excellence (IE) is designed to help colleges and universities integrate diversity, equity, and educational quality efforts into their missions and operations. A diversity office guided by these principles shall serve URM faculty to its fullest potential and in turn taking care of other stakeholders at the institution. However, IE implementation in academic medicine has been limited, which in this case may reaffirm and demonstrate the complexity of developing an inclusive excellence model given the complexity of academic medical centers' climate and culture. In addition, cultural competency and cultural humility approaches align with a CECE framework that advances the interests of diversity and inclusion in the context of culturally engaging and relevant campus environments. As with IE, CECE emphasizes the importance of inclusive environments. Simply, CECE provides the indicators that guide institutional action through the diversity/multicultural Affairs office or better yet, the institutional leadership. By stimulating these types of assessments and open discussions, URM faculty are able to participate in the discourse and assist in guiding a framework that would result in a substantial driver of their own success.

**Narratives of racism and microaggressions**

All Latino faculty in this study referred to instances of microaggressions and racist incidents within higher education and academic medicine environments. This is important to highlight because Black faculty participants did not elaborate about these experiences. However, this should not be interpreted as a lack of experiences around this topic. In fact, I recognize that it might have been my common heritage that opened the door to discuss these additional experiences and the ability to carry out interviews in Spanish and English.

Discrimination of Latino faculty can happen in several domains, but these narratives centered on culture and credentials (Verdugo, 2003). Scholars have shown that Latino faculty believe they are discriminated against because of their appearance and language accents, a belief that their positions are a result of affirmative action or diversity initiatives, and some deemed their research subpar (Verdugo, 2003). Not surprisingly, this aligns with the experiences shared by Latino faculty in academic medicine. In reference to accent, there are three instances shared by Latino faculty:

Three participants' experience highlights the challenges of speaking up in collegial environments that do not support inclusiveness.

Francisco: In another instance, negotiating a project at a meeting, I disagreed at a faculty meeting and I was told by a colleague "This is not Guatemala." Not only am I not from Guatemala (nor my parents), but I clearly got the message, implying that I was at the wrong place, or thinking the wrong way.

Alberto: *Me hicieron una pregunta que no vino al caso, era si teníamos carros en mi país, A lo cual muy profesional dije, sí tenemos carros de los mismos modelos*

*que ustedes tienen acá. Y no durante la entrevista pude ver, y de repente, porque estaba un poco defensivo en ese momento, pero podía ver las caras de incomodidad que algunas personas tenían con mi acento.*

[They asked me a completely unrelated question (during the interview), it was if we had cars in my country. Very professionally, I said we have the same cars, same makes and models as you do here. And during the interview I could see, because I was a bit defensive at the moment, that some of the faces were uncomfortable with my accent.]

For another participant, it was in a student space that his evaluations were of the highest standards compared to his White peers. The individual had been praised in the past by his teaching style and learning environment. However, his student evaluation read “oh, once he loses his accent he is gonna be excellent.”

There are several hypotheses concerning the faculty status attainment among Latino faculty, one of which stresses the structural barriers (Verdugo, 2003). However, the worst structural barriers are those that are not documented, the ones that are difficult to challenge for so many Latino faculty. As Francisco relays:

*Sin embargo, hubo...[sic] algunos colegas que no estaban tan welcoming. Y aún pasaron, pusieron algunas limitaciones para mi trabajo con residentes, por ejemplo: No tuve oportunidad de enseñar en el primer... Yo creo que era más para no, no apoyarme en eso., me lo negaron porque es una restricción que no existe decir... no, no eres. Hay gente que se... empieza a enseñar justo después de graduarse.*

[There were colleagues that were not welcoming and placed road blocks and limitations...in efforts to not support me, especially as an educator. For example, I couldn't teach my first year as faculty. There were restrictions that were not in existence or written down as policy. At that moment, I felt that they were negating something that I had worked for.]

Francisco is a highly accomplished, and highly regarded educator in a senior faculty rank at MSOM. Although in its first year of his academic appointment, he remember this story vividly. Francisco entered academic medicine because of his passion for teaching and learning. In fact, prior to pursuing his career in medicine, he was a science teacher. This was definitely an experience that had a tremendous impact as a new faculty member.

The last aspect of this narrative was that of credibility. Academic credibility appears to be one of the most salient issues relative to White faculty who do not experience the same level of scrutiny (Delgado-Romero, Flores, Gloria, Arredondo & Castellanos, 2003). Examples of credibility issues include whether Latino faculty are presenting "programmatic research agendas or a political/personal agenda" (p. 273); assessment of intellectual abilities because of where their work is published; and assessment of qualifications when their hires are deemed part of a diversity quota (Delgado-Romero, Flores, Gloria, Arredondo & Castellanos, 2003). The most blatant example of credibility was that recently experienced by Henok, a senior ranked faculty member who has been well funded by NIH and whose work warrants significant respect.

I was at a meeting with several PIs to discuss submission of a training grant.

Discussion moved to who should be the PI of the grant. Somebody suggested my

name because I have some experience with that type of grant. Then somebody else jumped in and said “it should definitely be Henok because he is Hispanic and the NIH loves that”. I know what he meant and you would think I would be used to it by now but it still feels like a stab through the chest the day after.

In this particular situation, Henok experienced pride in his work while being acknowledged for his experience only to quickly experience a microaggression. This quote demonstrates the lasting impact microaggressions have on URM faculty. The quote is especially significant because it was a subtle comment, a subtle reminder that Henok’s colleague did not recognize the impact of his words but also a reminder that those sitting at the table were not allies. His other colleagues attending the same meeting were not his champions and did not defend his work.

In addition, this type of experience makes the promotion and tenure process challenging. For Latino faculty the promotion and tenure process is seen as a “tool of fear,” a “moving target,”] temporary respect but not full membership to the faculty rank, and a driver of “*supervivencia*” (survival); to thrive despite unsupportive and non-welcoming climates (Urrieta, Mendez, & Rodriguez, 2015). The experiences of Latino faculty were important to relay because it was not only a matter of race or ethnicity; there is a vast diversity within the Latino group, but it also demonstrated how an accent can portray negative characteristics with absolutely no grounds to substantiate the majority group’s actions.

### **The Use of the Framework Cultural Engagement and Inclusive Excellence**

The Inclusive Excellence Model proved to be useful in understanding the institutional environment for this case study. The use of IE, assisted me in organizing the

data and provided the basis for a closer look at external environments, organizational behavior dimensions, organizational culture, scorecard and change strategy. The CECE framework provided an opportunity to consider the relationship between culturally relevant environments and their effect on faculty stages such as socialization, mentoring, and faculty development. Participants' responses regarding the areas of cultural familiarity, cultural service and cultural knowledge offered a glance that culturally relevant environments are of importance to URM faculty in academic medicine.

Participants struggled to find colleagues and others on campus with similar backgrounds, (CECE's cultural familiarity indicator) hence limiting the exposure and opportunities to interact with individuals like themselves. They recognized that this was an issue based on the number of URM faculty at the institution, but also expressed the importance that this socialization has on their satisfaction, sense of belonging, retention, leadership opportunities, and so forth. In addition, participants lacked a space in which they could connect with people of their URM community.

Rosana: So none on campus so much, I think I was fortunate because in my own department, there were a few people (of color). So we had a fair number in our department but on the campus it is not easy. I think it's really difficult to find other people of color, especially when you start putting events together to try to network with people and try to expose students to people, it's really difficult to identify and to find out who's who, it's difficult on campus, and everything is very silent here.

Often, participants seemed conflicted if this space was or should be the responsibility of the Office of Diversity/Multicultural Affairs or if it should be that space.

Rosana: When I first came here, they want things in the school of medicine to try to bring people together. But now, we have the students stuff that we are putting on, diversity affairs is putting together and things that the diversity council tries to bring people together (disapproval facial expression) and stuff like that, so it's like make your own, it's not there, you got to make it happen.

Unfortunately, participants expressed there were not enough opportunities to learn or highlight their own culture. Although, one participant, Henok, in particular spoke about a “spectrum”:

That is a very interesting question. Because I think to an extent it depends on the group I am working with. If I am with the [xx] department [with the majority], I don't highlight it, and I don't try to highlight it. It's more like, "I am one of you guys". [Laughs] I think if I am with students that include students of color, I am more likely to try to highlight it a little bit. If I am with just minorities then I highlight it more. It sounds horrible...

From the CECE perspective, the institution has not facilitated an environment in which cultural relevant knowledge can be shared with the majority. Specifically, as with students, this space, instead of spectrum would increase the likelihood of success and stronger connection to their institution. As it stands, Henok's ability to share his culture is only with other underrepresented faculty; otherwise, Henok may model his behavior as that of the majority.

With respect to opportunities to help improve the lives of people in their cultural communities or opportunities to give back to their communities, participants often spoke about service, the service that does not match the definition of the institution. It was clear



that participants value service in ways that gave them personal satisfaction but struggled with the notion that this service should be tied to academic currency otherwise, their success and advancement as URM faculty is even further suppressed.

Henok: If you are interested in service, how can you utilize that service and make that service in a way that it can actually get you promoted. It's something that I sometimes still, or the minority faculty struggle with.... The things that he has done are very publishable, but he doesn't brag about it. It's the self-promotion thing. It combines this self-promotion, but also translating that service thing to the currency...

