

Commentary: A Call for Culture Change in Academic Medicine

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Abstract

Disappointed by the lack of progress in the advancement of women and underrepresented minority faculty to senior positions and leadership roles in academic medicine and concerned by the prospect that these valuable faculty

resources were being lost, a group of five medical school deans agreed to embark on a multiyear project to change the culture of their medical schools for these underrepresented faculty. This commentary outlines the rationale and

motivation for the project and sets the stage for future reports from and wider participation in this initiative.

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Culture eats strategy for lunch every day.

—Old truism

A recent survey of medical school deans conducted by the Association of American Medical Colleges (AAMC) on leadership recruiting practices in U.S. medical schools revealed that the deans responding were highly dissatisfied with the numbers of women and racial and ethnic minority finalists in all department chair searches, particularly in those for clinical chairs.¹ This survey and the deans' responses illustrate the reality for academic medicine today. Even though we now have a large female cohort of highly trained potential leaders, senior physicians, and research scientists, women are still markedly

underrepresented in senior academic and leadership positions in our medical schools and teaching hospitals.

In 1980, women constituted 29% of students admitted to medical schools, and this proportion has increased steadily. Since 2003, medical school admissions for men and women have been virtually equal.² As of 2008, women constituted 35% of clinical science faculty and 31% of basic science faculty at U.S. medical schools. However, female full professors as a proportion of all female faculty at medical schools only rose from 9% in 1980 to 12% in 2008 (compared with 30% male full professors of all male faculty). In clinical science departments, less than one-fifth (17%) of all professors are women. Currently, only 17% of tenured faculty at U.S. medical schools are women. In medical schools, where half our trainees are women, there is an average of 35 female and 188 male professors per school. In 2008, female full professors constituted 4% of all faculty in the basic and clinical sciences. Only 8% of clinical science department chairs and 13% of basic science department chairs are female, and many schools have never had a female department chair. About 7% of deans (not including interim deans) are women.³

Similarly, despite the increasingly diverse U.S. population and medical student bodies (including 16% of students from underrepresented minority groups), academic medicine has been unable to recruit and sustain faculty from underrepresented minority groups. Only 3% of medical faculty are African

American, 4% are Hispanic/Latino, and 0.1% are Native American.⁴ Diversity among faculty enhances the ability of academic medicine to fulfill its educational, research, and patient-care missions.⁵ Failure to realize the full participation and leadership potential of all faculty—especially women and underrepresented minority faculty members—remains a pressing problem and challenge in academic medicine today.

In addition to this lack of diversity in leadership, a new generation of students and faculty, both male and female, seek balance across their personal and professional priorities, which may influence their future career choices away from the challenging environment of academic medicine. Additional indication of problems in the culture of academic medicine is that 37% to 47% of medical faculty may experience burnout.⁶ There appears to be a mismatch between the prevailing organizational approach and culture in academic medicine and its vital faculty workforce. It is increasingly clear that addressing these serious issues requires dedicated and innovative efforts and a renewed focus on the culture of academic medicine.

The National Institutes of Health (NIH) and the National Academy of Sciences, including the Institute of Medicine, have proposed directives to address the lack of women in leadership in biomedical sciences.^{7,8} A recent *New England Journal of Medicine* perspective speaks of the need to newly “envisage” women in leadership.⁹ The presidential address

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at the November 2007 AAMC annual meeting called for embracing a change in the culture of medical schools using leadership, courage, collaboration, and transparency.¹⁰

This realization of a need for an organizational approach to recurrent problems in academic medicine led five medical school deans to join in a new coalition to address culture in a more ambitious way than previously undertaken. Our five schools are very different geographically and organizationally, but our problems are strikingly similar. We realized that the time had come to address more purposefully these cultural issues in our institutions. And so we committed our institutions to partnering in C (Culture) - Change. C - Change is the informal name of the National Initiative on Gender, Culture and Leadership in Medicine,¹¹ funded by the Josiah Macy, Jr. Foundation and with supplemental collaborative support from the Office of Public Health and Science Offices on Women's Health and Minority Health, the NIH Office of Research on Women's Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

Much prior research regarding the lack of women and underrepresented minority faculty in leadership has focused on perceived deficiencies in these faculty subsets and work-life balance issues (e.g., altering career plans to accommodate pregnancy and raising children) that may differentially affect women. Instead of studying the characteristics and behaviors of the individuals who are underrepresented among our leadership, we chose to focus on the aspects of our institutional culture that could be contributing to this phenomenon. We wanted to develop a cross-institutional partnership which, through rigorous qualitative and quantitative research, would enable us to understand the culture of our schools and facilitate solutions for change. A hallmark of

C - Change is that it simultaneously addresses culture, organizational approach, and the personal experience of faculty within academic medicine. Early in the process, an interview study and a survey were conducted of a subset of faculty in each of our schools, and the results were shared anonymously with our group.^{12,13} Although we learned hard things, we realized how far we needed to go and why we needed to do this work.

As part of the project, we initiated a Learning Action Network among the schools to draw on each other's combined experiences to implement individualized change processes at each of our schools. We each chose what seemed right to work on first, and we learned from each other's ideas and critiques. Facilitated by the project, we continue to work toward incorporating lessons about bias from social science research, innovative professional development of our faculty, changes in policy and practice, effective leadership, communication strategies, and comprehensive efforts to make the environment of academic medicine more humane. We are confident our course of action is fully aligned with the national recommendations of the AAMC, NIH, and the National Academy of Sciences.

We have committed resources and time—our own and those of some of our senior faculty and administrators—because we believe that something different must be done to alter the status quo. We are well into this work, but we are not finished. As we build on the findings of the C - Change research and start to introduce changes in our schools, we will make these lessons learned available to the larger academic community. But since these changes take time, and since the problems of faculty culture are real and immediate, we have decided to make our project and its goals known to the larger academic community in the hope of enlisting more participants as we continue this work.

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