Published in final edited form as:

J Natl Med Assoc. 2017 ; 109(2): 72–78. doi:10.1016/j.jnma.2016.10.001.

Promoting Progress or Propagating Problems: Strategic Plans and the Advancement of Academic Faculty Diversity in U.S. Medical Schools

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Introduction¹

1.1

Medicine has sought to increase the presence of underrepresented minorities in medicine (URMs) for over thirty years.^{1–3} These groups have been traditionally defined as African-Americans, Hispanics/Latinos, Native Americans, Alaskan Natives, and Pacific Islanders.⁴ Medical leaders and health care advocates understand that increasing URMs is a mechanism to increase social justice, reduce health care disparities, and improve quality of care among these very same racial and ethnic groups.^{5–7}

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Other disclosures: None

Ethical approval: This study was ruled as non-human subject research (NHSR), and, thus, was exempt from IRB review.

Disclaimer: None

Previous presentations: Prior versions of this study were presented as an oral presentation at the National Conference of the Society of General Internal Medicine on May 12th, 2016 in Hollywood, Florida, and as a poster on June 25th, 2016 at the National Research Service Award Trainee's Conference in Boston, MA.

¹**Abbreviations:** URM= Underrepresented Minorities in Medicine, AAMC= The Association of American Medical Colleges

Despite the benefits of diversity in academic medicine being relatively well-established, the tools to increase URM faculty presence are few. Several successful case studies demonstrate how strategic planning can improve diversity and inclusion of URMs within academic medicine.^{8,9} Deas et al published the strategic planning for diversity experience at the Medical University of South Carolina in 2012.⁸ Through the integration of diversity into the organizational structure, they cite almost a doubling of URM faculty over a 10-year period.⁸ Use of strategies such as mentoring programs and pipeline programs to achieve this outcome were implemented as a result of strategic planning. While this case report illustrates successful development and implementation of strategic planning for institutional diversity, it is not clear how many other U.S. medical schools have undertaken the strategic planning process and how successful it has been to increase URM faculty.¹⁰ Although, organizations such as the Association of American Medical Colleges (AAMC) support strategic planning for institutional diversity, scant published literature explores how U.S. medical schools have operationalized this activity, and if doing so is associated with improved URM faculty representation.

1.1.1—The aim of this study is to investigate whether academic institutions that have engaged in strategic planning for faculty diversity, as exhibited by plan presence on their websites, have had a higher rate of URM faculty growth than institutions who do not have evidence of such planning. We hypothesized that utilization of strategic planning to improve organizational culture and institutional climate to grow and support URM faculty will lead to a higher rate of URM faculty growth. We also hypothesized that institutions with plans of longer duration will have had more growth in URM faculty, given these institutions have proposed organizational efforts to increase the diversity of their faculty for a longer period of time.

Materials and Methods

2.1 Study Design and Data Collection

We conducted an observational study using the *AAMC Faculty Roster* and strategic plans as available from AAMC-member U.S. medical school public websites. The *Faculty Roster* is a national database that tracks characteristics of essentially all full-time U.S. medical school faculty at Liaison Committee of Medical Education (LCME)-accredited institutions.¹¹ Submission to the database is voluntary. This study was deemed Non-Human Subjects Research (NHSR) and therefore exempt by the Institutional Review Board of Boston University Medical Center.

2.1.1 Percent Change—*Percent Change* was defined as the change in the proportion of full-time URM faculty presence from 1998 to 2015. We chose the year 1998 to account for the URM faculty state prior to the re-invigorated workforce diversification efforts catalyzed by the Sullivan Report and the Institute of Medicine's *Unequal Treatment* to reduce health care disparities and improve health equity.^{7,12} We defined URM Faculty as faculty described in the *Faculty Roster* as American Indian/Alaskan, Black, Hispanic, Native Hawaiian, and Multiple Race-Hispanic. Only institutions that reported data in both 1998 and 2015 were included (N=125). Historically black and Puerto Rico-based institutions (N=7) were

excluded from analyses as URM faculty representation has been a longstanding central priority for these institutions and their URM representation are statistical outliers. For the remaining 118 institutions, we calculated the proportion of their faculty that identified as URM (*Percent URM Faculty*) in 1998 and 2015. Then, we calculated *Percent Change* by subtracting the percent URM Faculty in 1998 from the percent URM Faculty in 2015. *Percent Change* was then dichotomized into *Minimal Growth* (institutions in the first quartile with percent change in URM faculty $\leq 0.4\%$) and *Higher Growth* (institutions in the second, third, and fourth quartiles).