Service and social justice are present values for all participants in the way they talk about what motivated them to science, academic medicine, to work with patients, to work with students.

Jessika: what might motivate me is about social justice and issues around sort of health and disparity and the impact of race and class and culture on health and race... It's all of that stuff. It's not apparent, but it's at the center of what I do... And so, when I sort of step back in terms of like big picture, like what I wanna be accomplishing in the world, I wanted to be like... A safer place for Black woman and girls, not just exclusively that, but that sort of I want to be doing work that is actually having impact. And I think that that's become the question mark with regard to trajectory, is whether or not the incremental change and impact that you can have in academic settings is one that is going to kind of afford me the ability to do that work in the most meaningful or effective way.

Jessika also struggled with feelings of selfishness in evaluating her service. Like other participants, she did not feel rewarded or incentivized by academic medicine and more specifically, the institution when it came to service. There appears to be a disconnect between the meaning of service for URM faculty wanting to serve at underserved community clinics but knowing that service with a national professional organization had more value to the institution, hence to their promotion and tenure, and overall faculty development or advancement.

Jessika: You get these messages about how you have to be selfish with your time early on and that you're not gonna be any good to all these people that you want to help or if you don't get promoted and you have to leave [laughs]. And so, I mean those are very explicit messages.....I think if they are ways to actually reward in a real way around promotion and tenure doing that work of advising and mentoring, doing that work of community service and community engagement, doing that work. If those things were things that could be counted toward promotion it would just create better alignment but a lot of that feels like free service that you're giving away that isn't going to ultimately translate or be accounted for in the equation when they're looking at the number of publications the real productivity measures.

Another participant, Elizabeth, equated her passion for service to the ministry. This is a powerful because it supports URM faculty values that are often not rewarded in promotion and tenure process.

Elizabeth: So one thing I really look at my position as Ministry, it is not just that I'm going in everyday to fulfill a pay check but I'm there to hopefully interact and have a permanent impact on others.

The question of value was always answered with some trepidation. Overall, participants had mixed answers about feeling valued. The answers were carefully crafted. The perspective was that many of them did not ultimately feel valued by the school and the institution but at their professional spaces, in their own departments many of them felt valued. As Francisco stated “value my culture, you value me”. CECE’s culturally validating environments positively affect success by validating the students’ cultural backgrounds and identities (Museus, 2014). URM faculty can validate minority students’ cultural backgrounds and experiences and in that manner decrease the cultural conflict experienced by those students of color (Museus & Quaye, 2009). Same could be true for URM faculty.

Alberto offered a good summary of this notion of value at the institution:

If somehow, we identify who URM faculty are, what are their potential, interests and how can they help the institution, maybe can do better, maybe they will feel valued, not only because of how good they are in what they do, but how good they are because of who they are.

By giving URM faculty a similar opportunity to acknowledge and validate their own cultural background and validate the strengths it provides to the institutions we may also decrease their own cultural dissonance.

### **Intersectionality and the Faculty Life Cycle**

There is a considerable range of intersectional research that addresses racial and ethnic groups, genders, sexual orientations, disabilities, nationalities, among others (Carbado, Crenshaw, Mays, & Tomlinson, 2013). Intersectionality posits that multiple social categories intersect at the level of individual experiences reflecting interlocking systems (Bowleg, 2012). For example, participants in this study centered their experiences and perspectives on their identity as Black or Latino faculty, however at several instances their narrative brought forward the intersection of sexual orientation, gender, and nationality. Specifically, Alberto noted:

*Soy minoría porque soy Latino. Soy minoría porque soy gay... Soy minoría y punto, porque ya no me identifico “yo soy Latino”, yo me agrupo.*

[I am a minority because I am Latino. I am a minority because I am gay...I am a minority period, because I no longer just identify as Latino, I identify with the group.]

Here, Alberto declares himself as a Latino gay male who found at this institution permission to embrace both of these identities. He expressed high regards for the senior faculty member who told him: “It’s ok to be gay”. In considering intersectionality its greatest strength is in the acknowledgement that individuals are more than their racial or ethnic identity. Although for participants, race and ethnicity constituted a salient identity, the intersection of these identities is not overlooked.

Jessika highlighted the difficulty of being a woman of color, the intersection of race and gender. Jessika stated:

I was just really mindful of the ways, of the additional complexities that come as sort of being a woman of color and the ways some of the issues are very much the same, and some of them aren't.

In 2014, women in academic medicine constituted 38% of full time faculty; Black or African American women 3.6%, Hispanic women 3.5% (AAMC, 2014). Their experiences differ greatly from a White female majority. In fact, in Chapter 3 I discussed the exclusion of a participant, Abigail, in the findings of this study. Abigail is a White female Associate Professor and her experiences focused significantly on motherhood, parenthood and work/life integration issues that created barriers and challenges for female clinical faculty. Interviews with Abigail were an obvious contrast from the other four female participants who were Latinas and Black women. Interestingly, these four women of color spoke about their experiences first in relation to their race and ethnicity; secondly, in relation to their gender. Even more interesting, is the fact that while Abigail primarily spoke about motherhood and it motivated a large portion of her interviews, three out of the four women of color were also mothers. This highlights the stark difference in experience and concerns of women of color in academic medicine.

Rosana briefly explored not just her identity as a Black woman, but also as a biracial person.

Identity is interesting. I had an interesting upbringing. But at this point, I identify with being Black. For the most part like at work, I'm Black and when I walk down the street I'm Black. But in my family I'm not, I'm biracial.

Rosana's identity appears to be closely tied to the spaces she inhabits and demonstrate the need to explore this intersection of biracialism. To not explore intersectionality, it may reinforce a misconception that there is a singular story within each race or ethnic group. An example of this single story is that of Latinos or Hispanics. Henok referred to the difficulty in grouping Latino faculty together. Their identity is presented as that of all Latinos, while institutions ignore separate cultures, traditions, and nationality aspects. Henok states:

I think that it (Latino/Hispanic faculty issues) are always left to the side and a bit ignored. I think part of it is because we don't understand it. It is difficult for people to understand because it is so diverse, the group itself.

In fact, Latino participants of this study represented three different nationalities and cultures, with one participant expressing three Latino identities. His identity was tied to the nationalities of his parents and the country where he was born and raised.

The topic of intersectionality is not a topic that is greatly explored in academic medicine, in fact, it departs from traditional biomedical, biobehavioral, and psychosocial standards (Bowleg, 2012). However, this study may advance its discussion along with promoting openness to external models, theoretical and conceptual frameworks. For example, the faculty life cycle model presented a visual representation of faculty experiences beginning with their recruitment and then moving through socialization, mentorship, career and professional development, retention, promotion and tenure, and ultimately career advancement. Consideration of participants' experiences and the intersection of their identities in relation to their career progress revealed that

socialization, mentorship, and faculty development are not isolated stages but are completely intertwined with the way URM faculty experience academia. The experiences of URM faculty with socialization, mentorship, and faculty development are unique because these experiences are greatly connected to their identity. A faculty life cycle and trajectory that does not take into account the identity and intersectionalities of faculty of color fits into the typical experience of a White majority, also characteristic of predominantly white institutional environments such as academic medicine. This seamless transition through faculty life is not the norm for underrepresented faculty populations. For example, URM faculty socialization includes the task of finding individuals that look like them, mentoring relationships are challenged by the lack of other mentors that understand and identify with similar academic experiences, and faculty development programs that present limited interventions. Intersectionality complicates this cycle by emphasizing the importance of the experiences of URM participants. A revision of this model should account for identity in the process.

### **Evelio's example**

This model and study also highlighted the importance of URM self-agency, resilience, and sense of belonging. Evelio's narrative shared throughout this study highlights the relationship between identity, the three subject areas of this study and examples of institutional navigation, resiliency, agency, and resistance. Evelio self-identified as a Black male. Currently, he holds a senior faculty rank and leadership role within his department. A second generation physician, his introduction to medicine began with his father, who was also a physician. His socialization into academic medicine started during his fellowship training when he realized that he was also

passionate about teaching. As a new faculty member, his process of learning about the institution and its history, values, culture, and practices had its challenges and set the tone for the manner in which he would navigate this environment as the “only one”.

So, for one, I’m used to big city. MSOM is not in a big city. So that was a culture shock for me. Then coming to an institution where I was the only one, was also very different for me.

Furthermore, in regards to his orientation and introduction to MSOM:

It was informative in terms of what the policies are, how to navigate through the system and navigate in terms of, for promotion. But they could not relate being me since they were the majority, how a minority orchestrates through our challenges.

The challenges encountered also extended to unspoken or unknown rules about the institution’s expectations about a dress code, a demonstration of resilience and resistance.

One of my colleagues, senior colleague for that matter, is very vocal in terms about how physicians should look in terms of their dress, which is respectable, everyone has a different viewpoint. But at a meeting, he made a comment about people wearing sweats and hoodies. I wear sweats and hoodies. I made a comment at the meeting based upon what that person said. And I know there are some things that we should try to implement in terms of what’s the acceptable dress code, my comment was, this is a cultural thing. So for me, sometimes I make statements that are not viewed very well by some and that’s why I think



how I am, how people view me, varies based upon a statement that I'm trying to make.

