Promotion and Tenure of Women and Minorities on Medical School Faculties

The American College of Physicians*

The moral and public health imperatives to increase the participation of women and minorities in medicine have been underscored in many recent reports and studies (1-7). An essential component of this process will be the number and visibility of women and minorities in leadership positions in academic medicine. By example and by design, leaders from these groups will influence institutional policies and ensure a continuing pipeline of minority and women physicians. Therefore, medical schools must continue efforts to promote qualified minorities and women to senior faculty positions.

By “minorities,” we are referring to racial or ethnic groups that are under-represented—that is, their percentage in the physician population is less than their percentage in the general population. Specifically, these groups are black Americans, native Americans, Mexican Americans, and mainland Puerto Ricans.

In the last 10 years, whereas the number of women entering medical school has increased from 26% to 37% of the class (8), the number of entering minority students has remained low and steady at 9% to 10% (9). During the same period, the percentage of female faculty has risen from 15% to 20%, whereas the representation of minorities on faculties has remained virtually unchanged at 3% (10). Generally, junior faculty from these groups have not advanced into senior academic positions at the same rate as their white male colleagues, and at many points along the academic pathway women and minorities are more likely to leave the path leading to advancement.

Many reasons have been proposed for the slower progress of minority and women faculty, including financial constraints, lack of knowledge about tenure and promotion procedures, heavier time commitments to teaching and patient care, discrimination, and lack of mentors or role models. However, systematic study of these issues has been limited, and many questions remain unanswered. This paper reviews the data on the status of women and minorities on medical school faculties and provides specific recommendations designed to increase faculty representation of women and minorities and to facilitate these groups’ ascent to more senior ranks.

The definition of tenure varies from institution to institution. In some medical schools, academic tenure entitles a faculty member to salary and fringe benefits indefinitely, whereas other institutions provide only academic title and resources for research and teaching. Some medical schools do not offer tenure at all. In reality, the definitions of tenure and tenure track vary so much among institutions that their use is limited as an indicator of the status of women and minority faculty in U.S. medical schools.

Information about academic rank (instructor, assistant professor, associate professor, and professor) is more complete and accurate. Every 3 years the Association of American Medical Colleges (AAMC) publishes a report on the national participation of minorities and women on U.S. medical school faculties (10). The report includes information on academic degree, rank, department, tenure status, and year of first faculty appointment for full-time women and minority faculty members. The AAMC initiated this report in 1975 to assist medical schools in constructing affirmative action plans, and it remains the most complete data source on the subject.

Women Faculty

As of 1989, women comprise 20% of all full-time faculty holding a doctorate and 16% of the physician faculty (10). In departments of internal medicine, a somewhat lower percentage (16%) of all full-time faculty are women. Overall, women faculty members are more likely to hold lower academic rank than their white male colleagues. According to 1989 AAMC data, 31% of male faculty are full professors compared with 9% of female faculty, and 26% of men are associate professors compared with 20% of women. In departments of internal medicine, 29% of male faculty are full professors compared with 7% of female faculty, and 25% of men are associate professors compared with 16% of women.

These data, however, are not corrected for age or date of faculty appointment. Have women simply entered the profession too recently to have risen to senior levels? In order to compare promotion rates more accurately, it is useful to examine either the rank of a single cohort at a particular time after first joining a faculty, or the change in rank of different groups over the last decade. In the cohort that first joined a medical faculty in 1976, 12% of men reached the rank of full professor by 1987 compared with 3% of women (8). In this particular cohort, female faculty members had slower academic promotion than their male colleagues. Overall, the percentage of female faculty members who are professors has risen from 7% to 9% in 10 years (while the percentage for men for the same period has

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risen from 26% to 31%). Similarly, the percentage of female faculty who are associate professors has changed from 16% to 20% (figures are 21% to 26% for men). Thus, women faculty have made some progress up the academic ladder during the last 10 years, although they remain disproportionately represented in the junior ranks.

Women are under-represented in other academic fields as well (11-14). The National Academy of Sciences, in a comprehensive report, presented information on the careers of women in the sciences and engineering (11). As in medicine, women tended to be under-represented in the ranks of professor and associate professor and to progress more slowly than their male colleagues. The report also found that over the last decade "the gap between women and men academics is narrowing but it has not been eliminated" (11).

