

SPECIAL COMMUNICATION

Stalled Progress: Medical School Dean Demographics

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Medical schools have an important directive: to train the next generation of physicians. Faced with a primary care physician shortage, increasing numbers of under-represented faculty leaving academic medicine, low representation of women in leadership positions, and an ongoing pandemic, medical schools have a duty to implement solutions to alleviate these issues. Efforts have been made to create more diverse medical school classes, but those efforts are not mirrored in senior faculty demographics. In this medical students' perspective piece, the authors analyzed the demographics of medical school deans in comparison with the United States' demographics and the current composition of active physicians. The authors looked at the specialty, race/ethnicity, and gender of medical school deans in 2019. Based on the analysis, in 2019 only 11% of deans were under-represented minorities, 16% of deans were primary care physicians, and 18% of deans were women. When compared with the makeup of physicians in the United States and the population as a whole, these numbers are unrepresentative of national demographics. By hiring deans with a variety of race/ethnicities, specialties, and genders, schools set an important precedent that could lead to more pipeline programs, increased under-represented faculty retention, and more primary care physicians. (J Am Board Fam Med 2022;35:163–168.)

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The COVID-19 pandemic has exacerbated and uncovered the health disparities present in our communities and has increased the push for health equity across the country.^{1,2} This has led to a movement to examine and find solutions for the health care system's role in perpetuating these health inequities in communities of color.³ Two essential ways to improve health equity are to increase the diversity of physicians^{4,5} and move health care upstream to focus on prevention and primary care.⁶

With a majority-minority nation on the horizon for 2044, the need for physicians who resemble and represent our population demographics is increasingly important.⁷ Studies have shown that medical school compositional diversity increases medical students' cultural awareness,⁸ decreases implicit bias,⁸ and encourages positive attitudes toward diversity.^{9,10} Hospitals with higher proportions of racial and ethnic minorities in senior leadership positions have more initiatives that aim to achieve health equity and reduce disparities.¹¹

Historically, minority populations have been restricted from opportunities and promotions in their medical training, memberships, and professional activities, which subsequently excluded them from participating and impacting decisions at the institutional level.^{12,13} There are various factors that perpetuate institutional racism and ostracize patients, students, physicians, and leaders from these minority communities. In medical education, such factors include lack of access to medical education for those under-represented in medicine (URM) and other neglected groups,¹⁴ medical student experiences of

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discrimination and bias,¹⁵ and minority faculty experiences of the “minority tax,” the increased burden placed on minority faculty to lead diversity initiatives.^{16,17} Historically Black Colleges and Universities (HBCUs) are leaders and innovators in supporting pipeline programs built to expose URM students to the health professions¹⁸ and tend to produce large numbers of minority medical school applicants as well as minority medical school deans across the United States.¹⁹ This trend continues even into medical school, with 20% of Black matriculants attending the 4 HBCUs with medical schools.²⁰ However, it is imperative that the task of diversifying medical education is not solely driven by HBCUs. Diversity must be actively embraced by all institutions, especially predominately White institutions.

Minority physicians are also important in solving the issues revolving around the shortage of primary care physicians. Black and African American physicians do not account for the majority of active physicians in the United States, yet a plurality of Black or African American physicians practiced primary care (41.4% vs 30.6% of White physicians) in 2018.²¹ Minority physicians are also more likely to work in medically underserved areas or in health professions shortage areas.²² One study found that 15% of White physicians practiced in a Medically Underserved Area, compared with 28% of African American physicians, 24% of Latino physicians, and 19% of Asian physicians.²³

Primary care physicians play an essential role in the prevention of hospitalizations and the management of chronic conditions, and evidence demonstrates more primary care physicians are associated with better health outcomes.^{6,24} Despite this evidence, it is estimated that by 2025 there will be a deficit of up to 31,000 adult primary care physicians in the United States.²⁵ When examining the causes of this shortage, studies have suggested students do not choose primary care due to lack of role models in primary care, burnout associated with addressing the social needs of underserved populations, and professional cultures that view primary care negatively.^{26,27} Deans and administrators are important in shaping the culture in medical schools and can help eliminate (or exacerbate) stigma against primary care.²⁷

