Taking Root in a Forest Clearing

A Resource Guide for Medical Faculty

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To Harold Amos, Ph.D.
(1919 - 2003)

who wisely mentored so many medical faculty
and contributed so broadly to academic medicine

The Editors

"He will live in memory as someone who genuinely cared about all kinds of people, with an incredible talent for identifying and bringing out the best in them. He celebrated the success of others, listened well and lent meaningful support when difficulties arose…[A young astrophysicist who knew Harold wrote,] 'We all know that he was a jewel on this planet. The best I can do now is follow in his footsteps.' What better legacy could one leave? Harold Amos was, indeed, a jewel on this planet."

Jocelyn Spragg, Ph.D.
Memorial Service for Harold Amos
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TAKING ROOT IN A FOREST CLEARING:

A RESOURCE GUIDE FOR MEDICAL FACULTY

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FOREWORD

WE SHALL ALL BE WELL-SERVED

"The community teaches. If it is healthy and coherent, the community imparts a coherent value system. If it is fragmented or sterile or degenerative, lessons are taught anyway—but not lessons that heal and strengthen. It is community and culture that hold the individual in a framework of values; when the framework disintegrates, individual value systems disintegrate." [1]

John Gardner (1990)

"The unhappy fruits of such moral disintegration are loss of meaning and loss of potency. A collegiate community must be more than a collection of buildings connected only by steam lines and fiber optic cables. It must be a set of relationships that recognize and celebrate a shared vision of purpose and values." [2]

E. Grady Bogue (2002)

Academic health centers (AHCs) should be viewed as 'national treasures' among North American health institutions. Confluences of health professional schools, teaching hospitals, referral group practices for academic clinicians, and scientific laboratories, the centers are unduplicated on any other continent. In the United States, academic health centers serve several critical functions – as centers of discovery and innovation in health professions education, centers of excellence in subspecialty patient care, and interdisciplinary centers for biomedical and other varieties of basic research. Because most future health professionals flow through their programs, their organizational environments produce the 'hidden curriculum' that so powerfully imprints itself on most future physicians – for better or worse.[3]

And some long-term observers of the academia in health centers believe that the effects of the AHC environment leave much to be desired.[4] Emphasizing the need for 'excellence' and believing that high community standards are relatively assured by performance criteria that emphasize competition and individual achievement, AHCs come to be places in which a certain kind of 'intellectual darwinism' and elitism prevail, interpersonal trust may create vulnerability, and communitarianism outside nuclear work groups is relatively absent. Unfortunately, it is in environments with these strong characteristics that we expect future physicians and nurses to become altruistic, empathetic, open-minded, and caring of others.[5]

Alas, it is also in these same environments that we hope to diversify the AHC workforce – for many good reasons, among them the need to have future physicians emerge as professionals in medical workforces that have the gender, race, and ethnic composition of the United States population generally and, in a social environment of this kind, to acquire the abilities to understand people unlike themselves and to work across cultures successfully.[6] As is abundantly documented elsewhere, our best efforts are not succeeding at the task of AHC workforce diversification. The proportion of women and minorities in our faculties, especially those above entry ranks, is not growing. Part of the challenge we face is a limited pool of candidates for these positions, but part of the problem is also academic survival for women and minority faculty in the challenging AHC environment.

Is adverse selection necessarily the dominant characteristic of Academe? I would think not – at least not as the only path to excellence. The defining characteristics of the successful academic environment were characterized, for example, by Ernest Boyer,[7, 8] the long-time President of the Carnegie Foundation for the Advancement of Teaching as:

- ***A purposeful community.*** A purposeful community is one in which students and faculty share learning goals, and the classroom is seen as a place where community begins and where "great teachers not only transmit information, but also create the common ground of intellectual commitment. They stimulate active, not passive learning in the classroom, encourage students to be creative not conforming, and inspire them to go on learning long after college days are over."
- ***An open community.*** An open community is described as one in which freedom of expression is nurtured and civility is affirmed. The virtue of civility recognizes the dignity of every person and is built on the reciprocity principle honored in every great religious literature.

- ***A just community.*** Prejudice and arrogance are the enemies of a just community. Thus a just community is one that affirms diversity and "is a place where diversity is aggressively pursued."
- ***A disciplined community.*** The report describes a disciplined community as "a place where individuals accept their obligations to the group and where well-defined governance procedures guide behavior for the common good." Codes of conduct and security plans are attended under this community value, as are the values of courtesy and privacy.
- ***A caring community.*** A caring community is one where a sense of connection between student and campus is cultivated, and the nobility of service to others is emphasized. The report suggests that "students also should be brought in touch with those genuinely in need, and through field experiences, build relationships that are inter-generational, intercultural, and international, too."
- ***A celebrative community.*** A celebrative community is one in which campus heritage and traditions are central to the culture of the campus and to student life. Both the physical environment and the ceremonial traditions mark it for memory and connection in the lives of its students.

Purposeful, disciplined, just, caring, civil, open and affirming diversity, honoring traditions – these are the characteristics I would hope could be characteristic of academic institutions, including academic health centers. If these were the dominant characteristics of AHCs and the faculty within them, we would be less apt to be concerned with the values of the future professions we were graduating and having less difficulty, I believe, with the recruitment and retention of women and minorities. The processes and resources of the academic community that could sustain these environmental characteristics would be different than those we typically have today. We would need more mentorship, more teamwork, the capacity to recognize and reward those who function as the interpersonal 'glue' of our teams (educational, scientific, clinical, leadership), more widely available critical information, more transparency in the activities of our leadership, and more robust resources for enhancing the effectiveness of those faculty who struggle early in their careers. From my perspective, these altered processes and resources would be good for all AHC faculty, not just for those at greatest career risk today.

This is not news. Whenever the needs of the relatively powerless are met, the good of all, the common good, is served. This is precisely why this little volume is relevant to us all. In the issues discussed, the perspectives presented, the voices of respondents, and the suggestions and recommendations advanced, we hear ourselves. When the issues that surface in this volume are approached seriously in all AHCs, we shall all be well-served.

~ Thomas S. Inui

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Common Ground

Characteristics of Academic Health Centers: What Does a Young Faculty Member Need to Know?

"Guidance from someone at the top of the academic ladder who had been successful advancing, who can give advice on how best to promote yourself [and] when you negotiate, what to expect."[1]

Academic Health Centers (AHCs) can and should be leaders in national and global health care delivery, cutting-edge research, innovative education, and community service.[2] Such a tall order means that AHCs are exceedingly complex. These complexities have grown with the increasingly high financial stakes involved in the patient care and research enterprises and with accelerating rates of change in financing mechanisms and in technologic advances. Substantial changes in the last decade include the rise of managed care, declines in revenue from new tangles of regulations related to Medicaid and Medicare,[3] as well as drops in the stock market, affecting the endowments of many hospitals and medical schools. Clinical faculty, even those with scholarly orientations, are bearing the brunt of this financial burden. Thus the relative balance between academic and clinical missions that characterized previous eras has been lost.[4] Intensifying pressures to bring in revenue means that time for teaching and other academic work has decreased for almost all faculty, and at a time when administrative and research assistant support has dwindled.[5]

Monumental complexities also arise from academic health centers' fusion of missions with traditional academia, hospital functions, and several levels of education all mixed in varying balances.[6] Multiple institutions with multiple missions inevitably involve conflict and competition for control of resources, such as for new therapeutic technologies.[7] As financial stakes have risen, so has competition.

The structure of AHCs is notable for "loosely coupled" systems, such that forces for integration are usually weak compared to the forces for specialization and autonomy.[8] Faculty are often more connected through mutual scholarly or clinical interests to disciplinary colleagues outside the AHC than they are to the staff and leaders within. Another feature of this "loose coupling" is the generally rigid departmental organization of most schools, resulting in decentralized

federations.[9] Departmental cultures tend to be deeply entrenched and heavily defended, with chairs determining which of their physicians are most favored.[10] Thus when any change to the culture or norms is attempted, turf battles erupt between those they perceive will win or lose power.

Probably only the military has a more rigidly-defined hierarchical structure than academic medicine. Prestige is linked to the amount of income an individual brings in and to the amount of professional autonomy one is accorded: Subspecialists have more weight than primary care physicians, and residents have higher rank than students. Differences among categories of health professionals are also obvious, with physicians at the top. And among physicians, subspecialists and long-time NIH-funded investigators, that is, older men, remain at the top.

Against this roughly sketched backdrop, one feature of particular salience for young faculty is academic medicine's Intellectual Darwinism, or pursuit of 'excellence' through competition, emphasizing individual achievement over teamwork or cooperation. Despite the interdependent missions and organization of AHCs, there are few multidisciplinary or multi-school teaching opportunities to observe work activities from the viewpoint of other health care workers, such as nurses, or pharmacists.[10] With its emphasis on hiring the best "soloists" available, medicine is not always adept at turning them into teams. Another barrier is the pervasive "win/lose" dualism, evident in the Tournament Model of bioscientific research.[11] A tournament fosters intense competition and amplifies small differences in productivity into large differences in rewards. For the sake of students, faculty and patients, academic medicine needs to move beyond Intellectual Darwinism and Benign Despotism toward an Academic-Community Building orientation, including information-sharing and team-building.[12]

Only recently has medicine's over-valuation of individualism begun to be viewed by some as a barrier to positive change.[13] The largely invisible work of preventing crises and maintaining relationships has been unrewarded. Since women tend to be doing the less visible, collaborative, relational work, their contributions remain under-recognized. New models of mutuality are needed to recognize and reward contributions of other members of the team.

Another negative example of the continuing tyranny of dualistic thinking is the "either advancement or family" dilemma facing most young faculty. This dualistic thinking interferes with creative exploration of alternatives to add temporal flexibility to tenure and promotion policies. Unrestricted availability to work – impossible for devoted parents — tends to be equated with competence and commitment to the profession. The chronic conflicts between jobs and families in academic medicine are increasingly surfacing as

more men seek to play greater roles in their children's lives and as trainees become less willing to sacrifice balance for the sake of an academic career.[14] With regard to improving professionalism, one important avenue is making explicit the link between personal and professional growth: "in a field that demands as much of us as medicine, anything less than the integration of personal and professional may be *insupportable in the long run."*[15]

The complexity and competition that mark AHCs perplex all but the most entrepreneurial. Those without sufficient experience to use as a touchstone, and often without financial and other resources, such as trainees and younger faculty, are much more vulnerable than their mid-career and senior colleagues.[6] Hard work and native ability may have been sufficient for succeeding during training, but more is necessary for success as a faculty member.

For the first time in recent history, AHCs need to be concerned about attracting the next generation of faculty and leaders[16] as well as losing productive faculty who are disenchanted and struggling in the current academic setting. Academic medicine has frequently been perceived as an insider's world, an "old boys' network,"[17] and junior faculty have often floundered trying to launch their careers, uncertain what they should know or how they are to learn it. These problems are even more daunting for women and minorities, who do not see others like themselves in senior academic positions. With physician shortages predicted during the next 15 years in many geographic and specialty areas, academic departments can expect more competition to attract and retain young physicians.[18]

The percentage of medical school graduates entering academic medical careers is declining.[19] For the medical school graduates of 1981, 11% of minority, 20% of white, and 51% of Asian graduates were medical school faculty in 1999. In contrast, only 7% of minority, 12% of white, and 14% of Asian graduates from 1993 were medical school faculty in 1999.[20] Given the escalating societal expectations of AHCs, young physicians and trainees need encouragement to enter Academe. In a study of trainees in Obstetrics and Gynecology, women and minority residents felt less mentored and less recruited to pursue academic careers than male majority residents.[21] Because of the cumulative career disadvantages they face, women and minorities in particular warrant assistance on as many levels as possible to enter academic careers.[22]

Despite the ubiquity of these challenges and complexities, few medical schools have successfully evolved mechanisms of faculty management and development that optimize the institution's balancing act at the intersection of the university and health care system.[23] Mechanisms are needed that enlist faculty in meeting the demands of the health care system, while also protecting the ability of faculty to be academically productive.[23] While

obviously needed, centralized faculty development resources are scarce.[24] No medical school has a comprehensive faculty development office; and most of the existing offices tend to be underfunded and understaffed.[24] Technology and business are more accustomed to competing for talent and have much more experience with astute recruitment and development practices. By comparison, academic health centers do little to assist faculty in maximizing their career potentials.[25] Academic health centers have not understood or acted upon this lost potential or the costs of faculty turnover and re-recruitment, which is far more expensive than a successful faculty development program. Each primary care physician who leaves her or his job requires a replacement at an estimated cost of $250,000.[26] Other costs associated with not changing the system include a deterioration of collegial relationships and decreased quality of patient care from physicians not able to cover their commitments to practice and academic activities, not to mention the costs of lost opportunities and of failed careers.[27]

As we completed a series of four different qualitative studies for the Josiah Macy, Jr. Foundation, we learned that the four areas studied— mentoring, negotiation, and challenges facing women and minorities— are tightly interwoven in very telling ways. Our findings constitute a primer on career building likely to benefit struggling junior faculty, and in particular, women and minorities. In this opening chapter, we explore the "common ground" of these four themes and their intersection with the most challenging characteristics of AHCs as outlined above.

