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Never Felt at Home: A Qualitative Study of the Experiences of Faculty From Underrepresented Groups in Family Medicine and Strategies for Empowerment

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ABSTRACT

Background and Objectives: Increasing diversity among medical educators is a vital step toward diversifying the physician workforce. This study examined how gender, race, and other attributes affect family medicine department chairs' experiences with sponsoring, mentoring, and coaching (SMC). We identified strategies at multiple levels to enhance SMC for faculty from underrepresented groups (URGs).

Methods: Our qualitative study employed semistructured interviews with the chairs of departments of family medicine in the United States. We used inductive and deductive thematic analysis approaches to describe the experience and name usable strategies organized along the social–ecological model.

Results: We interviewed 20 family medicine department chairs between December 2020 and May 2021. Many participants continued to be alarmed that leaders and role models from URGs have been rare. Participants described incidents of aggression in White- and male-dominated atmospheres. Such experiences left some feeling not at home. Some White male leaders appeared oblivious to the experiences of URG faculty, many of whom were burdened with a minority tax. For some URGs, surviving meant moving to a more supportive institution. Building spaces for resiliency and connecting with others to combat discrimination gave meaning to some participants. Participant responses helped identify multilevel strategies for empowerment and support for URG faculty.

Conclusions: Understanding the experiences of URG faculty is paramount to improving the environment in academic medicine—paving the way to enhancing diversity in the health care sector. Institutions and individuals need to develop multilevel strategies for empowerment and support to actively make diverse faculty feel at home.

BACKGROUND

Historically, multiple groups have been underrepresented in leadership positions in medicine—a trend that continues today.[1,2] Sponsoring, mentoring, and coaching (SMC) are tools to advance the careers of junior faculty members and help close this gap in leadership representation.[3,4] For members of underrepresented groups (URGs) who have obtained executive leadership positions, the existing literature is unclear regarding how much SMC has impacted their career trajectories or how they employ these tools themselves. We conducted a qualitative study using semistructured interviews with US family medicine department chairs to describe these leaders' experiences and identify practices that promote diversity and inclusion.

Ensuring physician diversity is in the nation's interest.[5–7] Physician ethnicity and race are strong predictors of choosing primary care specialties and of caring for Medicaid and uninsured populations. Patients are more likely to adopt recommendations provided by culturally concordant physicians.[7] Hispanic and Black patients are more likely to live in lower socioeconomic communities than their White counterparts.[1] Therefore, Hispanic and Black physicians have a larger role in caring for economically disadvantaged Hispanic and Black patients.[1,2]

Academic medicine lacks faculty diversity, with URGs having minimal leadership representation.[8] URGs in medicine can include women, individuals from historically marginalized communities such as racial/ethnic minorities, sexual and gender minorities, and persons with disabilities.[5] For decades, the

rates of matriculation for men and women have been similar. However, even with increased numbers, women dominate only at the instructor level. Women made up 13% and 12% of faculty in 2018 and 2019, respectively, mostly as assistant professors. Just 18% of department chairs were women during that same time period.[9] White men remain overrepresented in medicine.[10] Council of Academic Family Medicine (CAFM) data reveal that fewer than 30% of department chairs, program directors, medical student education directors, and research leaders identify as non-White, and less than 6% identify as Hispanic. About 12% to 13% of family medicine department chairs are Black, and only 30% are women.[11,12]

In response to this underrepresentation, the Liaison Committee on Medical Education established diversity accreditation standards in 2009. Since then, the formerly declining numbers of women and Black matriculants have risen again, while the upward trend for Hispanic matriculants has continued.[13] Academic organizations are now apologizing for perpetuating, promoting, and failing to address racism, discrimination, and hate.[14] Additionally, more majority educational leaders are acknowledging the racial privilege that favored their access to medical education and leadership.[15,16] Many in predominately White institutions understand the link between systemic marginalization of groups and their own privileges, derived from a racist system.[15] Increasingly, people are aware of their role in systemic racism, inequality, and stereotyping.[16,17]

A CAFM task force focusing on identifying ways to enhance diversity in family medicine leadership concluded that the sponsoring, mentoring, and coaching of URGs needs improvement.[3] Moving forward, including URGs necessitates deliberate SMC, especially by senior leaders. Each of these activities is crucial for cultivating future health care leaders.[4] However, we previously found that academic leaders see mentoring, a longitudinal process aimed at career development through dialogue-based guidance, as more important than coaching and sponsoring.[18] Additionally, members of URGs are more successful when they receive high-quality mentorship.[19] However, few studies have explored URG's mentorship experiences, and even fewer have explored their sponsoring and coaching experiences. Most studies highlighting the disparities have not suggested solutions.