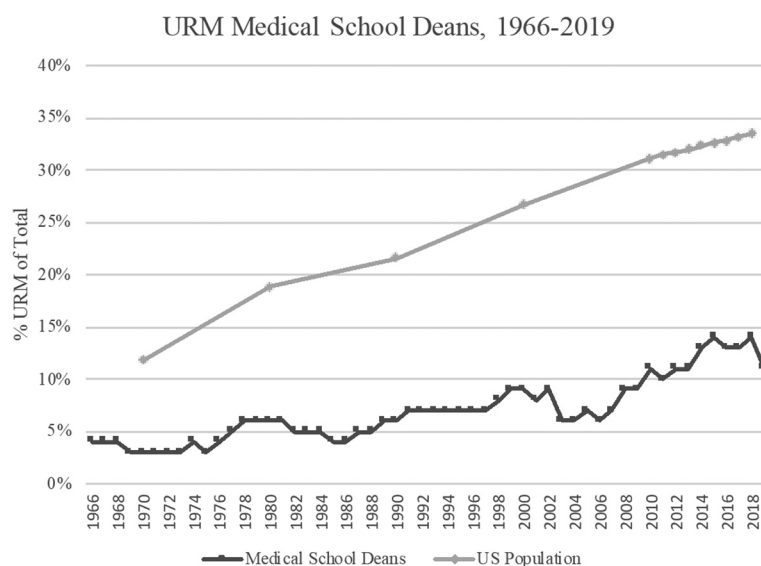
With women now making up over half of medical school matriculants, the medical leadership gap can no longer be attributed to the number of women choosing medicine. Nevertheless, women

are still under-represented in senior leadership ranks and department chairs.²⁸ Seeing this representation matters. Students who identified as female had higher odds of reporting that faculty lacked respect for diversity when compared with males.²⁹ Previous research has demonstrated that gender-based discrimination is still prevalent in medical education, and women are sorely needed in these spaces.²⁸

Senior leadership can help bring these much-needed changes to medical schools.³⁰ Leaders can bring in new perspectives and prioritize building a diverse and knowledgeable community. These changes might include structural changes, such as creating pipeline programs and re-evaluating admissions policies, as well as curricular changes, such as promoting community-based training, health equity curriculum, and removing content that perpetuates the myth of biological race. The aforementioned changes have been implemented in several medical schools, including the Medical University of South Carolina, with successful programs dedicated to increasing diversity. To enumerate certain critical elements, they focused on: (1) fostering an institutional culture that embraces diversity, (2) demonstrating a commitment to diversity within institutional leadership, (3) developing admission policies to promote diversity, and (4) clearly articulated institutional policies that uphold a culture supportive of diversity.³¹ Increasing primary care physician representation in senior leadership would convey to students that a career in primary care is respected and a path to future professional success. For students, diversity at the highest levels is an important signal of a school's priorities and culture and provides role models for future careers. This is evidenced by HBCU medical schools, headed by minority deans, leading medical schools in producing graduates that are URM, going into primary care, and pursuing work in underserved areas.^{32,33}

Amid the Black Lives Matter movement of the past year, many medical schools released statements on the value of a diverse representation of race, ethnicity, and gender in their schools and senior leadership. However, the ongoing calls for more diverse leadership demonstrate that this value is not being fully realized.^{34,35} Leadership roles need to be filled by individuals of different races, ethnicities, genders, and specialties to implement changes needed to strive toward health equity.³¹

Figure 1. US medical schools deans race/ethnicity, 1966 to 2019. Source: AAMC Council of Deans records, as of 8/17/2020; U.S. population demographics from U.S. Census Bureau. Abbreviation: URM, under-represented in medicine.