Women and Minorities in Academic Medicine

The challenges facing minorities and women are often conflated under the umbrella of diversity. Lumping the two groups, however, is rarely appropriate because many of the challenges are different and unique to one or the other group. Both minorities and women, however, have had difficulty being appropriately advanced in academic medicine.[28,29] Numerous studies have documented this phenomenon for both groups.[28,29,30,31,32] While advancement is more difficult for underrepresented minorities (URM), it also remains an issue for non-underrepresented minorities (NURM).[28] Disturbingly, a number of studies point to discrimination as a cause for the lack of advancement for these groups, as many of the studies have adjusted for the other known academic markers related to advancement, such as grants, publications, seniority, specialty, hours of work per week and institution, and reveal differences after adjusting for these known variables.[28, 29, 32]

Minorities

For URM, the issue is not only advancement; there are pipeline issues.[33] The "pool" of underrepresented minorities remains woefully small in medical school. A major contributing problem is that college participation by black students has actually decreased.[34] Major efforts for early intervention are necessary, beginning in high school and even earlier.[35] The proportion of faculty who are underrepresented minorities is decreasing.[20] Recruitment of underrepresented minorities into professional medical training is the lowest in over a decade despite efforts by the AAMC, the National Institutes of Health, the Robert Wood Johnson Foundation, and the Health Resources and Services Administration.[36,37] Yet the provision of quality healthcare to a diverse population clearly depends on an adequate supply of culturally competent providers and multicultural role models.[38]

Underrepresented minorities often arrive at medical school with poorer prior educational preparation, adding an additional challenge to their success. Early exposure to science and to others of their race or ethnicity in medicine can be pivotal for underrepresented minorities in pursuing a medical career, as well as growing up in a value structure that encourages education, a strong work ethic and service.[36] Discrimination for minorities is more a fact of life than it is for women—one to be managed cautiously and professionally.[39] Minorities are generally savvy about working on an uneven playing field[39, 40] and are more mentally prepared to deal with and not be demoralized by discrimination. For most, getting to a faculty position has required a strong sense of purpose, determination, and self-reliance.[40] An underappreciated stress and time-pressure on minorities is a higher "black tax" to serve on committees, to represent their minority group, and to care for patients of their racial group.[39] It is an unfortunate irony that while they experience this "affirmative abuse," they are also experiencing a sometimes painful and often confusing backlash against affirmative action, as expressed in the Hopwood decision in Texas and in Proposition 209 in California.[39]

Women

Since the late 1970s, women have been applying and being accepted in force to medical schools such that affirmative action has not been necessary.[41] As of 2002, forty-six percent of medical student enrollees are women[42] and many medical schools have similar numbers of men and women.[3, 43] Some specialties, especially surgical, however, remain heavily male-dominated.[42]

Women in academic medicine are more frequently US born, white, self-defined liberals, and board certified than men. They tend to work in urban areas, have fewer clinical hours, more non-clinical hours, earn less, and perform more continuing medical education. They have more patients with complex psychosocial problems and substantially less work control than men, including control over the volume of their patient load, the ability to select physicians for referrals, and overall office scheduling.[44] One large study found that women were 1.6 times more likely to report burnout than men.[45]

Common Ground for Women and Minorities

Both women and minorities face pressures to work harder and be better to achieve similar position to their male majority colleagues.[14, 29, 36, 40, 46] Both groups experience disadvantages in acquiring effective mentoring.[41, 47] And both groups, not surprisingly, report lower satisfaction with their careers[48, 49] and are more likely to leave Academe.[50] Both groups face limiting stereotypes from societal and cultural norms, which are often subtle errors of omission more than commission, such as being assumed to lack leadership potential or to not be included on the golf course. Majority faculty who are open to education about their negative mental models of race and gender can successfully unlearn these biases and become much more skilled at cultural diversity. Unfortunately, the very faculty who would profit most from this education often don't participate.[51]

Because there are few women and minorities in high level positions[3, 28, 29] and because of their lack of mentoring, women and minorities tend to find the structure and hierarchy of academic medicine difficult to navigate. Women and minorities are very aware of the imbalance in power and that it never seems to be in their favor.[52] They do not see others "like themselves" in senior academic positions. Thus both groups experience "cumulative disadvantages."[40, 50, 53]

Women minorities deserve special mention. Compared to white faculty, underrepresented minority groups actually have a higher proportion of women, although these numbers remain small.[54] Women from ethnic minorities face the "double jeopardy" of racial and gender stereotypes. A study of African-American women physicians found that the majority cited racial discrimination as a major obstacle during medical school, residency and in practice. Moreover, they perceived gender discrimination to be a greater obstacle than did non-African-American women physicians.[55] Thus, while increasing the number of ethnic minorities progressing in academic medicine presents different and more acute challenges than increasing women, largely unconscious bias related to "what a leader looks like"[56] remain delegitimizing forces for both.

The choice of specialty often impedes their academic advancement, with both women and minorities more frequently choosing primary care.[50,57,58] Both groups are more frequently represented in departments of Family Medicine than many other academic departments. Despite this, they are still less likely to be in leadership positions.[59] They are actually doubly disadvantaged, as being in a Family Medicine Department similarly works against their academic advancement.[60]

Mentoring in Academic Medicine

The importance of mentoring to careers in academic medicine has long been recognized.[61] Research in law and business as well as medicine reveals higher career satisfaction, and rates of promotion, particularly when mentoring occurs early on in a career.[49] Newer models of mentoring have often sought to provide such career-advancing advice to junior faculty even when they lacked a personal senior mentor.[61,62] Innovative methods to provide institutional and peer mentoring have evolved to fill this void.[62] Business, however, has more effectively developed and understood models that are particularly effective for minority faculty.[47]

Mentoring and the Challenges Underrepresented Minorities Face

It is difficult for a minority student to prepare for the isolation that he or she will face in pursuing a career in medical Academe because of the paucity of other minorities in most medical programs.[36] Another extra challenge facing minorities is that many of the traits that have helped them to be successful, such as being strongly self-reliant, can work against them in achieving a successful academic career. Being more guarded, and less open can impede the development of mentoring relationships, even with senior faculty who may genuinely wish to provide assistance. It can be difficult for minorities to trust a majority mentor. Cultural sensitivity in cross-racial mentoring is essential.[17, 40]

Success in Academe is also often contingent on the ability to work well with others and to collaborate. Anything that hinders effective collaboration can be detrimental to an academic career.[53, 63] Black faculty report fewer colleague relationships (8.0) compared to white and Hispanic faculty (9.2 and 9.8 respectively),[63] which may also result from their strong self-reliance and the lack of other minority peers and colleagues like themselves in Academe. Minorities in training programs frequently don't stay at their training institution and perceive less effort to recruit them.[21] A further barrier for minority mentoring is that there are few minorities in positions of power to serve as role models or mentors

to help them advance[34, 64] or even to provide the essential information and advising to enter academic medicine.[64] All faculty need superordinates in their networks and as mentors, and this is no less true for minority faculty.

Mentoring and the Challenges Women Face

> *"I think there is much more mentoring going on, people are much more in tune to it…I think it's just another era."*[1]

Women face gender discrimination during medical school.[41, 65] Yet most young women faculty assume the playing field is level until they repetitively encounter gender bias as faculty.[46] A "collective ignorance of what discrimination looks like"[53] and a lack of mentoring around how to address it mean that women still lose valuable time in establishing their careers. Not getting off to a strong start exacerbates the frequently experienced conflict between the tenure clock and the biologic clock. The paucity of women in higher positions provides few role models for women to follow or to provide mentoring in these gender-related issues.[66, 67] Senior women faculty also express concern that if they give too much attention to gender discrimination, they will scare away talented women trainees.[46] Despite the difficulties in determining how much to dwell on gender issues, senior women faculty remain the best source to provide invaluable assistance on strategies to address gender bias and discrimination.

Gender Challenges in Mentoring

Women are as likely as men to report access to a mentoring relationship,[48] but in some studies they gain less benefit from these relationships.[53] Male mentors are often not as forthcoming or comfortable with women mentees as men, which can also impede the value, quality, and amount of mentoring which women receive.[46] While women's family responsibilities are often a factor in their career development,[14, 68] too often potential mentors over-focus on these as an impediment, which can be a disservice to women.[46] Many men are also more used to dealing with women in terms of their social roles (father-daughter, husband-wife) than as professionals, which can unconsciously lead to paternalism, over protection and fewer opportunities in their professional relationships.[53] Cross-gender mentoring relationships can also be open to suspicion and rumor — another obstacle to their progress. Differences in

gender and power in the mentoring relationship are difficult to address, but these issues should be discussed and addressed at the start of the relationship. Role plays can also be helpful in learning how to manage these relationships, especially the gender and power aspects.

Education for awareness of gender and cultural issues and training in negotiation and conflict resolution can help women address these challenges in a non-confrontational way. Given the need for these extra skills and knowledge, many women understandably also endeavor to build collaborative and peer mentoring relationships to augment their more formal mentor relationships.[62]

Negotiation as a Tool to Navigate Academic Medicine and Its Interface with Mentoring

> *"Mentorship is an essential part of the academic process. Part of that mentorship means getting them [junior faculty] to hone their skills in negotiation. Getting them to develop strategic plans. To me, the lifeline of academic success is mentoring."*[1]

Negotiation is a process that can be learned as any other skill, but few medical faculty acquire this knowledge during the course of their training[69] and certain aspects of their medical preparation can actually make negotiation difficult.[52] The narrow curricular focus of medical schools often leads trainees to ignore courses that could further personal development and improve communication skills. The autonomy in physician clinical practice can also be an obstacle to effective negotiation, which requires effective collaboration to be successful. By the time trainees in medicine understand the need to know more of the process of negotiation, they have often reached the initial point where it is a very necessary skill to have – the negotiation for their first job.[17] Even if a resident or fellow has acquired negotiation skills, knowing what to negotiate for and succeeding in the negotiation are far from assured. In these days of budget cutbacks, increasing numbers of faculty are beginning their careers without sufficient resources to succeed in academic medical careers. In particular women begin with fewer resources, including less office space, less protected time for research and less grant support than their male

colleagues.[53] Minorities also tend to share these disadvantages and often have high salaries, but little administrative support for their careers. Mentoring at such a time is absolutely critical, but many individuals at this career stage, have not yet identified a mentor nor built substantial professional networks.

Success in that first negotiation requires a solid knowledge of both negotiation tactics and of what is "on the table," that is the value-added that you bring to the position and the resources required to achieve in the job description being considered. Trainees should open discussions with other faculty in their institution and other institutions to gain an idea of the resources they will need to build an academic career. Multiple perspectives are useful and can permit the junior faculty member to determine the most necessary resources ("the must haves") by their overlap among the various opinions that they acquire.[69]

Trainees also need to prioritize what they need during the initial phase of their first appointment – what is an absolute must to get a promising start, and what might be helpful, but not absolutely necessary.[70] In negotiating this first package, however high the trainee's debt load, salary may not be the most important part of the package.[70, 71] A high salary without the other necessary resources to succeed can be a recipe for failure.[16] Access to a research assistant or administrative assistant can greatly improve the productivity of a junior faculty member. Early success with grants and publications enhances the likelihood of further successes in winning grants and garnering greater resources and salary increases.

Academic medicine is not a meritocracy; many unwritten rules favor the politically savvy. Nothing facilitates faculty acquiring knowledge of the hierarchical culture of medical schools or of how decisions about resources and salaries get made as a trusted mentor. Mentoring is crucial to obtain an in-depth understanding of the organizational structures and the requirements to advance from junior to senior faculty positions.[72] Knowing the goals and priorities of the institution so as to align individual faculty goals with institutional goals is vital. Being able to discern when further instances on the career path are possible to negotiate is also key.[17] Performance reviews may or may not present opportunities for negotiation.[17]

True collaboration, as opposed to compromise, can improve the possibilities of both the faculty member and the institution.[52] Organizational policies, such as last minute budgets, however, can make negotiation difficult. Viewing annual evaluations as a further opportunity to review accomplishments and to align faculty goals as a means of potentially solving department problems is an effective strategy.[73] The interpersonal skills of medical faculty effective in patient care, such as listening and empathy, can also be effective in negotiation. Knowing the personalities of the negotiators, obtaining information, and

networking as well as learning from experience are key lessons for successful negotiation. In many institutions, however, medical faculty feel powerless to negotiate. The culture of such institutions may need to change for negotiation to be effective or even possible.[17]

The consequences of not having a mentor often include the stress and inefficiencies of not knowing what to expect or how to negotiate. Having a mentor opens doors and possibilities, improves self-confidence, and builds ties within and outside the institution. Effective mentoring facilitates achieving not only academic and research goals, but also personal goals. Sponsorship and mentoring actively promote a career, increasing both the internal and external visibility of the mentee. In contrast, partial mentoring only offers advice when the mentee is in difficulty and provides far more limited career promotion.[61] Effective negotiation and mentoring are closely interlocked and neither by itself is fully sufficient for success in Academe.

Negotiation and Gender

> *"A senior influential faculty member handpicked her to inherit the practice and specialty field, so she has come on as a full-time faculty member with an academic position with the expectation of academic productivity…Her mentor who handpicked her has not guided her into negotiating a start-up package for herself…She has no lab, no support, no resources she can tap into…no practical infrastructure."* [1]

Women are not as successful at negotiation[74] as their male colleagues. Women may not perceive negotiation to be as important to career success as men[17] and may underestimate its importance. Women begin with lower expectations and goals for salary;[75-78] and they may prioritize their goals differently than men. In the Macy study, space was more important than position or salary to women faculty, while men ranked position and salary first (tied) and space second.[17] Women tend to behave more cooperatively and less competitively in negotiation than men do.[79] When women do negotiate aggressively, these behaviors may be perceived negatively, evidence of the narrow range of assertive behaviors available

to women.[53] Since women feel less confident and less successful even when they use similar behaviors as men, achieving a style of negotiation that is both authentic and effective requires dedicated work.[53] When women do prepare well for a negotiation, they become more comfortable and more confident; for men, preparation is not necessarily a factor that is required for confidence.[17]

Failure to negotiate for the necessary resources at the start of a career results in cumulative career disadvantages. Since women often settle with little negotiation,[79] this may result not only in lower salary, but less space, less support staff and other resources that can be key to the success of an academic medical career, interfering with women's ability to achieve their full potential and with their ability to advance.[29, 30]

Negotiation and Minorities

Is negotiation an unrecognized problem for minorities? There is no direct evidence that minorities negotiate less well than their majority colleagues. In fact, they assess themselves as having equal negotiation skills.[80] They have similar to even slightly higher salaries than majority faculty.[48] However, this may reflect the more limited pool of minorities for faculty positions and a greater demand for their presence on academic medical staff, rather than similar to better ability in negotiation. The lack of advancement for minorities coupled with similar salaries to majority colleagues[28, 31] suggests that they may not be negotiating for the resources necessary for academic careers. In the packages they offer minority faculty, department heads need to mentor these faculty regarding the resources and tools they will need to succeed and advance in academic careers.

Both women and minorities frequently face a power differential in their negotiations. Recent research has revealed strategies to effectively address power differentials in negotiation, which could be helpful for both women and minorities. The 'Shadow Negotiation', that is how the discussion will be carried out and how the bargainers deal with each other, can make use of "strategic levers." These levers include power, process, and appreciative moves, to overcome these hierarchical barriers.[81] When one party sees no compelling reason to negotiate, a power move can bring the reluctant bargainer to understand that they will gain by negotiating. Incentives, pressure or allies can all accomplish this end. Process moves can reshape the negotiation, often by subtly planting ideas before the negotiation formally begins. Appreciative moves alter the tone of the negotiation to create a more collaborative atmosphere. All of these means can help to address the power imbalance[81] which can then allow a more collaborative and successful negotiation for minorities and women.

Promising Directions and Lessons: Improving Faculty Development in Academic Medicine

Clearly, all junior faculty need support and mentoring, whether in the older, more traditional format with a senior colleague or with some of the newer, innovative models using peers and colleagues for this function. If we are to encourage trainees to launch careers in academic medicine and to retain bright junior faculty, skillful mentoring is essential. There needs to be an institutional commitment to mentoring and recognition and rewards to mentors if this resource is to be promoted in Academe.[72] Recognizing that the challenges for women and minorities are greater than for other faculty, efforts for mentoring these groups are necessarily more complex and may require extra effort and thought to make these relationships successful. Broader mentoring beyond just the skills necessary for an academic career, but covering the scope of prejudices that these groups encounter is necessary to accomplish career-advancing mentoring.[47]

Additional efforts to make these groups feel welcome and part of academic medicine may also be necessary, including active recruitment of trainees into academic medicine[40] and assuring similar access to collaboration once they are in academic careers, including access to medical students, residents, colleagues, and senior faculty. In addition, women and minorities need to be able to recognize discrimination in all of its various forms, including the more subtle and difficult to perceive variations. They also need to know how to manage it; to be able to sit down with colleagues and raise awareness of the extra challenges, using education to overcome cultural misunderstandings and barriers to equity. Grounded workshops with senior faculty who have successfully dealt with these issues are necessary to alert and train faculty for these occurrences. It is equally important to be able to distance the systemic problems of discrimination, such that women and minority faculty members do not take it personally, and realize that while it is not always possible to change another's feelings about race or gender, it may be possible to influence behaviors.[40, 46]

The value structure in academic medicine is more aligned with a male model, with the modes of interacting assuming a vertical structure. Because of being less comfortable in this structure, women and minorities may feel less able to successfully mentor others in this environment. Women and minorities also see greater risks in becoming mentors, as they perceive that they have fewer qualifications to mentor, as well as less time because of a variety of confluences, such as the "black tax" and greater family responsibilities.[28, 68, 82] This can also mean that those who most need mentoring have greater difficulty obtaining it because of the fewer senior faculty who are black and female.