URGs have worked in a psychologically unsafe environment for far too long. Edmondson described psychological safety in 1999 as "a shared belief held by members of a team that the team is safe for interpersonal risk taking."[20] More recently, psychological safety has been identified as the number one characteristic of successful high-performing teams, especially in work environments where employee and customer safety are critical, such as in health care.[21–24] Our study focused on URGs' experiences with SMC during their career development and their use of SMC in leadership roles. We also evaluated the provision and reception of SMC by URGs, even at senior levels, by studying family medicine department chairs' experiences; given their extensive academic experience, their insights highlight the experiential differences between URGs and the majority.[18] Additionally, we identified strategies from their experiences that could enhance the SMC experiences of URG faculty and help create a more psychologically safe space.

METHODS

Our study used semistructured interviews with US family medicine department chairs, conducted between December 2020 and May 2021. We employed a purposive sampling strategy, prioritizing the inclusion of URG chairs based on race, gender, and sexual orientation. Additionally, we focused on the geographic diversity of departments and institutional size to ensure representation from institutions across the country. Participants were recruited through email invitations for virtual interviews. Given our team's composition, which included two chairs with a broad understanding of the chair community and the executive director of the Association of Departments of Family Medicine (ADFM), we had privileged access to a comprehensive list of chairs, complete with detailed demographics. In selecting URG chairs, we targeted individuals who either self-identified or were recognized within their communities as belonging to one or more URG categories. For non-URG chairs, our selection aimed to provide a contrast in experiences and perspectives, ensuring a wide-ranging understanding of the leadership landscape within family medicine departments.

The detailed methods, including the interview guide, were published previously.[25] We aimed to understand the factors influencing the provision and reception of SMC. We focused on both the chairs' experiences with and use of SMC in their current positions. After gathering the chairs' experiences, we posed two reflective questions on how personal attributes impacted their SMC decisions and whether they perceived differential treatment in receiving SMC related to their attributes. These prompts centered on URG faculty leaders' experiences and strategies supporting faculty development. Our study's methodology aligns with phenomenological research,[26] because it focuses on the lived experiences and perspectives of URG chairs in academic medicine. Participants self-identified their demographics at the interview's end.

Our team included the project lead, M.A., a family physician, research methodology PhD, and immigrant who identifies as Arab; D.S., a White family medicine department chair; J.S.P., the first Black and first permanent women chair at her medical school; T.R., a White family medicine faculty member; and A.W., the executive director of ADFM, who has a decade of experience with department chairs. The diversity of the team contributed to a rich perspective during our analysis. Two team members (J.S.P. and D.S.) also were interviewees. All interviewees were deidentified, and their quotations were merged into the larger data pool without specific identification. Deidentified codes were reassigned toward the end of the analysis, ensuring impartiality and that the findings accurately reflected the collective experiences of the entire group, not merely a subset. The University of Washington Institutional Review Board approved the study.

M.A. and T.R. conducted Zoom interviews, which were audio-recorded and transcribed commercially. M.A. led data coding with NVivo 11 Pro (Lumivero) qualitative research software. In our initial coding of the interviews for the thematic analysis, the team explored the experiences of the department chairs, dividing the strategies they used to address challenges into coping strategies (by the person) and supportive strategies (by others). Our initial codes delved into a range of experiences that URG chairs encountered, such as feeling isolated, experiencing aggression, and facing the minority tax. From these observations, we identified key themes in the interviewees' experiences. We revised our initial schematization of strategies as we saw potential alignment with a socioecological model, which added nuance and enhanced the potential usability of the strategies. This approach is consistent with the Association of American Medical Colleges' (AAMC's) framing of strategies for advancing diversity, equity, and inclusion in academic medicine.[27] We adapted these spheres into individual, interpersonal, departmental, academic community, and institutional categories for our context. We developed, explained, and summarized themes from our analyses, supporting them with direct quotations. We ensured trustworthiness through consistent peer debriefing, iterative coding, and reflective practice, and by leveraging our team's diverse backgrounds during the analysis.