Evelio spoke about other acts that challenged the institution and a system that did not feel welcoming. At a time when the number of Black males in faculty lines at MSOM equaled one in his department, his presence was even more visible, his message even more important. Evelio knew how to be assertive and use his identity as a tool for agency; one that ultimately connected with his patients.

I think society is fit to judge every one of us. And I think, unfortunately they judge without getting to know what a person is all about. So, I make statements purposely so that society can see, oh, that's different. I didn't expect that. So there is a period of time that I used to wear Timberland's all the time. And I was known as the surgeon with Timberland's and my patient's knew me, my private patient's they will see me and if I wasn't wearing my Timberland like what's wrong with your Timberlands? But the Timberlands was the expression based upon where I came from. I'm from the inner city, the hip-hop community of New York, City. Not too many people were happy about me but it was a step."

This orchestration created two different environments for Evelio. First, a work environment in which he had been socialized to follow the norms of the majority, but he also feels responsible for challenging, resisting, and relaying the unspoken rules, the hidden curriculum of academic medicine, to others, from medical students to other faculty. Secondly, it also created a separation and protection of the environment in which he can be a Black male without worrying about the norms of the institution.

I'm older now. When you're around your peers, that helps you, you can be yourself. And that allows you to flourish when you're truly yourself at whatever stage it is during your training. Some of my colleagues who are good friends and they're (part of the) majority, they frequently have commented how I'm very different around them as opposed to when I see people with color. Because I don't really care then. I was being me. But I'm able to turn it on and off.

This “off and on” switch may represent what Dennery (2006) refers to as behaving like the majority, which provides a zone of comfort for minority faculty: “It appears that the only way to be accepted is to truly 'fit in' by having White characteristics in a Black or brown exterior” (p. S47). In Evelio's case it signals a change of behavior, change of vocabulary, change of body language, and even situations in which his dress code must conform to the majority. As Evelio suggests, there is a freedom to be open about the challenges Black and Latino faculty face in academic medicine and the importance of spaces in which they can develop relationships and engage in the institution without being structured in ways that do not allow for individuality.

URM faculty experiences and perspectives presented a complication in a faculty life cycle model that tried to stratify or staged faculty advancement, however it emphasized the importance of other factors such as those discussed here. Agency and resilience have served as concepts from which to study the individual or internal characteristics of underrepresented minority groups. Resilience is an asset-based construct centered on protective or enabling factors while agency is the ability to intentionally influence one's functioning in certain environments (Cora-Bramble, Zhang, & Castillo-Page, 2010; Bandura, 1997). Along with these, and sense of belonging as the

study of the attachment to the campus community, they provide a more complete view of these perspectives, also uniquely experienced by students and faculty of color (Maestas, Vaquera & Munoz Zehr, 2007). Acknowledgment of intersecting identities and identity formation; socialization and proper introduction to the academy; mentoring from early career to seniority; and faculty programs that influence professional and personal development, are all part of successful career advancement and longevity for URM faculty in academia and the links amongst these elements cannot be ignored.

### **Summary**

In this chapter I presented the primary themes of socialization, mentoring, faculty development, diversity and inclusion, culture and climate and other subthemes. Inclusive excellence served as significant conceptual framework in organizing the data and evaluating the institutions and its environment. CECE model proved that culturally relevant environments are not only critical for student success but also for URM faculty in academic medicine as they evaluate their own experiences and perceive their value to the institution.

The purpose of this research is to explore the experiences of URM faculty as they specifically relate to their socialization, mentoring, and professional development within the environment of academic medicine. The findings associated with all three areas, but especially those associated with URM socialization experiences demonstrate the significance of this study. Socialization has been an area that has not been significantly explored in academic medicine and unfortunately it has been of disservice to URM faculty. Socialization as a process has been poorly done and neglected. It is a process which value has been greatly unexplored and underrated. For URM faculty, socialization

is clearly the starting point of their faculty career. It is a moment in which they realize their accomplishments and what it took to get here. Most importantly, the way URM faculty are socialized into the organization it is a first glance of the culture and climate of the institution, sets the tone for their engagement in the institution. Moreover, socialization is a period in which URM faculty's identities are heightened. The socialization process may create a new identity, not just as faculty, but as "minority faculty". This identity will quickly transform into a source of or hope for collective power within an institution. A challenge with the socialization process is that even though in this study I exalt its importance at the beginning of URM faculty career, it is not a process that ends. URM faculty at all ranks need socialization in contexts associated with cultural familiarity, knowledge, service, engagement, and value.

Mentoring is an area that has been extensively studied and at times programmatically exhausted. All academic medicine centers have programs and none claims to be the star model to follow. URM faculty in this study make it clear that mentoring is complex and that as institutional leaders, we have probably focused on the wrong areas to mentor URM faculty in or we are ignoring their actual needs. It is time to apply a holistic approach to mentoring and rethink it in terms of individual needs assessments. Mentoring comes in many forms, yet in academia we continue to approach it systematically and very compartmentalized. URM faculty want more than career advice. Their experiences and challenges are different, and as such it requires that institutional leaders admit it. Informal mentoring appears to be more critical to the experiences of URM faculty because it provides a more open relationship with other individuals and one that is free of burdensome bureaucracy. Moreover, the institutional

navigator or institutional agent is the most important role under the mentorship umbrella. In many instances this is the only role that URM faculty have and need at the institution. URM faculty have been able to negotiate their faculty career and experience with resources and individuals external to the institution for everything else. Perhaps mentoring cannot exist without savvy advice on navigating the institutions' political waters.

Faculty development programs are clearly necessary in the advancement and growth as faculty. The problem is that faculty developers while aiming to be inclusive of all ranks, fields and disciplines, do not focus enough on the identities that are marginalized due to the structural barriers in academic medicine. Faculty development has made great strides for women in medicine and science by creating spaces for them, spaces in which they can share one narrative. However, this is not the case for faculty of color. As Henok states: "Men now get it for women, but men and women still don't get it for faculty of color." is representative of an overall feeling. The value of URM tailored faculty development programs cannot be denied. Participants of this study made this clear, they are asking for URM faculty development programs, and they have firmly voiced what these spaces do for them. URM faculty development creates a space of networking, relationship building, accountability and perhaps most importantly, affirmation.

Academic medicine culture and climate findings indicate that it is critical to perform culture and climate assessments focused on equity and inclusion in these settings. Academic medicine is not a friendly environment to URM faculty. These findings presented an environment that is difficult, unwelcoming, and exhausting. URM

faculty voiced this unmistakably, however, this is the environment where they want to be. While it may seem a significant dichotomy, it makes sense. URM faculty in academic medicine are in this environment because of their values and ideals. They are in academic medicine because it's believed to champion social justice, because it is committed to addressing health disparities and health inequities in their communities, because they have the opportunity to teach the next generation of physicians and scientists to be culturally aware. The academic medicine system has a long road ahead for equity and inclusion, and MSOM is one place to start.

MSOM can elevate its commitment based on these findings. URM faculty are communicating their desire for a change in the organizational structure of the diversity/multicultural affairs office. The current reporting line is sending a message of lack of power and a diversity commitment that is only "on paper" (Evelio). A direct reporting line to Dean is a must, as well as qualified leadership and appropriate resources within this office. The broadening of the meaning of diversity is not a problem if the office can balance programmatic needs of the groups it says to represent. Focusing on one minority group and not balancing the needs of others is a result of lack of resources. In addition, the focus on students is critical in creating inclusive environments that ultimately motivate those students and trainees to consider a faculty path. However, URM faculty have needs and unfortunately, they are also looking at this office to assist them in this journey, in the meantime they are trying to find support externally to the institution. MSOM needs to strategically think about the offices mission and vision. The significance of these findings and implications for research and practice will be discussed in greater detail in chapter 5.



## Chapter 5. Discussion

Only a small number of underrepresented minorities serve as faculty members in the nation's medical schools and this should be a significant cause for concern. URM faculty in predominately White medical schools make up only 7.3% of all faculty (Nivet, 2010). With regards to faculty appointments, women URM are twice as underrepresented, particularly as the academic rank advances from the instructor to the professor level, and gender discrepancies occur more prominently when compared to White female faculty (Merchant & Omary, 2010). Although the percentage of White faculty has decreased, the low percentage of Black and Hispanic faculty has not changed proportionately (Merchant & Omary, 2010). As indicated in chapter 2, the numbers of URM faculty among U.S. medical school are markedly low when compared with their respective percentage of the U.S. population (Merchant & Omary, 2009). The increasing disadvantaged position in which URM faculty find themselves has developed through years of segregation, discrimination, tradition, culture, and elitism in academic medicine. That in turn has adversely influenced the recruitment, retention and career progress of URM faculty in medicine (Clark & Corcoran, 1986; Nivet, 2010).

The research questions directing this study focused on the experiences of URM faculty in academic medicine. Specifically, what are the (a) socialization, (b) mentoring, and (c) professional development experiences of URM faculty within academic medicine? How do URM faculty experience academic medicine's culture and environment? And what is their perception of the climate at their current institution? Lastly, what is URM perception on the impact of diversity and inclusion initiatives and offices in academic medicine?