Those least likely to have been effectively mentored, then are still expected to do the most mentoring for the women and minority faculty who follow.

Despite all of these challenges, the future of academic medicine is inextricably linked to the development of women and minorities in Academe. Eighty five percent of new entrants to the workforce by 2005 will be ethnic minorities and women.[83] Academic medicine will lose enormous talent if Academe cannot more successfully encourage these groups to enter and remain in our best medical institutions. Literature from the business world has made it abundantly clear that diverse teams outperform homogeneous ones, showing improved creativity, agility, and decision-making, especially in chaotic circumstances.[84, 85] Differences in management styles between women and men have also emerged that reveal advantages from encouraging women to assume managerial positions. The more collegial, collective styles of women, as opposed to the more singly-competitive male model have resulted in better worker performance and effectiveness.[86]

Strategies to improve the environment for women and minorities are less about gender and race than they are about progressive human resources and group process practices. Changes in the policies for women and minorities are beneficial for everyone's work and career. The very process of adding greater numbers of women and minorities to Academe will aide in producing more tolerant and open-minded future physicians, which can result in medical care that does not discriminate by gender or race. Such policies could help to eliminate the disparities in health care which have been so clearly demonstrated for minorities.

To attract the next generation of academic faculty, in addition to becoming more tolerant, Academe must also allow greater flexibility in achieving academic careers. The fall in medical graduates seeking careers in primary care and surgery in recent years has as much to do with life-style as with other concerns. The steps to enforce an 80 hour work week for surgical residents has resulted in greater numbers of residency applications in surgery. Both training for and careers in academic medicine must permit robust personal lives to attract faculty. Family life must be better integrated with professional life[12] and with variability in professional time commitments throughout the various stages of academic careers to obtain the best and the brightest trainees for faculty positions. Part-time pathways that can expand and contract as personal issues emerge are vital to making Academe competitive with other medical careers. Incentive bonuses and awards can also aide in promoting flexibility in academic careers. Mentoring, the most crucial component of the research environment, must be crafted during the recruitment process, as well as associations with research groups.[14] Linking clinical activity with research activity when possible can encourage translational

research. When hiring faculty from internal institutional training programs, it is essential to construct a career development program equivalent to that for outside recruits with similar start-up support and protected time.[14] For those contemplating health services research, extra degree work, such as a Masters in Public Health, can be essential to academic success in epidemiology and outcomes research. Those in the clinician-educator track require time for scholarly activities and to develop teaching skills. It is also essential to allow movement between tracks to encourage academic choice for medical faculty.[14] The future of academic medicine in the U.S. must encourage change and embrace new challenges if it is to remain at the forefront of medicine worldwide.

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MENTORING

EVERYTHING YOU NEED TO KNOW ABOUT MENTORING

"[Mentoring] put me in a positive position to interact with my colleagues…it put me in a more positive light in that when grant projects or other academic intramural things happened I was brought to the table a good deal more…it helped my esteem greatly…I had guidance and support…all kinds of possibilities, where no limitations were set." [1]

How Important is Having a Mentor?

"[Having a mentor is] kind of like going to medical school and they give you your advisor, and they invite you over to their house for dinner, that really makes you feel connected." [1]

"I really firmly believe, in being around medical students now, that they make their decision [specialty choice] based on a role model. In some cases that role model turns out to be a mentor." [1]

Mentoring has never been so important to individual career development or to organizational health. Mentoring relationships are not only key to developing productive careers in any field;[2-4] they are also crucial to building an organization's success in a "knowledge-based" economy.[5] Organizations that do not effectively share knowledge suffer tunnel vision and inefficiencies; whereas organizations that

purposely assist their new employees to acculturate and swiftly reach a desirable level of performance, improve productivity and reduce loss of valued staff. [5]

Over the last decade, new ways of thinking about mentoring have been evolving to keep pace with the changing complexities of work and organizational structures. The traditional one-on-one apprentice model resembled "academic parenting." This model assumed a relatively slow pace of change and of work and also that senior members of the organization hold the most important knowledge and can effectively transfer their knowledge and wisdom to their protégés over a period of years.

Contemporary organizations, however, intent on creating highly functional teams and improving knowledge sharing across units are dismantling hierarchies. In another contrast with previous eras, academic organizations are escalating revenue-producing demands so aggressively that faculty have less time for one-on-one sessions. Also, to be successful now, individuals must not only understand the systems in which they work, but also must be able to influence these systems and 'unlearn' techniques and knowledge that become outdated. To succeed in this pattern of continuous change, one mentor is not enough; trainees benefit from exposure to a variety of styles and options, the better to see what stimulates their own development.[5]

Thus, in today's academic medicine the traditional "academic parenting" model for mentoring relationships is better characterized as "collegial support" and "facilitative partnerships" in an evolving learning relationship focused on the mentee's learning objectives.[6] While these shifts in the characterization of mentoring do add to the challenge of summarizing key features, the traditional definition actually remains serviceable: "a dynamic reciprocal relationship in a work environment between two individuals where, often but not always, one is an advanced career incumbent and the other is a less experienced person, and the relationship is aimed at fostering the development of the less experienced person."[7] What do such relationships produce for the individuals involved, how do they materialize, what are the qualities of a sound partnership, how can they reach across differences, and what effects might they have on their 'host organizations'?

Why Do I Need Mentoring?

Mentoring is not just for the young; anyone desiring to become more effective and influential can benefit from mentoring. In fact leaders ought to be the most motivated of all to seek it (and indeed, executive coaching - that is very targeted mentoring in exchange for cash - is a rapidly growing field).

The focus here, however, is primarily the collegial mentoring of junior faculty; virtually all of the points discussed apply as well to trainees at the post-doctoral and residency levels.

Mentors can play a variety of roles in helping junior faculty define and achieve their career aspirations.[8, 9] Faculty with mentors feel more confident than their peers, are more likely to have a productive research career, feel greater support for their research, and report higher career satisfaction.[10, 11] Mentors also assist in the acculturation of junior faculty to the profession by modeling collegial behaviors and sharing knowledge. Mentors can provide constructive critical feedback on performance, facilitate introductions to key people, write letters of recommendation, submit names for awards, and help in grant and manuscript preparation.[12] Ideally, mentors can also advise junior faculty on managing difficult interpersonal problems at work and on balancing career and home-life.[3]

Unfortunately many junior faculty, particularly minorities and women, either fail to perceive the importance of mentoring or are unable to obtain or attract it (see the following section). The greatest danger for junior faculty in academic medicine is isolation. Faculty without mentors have less opportunity to learn "the rules of the game" and hence they over-rely on inefficient "trial and error" methods of gleaning essential information about themselves, their institutions, and career-building in general. Faculty without mentors often don't feel as closely tied to the department or institution[13] and express concerns about being exploited - working for lower salaries, not knowing their worth, not being positioned well in the institution and not finding their "niche." Faculty without mentors are also less likely to negotiate for what they need; because they lack access to the "unwritten rules," organizational decision-making seems "mysterious."[1]

How Do I Obtain Mentoring?

"I sought out people and eventually, in time, found peers and/or some people who were more senior that I drew off of and used for advice…find the people that you will interact with well…once I went to them and started to break the invisible wall, then all of a sudden they were more incredibly helpful."[1]

Some individuals appear to easily attract excellent advice and build a professional network, but a closer look usually reveals the work involved. Probably these individuals began seeking mentoring early (the earlier the better) and in many places (the more the better). The aim is a variety of developmental relationships with peers, with senior persons, inside and outside your department and institution, and even outside medicine and science; the latter help you to obtain the "big picture" of trends and expertise affecting your field.

Successful developmental relationships can come together informally, evolving naturally over time towards mentoring commitments, or from more formal mentoring relationships (see below). Strategies include junior faculty setting up individual meetings with other departmental faculty to discover faculty members' interests and work styles.[13] It is wise to experiment with different strategies for introducing yourself and approaching respected individuals for the different mentoring roles they might be able to provide. When contacting a potential mentor, you might simply request, for instance, "the opportunity to obtain feedback on research methods." Busy people are more likely to respond affirmatively to such a request than to the "M-word" because no future commitment is implied. But brief interactions can grow into a learning partnership, which might keep growing into a long-term alliance.

Thus, a strategic approach to obtaining mentoring is to build a "mosaic" of advocates, coaches, advisors, learning partners, and supportive colleagues. Some of these will be peers within your own institution and at other organizations who can provide significant support, sources of collaboration and knowledge. Fundamental to academic career development, such networking is indeed work (especially for introverts); this work requires careful, regular attention to connecting with individuals and building relationships. E-mail has become an essential tool in initiating and maintaining such relationships, but opportunities to speak and to see each other are invaluable for important exchanges.

What Should I Seek in a Mentoring Relationship?

"We have, at least, a marriage in how we think about our scientific problems. That becomes the person I feel I can draw off of…a lot of it is compatible personalities."[1]

"It has to be somebody that you trust…that's as important as [respect]…and someone established in the field." [1]

In the most highly prized mentoring relationships, the protégé and the mentor are "on the same wavelength" and "have the right chemistry."[13] This chemistry facilitates understanding of each other's working, communication, and relational styles. Other highly prized characteristics are a mentor who is: responsive and available, values mentoring as an important part of his or her professional role, and holds a high standard for the protégé's achievements.[13]

The effective mentor sets the stage by getting to know the protégé well enough to recognize the full potential of the mentee. Mentors engender a sense of possibility and encourage the protégé to reach to their highest abilities. Other important supportive actions include acting as an advocate for the junior faculty. When appropriate, the mentor promotes the protégé while protecting the protégé from the at-times-harsh interactions in Academe, "taking them under their wing." The mentor also supplies encouragement as well as constructive criticism; this can often expand the scope of the mentee's work and in some cases the actual direction of the work, improving the overall career, and "allowing it to unfold."[1]

Mentors who are widely respected in their fields can also help protégés gain access to leaders and to otherwise difficult to enter academic circles. The mentor can teach the protégé how to appropriately promote themselves, as well as teaching the "rules of the game" related to academic politics and networking. In these senses, "There is no school to learn what the mentor teaches."[1]

Characteristics that young professionals also seek in a mentor include: listening as an ally (leaving the protégé in charge while stimulating him to think more courageously); putting the protégé in touch with the best aspects of herself/himself; taking the long view (e.g. asking "how might this connect with what else is important?"); and constructively helping the protégé recognize areas of weakness. While the mentor can also be a key source of "reality checks," given the rapidity of change within medicine and science, both parties should keep in mind that career advice applicable even five years ago may no longer be current.[14]

In a successful mentoring partnership, both the protégé and the mentor understand their own communication and relational styles, and they respect each other enough to "reach across differences" for the good of the relationship. Ideally, every junior member of the profession is able to build a partnership

that supports their personal and professional growth and inspires them to the highest standards of achievement and behaviors. However, these days faculty are unlikely to find all these desirable attributes in one partnership. Given the complexities of both career-building and of all the domains of clinical excellence, research skills, and administrative acumen, they should not be discouraged but rather keep seeking to build relationships with role models they admire.

It must be admitted, however, that in some health centers right now, some young faculty and trainees are hard-pressed to find role models with enthusiasm, balance, and excellence. Unfortunately vocational burnout is taking a toll in medicine,[15] such that younger members of the profession see many exhausted and unhappy faculty who actually distance themselves from their patients and their students.[16] Dr. Thomas Inui's recent monograph on the modeling of professionalism is relevant here. He writes that most faculty are painfully aware of the gap between their ideals as a trustworthy medical professional and how they sometimes behave: "[But] we are silent or inarticulate about this dissonance and, in our silence, do not assist our students to understand our challenges when attempting to live up to our profession's ideals. Seeing so many differences between the ideals of medicine and actual behaviors, and hearing nothing from us about the difficulties we face, students are left to their own devices." To be sure, there are no quick fixes for this challenge, but faculty might keep in mind that their protégés require their authenticity and will learn from their courage. That authenticity may make all the difference to the next generation— and to whether they pursue careers in academic medicine and become mentors themselves.

What are the Responsibilities of the Mentee?

There is no substitute for self-examination. The clearer your sense of goals and assessment of what skill and knowledge areas need attention, the more efficiently and effectively you can seek mentoring. It is never too early or late to try to outline your own mission statement of what you value and hope to achieve; from this statement follow your short- and long-term goals. This written preparation, even if only a few lines, heightens the likelihood that you will proactively seek that combination of support and challenge which will effectively foster the growth of your vision. Perhaps the primary message is to accept responsibility for your own growth. This involves continuous learning, initiating developmental relationships, and letting others know what you're working on.

Another responsibility of the mentee is respect for both the time of the mentor and any privileged information that may be shared. Nothing jeopardizes a relationship more than a breach of trust, so hold in confidence any protected

information that is given. Also be economical with your mentor's time, that is, be prepared and organized to make the most of any exchange.

Understand that the relationship is reciprocal; your mentor may expect your assistance with projects and articles. Mentees should also remain alert to information and resources of possible value to their mentors and share these as appropriate.

Finally, keep in mind that the relationship will naturally change and evolve, and hopefully become an important source of colleagueship for both parties. However, unanticipated events or discoveries may render the relationship untenable or too difficult to continue.[13] Thus, it is critical that mentoring be a no-fault relationship that either party may terminate without harm to either.

Does Race or Gender Make a Difference?

"He was a white male and I am an African-American. I learned a lot from his perspective and I would like to think he learned a lot from mine…we learned by positively challenging…he came from the Midwest out of Indiana and I was probably the second African-American [he had contact with]…he had not had that experience so he and I got to learn about Kosher and about African-American experiences in things that he may have thought of in stereotypes or cultural things, and I learned a lot from him…It was a very good learning experience." [1]

"It's a rare man who has the insight into what a woman has to do in order to get where she's going." [1]

"Boundaries are well set. And I make certain the opposite gender person doesn't step across my boundary, and I am very careful not to step across her boundaries." [1]

"I have a lot of preconceived prejudices that I have to overcome. But as a man…to tell the truth, I don't have as much trouble cross-mentoring a male African-American as I do with a white female…It is much harder for me to mentor a female than a man simply because I don't always understand how they are thinking. That has nothing to do with my belief that they should be mentored equally well. I am just not sure I know how to do it." [1]

Given the paucity of women and minorities in senior positions, it is not surprising that a national study of medical school faculty found that most mentors were white men.[10] Naturally, some junior faculty greatly prefer a mentor of the same gender or race, even though, in some fields it may be unrealistic to find same-gender or same-race mentors who have the seniority and power to further the protégé's career.

The relative homogeneity of the senior faculty contrasts sharply with the heterogeneity of trainees and young faculty. In a positive vein, these differences may serve to stimulate mutual learning about other cultures. But they also add a number of challenges, including finding a common ground from which to begin the mentoring relationship.[18] For instance, in cross-gender mentoring, traditional gender roles may interfere; male mentors may assume a "father figure" role and treat the protégé paternalistically without at all intending this dynamic. Because they have little experience with women professionals, faculty mentors in specialties with few women often voice understandable concerns about cross-gender mentoring.