RESULTS

We interviewed 20 chairs with a variety of backgrounds (Table 1). The participants shared their career experiences and perspectives, and outlined strategies to support URGs.

The Experiences of URG Chairs

We identified themes in the experiences of URG chairs. Those themes, along with longer and exemplary quotes, are included in Table 2 and explained in the text that follows.

URG leaders were rare. Many chairs noted the severe underrepresentation of URGs as peers and role models during their careers and their experience of being surrounded by White male leaders. They also noted the strikingly low representation of Black men: "There are fewer black males in medical schools now than there were 30 years ago" (118). Despite this, some departments, notably those at historically Black colleges and universities (HBCUs) and those with a majority Hispanic faculty, maintained diversity.

Not walking into my grandmother's kitchen. Amid departmental homogeneity, URG faculty often felt alienated, unacknowledged, and underestimated, commenting, for example,

> If I feel like I am walking into my grandmother's kitchen all the time . . . I am always comfortable. If a good deal of the time, I feel like I am walking down some dark alley . . . that is going to be a much different experience . . . it is easy for me to come out feeling alienated because very often I will be treated differently than someone else who the person with power can identify with.
>
> *(106)*

Many women interviewees shared similar experiences of feeling overlooked at social events or during key conversations. When asserting themselves, Black faculty were often labeled as "angry."

Experiencing aggression. Beyond subtle discrimination and microaggressions, some URG chairs faced harassment, intimidation, and derogatory comments. Power differentials in the White male-dominated environment were significant factors:

> One of my mentors [spoke] up in a faculty meeting about a comment one of the guys made about girls. The person spoke up and said, "No, we are not girls. We are women." . . . it brought to life some of the things that women have to go through with comments that men make in a mostly male atmosphere.
>
> *(113)*

Some White male leaders continue to be oblivious of the experiences of URG faculty. Many participants felt that leaders supported those resembling themselves, primarily White men. While some White male participants recognized lack of understanding of URG faculty perspectives, others claimed color blindness, focusing solely on skills or qualities. Some even suggested that being White occasionally hindered their chances when selection favored URG, including women, for example, "Maybe I received more or better opportunities because I am a White male. And if anything, maybe sometimes it is a disadvantage, too, right?" (108).

Burdened with minority tax. URGs often overwork to prove themselves. Having few minority faculty members in departments leads to overburdening the few senior URGs, whose expertise as mentors is often sought from outside their institutions. Extra responsibilities come from diversity activities or committee service that benefit the institution more than the individual faculty member. Although minority status implied an excessive burden for many, some saw it as a door opener.

Moving to a more supportive institution. With little mentoring and support, some URG faculty felt stunted in their career development. When reflecting on their careers, many participants identified times when they felt they could not move forward or receive promotions and consequently left to find a more supportive environment, including HBCUs: "I needed to be in a different environment that is going to allow me to grow and develop" (104). At times, the hostility a person felt was related to a particular unsupportive leader, and the environment felt safer and more supportive when that leader was no longer there.

Building resiliency and antiracist work. Many URG leaders were motivated by a mission to serve the community and those

TABLE 1. **Participant Demographics**

Demographic	n (%)
Age group	
40-49	1 (5)
50-59	7 (35)
60-69	11 (55)
70-79	1 (5)
Gender	
Male	11 (55)
Female	9 (45)
Sexual orientation/gender identity	
Heterosexual and cisgender	18 (90)
LGBTQ	2 (10)
Race	
White	10 (50)
Black	7 (35)
Others (Asian or mixed race)	3 (15)
Ethnicity	
Hispanic	2 (10)
Non-Hispanic	18 (90)
Years as chair	
<=5 years	10 (50)
>5 years	10 (50)

Abbreviation: LGBTQ, lesbian, gay, bisexual, transgender, queer or questioning

who had been underrepresented: "That's been kind of a driving force of in my career" (111). They also found refuge and a home in antiracism work, especially when surrounded by supportive colleagues, through whose lenses they saw the potential in others and recognized their own struggles.

Strategies to Empower URG Faculty

We offer strategies recommended by our participants for empowering URG faculty. For brevity, a summary description from our analysis across all interviews as well as example quotes representing each of these strategies are included in Tables 3, 4 and 5 .