Consequently, the findings exposed areas that have been understudied in academic medicine and that provide insightful understanding of the experiences of URM faculty. In order to ascribe meaning to these themes and findings, I utilized the adaptation of two higher education conceptual frameworks, which had not yet been applied in academic medicine. The use of both Inclusive Excellence (IE) and Culturally Engaging Campus Environments (CECE) as conceptual frameworks offered an opportunity to combine models that embrace diversity and equity, and emphasize the importance of inclusive environments. Findings of this study are significant in three respects. First, it expanded the current higher education literature of academic medicine. Second, it is the first study to apply IE and CECE to academic medicine. Third, it is the first study to introduce socialization, mentoring, and faculty development as three separate stages in a faculty life cycle and the first to link these to academic medicine culture, climate, diversity and inclusion. The study's findings highlight four matters: the need for academic medicine to rethink socialization, mentoring and professional development of URM faculty; attentiveness to academic medicine culture, climate, and overall environment which has significant effect on URM faculty; thoughtful messaging and practice for equity, diversity and inclusion; lastly, application of conceptual frameworks to professional practices. These experiences and implications are further discussed in this chapter.

### **Key Contributors to URM Faculty Advancement**

#### **Socialization**

Socialization of URM faculty is an uninspiring process that has been undervalued, and underrated in academic medicine. Socialization is the process through which

individuals acquire and incorporate understanding of the organizational culture with shared attitudes, beliefs, values, and skills (Tierney, 1997). Socialization can positively or negatively affect retention and promotion of faculty of color and their introduction to the academy (Tierney & Rhoads, 1993). This study characterized socialization as the introduction to the institution and its constituents, as well as, highlighting the importance of continuous interpersonal socialization. URM faculty discussed aspects of socialization that indicate this process as pivotal in their career. Findings revealed that socialization sets up early career expectations through organizational socialization and develops their sense of belonging, as well as, a new identity as URM faculty.

The process offers a first glance at the culture and climate of academic medicine and the institution, hence, setting the tone for their engagement. Institutions have adopted on-boarding and orientation practices that focus on employee relations, such as benefit packages and institution-wide policies training. Unfortunately, institution-wide approaches fail to consider the important aspects of URM faculty socialization. However, given the size of institutions and URM faculty expectations, these findings may suggest manageable school and departmental approaches to socialization. I focused on Tierney and Rhoades (1994) socialization because it considers the organizational socialization aspect, as well as, cultural influences. These cultural influences include those held by individuals, the institution, professional, and based on discipline, which in academic medicine would refer to a field of study or medical specialty. URM faculty want a socialization process that it is comprehensive in its organizational approach, making for smooth transitions into the institution. When organizational socialization fails, URM faculty may internalize this as suggesting their self-worth to the institution

instead of the organization's flaw. Poor organizational socialization offers a glimpse to the culture and climate they will encounter.

Socialization also served as a period in which participants developed their new identities as faculty and more specifically, URM faculty. For example, participants in this study self-identified as Black or Latino Faculty. This identity as URM faculty was forced upon by the institutional leadership that failed to recognize individual uniqueness and opted for grouping of minority faculty. As this new URM identity developed, faculty quickly realized this new identity could be a source of collective power within the institution. While identity as URM faculty is not intentionally created by institutions, it appears to be a product of an institutional focus in diversity numbers. This focus in achieving some diversity in relation to numbers also categorizes individuals in ways that URM faculty deemed simply as "non-White" grouping. This type of focus ceases to acknowledge the individual and their assets to the institution. Recognizing the individual as an asset reinforces their sense of belonging.

Sense of belonging is an individual's sense of identification in relation to a group within the college community and it refers to relationship building and interactions that makes us part of something greater (Hurtado & Carter, 1990; Baumeister & Leary, 1995). Academic medicine has not explored at any lengths sense of belonging of faculty and more specifically, URM faculty.

Participants relied on individual socialization opportunities to build relationships with colleagues and the institution. However, the findings indicate the burden placed on new URM faculty to find other URM faculty on their own. In addition, URM faculty struggled to find spaces in which they could develop this sense of belonging and process

their experiences with others with similar backgrounds.

As mentioned in Chapter 4, IE's conceptual framework demands a socialization process that is inclusive in its on-boarding and orientation practices. It would also consider socialization as the introduction to diverse and inclusive environments that long for equity. Inclusive excellence can be used to create an academic medicine culture and climate that advances inclusion and therefore, eases URM faculty socialization. In an inclusive excellent environment, identity formation is a positive experience as URM faculty develop their identity as new members of the organization. IE would not impose identities that force grouping as non-majority members. An environment that is inclusive does not force the search for a collective source of power. CECE indicators are important, especially considering the emphasis that participants show in relation to culturally relevant environments, engagement, and cultural familiarity that could address and ease their socialization process.

It is important to note that socialization is not a process that ends. URM faculty suggested that it is continuously happening and actively sought after. URM faculty at all ranks need socialization in contexts associated with cultural familiarity, knowledge, service, engagement, and value.

### **Mentoring**

As a tool, mentoring is often considered a critical part of faculty success. There are innumerable programs that aim to provide faculty success in academia. Success is defined as achieving promotion, tenure, and funding. As mentioned in chapter 2, mentoring literature is mostly positive and will continue to evolve in academic medicine because approaches to mentoring programs are broad and their intensity varies (Beech,

2013; Zellers, Howard, & Barcic, 2008).

URM faculty made it clear that mentoring is complex. URM faculty views of mentoring are significant in three respects. First, mentoring cannot be generalized in a program or in its application. Second, informal mentoring may play a larger role in the success of URM faculty. Third, reflection of their own mentoring experiences determines and develops their own identity as mentors. Since mentoring is a large umbrella concept that includes: career mentors, role models, coaches, sponsors, allies, and navigators/agents, it is time to apply a holistic approach to mentoring and rethink it in terms of individual needs assessments and not as programmatic goals. Academic medicine insists on systematically and compartmentalized approaches, often accompanied by a bureaucratic process that requires forms, meetings, and progress reports. URM faculty wanted more than career advice because their experiences, perspectives, and challenges are different. Informal mentoring appeared to provide the most holistic approach. It appeared to be the process in which more open and meaningful relationships formed. In fact, at the institution, the institutional navigator was the most important role under the mentorship umbrella. URM faculty often ascribed mentoring roles to individuals outside of their home institution. This illustrates that URM faculty have been able to negotiate their faculty career by balancing external and internal resources.

In addition, for URM faculty mentoring equaled service. It demonstrated their strong commitment to service to others and the institution, but it did not come with recognition or acknowledgement. This I referred to as one of many “ghosts” commitments - commitments without recognition.

While the CECE framework does not specifically address mentoring, there are indicators that can relate. For example, cross-cultural engagement is associated with self-confidence, satisfaction and sense of belonging among both White and students of color (Museus, 2014). URM faculty did not state that individuals under the mentorship umbrella came from similar backgrounds, yet these mentors provided what they need in order to keep going in a difficult environment. Therefore, URM faculty suggest that cross-cultural mentoring is happening in ways that positively impact their career.

### **Faculty Development**

Faculty professional development includes support for activities such as finding research funding, writing academic articles, participation in conferences and professional associations, leadership and management trainings, as well as, other types of curricula (IUSM, 2015). The majority of participants in this study obtained their faculty development through professional organizations or equivalent networks, but spoke positively about the institution's offerings and the work that the institution's faculty developers do. Faculty development programs are clearly necessary for career promotion, ensuring tenure and reaching leadership positions. However, the literature suggests that URM faculty advancement barriers are due to limited access to role models and networks that support their faculty development and failure in understanding the unique demands, pressures, and environment places upon women and faculty of color (Tuitt, 2010). URM faculty in this study shared a lack of supportive professional networks and acknowledged that their networks were less effective in helping them build their professional development and reputation at the institution.

URM faculty suggested that faculty development cannot be generalized in ways that would benefit all faculty, all tracks, and all subgroups. Faculty development has made great strides for women in medicine and science by creating spaces for them, but the spaces developed for URM faculty are still limited. Based on the findings of this study, URM faculty value spaces that bring them together, where they can speak about their accomplishments, barriers, challenges, and opportunities in the academy. This represents the need for an inclusive excellent and culturally engaging campus environment.

URM faculty made it clear that there is great value in URM tailored faculty development programs. In fact, they have firmly conveyed what these programs and spaces really do for them. URM faculty development is important in several respects: it creates a space for networking, for relationship building, for accountability and perhaps most importantly, a space of affirmation. First, as in socialization, URM faculty need opportunities to share their experiences, perspectives, accomplishments, barriers and challenges. Secondly, URM faculty need to build institutional networks and one way to accomplish that is to build relationships with individuals that will become champions for them and their work. Thirdly, URM faculty benefit from accountability partners, colleagues that follow up on their progress, colleagues that seek collaboration, and colleagues that bring forward opportunities. Lastly, URM faculty development programs are spaces of individual and collective affirmation.

Affirmation is the most important value of URM faculty development programs. URM faculty development programs offer a reminder of their own accomplishments and why they are in academia. URM faculty development needs to acknowledge their

experiences while also recognizing the important value of their work, affirm that the work they are doing in advancing medicine and science is important. URM faculty development is the space that affirms that microaggressions, discrimination and overt racism are not imaginary; they exist in this academic medicine environment. In providing the tools for academic progress we need to equip URM faculty with skills and confidence, which are delivered through faculty development.