Many studies have found that women gain less benefit from the mentor relationship than men do. One internal medicine department found that mentors more actively encouraged men than women protégés to participate in professional activities outside the institution and that women were three times more likely than men to report their mentor taking credit for their work.[19] Among cardiologists, women found their mentors to be less helpful with career planning than men did and more commonly noted that their mentor was actually a negative role model (19% of women vs. 8% of men). They were also less likely than men

to negotiate for salary, benefits, travel, space, support staff, and administrative duties—reflecting a combination of naiveté and under-use of their professional network.[20] Women's informal networks are also less extensive and less likely to include super ordinates or colleagues from previous institutions.[21]

Most studies of the mentoring of minorities have been conducted in the corporate world. As with cross-gender relationships, cross-race relationships also encounter extra difficulties forming and maturing. For instance, the largest study of the mentoring of minority executives found that:

a) A mentor who holds negative racial or gender stereotypes is unlikely to give protégés the benefit of the doubt;
b) When the mentor has trouble identifying with the protégé, seeing beyond the protégé's weaknesses is harder;
c) A protégé adopting the behavior of the mentor might produce different results (e.g. an aggressive style successful for white men may get women and minorities labeled "angry").[22]

These difficulties have a grave effect on the careers of women and minorities because they actually have a greater need for mentoring than majority men do. For instance, women and ethnic minorities tend to be hesitant both to seek career advice and to draw appropriate attention to their achievements; they are also less apt to see themselves as successful even when their potentials and credentials are equivalent or superior. Moreover, our culture tends to devalue women's work and intellectual contributions. Lacking career-advancing mentoring, too often women and ethnic minorities remain isolated from their colleagues and from their own communities; this isolation further reduces their capacity for risk-taking, often translating into a reluctance to pursue professional goals or a protective response such as niche work or perfectionism (the obverse strategy of identifying a hot topic).[23]

If mentoring across such differences doesn't come naturally, faculty can work on improving their techniques of active listening, avoiding assumptions, and reflecting back. Majority men should also remember in advising women and ethnic minorities that a style that worked for them may not work for these protégés because our culture allows women and ethnic minorities a narrower band of assertive behaviors than white men are granted (e.g. he "exercises authority" but she's labeled "bossy").[24]

Building Organizational Capacity

Good mentoring relationships boost any institution's stability and leadership capacity. Academic institutions that bring new and junior faculty

together with senior faculty in a systematic way assist faculty to enter and navigate their complex academic environments more smoothly and to better assimilate its customs and expectations. Likewise, faculty development programs that facilitate career-important relationships contribute to faculty's academic advancement[25]; such programs are growing in importance and number, and likely cost much less than replacing and retraining faculty.[24]

Going one step further, some institutions and departments have created formal mentoring programs;[26] such programs facilitate mentor/protégé pairings and often provide both parties with resource guides and events to help bring them together. Clearly, there are several ways to facilitate mentoring matches without making assignments. In many doctoral programs, unlike in many medical academic programs, junior academic faculty are required to meet with each member of the department at the start of their time at the institution. This structured system facilitates the initial search for the right match and can expose the mentee to the many different styles and varying interests of the departmental faculty.

Another good example comes from a medical school that established and evaluated voluntary mentoring programs with minimal resources during major re-organizational change. Both of its programs (one-year preceptoring and multi-year mentoring) involved voluntary participation with junior faculty members selecting senior ones; 20% of junior faculty and 30% of senior faculty participated. Faculty indicated the program was worth the time invested, had a positive impact on their professional life, and increased their productivity. There was also high satisfaction with the mentoring relationship, especially the psychosocial aspect and a trend toward increased retention of minority faculty.[27]

Another model is that of collaborative mentoring programs within an institution, which is a facilitated group-mentoring program for junior faculty that provides a framework for professional development, emotional support, career planning, and the enhancement of personal awareness and skills important for a successful career in academic medicine.[28]

Mentoring is a professional activity that medical schools should formalize and recognize as a core academic responsibility.[26, 28, 29] The types of improvements that academic health centers can implement to support faculty in their responsibilities as role models and mentors cost virtually nothing. For instance, some schools now offer mentor-of-the-year awards; some include in the criteria the modeling of integration of personal and professional lives. Evaluation systems ought to better reflect the importance of professionalism and mentoring. Students deserve the opportunity to evaluate faculty on such areas as "provides timely feedback that both challenges and supports me,"

"demonstrates respectful attitudes," and "inspires me as a role model." On their annual review, senior faculty should be expected to name their protégés, and trainees and junior faculty asked to name their mentors and role models. In the faculty promotions process, promotions committees might count not only first authorships, but also last authorships when mentees are first authors.

A primary goal of all the efforts described above is building a supportive ecology in which collegial relationships develop naturally.[24]

Conclusion

Young faculty must continually explore all promising avenues for addressing their career needs, soliciting advice and seeking the guidance they need to keep growing. Likewise, whatever framework frees, facilitates, and inspires senior faculty to offer their gifts of expertise to the next generation should be employed. In addition to making time for these activities, one of the biggest challenges now, especially for senior faculty, is courageously reaching across differences. Effectively mentoring someone of a different ethnicity or gender often begins with opening ourselves to another culture, seeking to understand the historical realities of oppression and their continuing often subtle effects.

Breaking down the "invisible wall" that separate junior faculty from more senior colleagues should be an institutional priority. Systems of collegial support and productive facilitative partnerships within the academic community have never been more important than in today's rapidly evolving 'knowledge industry.' Academic health centers now have ample evidence of the value of stimulating, supporting and rewarding such faculty-faculty "bridges." Indeed, mentoring represents the most tangible bridge to continuing the excellence in academic medicine that is so challenged by managed care and budget constraints.

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Negotiation in Academic Medicine

Negotiation Skills and Their Use in Academic Medical Careers

"Junior faculty don't have much experience in negotiation. People in medicine, throughout their training, have been given jobs that don't require negotiation. Physicians are ill-prepared for negotiation…[They need] to be better prepared to at least reach the level of preparation that the average person would have. They need to know how to assess their own goals. What do they want to get out of this? They need to understand the importance of negotiation. You don't get what you deserve, you get what you negotiate." [1]

Negotiation is a strategy to resolve differences in situations where there are both divergent and convergent interests.[2] It requires effective communication of goals, needs, and preferences. Effective negotiation has been considered critical to the success of individual careers in the professions and business. Negotiating the conditions for success at work covers a broad range of critical issues. In academic medicine, these may include, but are not limited to, salary and benefits, assignments and rotations, support for research, protected time for personal life, performance evaluation, and career development.[3] Flexibility of job structure and work relationships can also be achieved through active negotiation.[4] If professionals fail to negotiate for conditions that will make them successful, they can find themselves increasingly disadvantaged in terms of opportunity and salary. The process of quality improvement in medicine also requires the use of negotiation skills to achieve better outcomes. Individual careers and medicine as a whole will gain by greater attention to, and training in the skills of negotiation.

By their professional propensities, physicians may not be optimally prepared for prevailing in negotiation processes. Certain characteristics of

physicians, useful for doctoring but arguably maladaptive for negotiation include a competitive orientation, a professional assumption of autonomy, an emphasis on equanimity and limited emotional expressiveness and a significant predisposition not to ask for help.[5, 6] Conflict management by physicians in negotiation may be particularly difficult, because they tend to be averse to confrontation.[7] Finally, a strong emphasis in medical training is given to gathering data to develop 'the one right answer.' Negotiation is a process, on the other hand, which contemplates the likelihood that there is no one right answer, only multiple points of view.

Insufficient Awareness of the Significance of Negotiation

"Fascinating question to think one has to be trained in these things [negotiation]. The issue of asking, how to ask, how much to ask for, comfort level, style, training, skills in negotiation basically. Just general approaches. It's learned behaviors and not intuitively obvious to some people. I wish I had learned that there was even a concept [of negotiation]." [1]

Many medical school faculty are unaware of the importance of negotiation to an academic career. In a study based on telephone interviews of medical school faculty who rated themselves as having poor to neutral negotiation skills (66% of faculty in the National Faculty Survey), only a few (4 out of 20) were fully aware of the importance of negotiation to their academic careers.[8] For those faculty unaware or not fully aware of the importance of negotiation, one frequently recognized limitation was an inability to perceive the opportunities for negotiating. Negotiation was only seen as helpful in the initial stages of a career, e.g. when negotiating for a first job. Subsequent chances for negotiation were seen as few. A number of faculty felt the current era of constrained resources in academic medicine also limited the importance of negotiation to their careers. There was little to negotiate for, and they competed for what there was with "the stars and superstars." Lastly, and perhaps most importantly, faculty did not consistently recognize that negotiation skills need to be learned just like any other skill.[8]

Gender Differences in the Importance of Negotiation

"When I became a faculty member, the fact that I was female would have made it [negotiation] impossible anyway. I came from an era where it was not particularly desirable to be a female and try to advance in an academic environment. So I don't know that it would have made any difference what skills I had [in negotiation]." [1]

Women in the Macy study perceived negotiation as less important to an academic career than did their male counterparts. [8] In previous studies, women in business have been found to have lower expectations,[8] goals for salary[9] and to feel less successful even when they use similar behaviors as men.[10] Women medical faculty ranked negotiation skills 7th out of 11 possible choices of factors promoting their career in academic medicine (such as mentoring, oral and written communication skills, etc.), while men ranked negotiation skills 5th.[8] In addition, the importance of the objectives for negotiations also differed for men and women: men ranked salary and position as the most important issues for negotiation, while for women space (first), support staff and salary (both ranked second) were the more important objectives.[8]

Gender Differences in the Process of Negotiation

"I'm a good listener and as a negotiator I guess I am always willing to see the common ground, and I've gotten better at stating my needs." [1]

Gender differences in negotiation skills have been cited as a cause for the lower salaries and slower advancement of women in academic medicine.[11] Studies have revealed that in business, women behave more cooperatively in negotiations, and in face-to face bargaining, less competitively than did their male counterparts.[12] New research supports the hypothesis that women do not initiate the process as frequently as their male counterparts.[13] There is evidence that in real negotiations, as opposed to simulations, women do not fare as well as men.[14] Although most studies of gender and negotiation suggest that men have the bargaining advantage, it remains unclear whether this is a result of inherent ability or of differences driven by stereotyped expectations by either men or women. In a recent study of gender stereotype and reactance in negotiations, women were shown to perform better when they had increased disidentification with negotiator traits perceived to be negative (and feminine- emotional, irrational, conciliatory), and identification with negotiator traits perceived to be positive (and masculine- assertive, rational, decisive).[15]

What Impedes Negotiation in Medicine?

Hierarchy

"There is a sense that there is just power at the top and not much you can do below that. Better communication…maybe a dispersion of power to lower levels…some feeling that there is movement up and down, which there really isn't…I mean my negotiations have to be taken to the person above me who takes them to the person above her who then makes some decision and in some unknown way and then it comes down in a positive or negative fashion…I don't feel like negotiations in my institution make any difference." [1]

There are both institutional and individual barriers to effective negotiation in academic medicine.[8] The hierarchical structure of most medical schools may impede successful negotiation, especially if there is difficulty with vertical (up the hierarchy) communication.

Secrecy, Mystery, and Powerlessness

> *"Medicine, at least in academic institutions, is an 'insider' world. And either you're an insider or you're an outsider…to get good advice is very difficult, especially for young faculty…You sort of feel helpless and powerless towards this big elephant."* [1]

Faculty often feel powerless against the behemoth of a large institution and often have the perception that the large, bureaucratic nature of an institution is unresponsive to individuals, unwilling to negotiate, and only "looking for a bargain," especially in times of constrained resources.[1]

Many faculty feel excluded from the information that is required to negotiate a successful academic career. Specifically, faculty desire to have the 'mystery' removed, and clear, transparent guidelines made available on salary, promotion and resources to individual faculty at their respective rank and job description. From the Macy study,[8] it is apparent that the dissemination of institutional goals, to the extent that it exists at all, is highly variable from institution to institution. If faculty handbooks and/or published guidelines do not exist, faculty should seek out this information from an appropriate senior faculty member, supervisor, or mentor. Clarification of departmental goals by a senior faculty member can enable individuals to align their personal goals and expectations with that of their institution. Ongoing annual or biannual reviews, initiated by the individual faculty or supervisor, can assure that this process continues on an ongoing basis and will help avoid the proliferation of institutional 'mystery.' Faculty development workshops, emphasizing negotiation, promotion, and publishing, can provide skills needed to address barriers to advancement in academic medicine.

The issue of power differentials with chairs and chiefs of departments may determine whether a negotiation takes place and the extent to which it does. There is the perception that in this climate, negotiation makes little difference. All of these institutional factors affect the individual faculty member - the hierarchy, the mystery and the lack of availability of information, and the bureaucracy. Efforts to address these issues will increase the willingness of faculty to attempt negotiation.

Addressing issues of parity, or equivalence of power in negotiation, Deborah Kolb describes *the shadow negotiation.*[16] It is defined as "the complex and subtle game people play before they get to the table and continue to play after they

arrive." Shadow negotiation determines the 'how' of the discussion.[16] Kolb's research has defined three strategic 'levers' that can be used to guide the shadow negotiation- power moves, process moves, and appreciative moves. Each of these tools can be used in negotiation, especially where a power differential exists between negotiators.

Power moves are designed to bring the individual faculty member to the realization that negotiation is necessary. These may occur through:

1) incentives (emphasizing the proposed value and advantages to be gained),
2) pressure (underscoring consequences without negotiation) and
3) enlisting allies (influencing both incentives and pressure).

Process moves are designed to influence the negotiation process itself, and are particularly effective when the negotiator is not being heard or decisions are being made without his or her input. Strategies for process moves include:

1) seeding ideas early- before a position can become fixed in the mind of the negotiator,
2) reframing the process- i.e. shift the dynamic away from personal competition to one that is more team oriented,
3) building consensus- a way to rally support for a position before the negotiation actually begins.

Appreciative moves involve the building of trust and dialogue to shift the negotiation dynamic from adversarial to cooperative. Soliciting new perspectives to help draw out another's agenda, faculty signal to the other side that they are open to differing opinions and suggestions.[16] Any one of these levers may be used alone or in combination to overcome the hierarchical barrier to negotiation.

The Negotiation Process and What Faculty Can Do to Improve Their Negotiations

> *"Be clear about your objectives. Understand as much as you can about [what] the person you are negotiating with wants to get out of it and don't take the negotiation as an assault on your character. Recognize that it is a process. Don't take it personally and recognize that what you get out of something is what you negotiate."* [1]

Prepare

"I wish I had realized before some of the negotiations I engaged in, how important it is to be prepared...Some kind of background, lay of the land, understanding about what other people are doing, because otherwise one feels one is starting from scratch. One has to do a lot of work to find out what other people have and therefore, what one can ask for, or should have had." [1]

Academic medical faculty generally have very little exposure to negotiation during their training, as compared to educational curricula of law and business. Faculty need to prepare for the process. Negotiation is a learned skill and preparation for successful negotiation involves three key areas: knowing your leverage, knowing your priorities (identifying needs and creating objectives), and understanding the process.