Individual Strategies (Individual Faculty)

1. Be proactive and confidently advocate for those with less power
2. Seek honest feedback about your performance
3. Identify the institution's priorities and use them to select areas for your growth
4. Do not underestimate your potential; embrace your vantage point
5. Identify your allies and lean on your support system

Interpersonal Strategies (Faculty and Those Who Support Them)

1. Develop genuine relationships and broad networks
2. Find allies within the team
3. Use your lens to identify those who need different or additional support
4. Seek to understand the impacts of previous experiences while supporting individuals based on their goals and passions.
5. Identify and consider the impact of your own biases

Departmental Strategies (Departmental Leaders)

1. Offer mentors and coaches at the appropriate leadership level
2. Find ways to measure career advancement using performance metrics that augment traditional value tools
3. Promote involvement in state, regional, and national organizations
4. Lead and be supportive when efforts to enhance antiracism and diversity present themselves
5. Be aware that what works for one group may not work well for another

Academic Community Strategies (Organizations and Other Formal or Informal Communities)

1. Create diverse and welcoming environments
2. Identify and address violations such as racism and sexism immediately
3. Empower the person to say no
4. Resist the minority tax

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TABLE 2. **The Experiences of URG Chairs**

URG faculty are still rare.
"For me, the wake-up call recently was the data showing that there are fewer Black males in medical schools now than there were 30 years ago. And the research was done starting when I was in medical school. And to think that we haven't progressed 30 years is an embarrassment." (118) "Even then at [institution], for instance, I think less than 5% of the faculty were Latino. It is kind of astounding even though we live in an area that is like 40% [Latinx]; so, it has taken me a while to really understand the dynamics of this area of the country and its ethnic demographic mix and diversity, but I try to make it very clear that I value diversity and inclusion." (109)
Not walking into my grandmother's kitchen
"The analogy often used is that if I feel like I am walking into my grandmother's kitchen all the time . . . I am always comfortable. If a good deal of the time, I feel like I am walking down some dark alley . . . that is going to be a much different experience. And I think the former is more likely to happen with people from the majority and the latter more likely to happen with folks who are in the minority. . . . I think it is a fundamental function of bias, and we tend to like people we can identify with. And so if the people who have power in the setting do not look like me . . . it is easy for me to come out feeling alienated because very often I will be treated differently than someone else who the person with power can identify with." (106) "They may have been in situations where they feel like they have to fight for their voice, or they don't have a voice. Their voice was ignored, or their voice was misunderstood. People were thinking that they were angry when they were just sharing their opinion." (120)
Experiencing aggression
"I did recently have a very unpleasant experience where I was publicly insulted by a male leader. . . . I started getting texts, and chats, and emails, from all these women who are like, "Oh, I have had the same experience." I was like, "Wow." So that is not so much a lack of mentoring. It is like antimentoring, and it felt really unsupportive." (111) "I was very impressed with one of my mentors when I was a young faculty speaking up in a faculty meeting about a comment one of the guys made about girls. The person spoke up and said, 'No, we are not girls. We are women.' And it was just this totally they-did-not-even-think-about-it kind of comment, but it brought to life some of the things that women have to go through with comments that men make in a mostly male atmosphere." (113)
Some White male leaders continue to be oblivious of URG faculty.
"I would be realistic to acknowledge that you won't treat everybody exactly the same, right? And folks that I don't see a lot of potential for, I am not going to offer them a lot of sponsorship opportunities. That's just the way it goes." (115) "I certainly am the privileged White guy. The way I look at it though is that I am just very thankful for all the opportunities that I had. . . . I haven't seen that being a big issue that maybe I received more or better opportunities because I am a White male. And if anything, maybe sometimes it is a disadvantage too, right?" (108)
Burdened with minority tax
"Looking back on my own career, I can probably see where I probably paid some minority tax and was not aware of it, and now I am much more conscious of watching out for that, for younger faculty members, my minority, and my female faculty members . . . [but] it cuts both ways. If you are a female minority, you will get invited to do more stuff because you are a female minority, so that can open some doors and get you into things that you might otherwise not have been first to get into." (103) "For race, a part of it is talking about the minority tax. The feeling like in certain circumstances you are the only one that is going to address minority issues and how to deal with that and how to find allies, and that will also bring up those things." (110)
Moving to a more supportive institution
"And then a light bulb comes up over the head and says, 'You know, you are right, I probably should have done so and so.' If I sent out a memo right now to every single chair in the country, I would say at least 20 of them could say that they have a situation like that going on in their department right now, but they had not thought of it because they are not putting that in front, and it has to be affirmatively put in front. This is a priority for our department. This is a priority for our medical school. We keep saying that we want to hire faculty who are minorities or hiring faculty who are women, we hire them, and then they leave. Why?" (105) "I just knew at that point in my career, I wanted to work for somebody who would really help me grow and develop. I needed to be in a different environment that is going to allow me to grow and develop." (104)
Building spaces for resiliency and antiracist work
"That's been kind of a driving force of in my career . . . as I mentioned, I was mentoring a lot of students early on. They were students in a program that I ran that was specifically for students from diverse backgrounds, many of them from disadvantaged backgrounds, many of them minority students, and LGBT students, and in the sort of diversity in the broad sense of the word." (111) "When you are in a position of being a minority, you see the world through a different lens. . . . You identify problems they do not even see, let alone see as problems . . . you tend to reflect back historically on who helped you and . . . why was that help important? And therefore, when you see somebody who you believe has potential but does not seem to be moving at the pace and in the direction that you think they need to, you recognize it may not be because they are not motivated. It may not be because they do not want to get there. It may be they do not have the help they need. And so what happens is you problem-solve differently because you analyze situations differently. And you analyze them differently because your journey has been different." (116)