### **Academic medicine culture and climates, and messages of diversity and inclusion**

URM in this study spoke about their faculty path to an academic medicine center and this discussion was always accompanied by pride and a clear passion for what they do. The academic medicine tripartite mission of clinical, research, and education were obvious motivators. Participants in the study are in academic medicine because of their love for science and medicine, their passion for discovery, their intellectual curiosity, the study and treatment of diseases, the hope to address health inequalities and disparities, serving the underserved, and teaching the next generation of physicians and scientists. Yet, in many ways these ideals did not align with URM faculty experiences and perspectives of the climate for diversity and inclusion.

Similar to the literature in which scholars have suggested that academic medical centers have a “conflict laden” culture, where competition and the associated struggle to remain “on top” are a way of life, where compensation is a model where “You eat what you kill,” where “bragging” is the only way to self-promotion; URM faculty in this study described the culture as “a win or lose system” and described the climates as difficult environments (Cole, Goodrich, Gritz, & Grimsby, 2009, p. 115; Pololi, Kern, Carr, Conrad, & Knight, 2009). While there is a significant dichotomy between ideals and



experiences, it makes sense. URM faculty in academic medicine are in this environment because of their values so the question is, when will we make this environment align with the ideals that academic medicine professes? Unfortunately, this is when diversity and inclusion initiatives have failed to live up to URM faculty expectations.

### **Diversity and Inclusion**

Taylor et al. (2010) summarized why should we care about diversity in academia; women constitute almost 60% of U.S. college students and minorities will exceed 50% of the U.S. population before 2050. The authors contend that we must do a better job of preparing and hiring more persons from these groups for faculty positions (Taylor et al., 2010). In order to achieve that goal, leadership should regularly present a strong and sincere message in support of diversity and identify those accountable for creating a climate of inclusion. Offices of diversity/multicultural affairs are often delegated with this role. For that reason, one of the research questions guiding this study was: What is URM faculty perception of the impact of diversity and inclusion initiatives and offices in academic medicine?

According to AAMC (2015), diversity embodies inclusiveness, mutual respect, and multiple perspectives, and serves as a catalyst for change resulting in health equity. Inclusion is defined as the creation of a climate that fosters belonging, respect, and value for all, and encourages engagement and connection throughout the institution and community. Dodson (2009) points out that diversity and “diversity work” means any activity that encourages inclusiveness. This approach was celebrated, but also questioned. Participants discussed that the broadness in diversity successfully champions marginalized and underrepresented groups in academic medicine. Current progress

highlighted a much-needed emphasis on programs addressing LGBTQ issues, and religious and spiritual competence and awareness. Participants looked positively at all levels of accomplishments within these initiatives, while also perhaps concerned that this progress might project a false sense of diversity related accomplishments by the institution. URM faculty suggested that this broadness in diversity may highlight progress in areas such as those addressing LGBTQ issues but should not be conflated with the advancement of racial/ethnic faculty minorities.

MSOM can elevate its commitment based on these findings. URM faculty communicated their desire for a change in the organizational structure of the diversity/multicultural affairs office. The current reporting line is sending a message of lack of power and a diversity commitment that is only “on paper” (Evelio). A direct reporting line to the Dean is a must, as well as, qualified leadership and appropriate resources within this office. The broadening of the meaning of diversity is not a problem if the office can balance programmatic needs of the groups it claims to represent. Focusing on one minority group and not balancing the needs of others is a result of lack of people-power and resources. URM faculty are looking at this office to assist them in this journey, however, find support external to the institution. MSOM needs to strategically think about the office’s mission and vision.

Inclusive excellence framework in the establishment of diversity/multicultural offices and initiatives in academic medicine would be significantly valuable. Inclusive Excellence (IE) is designed to help colleges and universities integrate diversity, equity, and educational quality efforts into their missions and operations. A diversity office guided by these principles shall serve URM students and faculty equally. However, IE

implementation in academic medicine has been limited, which in this case may reaffirm and demonstrate the complexity of developing an inclusive excellence model given the complexity of academic medical centers' climate and culture.

Academic medicine's cultural competency and cultural humility approaches align with a CECE framework that advances the interests of diversity and inclusion in the context of culturally engaging and relevant campus environments. As IE, CECE emphasizes the importance of inclusive environments. Simply, CECE provides the indicators that guide institutional action through the diversity/multicultural affairs office and institutional leadership. By stimulating these types of assessments and open discussions, URM faculty are able to participate in the discourse and assist in guiding a framework that would result in a substantial driver of their own success.

### **Implications**

The implications for research and practice represent opportunities for the study of underrepresented minority faculty in academic medicine while also communicating academic medicine's need to expand the utilization of theoretical and conceptual frameworks not traditionally applied in this setting.

### **Frameworks into Practice**

As a segment of higher education, academic medicine embodies clinical, research, education and service missions. It is in fulfilling these missions academic medicine has committed to innovation in all facets. Its operation is centered in this scientific and medical foundation that has the potential of being positively influenced and inspired by non-medical fields with evocative theoretical and conceptual frameworks.

The following implications for practice were informed and developed through two practical considerations established in the design of this study. First, how can the data collected inform the design of environments, practices, policies, and strategies that support inclusive excellence within a School of Medicine? This design was informed by utilization of inclusive excellence as its framework. Second, how can the Culturally Engaging Campus Environment (CECE) student-focused model be adapted to assess faculty environments in academic medicine?

In order to address the first question, it was important to assess the feasibility of IE incorporation into a departmental strategic plan that included an equity, diversity and inclusion agenda. It was important to create this plan while blending scholarship and practice. Moreover, IE provided the opportunity to develop these plans in thoughtful manners. For example, Inclusive Excellence is a model that offers full integration across all aspects and stakeholders of the academic institution and leaders have the ability to adapt it based on the institutional core mission and values or the microcosm of each discipline or department.

As a practitioner, I applied and adapted Inclusive Excellence in strategic planning. IE in the context of a Department of Medicine is the recognition that the Department's success is dependent on how we value, engage and include the rich diversity of faculty, students, staff, alumni, and past trainees. This comprehensive approach required transformation of the Department; one that intertwined with its strategic plan and aspiring culture; one that lended itself to active participation by all departmental constituents. The process is detailed below.

Equity, diversity, and inclusion were not solely about numbers, but a way to transform the Department and be thoughtful about the ways we look at demographics, policies, research, resources, leadership, hiring, education, organizational structure, technology, performance management, communications, promotion, recruitment, retention, assessments and evaluations. Adaptation of IE and its scorecard were integral components of this approach. For example, external environments were defined as the environmental forces that drive and constrain implementation of clinical, research, education, and service opportunities in manners that are inclusive of all opportunities and constituents. Its components were identified as political and power entities, shifting demographics and population health, workforce needs and training, and funding flow. Once all elements were redefined and components were identified the department could identify priorities, opportunities and challenges that would guide strategic planning efforts.



*Figure 2.* Inclusive Excellence in a Department of Medicine

Specifically, the department established four pillars: clinical, education, research, and service. While discussing initiatives under each pillar, the department's leadership had operational data, which included financial, human resources, capacity, and the like. In addition, within each pillar, task force committees were formed under the auspices of each pillar and asked a series of questions that would include tenants of equity, diversity, and inclusion. For example, under medical education, we were able to ask and discuss: how many URM residents and URM faculty the department had, we were able to receive feedback from those groups regarding their environment and challenges. We asked if the curriculum under internal medicine consider robust cultural competency education, how can we provide faculty development that incorporates cultural humility and safe discussions about race and racism in the curriculum? More importantly, how can we operationalize these needs within medical education?

The resulting plan led to the operationalization of IE within a strategic plan while placing emphasis on all facets of the department. This approach also led to the creation of two additional departmental missions: service and development. Service is in reference to the local and global community and career development as a mission of the Department to commit to faculty, staff, and trainee career and professional development. The process also integrated an inclusive mindedness and awareness throughout the Department. More information is available in Appendix F.

As demonstrated in my own Department's strategic planning and application of the frameworks, the data collected through this study can inform the design of environments, practices, policies, and strategies that support inclusive excellence within a School of Medicine. It is possible to expand the use of the IE framework to other

strategic initiatives such as Diversity and Inclusion Plans. Findings of this study support overarching goals and objectives, within a model of Inclusive Excellence and in alignment with an institution's mission, vision and values through three areas. First, the commitment to creating an inclusive culture, climate, and community championing the increased presence of historically underrepresented groups in academic medicine. Second, by monitoring departments' and medical schools' climate and engagement in all facets of diversity and inclusion while recognizing this is a path to create an inclusive and welcoming environment for all of their constituents. Third, by eliminating structural barriers that oppress and limit the advancement of URM faculty. Strategic plans and subsequent efforts regarding the clinical, research, and education mission must incorporate service and must be assessed and set forth in a manner that exalts its value to the institution.

The CECE framework provided an opportunity to consider the relationship between culturally relevant environments and their importance to URM faculty in an academic medicine setting. Based on these findings, culturally relevant environments are of importance to URM faculty in academic medicine, specifically those around cultural familiarity, cultural service, and cultural knowledge.