Know Your Leverage

"Have an idea of your value. Have the skill to judge your value and your place. It gives you more leverage to negotiate." [1]

Knowing your leverage involves an understanding of your worth and of the quality of your performance as compared to others in your department, and the ability to assess your value to the organization. Your worth can consist of the number of grants or the size of your clinical practice and your clinical referrals, both of which can bring in substantial income to the department or institution. The other side of knowing your leverage is the existence of other job opportunities that you may have in hand. The ultimate leverage necessitates being prepared to leave the institution for career growth and advancement. Assessing whether your goals are amenable to broader interests that might include others in the department or institution can lead to coalitions with

other faculty. Such coalitions can be useful to achieve wider goals and expand a faculty member's base of support.

As part of this preparation, it is necessary to obtain detailed information on both benchmarks for payscales and resources - what is reasonable to ask for, and what the range of resources that can be negotiated for are at any given time. There are several ways to obtain this information, but knowledge of the "academic game" is central to a successful career.[8]

For some faculty, the best and most reliable source for such information is a mentor.[17] Many faculty, however, lack a personal mentoring relationship and obtain their information from peers, senior faculty, and other colleagues.[17] AAMC resources can also be helpful in gaining this knowledge. Learning from your own experience is not an effective means of dealing with these issues and entails costs in time and advancement.

Know Your Priorities

"Going into these crucial negotiations…have a fair idea of what [you] want, what you're willing to concede…Start out in a position that's an advance of your bottom line…it's good to have something you can yield and also to have decided what you're not going to yield and really stick to that." [1]

Negotiation requires the effective communication of goals, needs and wants.[2] There are four basic steps that should be outlined in preparation for the negotiation process. These steps include:

1) identifying needs,
2) creating objectives,
3) establishing the best alternative to a negotiated agreement (BATNA), and
4) understanding the process of negotiation: identification of strategies and tactics.[2]

Identification of needs

To clarify needs, one should attach priorities to them.[2] Through the identification of "must-haves" (what you absolutely need) vs. wants (what would

be helpful, but not absolutely necessary), an individual can be more flexible and creative in the process of negotiation. Self-assessment is a critical step in this process. It helps to provide clarification of priorities, which can be later used in negotiation. A senior mentor may be particularly helpful in the self-assessment process. The prospective identification of needs/ priorities- "must-haves vs. wants"- of the other side is also important. By formulating the answers to similar questions from the other side's perspective, an individual faculty member can anticipate potential roadblocks to future negotiation. Ultimate agreement will require understanding and addressing your counterpart's problem/issues as a means to solving your own. Integral to this process is the identification of common needs and interests. This determines whether two parties can agree and on what points. The ability to identify and to work with common needs and interests during a negotiation depends upon the negotiating skills of a given individual. Anticipation of these common needs and interests is a first step in mastering the process.

Creation of objectives

Upon entering a negotiation, the individual negotiator should have a set of objectives, rather than a single inflexible one. It is important to remember that objectives can be flexible, whereas needs are not. These objectives should be specific and measurable. Questions to identify objectives should include: Does the attainment of the objective meet the most critical needs? Is the objective expressed in clear, concrete, and measurable terms?[2] Determining the range of a given objective, including a minimum and maximum point of settlement for each allows a faculty member to have further clarification of the desired outcome prior to the negotiation.

Establishment of the best alternative to a negotiated agreement (BATNA): What is the best outcome you could expect without undertaking negotiation? The business literature refers to this as a BATNA – best alternative to a negotiated agreement.[17] Determination of the BATNA further clarifies priorities prior to the negotiation process, and may involve walking away from a negotiation or prolonging a stalemate position. Questions to ask include: What are my alternatives to an agreement? What are my alternatives if we fail to reach an agreement? If the alternatives achieve my needs, why is a negotiated agreement important to me?[2] These questions help to define the immediate and long term 'costs' of reaching or failing to reach an agreement. Prospective identification of BATNAs (for both the individual and the other side) set the threshold above which any acceptable agreement must exceed.

Understanding the Process of Negotiation: Identification of Strategies and Tactics

> *"Anticipate the unfavorable response and plan the fall back strategy…and end it cordially and just say that I need to think more about this and just end it."*[1]

Following the preparation, including the clarification of needs, priorities, objectives, and the BATNA, faculty can use their "diagnostic" skills to facilitate the process of negotiation.[2] These skills, well known to clinicians, include active listening, establishing trust, asking questions, and reflecting/verifying through feedback. Ideas should be presented clearly and succinctly, using the few, most compelling rationales to back up arguments.[2] As in the establishment of an effective therapeutic relationship, it is more likely that sustainable results will be achieved if all parties perceive the process as personal, respectful, straightforward and fair.[18] Conventional wisdom in negotiation literature suggests that a collaborative and cooperative approach (win-win situation) to achieving common ground is preferable, but new teachings suggest that differences among parties may be an overlooked value in the negotiation process. As one researcher writes, "differences of interest or priority can open the door to unbundling different elements and giving each party what it values most- at least cost to the other."[19] In seeking out a mutual-advantage approach to the negotiation, individuals have the potential to build coalitions and trust for future negotiation.

The process of negotiation may be hindered by an individual's inability to promote her or himself, especially when dealing with difficult personalities. Knowing oneself, especially with respect to traits associated with effective negotiators, faculty can be empowered to engage more constructively in the process. There is evidence that this is particularly true for women and minorities.[8] In the negotiating process, the 'nurturing' approach is inappropriate. Being assertive and self promoting, however, is not necessarily the same for men and women, and a given individual may feel uncomfortable or unsure of their respective style. Practice through role play with a faculty mentor can assist an individual with this process.

Conflict Management and Negotiation

Negotiation can be used for conflict resolution as well as for the creation of more desirable conditions in the workplace. As physicians tend to be confrontation adverse, failure to confront and manage conflict prospectively can create a hazardous situation. In addition to the preparation for negotiation, outlined above, the following principles should be considered:

1) Anticipate conflict. As in most issues in medicine, prevention is often the best strategy. Contracts are one method by which conflicts can either be avoided or managed.[7] Clear delineation of expectations from the outset can set standards and provide guidelines for future systematic review.
2) Consider and avoid bias. Data from the business literature suggest that people tend to unconsciously interpret information pertaining to their own side in a strongly self-serving way.[18] Even worse is the tendency to assess the other side - especially in an adversarial position(s). The competitive us-vs.-them bias, autonomy bias and hierarchy bias, all inherent to physician training and the professional culture of medicine, exacerbate the challenge of conflict management.[20] These biases can lead physician faculty to unrealistic expectations regarding their own requests with respect to others. Recognition and acknowledgment of these biases is the first step toward overcoming these challenges.
3) Conflict assessment. By seeking views of uninvolved parties, one is more likely to discover bias-free common ground, leading to more genuine collaboration. Use of an advocate/mentor to assist in the preparation of the strongest possible case, through preparatory role play, is also valuable.

How Can Institutions Facilitate and Enhance Effective Negotiation?

"I think that it has traditionally not been in their best interest to have the faculty feel empowered in negotiating for what they need…leadership needs to educate themselves about the negotiating process. And I think that the faculty should also be encouraged…Outside negotiating resources that emphasize negotiating skills that are not a part of our training program should be brought to bear to inform all of us about it [negotiation]."[1]

"Effective negotiation benefits institutions and needs to be recognized as critical to their success. Negotiation can enable more effective use of resources, empower faculty to contribute innovative ideas and improve the collegial esprit de corps, which is central to any thriving organization." [1]

Faculty have identified the following four areas where institutional changes should occur.

Make Relevant Information Available

"What academic medicine has been lacking, although there is some attention being paid to it now, are reasonably good guidelines and expectations that are written down and really adhered to, and that's the bottom line." [1]

Medical schools need to provide more information. Formal systems for publishing and disseminating information, particularly on salary and pay scales, are fundamental to furthering the negotiation process. Greater information on appropriate resource availability for faculty by rank and position is similarly important. In addition, guidelines for promotion, compensation and other important policies need to be written down and adhered to by the institution.

Exert Oversight

"You have to have somebody to oversee the chairman or chairperson…some sort of regular review by a committee that accesses specific instances that had to do with faculty

development primarily…We meet once a year with the chairman and discuss performance and salary…I think that has to be documented in some way and there needs to be a process for reviewing so that it doesn't remain something that's kept behind closed doors." [1]

There is a perceived need for institutions to provide oversight of both the promotion process and compensation of faculty.[1] Such oversight would monitor in particular the actions of department chairs, as they are central to both compensation and promotion decisions. Faculty voiced concern that chairs could not always be trusted to do this. Parallel with providing oversight of department chairs and division chiefs, institutions need to establish a grievance procedure for handling disputes using an impartial mediator.

Empower Faculty

"For negotiation to be effective, the culture of the institution would need to change…Faculty need to be able to present a point of view cogently and both chairs and faculty need to learn to meet coming from both sides of the issue." [1]

Institutions need to empower faculty to negotiate. This goal can be accomplished by promoting knowledge of negotiation skills to faculty, as well as providing more information to faculty such that they negotiate from a solid understanding of institutional policy, goals, and resources. Creation of faculty development workshops and development of mentor networks are two ways in which these goals can be accomplished.

Broaden the Network to Include More Women and Minorities

Lastly, institutions need to substantially increase the numbers of women and minorities in academia. Providing more open information will enable these groups to participate more fully in academic life, but it is equally essential to increase their numbers to broaden their support network.

Conclusion

More effective negotiation in academic health centers can improve the ability of Academe to creatively utilize resources and to meet institutional problems with more collaborative and resourceful methodologies. Should individual faculty and institutional leaders embrace and facilitate greater use of negotiation in academic medicine, it would benefit the institutions and the individual faculty.

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GENDER

The Cumulative Career Disadvantages Facing Women Faculty

How Important is Gender in the Careers of Women?

With regard to women in medicine, the good news — the high numbers of women entering medical schools — is obscuring the bad news — that academic medicine still greatly favors the development of men. Three decades after women began entering medicine in force, they remain scarce in board rooms and executive committees. In twenty years, the percentage of women faculty in the rank of full professor has risen only 2%, such that in 2003, a mere 12% of all women faculty, compared to 31% of all men faculty, are full professors.[1]

Cohort analyses reveal that men and women begin their first faculty appointment with the same degree of preparation for an academic career in terms of board certification, advanced degrees, and research during fellowship training. But women are less likely to have office or laboratory space, protected time for research, or to have begun their faculty careers with grant support.[2, 3] Women also receive fewer rewards for their work, with lesser advancement and salary than similarly accomplished men.[4]

Numerous schools have conducted studies comparing the career experiences of their men and women faculty.[5, 6] The University of Arizona's recent in-depth study found that among the medical faculty there were no differences between men and women in the self-reported importance of career advancement; extent to which work and personal life conflicted; desire to work part-time; and self-assessed leadership abilities or aspirations to hold leadership positions.[7] The findings of a national study support similar motivation and aspiration of women in academic medicine as the Arizona study.[8] The Arizona analysis of its faculty databases concluded that: Women were as academically productive as men, despite having less research space and less influence in their departments; women's contributions were less likely to be recognized with tenure or salary increases; and despite equivalent self-assessed leadership abilities and aspirations, women were much less likely to be asked to serve in leadership positions.

Because women are just as different from each other as men are from each other, the impact of gender on a phenomenon as complex as career development will remain difficult to describe and pinpoint. Clearly no one barrier or "glass ceiling" keeps women from advancing, but the weight of the cumulative career disadvantages they face translates into a *defacto ceiling*. Because these obstacles are cultural and systemic, that is deeply engrained views of women and of

expected career trajectories, sustained organizational change initiatives are necessary. Attempts to "fix" or "re-engineer" women to make them be more like men are doomed to have limited impact.

This chapter summarizes the most identifiable cumulative career disadvantages that women face, emphasizing the subtle gender-related discrimination with which women still, mostly silently, contend. It concludes with recommendations and change strategies to individual women and to institutional leaders.

What are "Mental Models" of Gender?

> *"I think most women feel that there is something wrong with them, it is their flaw, and that they are the only one that is being harassed. They have so little support structure to either teach them that isn't the case, or to resolve the problem. They don't have much of a place to turn or a way to solve the problem and tend to internalize it and that tends to isolate them further, which has obvious consequences, adversely affecting their careers."* [9]

While most health centers have now instituted serviceable policies prohibiting sexual discrimination and harassment, these behaviors continue to detract from the education and opportunities of women professionals.[10, 11] Even medical school department chairs admit to witnessing inappropriate sexual behavior, including the pressuring of women to participate in sexual relationships.[12]

Almost half of American women physicians believe they have been harassed during their careers, and most cite medical school as the location. Harassment is associated with depression, suicide attempts, and a desire to switch specialties.[13] Abused students are more likely to lack confidence in their clinical skills and in their ability to give compassionate care.[14, 15] Women faculty who have experienced such discrimination report lowered career satisfaction and professional confidence.[16]

As troublesome as overt harassment and discrimination continue to be, subtler, non-actionable, forms of bias pose a much larger challenge to women's development as professionals. Both men and women asked to rate works of art, articles, grant proposals, and curriculum vitaes give lower ratings when they believe they are rating the work of a woman.[17] For instance, an analysis of peer-review scores for postdoctoral fellowship applications revealed that women applicants had to be 2.5 times more productive than the average man to receive the same competence score.[18] Students judge women faculty who are not nurturing much more harshly than they do men professors who are not nurturing.[19] These biases also mean that women must work harder than men to be considered professionally competent. Women also report feeling "invisible" and frequently having their contributions at meetings ascribed to men.[20] The cumulative experience of fighting gender stereotypes feels like a 'ton of feathers.'[16, 21]

The concept of "mental models" is helpful in examining how assumptions act as filters through which we continuously select data from the stimuli surrounding us (see also the Chapter on Minorities). But these "shortcuts" exact a price. "Mental models" of gender deny individuals the opportunity to be appraised positively on the basis of their unique traits. Indeed, men or women who act "against type" tend to be dismissed or marginalized: a man who displays more sensitivity than is culturally normative risks derision; assertive women are often perceived as "uncaring." Both men and women still tend to devalue women's work and to allow women a narrower band of assertive behavior. Outdated mental models persist, in part, because individuals, especially dominant personalities, tend to ignore information discrepant to their stereotypes.[22, 23] Nonetheless, most scientists and physicians appear to believe that they work in a meritocracy and that they are not influenced by stereotypes.[24]

Thus, as psychiatrist Linda Austin has observed: "Women must be even more psychologically brave than men to succeed…The achieving woman must separate from gender norms decreeing that women are 'good' not 'great'…At every step she is challenged to develop her own version of achievement. Neither women of previous generations nor males of any era have been challenged to individuate to such a high degree."[25] Because this is such a tall order, it is no wonder that so many women internalize the difficulties, which becomes a virtual "personal glass ceiling." Women who do persevere and advance face the extra challenge of "surplus visibility." Because the higher they go, the fewer they are, women become ever more exceptional by their mere presence on the academic scene and visible to the point of inviting critical scrutiny. While this visibility can represent an opportunity, living in a "glass house" with no room for error, is more often experienced as an isolating stress.

What Can Women Do to Address Discrimination?