Abbreviations: URG, underrepresented groups; LGBT, lesbian, gay, bisexual, transgender

TABLE 3. **Individual and Interpersonal Strategies to Empower URG Faculty**

Strategies	Explanatory quotes
Individual strategies	
Be proactive and confidently advocate for the voices of those with less power.	"Your experience . . . brings something new to the table. It's extremely valuable, so don't minimize your voice. When you sit at the table, sit at the table confident with who you are . . . with your voice, skills, and all of that because that's bringing diversity and that's bringing value, and that's adding value to the table." (120)
Seek honest feedback about your performance.	"I have told my faculty, 'If you sense someone not doing a good job, it is your responsibility to tell me to my face that I am not doing a good job and it is time to let somebody else do this.' If I do not have the confidence of the people I am leading, it is time for somebody else." (102)
Find the institution's priorities and identify from them the areas for you to grow.	"The more I learn about mentoring, the more I understand that it requires some reflection and some critical thinking. What would be most helpful to you in terms of your growth and development? There are multiple competing priorities in a health system and in a world that is changing so rapidly right now. That just makes it really hard because maybe we set the goal yesterday in one place and today we are setting it in a completely different place." (104)
Do not underestimate your potential; embrace your vantage point.	"But the other part of it too is that I know I think about things differently and I like a challenge; so, as soon as you underestimate me, watch out, and you will not see it coming because I am so nice. My White male colleagues, they do not understand that; so, I can do things and I really am interested in a strategy that sometimes they will leave a meeting just amazed that I got over with something that they did not even see coming and leave them with their mouths open." (104)
Identify your allies and lean on your support system.	"the feeling like in certain circumstances you are the only one that is going to address minority issues and how to deal with that and how to find allies who will also bring up those things . . . how to identify and deal with microaggressions, and race, gender, and sexual orientation issues." (110)
Interpersonal strategies	
Develop genuine relationships and broad networks.	"I will tell you that I have had really helpful advice and useful feedback that was very different from different people in different spaces, and they were not all women and they were not all Black women. I just think it does people a disservice if they do not have a broader network than just the people who look like them." (114)
Find allies within the team.	"I think I have tried my best to use my sexual orientation as a way to offer to ally with people, and sort of recognizing that they get to make the call, but just sort of be in a community and a population that is sometimes marginalized in health care and also at a leadership level." (111)
Use your lens to identify those who need different or additional support.	"So if that happens constantly and your people are dealing with impostor syndrome . . . the voice might get small, depending on the personality of that person. I think being aware of all of that and witnessing some of that stuff has impacted my desire to make sure that I try to be the sponsor at the table or the advocate for the voice." (120)
Seek to understand the impacts of previous experiences while supporting individuals based on their goals and passions.	"If it is clear that someone is having some difficulties, struggling in some regard, and that may be due to some disruption in their personal life or it may just be that they are challenged with some aspect of the work that they are doing then. Well, yes, that usually requires some intervention. And most of that is probably more coaching and maybe some mentoring with regard to trying to help them, not necessarily with specific tasks and skills but maybe a bit of the vision thing." (106)
Identify and consider the impact of your own biases.	"The training was trying to raise awareness of the unconscious bias. Wow! I like to think I am not a biased person, but by golly I am. My default neural network thinks in this way. It was kind of experiential training. It is one thing to read about it. It is one thing to think, yeah, everyone deserves the right thing. But until you can at least put yourself in their shoes for a little period of time . . . ." (117)