What are the barriers to the advancement of women faculty? The following section explores the reasons, but research data on some of these issues are limited. No large-scale study has examined the process of career advancement and career attrition in female compared with male faculty.

Career interruption related to child-rearing is often offered as a reason for slow career progress. Frequently, women physicians delay childbearing until after they have completed medical school, residency, and fellowship. In a recent study of women holding full-time faculty appointments in departments of medicine, 46% of those with children had their first child after completing residency and fellowship training. Most of these women held junior faculty positions when they had their first child and subsequent children (15). These women tended to take a relatively short period of time off work after delivering their children (median, 6 weeks) in order to minimize interruption in their teaching and research. Most (86%) returned to full-time responsibilities, working 52 hours a week or more. The conflicting demands of childbearing and an academic career are difficult to balance. Overall, 67% of the full-time women faculty studied reported that their career had been slowed or markedly slowed by childbearing (15).

Family responsibilities may make women more likely to leave academics or pursue nontraditional career paths (that is, part-time) than their male colleagues. Often these nontraditional career options put the faculty member at a handicap in meeting requirements for promotion. In many institutions the period between joining the faculty and consideration for promotion is not modified for a person choosing to work less than full-time. Faculty members may be forced to choose between family and career responsibilities because of lack of flexibility in the institutional structure.

Promotion and tenure decisions usually emphasize research accomplishments, including publications and external grant support. A few studies have compared research activities of men and women faculty, but these studies pose as many questions as they answer (16-18). An AAMC gender analysis of faculty research activities in departments of medicine in 1982-1983 (16) found that 29% of women had no current research involvement compared with 19% of men, and that 26% of women had no research training compared with 16% of the men. In addition, men were more likely to have external research funds, be assigned research space, and to have first authorship on an article (18). The reasons for the differences remain unclear, but some studies suggest that women have less protected research time and more clinical and teaching responsibilities, which are not as likely to support their application for promotion as research activities (19, 20).

Another barrier to junior faculty advancement stems from a lack of accurate information about promotion and tenure expectations. Many junior faculty do not receive clear written guidelines about tenure criteria and the promotion process. They may need guidance from senior faculty members about ways to make their efforts to obtain tenure more successful. However, a study conducted by Yale University School of Medicine of faculty who left the institution between 1981 and 1986 found that a greater percentage of women than men felt that they were not adequately informed about tenure expectations (Report of the Task Force on Women Faculty, Yale University School of Medicine, 1988. Unpublished data).

Senior mentors are demonstrably important in the professional career advancement of women (21-23). Junior faculty with mentors publish more articles (15, 24), have increased employment opportunities (22), feel more confident of their capabilities (25, 26), and are more satisfied with their careers overall than those without mentors (15, 27). In a survey of women faculty in internal medicine, having a mentor was positively associated with career satisfaction, although 40% of respondents had no mentor during their own training and most often the available mentors were men (15). No comparable data are available on the percentage of men without mentors.

Some sociologic studies report that mentors of the same gender as the student may be more effective career sponsors than those of the opposite sex (28, 29). A recent survey of female physicians, however, compared the experiences of those who had male mentors with those who had female mentors (2). Respondents with high-ranking male mentors reported more effective career sponsorship, whereas those with lower-ranking female mentors reported more personal advice and fewer problems retaining their autonomy in the relationship. Effective career sponsorship was positively associated with the mentor's rank, whereas a personally satisfying relationship was associated with having female mentors. The authors of the study suggest that the presence of more women in senior positions would solve this dilemma by giving young women physicians the option of a mentor who can provide both sponsorship and personal advice.

In addition to facilitating the career development of students, same-sex mentors may act as role models in both the professional and personal domain. For example, senior women role models can help their junior colleagues consider alternative ways of combining career and family responsibilities. Studies in the medical field demonstrate the importance of role models in encouraging women medical students or junior faculty to pursue academic careers (20, 30). In the study of women in internal medicine, most respondents thought
that women medical students need role models of successful tenured women (15). In general, most women faculty do not have available role models because of the relative scarcity of women in senior and administrative positions (31) in medical institutions. Some may be the only women in the division or department.