"Discrimination ends up being a 'ton of feathers.' I think you have to stop it at the first feather. That takes some kind of consciousness raising and sensitivity very early on…you need to learn from other cases…you raise consciousness enough where little tiny transgressions can be caught…The idea is to stop inequities and exploitations where they begin, be proactive. One of the biggest problems is being tolerant, you allow it to progress to a damaging and severe level, and at that point it is too intimidating to confront."[9]

Personal Responses

For a variety of reasons, including shock, women tend to remain silent in the face of discrimination. Certainly, decisions about whether and how to respond to a personal instance of gender discrimination are complex. Isolation adds to this challenge.[16] In fact, women's relative isolation reinforces the silence and their reluctance to discuss discrimination, even with each other. Many adopt the strategy of staying focused on their work and "staying out of sight." Some report that if they allowed themselves to focus on the problem, their anger would interfere with their work. They, therefore, try to ignore the sexism they encounter.[26] There is also a natural tendency to tolerate bias and unprofessional behaviors rather than to draw attention to them, in the hope that they will cease. But the response of silence can backfire, with the bad behavior progressing to the point where it feels too intimidating to confront. Dealing proactively with small incidents of gender bias can actually prevent further instances.[16, 19]

The first positive step in a strategic response is to de-personalize the problem and recognize that you have not caused the discrimination or belittlement. Try to achieve some objectivity and clarity about the mistreatment; Many discriminatory incidents depend on the "eye of the beholder," i.e. where some

see a sexist insult, others see an innocuous joke. This process of achieving objectivity is assisted by the council of trusted colleagues. A mentor and trusted peers are invaluable here.

Even in the absence of colleagues to serve as a sounding board, you can become more skilled in handling discrimination. To begin with, if you feel trapped within an exchange or conversation, this is a sign you may be dealing with an "Invalidator," i.e. someone who makes intentional use of sexist remarks to manipulate and control women.[27] Try following this advice:

a) take a deep breath, "exhaling" rather than inhaling the Invalidator's comments;
b) become more aware of what's happening, of the context, of who else is present, of your own physical and emotional reactions, and remember to breathe deeply;
c) look beneath the insult: *why* is the "Invalidator" putting you on the spot?; is the insult intentional or unconscious?;
d) analyze the insult, i.e. divide the remark into parts and respond to each. For example, "even a woman should be able to understand this," respond: "when did you start thinking of women as inferior?"

Since men are still the ones with the "lion's share" of power in organizations, they remain best positioned to address discrimination; whereas only the most powerful women can take on these issues with impunity. One forward-looking technique is thus to "adopt" and mentor fair-minded men into becoming effective allies in standing up to "Invalidators" and in calling attention to the detrimental effects of sexism. Select motivated colleagues, i.e. men of good conscience or "closet feminists," with the potential to become an ally, to become a more skilled mentor of women. Offer to become their "learning partner" in developing these skills. Here's some advice to offer such colleagues:

- Find a couple of female colleagues with whom you feel safe, tell them your learning goals, and ask them to assist and critique you;
- Talk similarly to the women who are closest to you, such as a partner, daughter, sister, or friend. Because of the established emotional connection, you may understand things from them that you would not understand from a female colleague;
- Become more observant of the times that a woman offers a view different from most of the men. Pay attention to how a different perspective might improve the outcome; and
- As your "ear" and "eye" become educated, be the voice that interrupts a demeaning or patronizing behavior or comment. Women cannot very often point these out without acquiring the label of "whiner."

Institutional Resources and Responses

To meet the additional gender challenges women professionals face, they need mechanisms for sharing perceptions and experiences with other women so that they can assist each other in developing skilled responses. A women faculty organization or a gender-issues committee can be instrumental in creating such a forum and opportunities.

An active Women in Medicine (WIM) program can add many other kinds of value to an institution beyond bringing women together for this purpose. Whether the focus is a WIM office, a faculty organization, dean's committee, or an outgrowth of one department, such units usually contribute activities, initiatives, and energy far beyond the scope of "women's issues" — an inaccurate label in any case, since women's inability to realize their potential detracts from patient care and from medical education. At many schools, WIM programs have resulted in improvements to: initiatives on professionalism, mentoring programs, faculty orientation and development, promotion and tenure policies, and leadership skill development.[28]

Building an optimally effective WIM program requires:

1) a respected leader's commitment — both financial and "walking the talk" (embodying a commitment to gender equity in all actions);
2) a WIM organization with multiple sources of energy, i.e. not being over-dependent on one or two persons; and, also
3) the assistance of an organizational development expert or other change-facilitator. Schools lacking a WIM focus now have numerous examples of how to create and sustain one.[29, 30]

Another valuable resource is an ombudsperson (a neutral complaint handler)[31] dedicated to hearing complaints and giving advice on conflicts. Informal discussions with such an expert in legal and psychological areas can be instrumental in determining whether and how to make a formal complaint. Many universities and health centers (e.g. Harvard, Stanford, Yale) have long-standing ombuds offices serving all faculty and staff.

In addition to the above, institutional leaders are needed who do not tolerate unprofessional behaviors or inequities and who persevere in creating environments conducive to the growth of all. Because they tend to have so much more positional power than women, individual men, in all their management responsibilities and in all of their work on committees, need to take the lead or partner with their women colleagues in addressing the often subtle denigrations of women's abilities and commitment.

What Can Institutional Leaders Do?

Assess the Costs of Not Acting

A prevalent assumption among many men and also many young women is that gender equity has been achieved. But this is a "pipeline dream." Institutional improvements do not develop out of the coping mechanisms of isolated individuals. The paucity of women achieving senior ranks and leadership positions in medicine is becoming an ever more-glaring liability. There is increasing recognition that diverse teams outperform homogenous ones[32] and that in natural systems, as diversity increases, so does stability and resilience.[33] There is also increasing evidence that diverse businesses outperform their homogeneous counterparts.[34] As women constitute an increasing proportion of medical students, only institutions able to recruit and retain women will have the best residents, staff and faculty.[35] While mostly hidden, there are also many costs associated with the wasted potential of so many women, not to mention their higher attrition and the costs of replacing them. A marketable women's health center and the effective mentoring of women medical students depend upon women leaders. It is thus "good business" and "good education" to support the advancement of women.

Visionary leaders see the need for more active intervention now. As AAMC President Jordan Cohen has stated: "Grooming women for leadership positions and eradicating the barriers currently impeding their success are essential…Those institutions that fail to seize the advantages offered by elevating talented women to positions of power are destined to be eclipsed by those that do."

Assess and Improve Institutional Practices

> *"Everything that is written about difficulties of women and advancement in their career focuses on more family balance. I think that is a disservice to women. That is not the only issue why they don't advance. It's not like there are not work family balance issues or that people don't need help in strategizing how to do that, [but] by the time most women get into faculty positions they have already figured that out."* [9]

The Association of American Medical Colleges' (AAMC) *Increasing Women's Leadership in Academic Medicine* report provides a template for accomplishing the culture changes necessary to better leverage women's intellectual capital.[1] It's most far-reaching recommendation is to assess which institutional practices tend to favor men over women's professional development, beginning with such questions as: What's wrong with our systems and organizational culture that women have such a hard time succeeding in them? The most obvious example is the timing of most tenure and academic promotion systems. The tenure system rewards unrestricted availability to work (i.e. neglect of personal life), forcing "either advancement or family" choices during the decade following training when most women (and men) professionals have young children. This model of career development remains rooted in an image of the "ideal worker" as someone never needing extended time away for any purpose, especially during their twenties and thirties. This outdated mindset about the "ideal worker" is becoming less a "gender issue" as more men in Generations "X" and "Y" seek work situations that allow for a high-quality personal life outside of work, without decades of deferred gratification.[36] But, currently the "career costs" are still disproportionately borne by women.[10]

Family leave policies rarely allow more than three months and require women to use up annual and sick leave. Young faculty need flexible, less-than-full-time options that do not require sacrifice of benefits or of academic opportunities.[37] Even where more flexible policies exist, the academic culture still tends to negatively label individuals who take advantage of them as "selfish" and "uncommitted." Now that the healthy human life span has expanded and retirement benefits have declined, most individuals are likely to have longer careers; thus such negative value judgments are even more shortsighted. Individuals who spend time during their twenties and thirties on their families and who establish healthy habits may actually contribute more over their life span than those who burnout or develop health problems in their 50's.

Another category of practices deserving assessment is the definition of "academic success" as largely an independent act. Because they are so often attracted to team efforts and less likely to get credit, the work that women do tends to "disappear."[38] The culture of the independent investigator, in academic medicine and science, is problematic for other reasons as well. It creates disincentives to participate in interdisciplinary efforts at a time when society's most pressing problems require investigation by interdisciplinary teams in the real-life "swamp."[39]

Industry has developed methods to reward interdisciplinary team efforts; but in academic medicine and science, turf protectors and defenders of

traditionalism stand in the way of such innovations.[40] Professional societies and medical schools need to work together to develop methods to recognize and reward contributions of all members of the team not only the director or head.

As these examples illustrate, many improvements are less about gender than they are about progressive human resources and group process practices. In any case, no evidence supports the notion that initiatives to develop women lower academic standards or disadvantage men. In fact, interventions on behalf of women tend to improve the environment for men as well. For instance, when the Department of Medicine at Johns Hopkins evaluated its interventions to increase the number of women advancing to associate professor in the department, the proportion of women expecting to remain in academic medicine increased by 66% and the proportion of men increased by 57%.[41]

Improve Faculty and Leadership Development

A healthy, empowered, faculty is necessary for sustained productivity, which is unlikely unless the medical school invests in its workforce. Since much of the process by which disadvantage is created and reinforced occurs at the department level (e.g. recruitment, access to benefits), the department head is key.[26] Emphasizing faculty diversity in departmental reviews, evaluating department chairs on their development of women faculty, would likely help to motivate chairs along these lines.[1]

The professional development needs of women are best addressed within the context of assisting all faculty to make the most of their faculty appointments. But, at too many schools, a strong faculty development context is lacking; no medical school currently has what might be considered a comprehensive faculty development system.[42] Examining how the costs of turnover and recruitment exceed the costs of faculty development may help to motivate institutional leaders to upgrade their faculty development programs.

Mentor and Select Women for Leadership Positions

Mentoring can be thought of as the process by which the current generation of power-holders in an organization or culture guide new members in assimilating the practices and norms, so that they maximize their chances to flourish.[43] At the heart of such relationships are trust, comfort, and rapport. Relatively few women have been "selected" or appear to "qualify" for this high level of mentoring.

For many men, thinking beyond their cronies and becoming an effective mentor of women requires extra work and stretching beyond their comfort

zone. Because relationships do occur most naturally between "like" individuals, extra motivation and effort are necessary. When men relate to women more in terms of their social roles (e.g. father-daughter) than as professionals, the mentoring dyad cannot mature. While well-meant, a paternalistic orientation usually limits the relationship, under-crediting and underestimating women protégés. Without being aware of it, many men are more comfortable with women who smile and defer than with those who are goal-oriented and outspoken. But, when men become alert to their own gender stereotypes and to the comparative disadvantages that women face in career-building, they can become excellent mentors of women, more actively offering collaborations and facilitating introductions. The benefits can be considerable – both in terms of women protégés' loyalty and the opportunities to help develop the next generation of medicine's leaders. With more men effectively mentoring women, more women will be successful candidates for top positions.

In the meantime, health centers can do a great deal more to enhance the effectiveness of their search committees to attract women candidates, beginning with an assessment of group processes and of how candidates' qualifications are defined and evaluated. Since members of search committees may not be aware that their "mental models" of gender role expectations influence their decision-making, they need processes to facilitate self-examination with regard to their treatment of women and other minorities. An organizational development specialist or other skilled facilitator can assist committees in gaining objectivity, as well as in recognizing gaps between what committee members say they seek in candidates and how they actually behave. Other tips include the use of search consultants to increase the diversity of the candidate pool and addressing early in the process any partner/spouse relocation issues.[1]

Because so few women hold highly visible positions, their failures stand out more than men's failures, with negative memories lingering for years. Rather than "blaming" the women, institutions where such failures have recently occurred, and schools with low success at recruiting and retaining women in senior positions, might better investigate what institutional characteristics may be contributing factors. A proactive strategy to increase the likelihood of a new woman leader's success (especially if the position has not been previously held by a woman) is to build into her recruitment package the services of a professional coach. In addition to long-term mentoring and to improving search processes, individual men can also use their power to challenge their colleagues' gender stereotypes and to nominate women whenever possible for awards and as speakers and candidates for top-level positions.

How Can Women Rise to the Challenges of Career-Building?

Build Strategic Career Management Skills

First, it is important to take the "long-view" of career development; women often shortchange themselves by adopting a narrow, monogamous "job" focus.[44] Writing a vision statement and short-term, mid-range, and long-term goals are key. These questions can provide a helpful stimulus to this self-examination process: What is your "True North," i.e. what do you like to do and do well? What gives you energy? What are you most enthusiastic about? If you have multiple responsibilities outside your career, try thinking in terms of "five-year plans" of relative emphasis, rather than trying to emphasize all activities at once.

Women who are mothers have less time for work,[45] so achievement requires greater initiative and thought in defining problems that are worthy and that will advance their goals. Unfortunately, women often respond by scaling *down* their expectations and seeking problems that are less interesting and important.[25] Seeking high visibility projects and membership on key committees at the institution and in professional societies is even more necessary for women to succeed.

A variety of skills not covered in professional education are necessary for building an academic career, e.g. conflict resolution, negotiation, grant writing, CV preparation, communication skills, and financial management. Some health centers and universities with business schools offer courses in these areas. Increasingly, professional societies also offer career skill development programs. At the national level since 1989, the AAMC has offered annual seminars for women faculty aiming to advance in academic medicine. Women preparing to seek a leadership role should explore the Executive Leadership in Academic Medicine (ELAM) Program.[46]

Expand your Network

As discussed more fully in the Mentoring Chapter, women tend to gain less benefit from the traditional mentor relationship than men do and to face more challenges in building developmental professional relationships. Moreover, greater numbers of women students and junior faculty are now seeking the mentoring of mid-career and senior women, who feel handicapped both by their lack of time and by the lack of mentoring they themselves received. It is an unfortunate irony, then, that those who most need mentoring remain least likely to obtain it; even worse, those least likely to have been effectively mentored are then expected to do the most.

At any rate, because of these extra pressures, network development is even more critical for women than men, even though they have a smaller pool of candidates similar to them from which to construct role models. These strategies may be useful:

1) if you are an introvert, accept that networking is work, but that your efforts will pay off, for instance, recognition attracts new opportunities;
2) if large societies seem off-putting, choose a small professional organization and become very active. One should:
    1) present at least a poster at every national meeting and discuss your work with enthusiasm at every good opportunity;
    2) maintain contact with colleagues, e.g. send them clips of interest;
    3) look for ways to acknowledge the contributions of others and strengthen alliances;
    4) maintain a personal database, including personal notes, to help you recall details of the lives of your new acquaintances; and
    5) in conversations, learn to go deep fast, quickly moving past chitchat to connect on a useful level, e.g. what's your big issue right now?

Closing advice along these lines: become visible in ways comfortable for you to increase chances you will get to know who you need to know, remembering "it's not what you know, but who you know, and who knows *you*."

Develop a Style that Works

Women professionals must work at developing a style that is "adequately aggressive" but not so aggressive that others become uncomfortable. While independent action is clearly within the scope of expected "male" behaviors, boldness puts women at odds with the role society expects.[25] Women risk more than men do if they appear too aggressive or unsympathetic. This narrower band of assertive behavior allowed women encourages women to play down their authority. But if they act in ways that denigrate their power, others may doubt that they have it. A related doublebind is that if they talk like women, they will be more liked than respected; if they talk like men, they will be more respected than liked.