The CECE model can be adapted to faculty and academic medicine environment. But, it must start through the careful translation of uncommon language. CECE's indicators and corresponding elements need to transcend higher education and academic medicine. There is currently a gap in practice and knowledge between higher education and academic medicine, and vice versa. Because of the nature of these sectors the terminology used it is not always the same and both sides may lack critical expertise. As

researchers and practitioners, we need to acknowledge that there are differences in the terms and language used and the population they refer to. For example, in higher education we are mostly referring to undergraduate and graduate students, in academic medicine, they are referring to graduate and professional students, medical students, residents, fellows, and post-doctoral trainees. As we speak about “positive results” in higher education we might be referring to a positive impact, while in academic medicine it may point to the presence of an infection. While higher education commends safe spaces, academic medicine commends patient safety. We have to be able to speak in ways that educates both sectors and in ways that helps us navigate both spaces. For example, medical education is an area in which medical schools must focus considerable efforts towards student success. This success differs in the way that is measured in higher education because it is not just about passing grades and commencements. In medical schools this success includes meeting course requirements, year-to-year student promotion evaluations, and passing scores on Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE). In addition, medical education is generally led by medical educators who can benefit from higher education’s innovative education models, adult education theories, and trained student affairs professionals.

Practitioners in academic medicine should consider using CECE along with climate assessments to paint an all-encompassing picture of their environment. Again, expanding the use of tools can help to examine and improve academic medicine environments. In accordance with what was earlier stated, the practical use of CECE translates into other populations present in academic medicine centers. In addition, since



CECE is a student-centered model, more research and ultimately practice will assist in the creation of inclusive environments.

### **Implications for Practice**

As a practitioner scholar, it is important to balance practice and administration with scholarship and evidence. This study contributed to an understanding of URM faculty experiences with socialization, mentoring, and faculty development, therefore, it raises opportunities and implications for practice. It is important to gain a deeper understanding of how socialization can be improved as a process; how we can rethink mentoring in ways that enhances the experience of URM faculty; and how we can endorse URM faculty development programs.

I suggest that although organizational socialization may start upon employment, the process should be further localized at school, department, and divisional levels. Practitioners and academic leaders must recognize that this step comprises the first glance of the institution's culture and climate towards URM faculty. In addition, socialization is the starting block to relationship building that develops into a sense of belonging. Therefore, more positive socialization by URM faculty, the more sense of belonging they will develop, the more connectedness, the more community they will build. The process of making URM faculty feel welcomed in a department it is not a difficult practice, but it requires individual touch and inclusive practices that make individuals feel valued and an asset to the organization. It also becomes paramount to value the individual contributions of URM faculty while encouraging a sense of community amongst other URM faculty, and cross-cultural development of equity, diversity and inclusion champions.

Although, not prominently highlighted, interviews indicated the importance of anticipatory socialization. For example, a few URM faculty participants had trained at the same institution in which they first became faculty. The brief experience at the institution in a trainee role had provided some social capital and familiarity with certain aspects of the institution, therefore making the transition to faculty a bit easier. As practitioners engaging these new faculty, it will be important to recognize the difference in knowledge about the institution and address gaps and concerns. In addition, anticipatory socialization can attract current, URM medical students, residents and fellows into academic life by exposing them early on to faculty life through mentoring, teaching, service in the community and school wide committees, networking opportunities with diverse faculty, and inclusion in departmental communications. URM students, residents, and fellows are the faculty pipeline, as such, we need to engage them from the very beginning so they can see themselves in academia.

As part of URM faculty recruitment and retention, leaders should consider the facilitation of a process that finds institutional navigators and considers the mentoring framework in the context of a family of five individuals: mentors, coaches, sponsors, champions and navigators. We need to inform URM faculty, especially those in early career stages that mentoring is a group effort and a “collection” of individuals. In addition, recruitment efforts for URM faculty should not be limited to early and mid-career, but inclusive at the highest levels of seniority in the institution. Senior URM faculty who can serve as role models and mentors to other URM faculty are equally necessary. While there is no perfect mentoring program, leaders should consider URM

faculty mentoring that is sincere and holds conversations of the unique experiences of faculty of color in academic medicine.

Moreover, departments and school leaders need to find ways to provide recognition for all activities that encompass mentoring, formal and informal. For example, administrators can incorporate in faculty annual evaluations any informal mentoring efforts, consider the same for school level promotion and tenure processes, provide resources to cover protected time for mentoring activities, and collaborate with national programs that extend URM faculty network.

In addition, faculty developers should consider the development of uniquely tailored URM faculty development that combines acknowledgment and affirmation of their experiences, conversations about cultural taxation, isolation, micro aggressions, and racism, in combination with inclusive faculty development models that uphold the importance of diversity and inclusion. Tuitt (2010, p.240) described this inclusive practice in 6 tenants:

- (1) Highlight that their unique cultural characteristics, not only gender and skin color, will be an asset to the institution and URM faculty will be appreciated and respected as intellectually competent.
- (2) Faculty developers are aware of URM faculty unique experiences and challenges in the academia.
- (3) Faculty developers are invested in URM faculty growth, development and success by ensuring support and resources.
- (4) Faculty developers committed to diversity and excellence.
- (5) Faculty developers pay attention to URM climate and culture.

(6) Faculty developers can serve as potential allies.

In the context of academic medicine, tenant number 2 should include the awareness of these unique experiences and challenges not only in academia but outside of this setting, given also the particular state demographics and current societal issues that have recently and prominently surfaced. In addition, these tenants should include and address institutional leaders individually. Their messaging of diversity and inclusion is critical in creating inclusive excellent environments and communicating commitment to all faculty. Moreover, faculty developers in academic medicine must also focus on opportunities that present culturally relevant curriculum to all faculty. This curriculum can expand the cultural competence foundation into cultural humility, as well as, elevate health disparities and inequities content to race and racism in medicine.

In the face of these findings, it is clear that academic medicine can be a difficult environment for URM faculty. Therefore, it is important to administer climate assessments combined with CECE that can evaluate the learning environment of multiple stakeholders in academic medicine, but especially URM faculty. In addition, inclusive excellence provides a framework from which to strategically think about equity, diversity, and inclusion at several levels of the organization. URM faculty in this study addressed the challenges of the current office of diversity/multicultural affairs. This type of office needs to balance priorities and its mission with initiatives that are inclusive. Leadership needs to be aware of the message that their actions, or lack of action, in relation to equity and diversity send to URM faculty. It is often the case that diversity issues seem to be important only on paper, as such, perhaps is time to change this

narrative into one that re-energizes champions for spaces that promote equity and inclusion, and referred less in terms of “diversity”, but equity.

### **Implications for Future Research**

Throughout chapter 2, I reviewed studies that examined issues of recruitment, retention, promotion, tenure, and development. However, there was a definite need to delve deeper into the experiences of URM faculty in academic medicine within specific stages. This study brought forward socialization, mentoring, and faculty development experiences, however, future research should continue to explore all stages of the faculty life cycle. There is a need to explore the links between socialization and sense of belonging, as well as, socialization and identity formation. Future research should examine the multiple identities and intersectionalities that come into play when we try to group URM faculty as simply, “non-White.” These intersectionalities are part of one’s identity and present themselves throughout the entire faculty life cycle. In addition, concepts like agency, resilience and sense of belonging have been reviewed in relation to student environments and not as expanded with other constituents, such as faculty (Cora-Bramble, Zhang, & Castillo-Page, 2010; Bandura, 1997, 2008; Kiyama, Lee, Rhoades, 2012; Pololi et al, 2012, Museus, Yi, & Saelua, 2017; Museus & Maramba, 2011). In a similar manner, future research should address the magnitude in which these impact URM faculty in academic medicine, along with additional considerations for intersectional research.

Future research in the area of mentoring should rethink mentoring in ways that study the value of informal mentoring and propose promotion and tenure systems that

value service and mentoring in academic medicine. Future research should examine the ways in which URM faculty enact their own agency, resilience, and service when mentoring others in an effort to further understand how these mentoring roles assist them in finding a sense of place and belonging within the organization. Larger studies should evaluate URM faculty development programs with the goal of customizing practices that in similar ways have advanced the status of women in medicine and science. Insufficient research is currently directed at improving the culture and climate in academic medicine, especially research that produces clear practices for implementation.

The narratives of microaggression and discrimination expressed by Latino faculty posed interesting questions and much needed research in academic medicine. The exodus of Latino faculty and administrators at predominantly White institutions is said to be due to poor institutional climates and instances of racism (Castellanos & Jones, 2003). A similar study should look at the retention and the exit of Latino faculty in academic medicine. The examples presented in this study were those of Latino faculty who were in senior ranks in academic medicine. As Latina faculty and administrator myself, I can reaffirm the importance of such research. Multicultural programs that commit to diversity but also recognize the diversity within Latino culture are examples of inclusive excellence and culturally relevant environments. It is time to shift the Latino faculty paradigm, which insists to group all Latinos and Hispanics as one culture and counters their credibility based on accents, appearance, and where they attended college.