Minority Faculty

Minority representation on university and college faculties has not changed in 10 years. The “pipeline” of qualified minority candidates has stagnated on all educational levels and across most academic fields. The 1970 AAMC goal of 12% minority first-year enrollment in medical school (based on population data for blacks only) has never been met.

A recent National Research Council report on the status of black Americans (1) noted that blacks represent less than 5% of full-time faculty at universities, that black faculty are concentrated in black institutions, and that there has been a 6% decrease in the number of full-time black faculty at public 4-year institutions between 1977 and 1983. The report stated that “there is little prospect for growth in black representation in light of the decline in both the percentage of blacks going into college and the percentage pursuing graduate and professional degrees.”

Data from the AAMC provide information about minority students and faculty in medical education (9). In 1988, a total of 7.9% of medical school graduates were from minority groups, including 5.3% black Americans, 0.4% native Americans, 1.5% Mexican Americans, and 0.7% mainland Puerto Ricans. Eighteen percent of the black students are enrolled in the three predominately black medical schools (3). As in other fields, the percentage of minority students in medical school has not improved over the last decade.

Given the limited pool of minority medical graduates, their under-representation on faculties is unsurprising. In 1989, minority faculty accounted for 3.0% of all faculty at U.S. medical schools; this figure includes 1.9% black Americans, 0.1% native Americans, 0.3% Mexican Americans, and 0.7% Puerto Ricans. Demographics for departments of internal medicine are similar. These figures have remained virtually unchanged for the last decade. Available data indicate that minority faculty tend to hold lower rank and have slower promotion rates than their white colleagues (1, 13, 32). In medicine, most minority faculty are either assistant professors or instructors. Minorities account for 1.9% of all professors, and 2.6% of all associate professors (10). The AAMC states that there has been no significant change for minorities in rank distribution or movement up the academic ladder during the last decade, in contrast to some gains for women faculty (10). An unpublished study of faculty at Harvard Medical School examined the promotion rate of a 1983 cohort of faculty, including subgroups of women and blacks. Although the sample size was small (n = 18), the study showed that promotion rates for blacks were substantially lower than for other groups (Evans C, Director, Office of Academic Careers, Harvard Medical School. Personal communication).

What barriers do minority faculty face? The limited available information comes primarily from fields other than medicine. As junior faculty, minorities face many of the same barriers as do women; other obstacles, however, are specific to minority groups.

Economic circumstances and financial barriers pose a particularly heavy burden to minority students. Black PhD candidates are more likely to be dependent on their earnings and loans than are whites and less likely to receive federal awards (33). Most black medical students come from families with annual incomes below $20,000 (34), and in 1987 black medical school graduates had a mean debt of approximately $44,000 (all minorities averaged $41,000, whereas nonminority students averaged $35,000) (3). Further, student financial aid has significantly decreased in the last decade, and the mean debt for minority graduates has actually doubled since 1983. This poses the real possibility that the number of minority students entering and graduating from medical school will continue to fall in the future and consequently that the number of minority faculty will also decline.

Minorities, like women, face the problem of balancing their time among teaching, research, clinical, and administrative duties. Studies in departments of psychology indicate that minority faculty perceive heavy teaching and advising responsibilities to be a major obstacle to career progress (13, 35). In the Harvard study, the black medical faculty tended to spend most of their time in patient care, and very few devoted a significant percentage of their time to research. Despite knowing that research activities were most important for academic promotion, the faculty reported satisfaction with their time allocation (Evans C. Personal communication). Because of their numbers, minority faculty often face greater service demands than their white colleagues (13, 35, 36). In a study of black faculty in higher education, blacks were more likely than whites to report that administrative work and student counseling reduced their time for research and teaching and that the institution did not provide enough formal rewards for their service activities (13).

Because of the under-representation of minorities on faculty, minority students have poor access to same-race mentors and limited exposure to role models who can foster their careers and provide support and encouragement. A study of black students during graduate and professional education found that one in eight had a true mentor (36). Further, although white faculty can serve as mentors for minority group students, mentors tend to select as proteges persons of the same gender and race (36, 37). This tendency may leave junior minority faculty—the individuals who might most benefit from guidance from senior members—without appropriate mentoring. The dearth of role models for minority students affects the “pipeline” at all levels, from interest in the profession to entry and advancement within it.