Another advantage of a broad network is the opportunity to observe the styles of women who are successful in getting their ideas implemented and in achieving influence. A style will not be effective if it is not authentic, but much can be learned from the experience of others. Asking a role model for tips can be a source of assistance. A career coach or a professional who teaches self-presentation can be invaluable if role models (or courage) are lacking. Such professionals can assist with the development of the physical control

needed to improve vocal technique, posture, walk, and other body language necessary for success. That men can get ahead without attention to these features, matters not.

Many women also suffer from the illusion that their work speaks for itself and will gather the credit it is due. In fact, each individual is responsible for "tooting her own horn" and needs to become skilled at strategic self-presentation.[47] So practice telling your "career story" with enthusiasm and conviction, emphasizing specific accomplishments and goals. Everyone can use an "elevator" (i.e. 1 minute) version and longer versions for use in networking conversations and job interviews.

Individuals from Asian, Hispanic, and Native American cultures often feel uncomfortable drawing attention to themselves in this way. Compared to the West's tradition of rugged individualism, such cultures emphasize a more collectivist orientation. Perhaps recognizing that these are opportunities to credit their team and to acknowledge the contributions of others may provide such individuals with helpful encouragement.

Conclusion

Because almost 50% of first-year medical students are women, many leaders have concluded that equal opportunity is now, or soon will be, a reality. The continuing career disadvantages facing women faculty receive comparatively little attention, in part, because the women who are leaving academic medicine — or simply not gaining promotion — tend to be invisible. But, the future of the health professions is inextricably linked to its development of women professionals.

As the paucity of women achieving senior ranks and leadership positions becomes more of a liability, medical schools, teaching hospitals, and academic societies are likely to become more responsive to strategies for capitalizing on women's intellectual capital. Both sexes of faculty and trainees stand to gain from an environment where assumptions and judgments about individuals' competencies are not colored by their sex, where women's goals and traits are as valued as men's, and where non-punitive options facilitate the combining of professional and family responsibilities. These developments will strengthen academic medicine and, ultimately, patient care.

In the meantime, as outlined here, there is a great deal that individual women can do, beginning with a clear, hard look at the disadvantages they face. Taking a long-term, forward-looking approach to career-building, women can rise to these challenges. Building the necessary career

management skills, expanding their network, and developing a style that works take time; but many more supports and role models are now available than a few decades ago.

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Minority Faculty

Race/Ethnicity and Related Disadvantages of Minority Faculty: Learning from a Collective Experience

The US is becoming more ethnically diverse, with black Americans, Native Americans, and Hispanics now representing 30% of the population.[1] By 2005, 85% of the entrants to the US labor force will be minorities and women.[2] Despite this growing racial and ethnic diversity of the general American population, under-represented minorities (URMs, which does *not* include Asian) constitute only 7.6% of the faculty of schools of medicine.[3] The proportion of underrepresented minorities in academic medicine has essentially remained unchanged over the past decade[3, 4, 5, 6] and is actually predicted to decline.[7] This lack of progress stems from multiple factors, including low numbers of minority medical school graduates, indebtedness of minority postgraduates, lack of recruitment into faculty positions, and a paucity of academic role models.[8] Once on faculty, URM faculty advance at a much slower pace than majority faculty[9, 10] even with equivalent credentials.[11, 12] Thus, few minority faculty reach senior ranks and leadership positions.[13] Even those minority faculty who succeed continue to experience racial discrimination.[14]

Given legal challenges to affirmative action, as well as the socio-economic and educational disadvantages that URMs face, most US medical schools' efforts have understandably focused on how to increase the numbers of minorities *entering* medical school (increasing "the size of the pipeline"). But minority faculty development (supporting those "in the pipeline") deserves far more attention than it has received.

A diverse staff and leadership team have been shown to enhance the success of businesses. In natural systems, as diversity increases, so does stability and resilience.[15] Basic biology teaches us that on-going variability of the gene pool is key to the health of any organism or species. And as any sports fan knows, a great team depends for its success on the coordination of a variety of talents. Diversity is therefore not so much a problem in need of a solution as an opportunity. The corporate world has been quicker than academia to recognize such opportunities in concluding, for instance, that diverse teams outperform homogenous ones.[16] Exposure to diverse colleagues helps managers make better decisions and cultivate new ideas by drawing on a larger pool of information and experiences; diversified staff also help increase market share by facilitating marketing to an increasingly diversified customer base.[2] Moreover, companies with reputations for good management of diversity are more successful in

attracting and retaining top-quality employees; such organizations often link managers' compensation to their success in recruiting and advancing minorities.[17]

While achieving such diversity is far more complex than simply recognizing and overcoming discrimination based on race or ethnicity, this barrier is still interfering with progress and so deserves greater understanding and directed action.

What is Racial/Ethnic Discrimination?

> *"I don't think people meant to do it, it is something they do unconsciously. It is more ignorance on their part [as] opposed to just people who are truly intentionally racist…Whether it is done in ignorance or intentionally, it still has the same results."* [18]

Racial and ethnic discrimination occurs when an individual is treated differentially and unfairly based on his or her race or ethnicity rather than on more salient factors such as ability and talent. As with discrimination based on gender, racism is now illegal and is thus rarely overt. But rather than being "cured," some would observe that bias has gone underground, making it increasingly subtle and hard to identify.[19] The most persistent and common form of racism may be the consequence of race-based stereotypes. Such "mental models" are perceptual shortcuts acquired early in life. In Senge's words, "Mental models are assumptions and stories which we carry in our minds about ourselves and others…Like a panel of glass framing and subtly distorting our vision, mental models determine what we see."[20]

Negative mental models of minorities, e.g. that they are lazy and unintelligent, persist in our culture. Such distorting filters can interfere with evaluations of competence. Yet, few scientists and physicians are aware of the influence of their mental models. Most maintain that they work in a meritocracy with all rewards distributed strictly on the basis of merit and that they themselves are never influenced by bias or stereotypes.[21] But features of the work environment common to clinical medicine, for example time pressures and cognitive complexity, actually stimulate stereotyping and "application error"

(i.e. inappropriate application of epidemiological data to all group members).[22] Moreover, dominant personalities, common in medicine, tend to ignore information discrepant to their stereotypes.[23] The tendency to privilege what is familiar and judge critically what is different exacts its cruelest price on those with the least power, leaving the burden of the problem of stereotyping on those who are the most vulnerable.[24]

A helpful theoretical framework for examining racism and its effects classifies race-related discriminatory forces into three categories: institutional racism, personally mediated racism, and internalized racism.[25] Institutionalized racism is "differential access to the goods, services, and opportunities of society by race…It is structural, having been codified in our customs, practices and law…(and) manifests itself in material conditions and in access to power." Personally mediated racism is "prejudice and discrimination, where prejudice means differential assumptions about abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race…this can be intentional as well as unintentional, and it includes acts of commission as well as acts of omission." Internalized racism is the "acceptance by members of the stigmatized groups of negative messages about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right of self-determination, and one's range of allowable self-expression."[25, 26]

This framework reveals the challenges that URMs face in disproving their inferiority – in the face of prevalent adverse attitudes and experiences, they must keep from internalizing this negativity, persist in holding high expectations for themselves, and work hard enough to avoid loss of career momentum.

What Other Disadvantages Do Minority Faculty Face?

Compared to majority faculty, underrepresented minority faculty have lower career satisfaction and are more likely to leave academic medicine. A large national survey found that 63% of URMs perceived racial or ethnic bias, manifested most frequently as inadequate recognition of their work.[27] Those faculty reporting discrimination had lower career satisfaction and felt less welcome at their institution.[14] Similarly, in an analysis comparing black with white Americans at one medical school, the former expressed greater dissatisfaction with their medical school experience and with the social environment of the school.[28] In the Robert Wood Johnson National Faculty

Survey, 46% of minority faculty reported some experience of racial or ethnic discrimination in the course of pursuing an academic career.[19]

A qualitative study of the experiences of underrepresented minority faculty likewise revealed a disheartening composite of experiences.[26] In a focus group of minority faculty convened as part of the Macy study,[18] minority faculty described their experience as: feeling socially unwelcome, held to double standards, social and professional isolation, stereotyping, lack of respect and acknowledgement of accomplishments, being overlooked, receiving fewer referrals, surprising referred patients because of their race, receiving only referrals of minority patients, and being identified by appearance and not abilities.

Even after controlling for factors relevant to promotion such as academic productivity and seniority, minority faculty progress more slowly than their majority peers.[9, 10] In addition to racial stereotypes, other systemic disadvantages that URMs face include disproportionate participation in activities that are not career-advancing.[18, 30] Serving larger marginalized patient populations than their majority counterparts brings in fewer dollars and can be more draining emotionally.[8, 31] Pressures to serve on time-consuming but low-visibility committees are also more prevalent for URMs.[11] Given their small numbers, they are also often sought after by minority students and residents to act as tutors, advisors, and mentors.[30] These activities have been referred to as "affirmative abuse" or the "black tax"; non-minority faculty tend to remain oblivious to these extra pressures.[18]

Another feature of the URM experience is being "pigeon-holed," i.e. a person of a certain ethnicity is assumed to represent and understand that entire group. In fact differences in socio-economic backgrounds can be far more differentiating than race or ethnicity: "Just because you are the same ethnicity, you cannot assume you now what it's about."[18] A related phenomenon is expecting that when an URM arrives, that person relieves everyone else of responsibilities to attend to race-related issues.

Obtaining mentoring also presents many extra challenges. A study comparing minority professionals at US corporations who became executives with those who plateaued provides insights valuable to medical educators. Even though they were not on an obvious fast track early in their career, minority professionals who became executives had influential mentors who were investing in them as if they were on a fast track. These relationships included both coaching (i.e. technical advice) and counseling (i.e. experiential cues and emotional support) and opened the door to challenging assignments and protected the protégé from unfair criticism. By contrast, professionals who plateaued had much less robust developmental relationships with mentors.[32]

This study also found that cross-race relationships encounter numerous extra difficulties in forming and maturing. A mentor who holds negative racial stereotypes is unlikely to give protégés the benefit of the doubt and a "protective hesitation" can interfere with communication about race and other thorny issues. When the mentor has trouble identifying with the protégé, seeing beyond the protégé's weaknesses is also harder. A protégé adopting the behavior of the mentor might produce different results (e.g. an aggressive style successful for white men may get women and minorities labeled "angry"). Because cross-race relationships are rare, people focus on them, adding to their fragility and discouraging people from participating in them.[32]

Women ethnic minorities experience "double jeopardy." A study of African-American women physicians found that the majority cited racial discrimination as a major obstacle during medical school, residency and in practice. In addition they perceived gender discrimination to be a greater obstacle than did non-African-American women physicians.[33] Women of color must frequently overcome assumptions that they owe their positions to affirmative action rather than professional qualifications. Thus, speaking and acting with authority present particularly complex challenges. At the same time, minority women encounter severe "surplus visibility," that is, their mistakes are more readily noticed, and they're less likely to be given a "second chance." Compounding all of the above extra challenges, minority female physicians are also at highest "risk" for institutional service obligations.[34]

All the above studies likely underestimate the full effects of discrimination since many minority faculty leave academic medicine. Moreover, the stresses of disadvantage and discrimination tend to accumulate over a lifetime—yet few majority faculty develop any understanding of or empathy with the struggles of URMs.

What Traits Enable Minority Faculty to Build Careers Despite These Extra Challenges?

> *"You have to find yourself; you have to have enough confidence in who you are and what you are about. You have to be able to stand alone…you are who you are…you have to develop strategies that empower yourself."* [18]

Self-reliance

Given their small numbers, virtually all minority faculty experience isolation in Academe. In some health centers, URM faculty may not see a colleague who "looks like them" for weeks at a time. As they cannot take for granted professional relationships that are an extension of a lifetime of social experiences for majority faculty, minority faculty of necessity develop a strong sense of self-reliance.[18] Minority faculty thus describe the need to empower themselves and to be able to, at times, "stand alone" and to "steel themselves." At such times, leadership "comes from within." Such self-reliance entails a high degree of self-knowledge and self-definition, especially since so many others are inclined to define minorities negatively. The danger, however, of self-reliance is *over* reliance leading to even greater isolation and less interaction with colleagues, which is death to career development in science and medicine.

Realistic Assessment

> *"Be a realist and identify the problem for what it is and then move on. People walk around in denial thinking it is their hair or their dress and it is nothing. It is something the other person feels; you can't fix it, it has nothing to do with who you are."* [18]

Successful minority faculty are realistic and honest when dealing with racism and discrimination. De-personalization is important here, separating the cultural problem of racism from the individual attack or instance. Consultations with appropriate resource persons within the institution, such as an ombudsperson,[35] can help set reasonable expectations of what constitutes discrimination or unprofessional behaviors, when to seek redress, and how to work toward institutional solutions to problems.[36] Tempered expectations are always more sensible than unrealistic hopes that any one intervention can effect meaningful attitudinal or behavioral change.

Resourcefulness

Many minority faculty sense that they are continually tested and experience constant pressure to prove themselves to their peers and superiors; no matter how hard they work they feel vulnerable. Successful minority faculty are

resourceful in the sense that they maximize the impact of their hard work. One key element of resourcefulness is identifying and using available leverage, i.e. determining and expanding prime areas of influence. For clinical faculty, closeness to a minority patient population and a large clinical practice are forms of leverage; for research faculty the equivalent is grants. An accurate and strategic understanding of the expertise and resources they bring to the table and of how they can keep building on the value they add is essential.[36]

Mentors, Networks and Supportive Developmental Relationships

"Scientifically, it is difficult to thrive if you are isolated. You have got to be able to seek out collegiality…You have to look for avenues that will allow you to interact with colleagues on a professional level."[18]

"I don't think it is color as much as it is who you know. Because the majority has a broader network…one gets invited to present a major talk because you know somebody…Provide access to the old boys' network, which I think is really what it is."[18]

"Support of the family is very important. You can get support from your colleagues, but sometimes it is not possible for colleagues to give you enough support."[18]

A supportive base of relationships is crucial. For many minorities, relationships outside the institution, e.g. family, clergy and community, may be particularly important. Confidential professional help may also be invaluable at certain times. Most important of all is a mentor who serves as a career sponsor; a robust, trusting relationship with a highly regarded mentor, preferably one with a track record of fostering such a relationship, is paramount.[37] This relationship is ideally strong enough to address the challenges of negative stereotypes, public scrutiny, and lack of accessible role models.[32] If such a mentor cannot be discovered, an alternative is finding a knowledgeable senior

faculty member or Dean's Office representative who can serve as a career resource and network facilitator.