As established, this is the first study that focuses IE and CECE in academic medicine and the first to investigate the use of CECE with URM faculty in medicine. In building the case for expanding the use of theoretical and conceptual frameworks in

academic medicine, researchers can also contribute to this field and sector through other theoretical and conceptual lenses and higher education sectors. For example, this study focused on the experiences of URM faculty, however, faculty were once the very students and trainees that are in the pipeline. Graduate and medical schools, residency and fellowship programs goals are to graduate professionals in this field, however, it is the job of academic medicine to keep them in academia where they can continue and contribute to the missions it professes. IE and CECE can become part of the understanding of how to create inclusive environments for them and explore what is missing based on CECE indicators. Additionally, higher education literature lacks substantive scholarship on professional schools, not just academic medicine, but law schools and veterinary schools, as a couple of examples. Between 1987 and 2014 there was a 161% jump in minority student enrollment in law schools (American Bar Association, 2015). A 2008 review revealed that 92.4% of veterinary professionals were listed as “White non-Hispanic”, as well as, 82.8% in dentistry, 86.5% of optometrists, 78.9% of pharmacists and 80.4% of registered nurses (Cima, 2008). Additional research should apply IE and CECE frameworks to the study of URM students and faculty in different higher education sectors.

Furthermore, this study discussed the aspects of compensation and business models that create an environment in which “you eat what you kill.” Academic medicine and the academic health center has demanded changes in the education of its health professions and scientists, in the healthcare delivery, grown dependent of federal funds for research, and forced new academic medicine models (Wartman, 2007). Researchers should specifically look at academic-business partnerships that are in conflict with their

academic counterpart, as well as, the ideals set forth by the academic counterpart. As Wartman (2007) points out:

It is critical that the new “corporate” paradigm not overshadow the fundamental academic ethos and the creativity, intellectual spirit and unique public standing of these institutions. It has never been more important for the academic health center enterprise to take to heart the full implications of the societal missions of their institutions as they evolve into global competitive enterprises. The greater public good—which means balancing all mission areas to serve the public— must always be the *raison d’etre* behind the organization and structure of the academic health center for the future (p.3).

As stated previously, URM faculty find themselves in a system that has developed through years of segregation, discrimination, tradition, culture, and elitism in academic medicine. Diversity in academic medicine fosters service and engagement, exposure to different educational approaches, different research and scholarship interests, and cultural awareness. URM faculty impact on medical education and their role in addressing health disparities and inequities should be further studied. While the term decolonization may not be clearly understood in academic medicine and it is unlikely to be used, diversity and inclusion have gained momentum and a place at the table. We may not be only failing in our inclusion initiatives, but we might also be framing these as a deficit of valuable knowledge, skills, and experiences (de Oliveira et al., 2015). This study began to question if we are properly valuing the knowledge, background, expertise, skills, and overall experiences that URM faculty bring to the institution? In the case of academic medicine, underrepresented minority faculty are insulated judging by the numbers. I



surrender to the possibility that diversity and inclusion initiatives may not progress at the level that is needed if we do not consider its academic structure and hierarchy that create barriers for underrepresented minorities but also move the needle only so far as to allow a few diversity and inclusion initiatives become beacons of great institutional accomplishment. Without challenging these organizations, hierarchies, and dominance, we leave the same structures in place and accept progress in the smallest increments. As Hiraldo (2010) cautions, it is also important to reflect along the way to see if these changes are also perpetuating structures that counter the advancement of URMs.

Incorporating IE and CECE models into the foundation of academic medicine, the one that creates admissions processes, curriculum, promotion and tenure criteria, establishes programs and offices, could really have an impact on these areas and the success of URM faculty in this setting.

### **Limitations and Future Considerations of the Models**

As mentioned, the faculty life cycle model provided a visual representation of faculty experiences beginning with their recruitment and then moving through socialization, mentorship, career and professional development, retention, promotion and tenure, and ultimately career advancement (figure 1). The model also considered self-agency, resilience, and sense of belonging. This initial representation of faculty life helped narrow down the areas of focus to: *socialization, mentorship and development* and established the organization of this paper.

Although, the model helped establish these research areas, its utilization proved to be restrictive in several ways. First, the model restricted organization of the study based on these areas, which subsequently restricted use of IE and CECE as conceptual

frameworks. A more unguarded approach would have considered all CECE indicators and studied how these may influence faculty advancement and inclusive environments. The indicators used: Culturally Familiarity, Culturally Relevant Knowledge, and Cultural Community Service are not necessarily exclusive in their relationship to socialization, mentoring and faculty development. In fact, the analysis would suggest URM faculty narratives that already surface issues around Cultural Validation, Cross-cultural Engagement, and Cultural Responsive indicators, such as Proactive Philosophies and Holistic support. A complete use of CECE indicators could have promoted an equally valuable study on the application of these indicators as part of a broader impact on faculty advancement. The use of all indicators would have delved deeper into their potential impact on the study of culturally relevant and engaging campuses for faculty and served the review of these narratives based on each indicator.

For example, a deeper look at cultural familiarity may have suggested that the intersectionalities of participants also constitute memberships into different cultural communities. Hence, participation in these different communities, such as those of women of color (Rosana, Blair, Jessika, and Elizabeth) and sexual orientation (Alberto) demand an additional look at cultural familiarity regardless of their faculty stage or socialization, mentoring, or professional development. For example, the following expressions highlight salient communities for Rosana and Alberto.

Rosana: So, I got involved in AMWA, and it was kind of like finding your people. I was very comfortable with the women, and all the people in AMWA.

Alberto: I am a minority because I am Latino. I am a minority because I am gay...I am a minority period, because I no longer just identify as Latino, I identify with the group.

Blair also indicates how this cultural familiarity component does not have to be identical:

And you don't have to be identical, but I think you have to have some understanding of kind of what they might be going through so you can anticipate it before it happens.

This notion that one's culture may not have to be identical in order to connect may support a group identity as URM faculty. Participants demonstrate via their experiences how cultural familiarity is important and when asked directly about its importance, all those asked said it is important. Cultural familiarity supports socialization in the way URM faculty would like to interact with more individuals of similar background, supports mentoring, and a desire for URM specific or targeted faculty development. Additionally, it appears that CECE indicators could provide the overarching themes from which to evaluate the entire faculty experience. A reanalysis under this conceptual framework would be a novel approach to URM faculty studies.

Secondly, socialization, mentoring and faculty development are constant contributors to successful career progress and not isolated events. In organizing this paper based on these areas it may suggest these only as serial steps that lead to faculty advancement, therefore restricting the study of URM faculty. However, this study highlighted the importance of continuous socialization, mentoring and faculty development as key contributors to retention, promotion and tenure, and leadership advancement. Hence, an improved model would account for this.

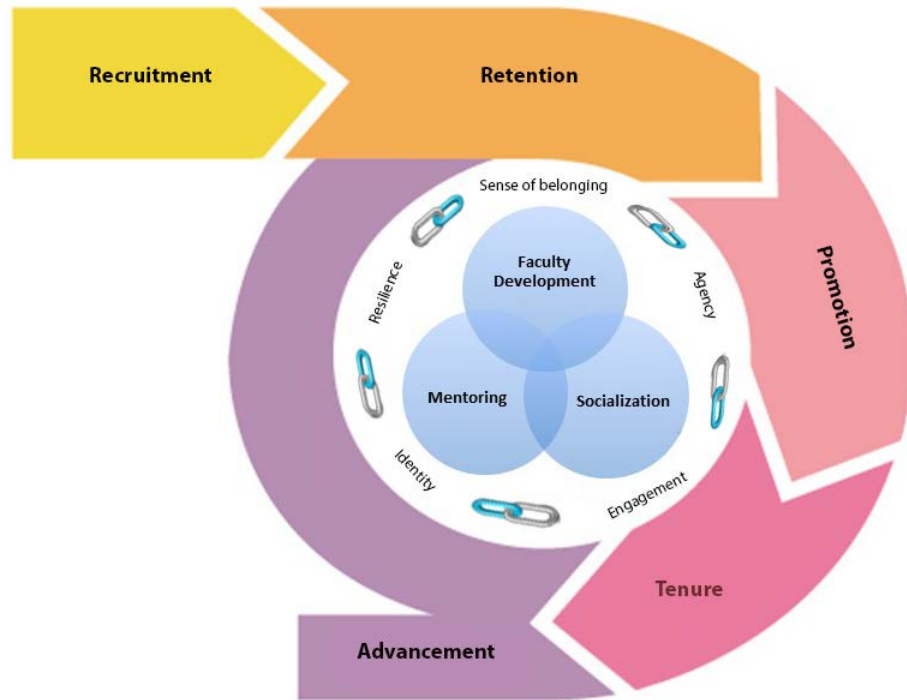


Figure 6. Faculty Life Cycle Revised.

Figure 6 places at the center socialization, mentoring and faculty development as key contributors to faculty trajectory and advancement while acknowledging the impact and links to experiences marked by identity, agency, resilience, sense of belonging and faculty engagement. As previously mentioned, participants of this study offered examples of these concepts through out their narrative. For example, Evelio's narrative was powerful in ways that demonstrated his own resilience and agency. In addition, his story countered the White-majority narrative in academic medicine and it reinforced these elements as critical part of faculty advancement and inevitably, the experiences of URM faculty through socialization, mentoring and faculty development.