Although affirmative action programs have fostered the hiring of minority faculty, they have not ensured a process for monitoring the progress of minorities. Hence, minority under-representation is a problem of both recruitment and retention of qualified faculty mem-
bers. Unfortunately, no studies have explored the guidance process for minority medical faculty, and only limited data are available from faculty in other fields (13, 35).

Minority women have been increasing their representation in medical school at a faster rate than nonminority women and minority men. In 1987-1988, women comprised almost 50% of the minority entering class (3). The number of black women entering medical school has increased by 32% in the past 5 years. This optimistic note should be tempered by the disturbing statistic that the number of entering black male students has decreased by 13% in the same period (38).

It is in the best interest of any university to attract and retain the most creative and qualified scholars. Barriers to minorities and women are unfair; they deprive the institutions of potential scientific and social contributions from these groups, and deprive the individuals of opportunities for advancement. The American College of Physicians (ACP) makes the following recommendations in order to increase the representation of women and minorities on medical school faculties.

Position 1

The ACP recommends that academic institutions reaffirm their commitment to increase the numbers of qualified women and minority physicians on their faculties.

Rationale

Despite the guidelines of affirmative action, increased representation of minorities and women on faculties depends on the commitment and special efforts of deans and key administrative personnel. The leadership and advocacy of deans are vital to the success of these efforts. For example, the Dean of Yale University School of Medicine led a drive to increase a percentage of women faculty, which culminated in a task force recommendation to set a goal of increasing its tenure female faculty from 7% to 12% in 5 years. Minority and women physicians in key administrative positions themselves could combat institutional biases and promulgate affirmative action policies. In 1988, however, there were only 3 (2%) women deans; approximately 65 (3%) of departmental chairs were women (15), none of whom were in internal medicine. At nonminority medical schools, there were no black deans, and approximately 6 black departmental chairs (39).

The problem of minority under-representation needs to be addressed comprehensively at multiple levels. Programs to recruit and retain minority medical students should be encouraged, expanded, and funded because they have been proved to work (6, 39-41). Financial aid programs must be enhanced by both private and public funding sources. Toward this end, Congress recently passed the “Minority Health Improvement Act of 1990,” which includes loan and scholarship funds for health professions schools that initiate formal programs for recruiting and retaining minority students and faculty. The loan program is authorized $20 million each fiscal year from 1991 to 1993; the scholarship program is authorized $25 million for 1991 and unspecified sums for fiscal years 1992 and 1993.

Increased public funding has been fueled, in part, by recent reports linking minority practice patterns to access-to-care issues and minority health indicators. “Minority physicians practice primary care to a greater degree than their non-minority counterparts, disproportionately serve underserved and minority patients, and locate in federally designated health manpower shortage areas” (3). Clearly, there are moral imperatives (racial justice, equal opportunity) to encourage minority participation in medicine; there are also compelling public health goals: to make quality care more accessible to the medically underserved and to improve the health status of all Americans. The U.S. Public Health Service has acknowledged these goals in Healthy People 2000: National Health Promotion and Disease Prevention Objectives (5). It calls for increasing to at least 15% the proportion of all degrees in the health professions awarded to minorities by the year 2000. The importance of minorities in medicine extends beyond their present practice patterns, which might change as barriers to full participation in “mainstream” medicine are eliminated. Public health goals cannot be achieved until minorities are integrated into the profession as mentors and role models, educators, policy advisors, and primary care providers. The ACP adds its voice to the many academic and governmental groups in calling for a renewed commitment to increased minority representation in medicine.

Position 2

The ACP urges all medical schools to adopt institutional strategies that will foster the promotion of minorities and women from junior to senior faculty positions.

Rationale

As the example of women has provided, increasing representation on medical school faculties does not automatically create equal opportunities for advancement. The ACP recommends that all medical schools implement the following strategies.

1. Wide dissemination of written guidelines for tenure and promotion procedures: Each junior faculty member should have written guidelines from the institution that delineate the requirements for academic advancement. Although most institutions have written guidelines for their promotion and tenure committees, these are not always widely distributed, and junior faculty may lack access to important information.

2. Establishment of a formal career counseling program for junior faculty: Formal structures are necessary to ensure that each junior faculty member has mentorship and guidance (42). Each member should receive individual counseling from the department chairperson at the time of joining the faculty. The job description should be reviewed, and the chairperson should provide an assessment of the prospects for promotion and tenure. The progress of each faculty member should be reviewed at least annually by the department chairperson or division chief. This formal review process en-
sures ongoing evaluation of career progress and provides an opportunity for suggestions to modify work patterns.