Abbreviation: URG, underrepresented groups

5. Create additional opportunities for those who are impacted by bias

Institutional Strategies (Medical Schools, Health Systems, and Other Institutions)

1. Create policies addressing inequity
2. Provide opportunities for everyone
3. Correct injustices
4. Implement initiatives that center the community's voice

DISCUSSION AND CONCLUSIONS

Our study revealed the experiences of current URG family medicine department chairs. During their careers, they often have felt isolated and invisible, or worse, suffered discrimination. Our study identified multiple strategies that can be useful in improving the experiences of URGs in academia.

Many URG faculty described feeling isolated, or as one participant poignantly put it, not "walking into my grandmother's kitchen." As the usual pressures of academic productivity, administrative responsibilities, and even conflict accumulate and impact individual well-being, faculty may feel psychologically unsafe. Psychologically safe environments are those in which individuals feel safe to voice ideas, seek feedback, collaborate, take risks, and experiment.[20] In these environments, employees can be authentic and not rejected

TABLE 4. Departmental and Academic Community Related Strategies to Empower URG Faculty

Strategies	Explanatory quotes
Departmental strategies	
Offer mentors at the appropriate leadership level.	"So I think it is always good to have more than one mentor, have several mentors. . . . One mentor might be trying to help you be successful in your particular position that you are in, but another one may be able to see past that and help you be successful in all future opportunities you have." (113)
Find ways to measure progress in career advancement that redefines value.	"One thing that has increased in academic medicine over the past decade or two is widget counting. How many patients do you see per hour? When you start evaluating faculty by how many widgets they produce . . . it makes it harder to talk about your career or harder to talk about what type of return you can get on investment of time and effort." (105)
Promote involvement in national organizations.	"The other place I find that sometimes comes in handy is like groups. I think organizational medicine is incredibly important, and it is not always important for every group in the same way or at the same place, depending on where you are in your career . . . but for me, that was the only place where I often saw lots of other Black doctors." (114)
Lead and be supportive when efforts to enhance antiracism and diversity present themselves.	"So, we have this historical racism that has created this condition that now is difficult to change, but we can change it and so we have launched this whole Black Thriving initiative that we're part of . . . and the dean actually identified me to be the representative for the school of medicine." (109)
Be aware that what works for one group may not work well for another.	"Again it comes back to that whole idea about there are just certain things and ways that you are supposed to navigate the space that look a little different, depending on what you look like and how other people perceive people who look like you." (114)
Academic community related strategies	
Create diverse environments that are welcoming.	"You basically make it clear to that person that they are welcome. You make an effort to make them feel comfortable. You seek them out. You try to understand what their preferences are, what they feel they may need to be successful, and make yourself available to them. It is not difficult. You just basically treat them like someone who matters." (106)
Empower the person to say no.	"If there are only one or two of you in an institution, you cannot say yes all the time, and that is okay. You are not a bad person if you do not say yes all the time. You are not letting anybody down." (112)
Pay attention to minority tax.	"I encourage people to run opportunities by me, particularly the women and the minorities because they get caught in that whole minority tax thing. . . . to help them sort out what are higher priority areas and [so] they do not invest their precious time on things that check a box for the institution but not for themselves necessarily and because they can really get swallowed up in that stuff. [If] a minority woman . . . checks two boxes, [she] gets called for everything." (103)
Create appropriate/extra opportunities for those who are impacted by bias.	"And if I put, let's say, an African American woman or some other person or a female, really anybody who might have had historically disadvantaged, I put that person, or purposely work with them on leadership development or opportunity development and then put them in a leadership role. I think that is the very most powerful thing you could do because they bring that perspective." (117)