A strong professional network of individuals outside the institution is also essential for a successful career. Opportunities that come from gaining inclusion in the right networks are vital and can overcome many other disadvantages. Some minority faculty, however, sense peer resentment and suspicion from both majority faculty and other minority faculty; this "squeeze" can produce conflicts no matter how they proceed.[18, 36]

Academic and Political Skills

Success in academic medicine requires knowledge of the culture and of the academic game; these are largely acquired from mentors and networking. A broad range of additional skills, sometimes requiring training beyond residency, are also necessary to thrive in academic medicine.[38, 39] Research faculty require ever-sharpening grant and manuscript preparation skills. For clinician educator faculty, continuing contributions as a scholar demand excellent teaching, facilitating and evaluating skills. Effective communication skills are especially essential for URM faculty, so that they rise to the challenges of negotiating, conflict resolution and staff management that they face. Because of poorer preparation in their early education, some minority faculty may need more assistance in these areas than majority peers. Similarly, as for women professionals, developing an adequately aggressive style that works presents extra challenges because of the care that must be taken not to make majority individuals uncomfortable.[40]

How Should Individuals Respond to Discrimination?

"That would be my biggest tip. Do not overreact. Sit down and talk with someone about the situation and make sure you are not misinterpreting something. Then address it in the most professional manner…cool down a bit and discuss it without being emotional about it."[18]

Be Cautious and Keep a Cool Head

Careful assessment is the cornerstone of dealing with discrimination—and keeping it in perspective, that is, "don't make it the total issue."[36] Remaining cautious and professional is also necessary to keep the support of majority colleagues.[36, 37]

Minority faculty must endeavor not to be demoralized by discrimination, but to look at the big picture of the history of racism.[18] Many racially charged situations occur out of ignorance. In such circumstances, the initial response needs to be one of education. Ignorance, however, can be a daunting foe, and at times educating one's colleagues and patients may not always be possible - "sometimes you just can't do anything with ignorance."[18] Leading by example, however, can be quite effective in allaying bias and preconceived prejudices.

With regard to learning to handle discrimination, minority faculty state that formal training is not necessarily effective. Skills for handling inequalities evolve from a process of learning from one's own and other's experiences.

Get Information

Since so many processes and practices are political (as opposed to rule-based), "differential treatment" of any kind is very difficult to prove. Written criteria for advancement are detailed and specific, but still represent only the tip of the iceberg of how one is evaluated.[21] When differential treatment is suspected, careful documentation is of paramount importance. The next step is to talk with appropriate resource persons (e.g. the Equal Employment Opportunity Commission, the ombudsperson and appropriate administrators), asking a full range of questions about how similar situations have been handled.

It is also important to stay in touch with colleagues at other institutions and with one's residency program director, who can often provide insight and additional perspective. Gathering information is particularly key when searching for a new position; seek details of how other minorities have fared at that institution and in that department.

Taking Action

When minority faculty have clear evidence of discrimination, they are faced with a critical decision of whether and how to confront the matter. This is a difficult decision which could jeopardize the professional success they have painstakingly gained, even if it is for the sake of institutional improvement, which is not in any case assured.

Any action should balance assertiveness with approachability. One approach is sitting down with the problematic colleagues and articulating the experience, attempting to raise their level of awareness. But sometimes biases are so deeply embedded in "normal" practice that they are not evident; it may actually appear that the person raising the issue is creating the problem by raising it. Most institutions now have processes and resources for handling disagreements, for instance, an ombudsperson (a neutral complaint handler) who may offer an alternative path to address the issue.[35]

If the issue still is not satisfactorily resolved, then going *above* the individual who is discriminating is a possible strategy, particularly when dealing with someone behaving in an abusive manner. Most organizations have a grievance procedure and/or an independent investigative body to assess allegations.

If the discrimination is recurrent and the institution is unwilling to act, the only solution may be to leave the position; legal recourse remains an option if documentation has been thorough, but there are many long-term career and financial consequences to a lawsuit which must be fully considered.

Working Toward Institutional Change

> *"Physicians tend to feel that they don't need that kind of thing [diversity training]. They are already compassionate and sensitive to people regardless of differences…physicians are really resistant to this [sensitivity training]…Most physicians think, 'Well, there is no racism now because everything is equal,' but it is not and it is very hard to say it is not."* [18]

Focusing on systems-level improvements rather than on individual instances of discrimination broadens the agenda, and more individuals have a stake in a solution. In this regard, minority faculty can more effectively present problems when they act as a group; when a group presents an issue, it is much less easily dismissed as an isolated problem.[18] Minority faculty need to be specific about the outcomes they are seeking, e.g. that a salary study be conducted by a certain date or that a chair who makes racist comments be asked to resign. They also must realize that solutions at times can be incremental and still ultimately succeed.[18]

Rather than being disempowered by their "differences," minorities who work to change their organizational culture can make a lasting difference. Such change leaders may benefit from Myerson's study of "tempered radicals." Such individuals are, for instance, women and men concerned about social justice in profit-motivated corporations and people of color in predominantly white organizations working to expand inclusion of URMs. Tempered radicals want to rock the boat, and they want to stay in it. Myerson presents a spectrum of approaches that such change agents have effectively used to walk the fine line between difference and fit and to use their differences to inspire positive changes in their organizations.[41]

How Can Institutions Rise to the Challenges of Diversity?

> *"It is the intimate contact and wanting and learning to accept people who are different. Training is all a part of what you do for yourself. . . You just have to seek out individuals and talk to them and learn about their experiences. . . You can't beat someone over the head and say 'you can't discriminate.' It is a matter of learning and growing."* [18]

One way of looking at an organization's approach to diversity is to describe behaviors along a continuum—from *Intolerant* (policies based on stereotypes) to *Tolerant* (policies comply with legal requirements) to *Valuing* (policies responsive to special needs voiced by employees) to *Inclusive* (anticipating the needs of different groups and establishing progressive policies to meet them).[42] A pervasive barrier to achieving "Inclusion" is the tendency of people to be attracted to people who are like themselves; this similarity creates psychological comfort but works to keep out others of different nationalities, ethnicities, and political beliefs.[43] "Homosocial reproduction" is the organizational consequence of this usually unconscious tendency.[24]

Since majority faculty tend to be unaware of this systematic disadvantage faced by minority faculty, they also tend to be complacent about the need for self-examination or education on these subjects. Thus the motivation to become more inclusive and to change the mind-set around race —a critical precondition to creating change—is usually lacking.

Sensitivity Training

> *"I get the sense there is a greater backlash against women and minorities when those programs (sensitivity training) occur. It raises issues of affirmative action in people's minds. The pie is only so wide, if we give them [minorities] something, I can't get something. . . You [minorities] want to fly below the radar."* [18]

Many organizations have employed "sensitivity" or "diversity" training as an educational tool.[44] But rather than changing mindsets about differences, such training may instead teach people to keep their unfavorable attributions to themselves. Moreover, minorities often worry about a backlash from sensitivity training.

What is needed is for people to see that we create the experience of difference by viewing the "other" according to our own preferences. Informational training alone rarely assists individuals with this kind of learning; transformational education is required, that is, a 'leading out' from an established habit of mind. The resulting heightened psychological complexity naturally takes time to evolve; but there are multiple dividends from helping people reach a fuller consciousness.[24]

Clearly, strong leadership is essential to create motivation for this work. A tool that institutional leaders can employ at the beginning of diversity initiatives is surveying faculty and staff about their career development experiences (e.g. with mentors) and their perceptions of the environment, and comparing the responses by ethnicity and gender. Such a data-gathering process reveals the most significant differences by race and gender, establishes a baseline for future assessments, builds institutional awareness, and can guide a variety of initiatives. Educational opportunities including Grand Rounds and other presentations and programs can grow out of the results. For instance, the Dean's executive meetings with chairs might regularly focus on the minority and women faculty development issues identified, perhaps built around a case study and facilitated by the faculty affairs administrator or by an organizational development expert. One goal is to assist senior administrators in becoming aware of how their own 'mental models' influence their decision-making. A skilled facilitator can greatly assist necessary self-examination.

Departmental reviews afford a critical opportunity to emphasize diversity issues: how effectively is the chair recruiting and developing women and minority faculty, serving as a role model for the role models, planning for his or her succession? Two reinforcements would optimize this strategy:

1) award chairs who achieve diversity goals a bonus or some important form of recognition;
2) offer chairs having difficulties developing a diverse workforce a safe place to acknowledge their developmental needs and to build skills.[40]

Institutional guidelines for promotion and tenure should be examined to see if any practices tend to favor the professional development of majority faculty more than the professional development of URM's; for instance, traditional definitions of "academic success" may exclude "non-mainstream" areas of research that URMs often select.

Particularly when numbers of minority faculty are small, it is important to provide support groups and to continue to work at increasing the pool of minority faculty. Early identification and consistent mentoring of potential minority faculty, beginning during their training, is the most reliable method of assuring recruitment—followed by support and continued mentoring.[37, 38, 45, 46]

Majority faculty can considerably assist all these efforts by initiating more interactions with minorities.[47, 48] A key task is helping minority colleagues and protégés build a broad network of colleagues. Dedicated majority faculty can also help more reluctant colleagues to manage and overcome their discomfort with race. The institution can use annual awards, for instance, to recognize majority faculty who devote substantial energy to mentoring minorities and to creating a healthy, open, and diverse climate.

Another possible strategic intervention is creation of a body such as a "diversity council" to serve as a sounding board for the leadership on these matters. An alternative is to have a knowledgeable senior minority faculty member who plays this role. Ultimately, it is proactively evaluating the institutional environment and addressing issues early on that will lead to improvement and ultimate success in making minorities welcome members of the institution.

The organizational leadership team and the faculty also need to be diverse and foster policies that create a diverse faculty.[49, 50] In addition to placing more than token numbers of minority faculty on search committees for leadership positions, majority faculty on the committees also need to be committed to diversity. All search committee members interviewing candidates for chair and dean positions should question candidates on how they have handled and plan to handle a whole range of diversity and racial equity concerns, as well as about

their approach to faculty development and recruitment.[40] An organizational development specialist or other skilled facilitator can also assist committees in gaining objectivity, as well as in recognizing gaps between what committee members say they seek in candidates and how they actually behave.

Conclusion

Beyond their painful isolation, minority faculty continue to face many additional challenges in medical Academe. Greater understanding of their experiences, improved supports and expanded mentoring are necessary to sustain minority faculty and to facilitate their advancement to senior positions. Institutional leaders must use every tool at their disposal to encourage majority faculty to overcome any negative mental models of race that may be interfering with their evaluation of the competence of URMs. For instance, a skilled organizational development specialist can facilitate necessary self-examination on the part of key administrators and work groups. Annual evaluations and departmental reviews are critical opportunities to emphasize diversity issues with faculty and administrators. Simultaneously institutional practices should be examined with an eye to amending those having differential negative impact on URMs. By initiating more interactions with minorities, majority faculty can play a very positive role in helping URMs build their networks and obtain mentoring.

Diversity can be seen as not so much a problem in need of a solution as an opportunity. Institutions have many incentives to commit to increasing faculty diversity. By 2005, 85% of the entrants to the US labor force will be minorities and women. A diverse staff and leadership team make better business decisions than homogeneous teams. Organizations with reputations for good management of diversity are more successful in attracting and retaining top-quality employees. Academic medicine can achieve similar gains with greater attention and efforts for minority faculty. The challenges of increasing faculty diversity are considerable but not insurmountable. To meet these challenges, strong persistent leadership is necessary.

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POSTSCRIPT

A LIVING LESSON FROM THE FOREST

"Ecologists tell us that a tree planted in a clearing of an old forest will grow more successfully than one planted in an open field. The reason, it seems, is that the roots of the forest tree are able to follow the intricate pathways created by former trees and thus embed themselves more deeply. Indeed, over time, the roots of many trees actually graft themselves to one another, creating an interdependent mat of life hidden beneath the earth. This literally enables stronger trees to share resources with the weaker so that the whole forest becomes healthier. Similarly, human beings thrive best when we grow in the presence of those who have gone before."[1]

Parks Daloz (2000)

Academic health centers (AHCs) in the United States face many challenges in their efforts to sustain the excellence they have come to represent worldwide. The balance between clinical and academic missions has become increasingly difficult, and likewise it has also been difficult for AHCs to meet the diverse and pressing needs of their immediate communities. For academic medicine to meet these challenges, the talent of all potential academic faculty will be needed. Meeting this need will require a more successful inclusion of women and minorities into Academe. Enriching our faculty diversity will both increase the size of the pool of talent to meet our challenges as well as expand the capacity of academic medicine to serve the needs of special patient populations. To achieve this diversification, academic medicine as a whole needs to become more welcoming and provide the "roots" for new faculty to grow on and gain strength and support. The challenge, however, is a major one. To recruit and retain faculty members who are now

in the minority (by gender, race, ethnicity, or other characteristics), significant changes in AHC environments will be needed. We will need to find ways to mollify the effects of academic hierarchy, diminish asymmetry of knowledge about how our institutions actually work, achieve greater transparency, and increase the dissemination of key information about such important matters as promotion and salary-setting. This monograph is meant to provide a guide for faculty and institutions to the need for some critical changes if we wish to foster a greater sense of inclusive community within the AHC. If we wish to change the adverse circumstances of AHCs, it may first require deeper self-knowledge and self-change – an old story. Stengthening community within the AHC may permit it to become more attuned to its local community and to fulfill its social contract more robustly.

How will this change in AHCs be accomplished? If nature is our teacher, sustaining the vitality of the AHC community can only be achieved by *enriching its diversity, enhancing its resilience* in the face of changing external circumstances, and *strengthening the forces that hold it together* in the face of the many centrifugal dynamics that threaten to dismember it. AHCs need to 'learn from the living lesson of the forest.'

What does it take to 'make a clearing' in an AHC for new faculty, perhaps especially faculty who would now be in the minority? We must begin by focusing attention on the needs of junior faculty, including: achieving clarity within the institution about why they are needed for the mission of organization; being careful to marshall the resources that will be needed (financial, collegial, and other) to allow them to work to their full potential; creating well-formed (and resourced) opportunities, responsibilities, and authorities in efforts to assure that they have what they need to thrive in Academe; establishing a welcoming environment to recruit the best available talent; 'planting' promising newcomers strategically, and nurturing their progress through broad-spectrum, experienced mentoring in order to help them negotiate the challenges of early careers and begin to generate their own resources. All of these actions are required for vulnerable newcomers to the academic community to 'take root' and find their way in the deep loam of the AHC.

And how will the AHC become more resilient and sustainable? Nature teaches us that *diversity* produces sustainability; monoculture fails. Oceans, forests, fish and animal populations all provide evidence to this effect. In the face of major challenge - fire or drought, for example - plant and animal life flourish when the existing speciation and variation are diverse. When gene pools are restricted, they are vulnerable – to a new virus or pest, to displacement

by invading species, or to temporary climatologic change. When diversity prevails, the ecology contains within it the resources to rally and prevail.

What does nature teach us about how 'communities' hang together - in Daloz's metaphor, what keeps the forest a coherent ecology? Interdependence! The diverse entities within the ecology *need* one another, depend on one another, are even synergistic. This is also how it has been through history with sustainable human communities: Shoemakers need grocers, healers need transportation workers, agricultural regions need manufacturing regions and *vice versa*. So it must be within AHCs. We must achieve the full integration of a diverse faculty. "Old boys' networks" have certain advantages, of course, but they are an 'academic monoculture' that reduces diversity and minimizes the development of new interdependencies.

Academic health centers can only continue to thrive if we attract and retain diverse and talented junior faculty. For such faculty to flourish, they must be able to follow the root paths of those who have gone before. If this is to be accomplished, we must together break new institutional ground, and find a renewed sense of community within AHCs. It may be only in these circumstances that we will be able to turn to the work of reestablishing the trust of the larger community in the medical profession.

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