As noted, studies in many fields, including psychology, law, business, and medicine, indicate the importance of mentorship (13, 21-23, 27, 30, 43). In a study of career development of physicians, women who were interviewed reported that the difficulty of obtaining informal support was an important deterrent in continued career advancement after medical school (44). Mentors were considered particularly important in demonstrating opportunities for research, further training, and superior practice arrangements. Minorities have identified the same concerns. Formal programs designating a senior counselor can establish potential relationships that support junior faculty and encourage qualified faculty to continue their academic careers. Specifically, mentors should provide information about the promotion and tenure process, discuss the balance of time commitments to patient care, teaching, student counseling, research, and administrative duties, and help junior faculty establish a network of appropriate colleagues. Mentors should be selected on the basis of their skills in counseling junior faculty or should receive training to make them effective in this role.

3. Establishment of a faculty development program: In addition to counseling, junior faculty need certain skills essential for academic success, such as knowledge of research methods, information about private and governmental funding sources, and journal-writing skills. Institutions should develop and foster programs to enhance the knowledge and skills of junior faculty. The Department of Health and Human Services has encouraged programs of this nature during the last 6 years, offering faculty development grants in general internal medicine.

4. Development of flexibility in tenure and promotion procedures that allow faculty to accommodate personal and family responsibilities while continuing academic work: Interest in part-time faculty employment in colleges and universities has increased over the last decade. The Association of American Colleges’ Project on the Status and Education of Women published a review of the status of part-time faculty employment in American colleges in 1976 (45). The report points out the advantages of part-time arrangements both to individuals and to institutions. It suggests that these arrangements may allow institutions to retain talented faculty as well as to diversify their departments without significantly increasing costs. Additionally, it states that increasing opportunities for part-time employment offers an “attractive alternative to laying off faculty. This is especially important for women and minority group members who...are sometimes overrepresented in the junior and untenured ranks and hence are the first employees to be terminated when dismissals are made strictly on the basis of seniority and tenure” (45).

The problem with part-time arrangements for junior faculty has been that the “time to tenure” clock keeps ticking while the faculty member is away, hence limiting the likelihood of meeting promotion and tenure standards. No national data are available on the number of institutions that have flexible tenure policies, although informal surveys indicate that most do not (15). Although no studies have measured the effect of flexible work policies on faculty attrition rates, “alternate track” or “stop the clock” policies have been suggested as possible ways to accommodate less than full-time arrangements (7, 8, 15). For example, in an “alternate track,” a part-time faculty member could have the tenure deadline calculated on the basis of his or her work schedule. A faculty member working 50% for some period of time would be given longer to achieve standards for promotion than those working full-time. Other flexible arrangements such as “job sharing” could help to facilitate the careers of junior faculty members wishing to divide their time between work and other endeavors.

5. Encouragement of the involvement of women and minorities on policy-making and faculty recruitment committees: Representatives of these groups may act as advocates for the needs of minorities and women. At UCLA’s School of Medicine, the dean recently implemented a policy to ensure that at least one woman was appointed to every search committee within the school (46). Although this type of policy leaves the school open to a charge of “tokenism,” such a strategy can redress some of the longstanding institutional barriers to the advancement of minorities and women. Committee work can introduce these persons to the organization’s structure and informal power networks. Appointment of women and minorities to these committees raises the potential problem of overextending a faculty member, thus decreasing his or her time for academic endeavors. Institutions must either reward the faculty for service on these committees by stronger consideration of these accomplishments in promotion and tenure criteria, or they must counsel the faculty member carefully in balancing time commitments.

6. Establishment of a formal monitoring process: Institutions should establish a formal process for evaluating the effectiveness of these efforts. Career progress of faculty members should be monitored yearly by compiling and analyzing data on sex, race, and length of time since faculty appointment.

In summary, the ACP encourages universities to make special efforts to foster the career development of qualified women and minority physicians. The strong future of our institutions depends on the recruitment and retention of faculty capable of scientific excellence. Universities must strive seriously and consciously to decrease the existing barriers to academic advancement for women and minority faculty.

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