Abbreviation: URG, underrepresented groups

TABLE 5. Institutional Strategies to Empower URG Faculty

Institutional strategies	Explanatory quotes
Create policies to address inequity.	"There is a need for affirmative action. The White chairs have to say, 'There is a natural impulse that I probably cannot even control that all of the things being equal, I am going to choose someone who looks like me.' So what do I have to do affirmatively to make sure that that does not happen? That has to be a conscious choice, to go against their tendency, to do what is necessary." (105)
Provide opportunities for everyone.	"It is like I want the best people, and the best person is a particular gender or color . . . that they are gay, or whatever. It really is irrelevant. In fact, it is irrelevant to the role, but it is relevant to the message and the culture because it recognizes that there is diverse talent and it also meets a need for role models and mentors and sponsors and coaches." (117)
Correct injustices.	"Our CEO had a series of panels with people of color in the organization at all levels. These folks are very open and courageous about their experience in our organization, and it was really quite moving; so, I think for chairs themselves, they of course have to have the awareness. They have to be aware of their own sort of mental model and then make a commitment to behaving in such a way that moves past that sort of cultural legacy that we grew up with." (117)
Implement initiatives that center the community's voice.	"We have for the last maybe 5 years taken a major kind of DEIA culture. . . . We are trying to expand the diversity of the faculty so that we can be more inclusive and provide more equity for our patients and learners. We are very open about that. We are very public about that." (119)

Abbreviations: URG, underrepresented groups; DEIA, diversity, equity, inclusion, and accessibility

by others because of who they are; they are respected and recognized for their competence. A longitudinal assessment by Google's People Analytics unit found that psychological safety was the number one characteristic of successful high-performing teams[22] and that it is essential to enhancing safety in work environments such as health care and aviation.[23,24] Unfortunately, our current study is consistent with older literature on the experience of URG faculty. In Pololi et al, URG faculty reported a low perception of relationships and inclusions.[28] They judged their institutions lower on equity and efforts to improve diversity. Our study is also consistent with the framing of experiences of minorities influenced by elitism in academic medicine, where individuals experience exclusionary identification, racism, and aggression.[15]

Additionally, URG faculty often are burdened with a minority tax. Our findings are consistent with the existing literature.[28,29] Many URG faculty find themselves pushed to carry the burden of social justice efforts. The effects of a minority tax can be exacerbated by racism, lack of faculty development, lack of mentorship, isolation, and disproportionate expectations to do diversity work, which can result in minority faculty leaving academe.[29–31]

Our approach in presenting strategies for support and coping is consistent with AAMC's framing of strategies that can advance diversity, equity, and inclusion in academic medicine.[27] The multilevel, multidomain approach promises to address the complexity of structural racism implicated in the failure of academic medicine to respond to the needs of communities.[32] Mentoring is crucial, given the experiences that URG faculty have in the unsupportive environments they described. South-Paul et al's recent article outlined the evidence that mentoring serves as an effective solution for the challenges brought by a lack of diversity within academic medicine.[33] While mentoring is known to have benefits for career and personal development, it also plays a unique and often unacknowledged role as a buffer for women and people of color, especially when they work in institutions that lack diversity. Mentoring helps in the development of future leadership, research, and programs within academic medicine and the health professions.[33]

Our study has important practical implications. URG faculty need training on strategies to empower their career development, along with funding and resources to attend the training. Some existing programs include Drexel University's Executive Leadership in Academic Medicine program,[34] the ADFM Leadership Education for Academic Development and Success program,[35] the Minority Faculty Leadership Development Seminar from the Association of American Medical Colleges,[36] and the Society of Teachers of Family Medicine's Underrepresented in Medicine Leadership Pathways in Academic Medicine course.[37] A notable challenge, as highlighted by a CAFM task force, involves not only the direct costs and time commitments but also the lack of institutional financial support for URG faculty to attend such training. Additionally, the requirement for external referees, who are not always accessible to URGs, further complicates this issue.[3] Department chairs are in a key position to influence the future of URGs in family medicine by directing resources that can positively impact the future of junior URG faculty. The ultimate test of their success will be an increase in URG faculty assuming leadership roles.

Our study's strengths lie in the diversity of the interviewed chairs, who revealed a wealth of experiences and perspectives. The use of semistructured interviews facilitated the exploration of an array of emergent topics. The limitations of the study include the fact that the interviewees did not represent the entire spectrum of chair experiences, and they did not fully capture the vast ethnic and racial diversity of the United States. As a result, some viewpoints remain unrepresented. Future studies could investigate effective strategies employed by chairs in supporting URG faculty and evaluate the impact of such strategies on career development.

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