Medical School Deans in 2019

To shed light on these issues of representation, we examined the specialty, gender, and race/ethnicity of 153 allopathic medical school deans. Information regarding the gender of medical school deans is publicly available online by the Association of American Medical Colleges (AAMC). We further obtained data on the race/ethnicity of deans from the AAMC, which they collect through their AAMC Council of Deans. We focused on the data contained in the AAMC report, which excluded osteopathic deans. We determined the medical specialties of deans in 2019 by reviewing their online biographies or dean's announcements.

Based on our findings, as medical students and future physicians, we are deeply concerned with the lack of diversity among the highest level of leadership within our medical education communities.

While the number of women deans has increased since 1990, when women represented just 1% of deans,³⁶ in 2019, women continue to be severely under-represented at just 18% of medical school deans. Women have made strides in terms of representation within the overall medical community; however, this has not translated to the leadership level at medical schools. We need more women in higher positions of power in medical schools across the country.

In 2019, 11% of deans were considered to be URM, compared with 33% in the US population.

The AAMC defines URM as those “racial and ethnic populations that are under-represented in the medical profession relative to their numbers in the general population.”³⁷ This lack of diversity has been present since data were first collected in the 1970s, when the percentage of URM among medical school deans was 4%, compared with 12% of the general population. Even as late as the early 2000s, only around 9% of deans were URM, compared with 27% of the population (Figure 1). Despite these increases, the rate of the diversifications of deans is not proportional to that of the nation, as seen in Figure 1. The 8 HBCU and Puerto Rican medical schools from our analysis disproportionately contribute to URM representation among medical school deans. For instance, in 2019, they contributed almost half of the 17 URM-identifying deans.

We found that only 16% of deans were from primary care fields, while 32.1% of active physicians practice in primary care.²¹ Specialties we categorized as primary care included family medicine, internal medicine, and pediatrics, with no further specialization.

A Road Map Forward

The diversity of senior leadership matters to students.²⁹ Medical schools should hire deans and senior leadership that represent a diversity of

specialties, genders, races, and ethnicities. Future physicians need to acquire skills to care for increasingly diverse groups by learning about the unique needs of minority populations and by including social determinants of health, cultural humility, and systemic racism in medical curricula.^{38–41} Schools should prioritize issues that matter to their primary constituents—their students.³⁸

While the medical school enrollment gender gap has been closed, the number of women in senior positions lags behind.⁴² When implemented, evidence-based practices that use targeted mentorship and career development programs, education of search committees, and institutional accountability measures increase the number of women in faculty positions.^{43–47} However, current uptake of these methods is scattered and typically limited to individual institutions.

The number of under-represented minorities in medicine continues to trail behind general population numbers, with research showing it would take nearly 1000 years for the numbers of Black physicians to catch up.⁴⁸ We must create a positive cultural change to support URM students and their aspirations and the retention and promotion of more URM faculty through increased support for pipeline programs as well as mentorship and faculty development for junior faculty.^{49–51} We need URM leaders in the highest level within all medical schools to serve as role models for success, not just at HBCUs and in Puerto Rico.^{52,53}

While the choice of primary care careers is also driven by factors such as income and practice challenges, the number of deans from primary care fields remains unrepresentative. Given the importance of primary care in the prevention and maintenance of health, as well as the growing primary care shortage, we believe that more primary care deans are needed. Institutional culture affects how students perceive different specialties, and primary care physicians in leadership positions will positively change this culture.²⁷ More programs such as the Society of Teachers of Family Medicine's Bishop Fellowship program that provides training and support for family medicine faculty looking for senior positions, including access to a dean for 3 weeks, could help family medicine faculty to take up these roles.^{5,54} Deans who represent these fields serve as an inspiration to students and show that leadership in medicine need not be limited to specialty practitioners alone. It also demonstrates that

promising future careers await those who pursue these critically needed specialties.

Based on our findings around the lack of representation of women, URM, and primary care physicians as deans, medical schools should increase efforts to develop faculty that identify with these groups. These changes could be achieved through pipeline programs, increased focus on the mentoring and career development of URM and women, and continued mentorship for those interested in primary care. These adjustments would help make medicine more inclusive and representative, not only for the next generation of physicians but also for the populations we serve.

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