2.1.2 Plan Presence—We identified strategic plans through internet searches of institutional websites accessed through links hosted by the AAMC website. Specifically, we searched each institutional website's homepage search function for the terms “strategic”, “plan”, “diversity”. We then screened for strategic planning documents for the institution. When multiple pages of results were found, we manually search the first 10 pages for a strategic plan. We read all such documents to confirm stated goals, policies, or statements of commitment to increasing racial, ethnic, or multicultural diversity within the faculty or workforce. We, then, performed a secondary search for strategic plans using institutional site maps. We manually explored websites starting at the homepage with progression to ‘About Us’ or equivalent pages, the pages of the Offices of Diversity/Inclusion, or whatever organizational pages could be found related to multiculturalism. As a third search, we conducted an advanced Google search of the institutional domains using the search terms “strategic OR plan OR initiative OR diversity”. From these results, we examined up to 10 pages of results. Plans based at the medical school and plans based at the associated university were both considered for this study.

2.1.3 Plan Type—We also collected data on whether the strategic goal to increase faculty diversity was communicated in a strategic planning document specifically designed to address the issues of institutional diversity, or a *Diversity-specific Plan*. We defined a strategic planning document as being “diversity-specific” through review of the title and introduction for the identifier of “strategic plan for diversity” or other similar statement. For plans that did not fit this description, but had a goal for faculty diversity, we termed them *Integrated Plans*. We collected data on this distinction (*Plan Type*) as the AAMC guide for strategic planning for diversity suggests that diversity goals should be intertwined with other institutional goals, and not “siloe”, or marginalized from other university goals and initiatives.¹³ The guide suggests this behavior potentially hinders the effectiveness of strategic plans for diversity.¹³

2.1.4 Plan Duration—We searched the text of the strategic plans for an implementation start date and end date. *Plan Duration* was then calculated by subtracting the start date year from the year 2015. In cases where multiple plans were found the plan with the earliest start date and mention of a goal to increase faculty diversity was used to calculate *Plan Duration*. For analyses, we dichotomized Plan Duration into plans with a duration of greater than five years and those that had been established for the first time within the prior five years. We chose five years as literature on strategic planning suggest that the average lifecycle for a strategic plan is three to five years.^{14, 15}

2.1.5 Private Status—Private or public funding status of the school was determined through institutional websites and listing on AAMC’s website. We hypothesized that this designation status may serve as a proxy for other school characteristics, such as funding sources, regulations, faculty and student body size, and institutional infrastructure that may be associated with strategic planning behavior and communication, as represented by the plans themselves.

2.1.6 Region—The location of an institution is a factor in the AAMC framework for diversity and inclusion in academic medicine.^{6,16,17} To explore for regional variation in strategic planning for faculty diversity, we assigned school region based on the AAMC-member regional categories: Central, Northeast, South, and Western.

2.2.1 Statistical Analyses—The characteristics for *Plan Presence*, *Plan Type*, *Percent Change* status, or *Plan Duration* were not normally distributed; therefore, non-parametric tests were used to generate descriptive statistics. Wilcoxon-rank-sum test was used for continuous variables and Chi-Squared (χ^2) Test of Independence or Fisher’s Exact Test for dichotomous variables. We used the Kruskal-Wallis Test to investigate differences within categories based on institutional region. All results are reported as median and interquartile range (IQR). A χ^2 Test of Independence and a Wilcoxon Rank Sum Test were performed with 118 institutions to test the null hypothesis that strategic plan status (*Plan Presence* and *Plan Type*) was independent of *Percent Change* in URM. We performed a secondary χ^2 Test of Independence with the 73 institutions for which *Plan Duration* could be calculated to test the null hypothesis that strategic plan duration (greater than five years or less than five years) was independent of percent change in URM faculty status. All statistical analyses were performed using RStudio version 0.99.892 (RStudio, Inc., Boston, MA) and SAS version 9.3.0 (SAS Institute, Cary, NC)