As conceptual frameworks that worked in concert with this model, IE and CECE, offered a combination of frameworks that embraced diversity and stressed the importance

of inclusive environments in the success of student populations. The AAC&U argued that racially minoritized students succeed when an inclusion framework is at the core of higher education (Harris, Barone & Davis, 2015). CECE explained the ways in which campus environments shaped the experiences and outcomes of diverse student populations and asserted that this culturally engaging campus environment yields positive experiences and outcomes. Both conceptual frameworks are transferrable to faculty environments in academic medicine as demonstrated in this study. However, IE was useful in studying the organizational structures that could lead into changes of current structural barriers, but it needs revisions in order to be used in concert with other frameworks that specifically look at faculty progression. CECE has potential for faculty and administrative applicability, but perhaps additional indicators would strengthen its consideration of External and Internal Influences that dictate organizational structures and daily operations. The importance of translating higher education literature and related interventions

### **Conclusion**

Professional schools and academic medicine are often not included in conversations around higher education. Too often, academic medicine related professional organizations are left in charge of organizational, faculty, and trainee development. In addition, their environments often lack participation from higher education professionals. This study benefits all facets of higher education in its research of URM faculty, especially academic medicine. It draws from other disciplines to elevate conceptual and theoretical frameworks utilized in academic medicine while also laying a foundation for more higher education professionals in these settings, hence advancing

collaborative efforts. With this study, I bridge academic medicine with higher education and social sciences literature.

The study highlighted the need for academic medicine to begin thinking about socialization, to rethink mentoring, and to sponsor professional development of URM faculty. Furthermore, as practitioners and scholars we need to be more attentive to academic medicine culture, climate and overall environment which has a significant impact on URM faculty. Lastly, we need to change the current narrative of diversity. As a professional in academic medicine, I have seen a shift in diversity conversations. The simple use of the word “diversity” triggers skepticism. We need more thoughtful and reinvigorating messaging, as well as, effective practices for equity, diversity and inclusion.

## Appendix

### Appendix A. Interview Protocol/Prompts

1. Please describe your current rank, department and discipline, and any membership to external organizations and/or internal committees.
2. How long have you been in this position?
3. What made you decide to become or take the faculty path? Talk to me about your recruitment and appointment process into your current faculty position?
4. Researcher will probe for: perceptions about academia and faculty, the recruitment process, and appointment. Upon arrival at the institution did you feel prepared for faculty life? Were you welcomed, was your new faculty appointment announced, did someone show you around, did someone take particular interest in introducing you to others, showed you where to find rooms, policies, etc.?
5. When you think about mentoring, how would describe your least or most successful relationship?
6. What are your thoughts on professional development programs? As a minority faculty what kinds of programs would you prefer or would be more beneficial to your career?
7. What development opportunities have been or would be beneficial to you personally? To URM as a group?
8. How would describe the current culture of the school of medicine?
  - a. How would describe the current climate of the school of medicine?
9. Is there anything else that you would like to add that I didn't ask?

### **Appendix B. Journaling Prompts**

Please use the following journal prompts to reflect on our first interview and the topics of recruitment, socialization, mentoring, and development that have occurred as part of your faculty path.

1. How did you feel about the topics in the first interview? Was there something we didn't talk about in the first interview, you would've liked to talk about or explore further?
2. What is your perspective about the college's diversity and inclusion initiatives?
3. How do they support URM faculty and their advancement? What needs to be improved to better support URM faculty and their advancement?
4. What do you see as the function of Office of Diversity and Inclusion? How do they serve URM faculty? How might they better serve URM faculty?



### Appendix C. Interview 2

First debrief on the first interview and journal prompts. How as that experience for the participant?

#### CECE Items

1. How have you found other people on campus with similar backgrounds? What was your experience? (Probe for when was this most important socialization, mentoring or during professional development?)
2. How often do you interact with people of similar backgrounds? (Probe for when was this most important socialization, mentoring or during professional development?)
3. Is there a space on campus to connect with people from your community (faculty, staff or students?) and similar background? (Probe for when was this most important socialization, mentoring or during professional development?)
4. Are there enough opportunities to learn about or highlight your culture or different cultures? Or opportunities to highlight important issues of specific communities? (Probe for when was this most important socialization, mentoring or during professional development?)
5. Are there enough opportunities (research, community service projects, etc.) to help improve the lives of people in your cultural community or other minority communities? (Probe for when was this most important socialization, mentoring or during professional development?)
6. Do you feel there are enough opportunities (research, community service projects, etc.) to give back to your cultural community or other minority communities in

- the area? (Probe for when was this most important socialization, mentoring or during professional development?)
7. Do you feel that people on campus value knowledge from your cultural community? (Probe for when was this most important socialization, mentoring or during professional development?)
  8. Do you feel valued?

## **Appendix D. Informed Consent Sample**

### **Experiences and Perspectives of URM Faculty in Academic Medicine**

You are invited to participate in a research study learning the experiences and perspectives of URM faculty in academic medicine, specifically focused on career progress, academic medicine culture and climate, and views of diversity and inclusion initiatives. You were selected as a possible participant because you hold a faculty appointment and have self-identified as URM. Please read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Sylk Sotto [REDACTED]

#### **STUDY PURPOSE**

The purpose of this study is to explore the experiences of URM faculty while filling the gap in what we know about those experiences and perspectives. The study will ask questions about your career progress, your environment, and your views on diversity and inclusion initiatives and programs.

#### **NUMBER OF PEOPLE TAKING PART IN THE STUDY**

If you agree to participate, you will be one of potentially 5-15 individuals who will be participating in this research.

#### **PROCEDURES FOR THE STUDY**

If you agree to be in the study, you will do the following things:

You will participate in two interviews and an opportunity to journal and reflect on these interviews and a few general topics. The interviews will be conducted at your convenience, as well as a location where you feel comfortable. Each interview should take no more than 1 hour. The time you spend reflecting through journaling is up to you, however it is not expected to be longer than 30 min to an hour.

#### **RISKS OF TAKING PART IN THE STUDY**

While on the study, the risks associated with discomfort would be those of potentially recalling upsetting experiences throughout your career and becoming uncomfortable answering the questions. While completing the interview, you can tell the researcher that you feel uncomfortable or do not want to answer a particular question.

#### **BENEFITS OF TAKING PART IN THE STUDY**

The benefits to participation that are reasonable to expect may not be individual. Instead the study benefits academic medicine in general in understanding the experiences of URM faculty. However your time and candid responses may improve our understanding and provide opportunities for new programmatic efforts in support of URM. Payment to subjects is not considered a benefit of participating in the study and should not be listed in this section.

#### **ALTERNATIVES TO TAKING PART IN THE STUDY**

The only alternative is not participating.

### **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. Audio recordings will be made, and only the researcher will have access to these. After transcription, they will be destroyed and credited to a pseudonym.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the [REDACTED] Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA) etc., who may need to access your medical and/or research records.

### **PAYMENT**

You will receive a \$25 Starbucks gift card for taking part in this study. Prorate available: \$10 per interview and \$5 for reflection journal.

### **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study or a research-related injury, contact the researcher [REDACTED]

### **VOLUNTARY NATURE OF THIS STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with [REDACTED].

### **SUBJECT'S CONSENT**

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

**Subject's Printed Name:** \_\_\_\_\_

**Subject's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

by the subject)

(must be dated

**Printed Name of Person Obtaining Consent:**

**Signature of Person Obtaining Consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Appendix E. NVivo Codes**

Nodes	
Name	
Acad Med Culture and Climate	
CECE	
D&I	
faculty vs students	
leadership org structure & hierarchy	
office importance	
meaning broadening	
microaggressions	
Minority Groups	
Women's	
Supportive communities	
Faculty Development	
Academic currency	
Advice, Networking, Opportunities	
Personal Touch_URM specific	
Identity	
inter and intra group microaggressions	
Perseverance, Resilience	
Mentoring	
coach, sponsor, advisor, institutional nav	
Midwest State	
Others_Tentative Hold	
importance of service and teaching	
phd vesus MD	
Socialization	
faculty transition	
recruitment	
relationship & accountability	

**Appendix F. Department of Medicine Diversity and Inclusion Strategic Plan**

**Place Holder**

**Appendix G. Academic Medicine Advisory Panel**

1. Mark Geraci, MD  
Professor and Chairman, Department of Medicine,  
Indiana University School of Medicine
2. Rob Winn, MD  
Professor, Associate Vice Chancellor for Community-based Practice,  
Director of University of Illinois Cancer Center,  
University of Illinois-Chicago
3. Brenda Allen, PhD  
Professor and Vice Chancellor for Diversity and Inclusion,  
University of Colorado Denver and Anschutz Medical Campus
4. Denise Cora-Bramble, MD, MBA  
Professor of Pediatrics, The George Washington University School of Medicine,  
Chief Medical Officer and Executive Vice President of Ambulatory and  
Community Health Services, Children's National Health System
5. Laura Castillo-Page, PhD  
AAMC Acting Chief Diversity and Inclusion Officer,  
Senior Director, Diversity Policy and Programs and Organizational Capacity  
Building  
Association of American Medical Colleges (AAMC)
6. Linda Pololi, MBBS, FCRP  
Senior Scientist and Director, National Initiative on Gender, Culture and  
Leadership in Medicine  
Brandeis University
7. Jeff Milem, PhD  
Professor, Dean, Gevirtz Graduate School of Education of Education,  
University of California Santa Barbara



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