Theory

3.1

Researchers have examined many facilitators and barriers to URM representation in the workforce.^{3,7,18–20} Pipeline initiatives, holistic application review and increased institutional financial support have shown efficacy in improving diversity among applicants and trainees.^{5,6,21,22} In fact, the gap in proportional representation with non-URM students/trainees is closing in the STEM training pipeline.²³ However, improvements in student and trainee diversity have not led to proportional improvements in the representation of URM among academic faculty.²³ In 2014, URM comprised 31% of the U.S. population, while constituting only 8.6% of the U.S. physician workforce.²⁴ In academic medicine, URM make up 8% of academic medical faculty, a proportion that has risen by less than 1.5% over the past 20 years.¹⁸ Studies examining barriers to URM recruitment, retention, and promotion among academic faculty suggest perceived social isolation and lack of transparency in promotion requirements as contributing factors to the lower recruitment and higher attrition rates of URM than their non-URM peers.^{18–20,25} In addition, an unequitable distribution of non-career advancing obligations, also known as the “responsibility disparity”, contribute to this phenomenon.^{19,26}

3.1.1—While mentoring programs and faculty development programs of sufficient intensity have been shown to improve URM faculty presence in academic medicine, studies also suggests that organizational culture change can and should be used to reduce barriers.^{16,18,20,27} The AAMC reinforces this by making *Structures and Policies* a central construct in their conceptual framework for diversity and inclusion within academic medicine.^{6,17} Operating within this construct is strategic planning.¹³ Strategic planning is an organizational management activity characterized by a taskforce or committee charged by organizational leadership to establish goals in line with the mission and vision of an institution.¹⁰ Clear strategies are then assigned to goals, as well as metrics, that help guide the institution to fulfill its goals.^{8,9} The process of strategic planning is iterative and adaptive, meant to change with organizational needs and shifting priorities.^{10,14,28} One feature of strategic planning is sharing and communicating the plan with stakeholders at all levels of the institution; creative use of websites, social media, or other platforms is encouraged to facilitate dissemination and implementation.^{29,30}

Results & Discussion

4.1

We found that 116 (98%) of the 118 schools that existed in 1998 had some form of a strategic plan at the medical school or larger university level. Of these, we identified 86 (74.1%) with a goal for faculty diversity. *Percent Change* for the 116 schools that existed in 1998 ranged from -3.8% to 8.7% with a median (IQR) of 1.7% (2.1%). Of the 86 schools that had a plan with a goal for faculty diversity, we were able to calculate *Plan Duration* for 73 (84.9%). The median *Plan Duration* was 4 years (IQR 5 years, range: <1 to 22 years) and 52 (71.2%) had a duration of five years or less. As shown in Table 1 and Table 2, we found no significant difference in *Region* by *Plan Presence* ($p=0.65$), *Plan Type* ($p=0.17$), *Percent Change* status ($p=0.49$), or *Plan Duration* status ($p=0.61$). The institutions with *Higher Growth* status had lower proportions of URM faculty in 1998 (4.8% IQR 2.9% vs. 5.7% IQR 2.6%, $p=0.03$) but higher proportions of URM faculty in 2015 (6.7% IQR 4.3% vs. 5.1% IQR 2.8%, $p=0.001$). Moreover, we found a significant association between school Private/Public status and *Percent Change* status ($p=0.008$). A greater proportion of public schools (83.6%) were of *Higher Growth* status when compared to private schools (75.0%).

4.1.1—Both χ^2 analyses (shown in Table 3) and Wilcoxon Rank Sum Test analyses (shown in Figure 1), demonstrated no significant relationship between *Plan Presence* and *Percent Change* ($p=0.43$ and $p=0.13$, respectively). We found no significant association between having a goal for faculty diversity communicated in a *Diversity-specific Plan* vs. in an *Integrated Plan* and *Percent Change* status ($p=0.14$). We also found no significant association between *Plan Duration* and *Plan Type* ($p=1.0$) or *Percent Change* ($p=0.64$).

4.1.2—The results of this study align with prior studies that suggest URM faculty growth has been meager over the past 20 years.^{1,2,31} The presence of a strategic plan to increase faculty diversity was not associated with higher URM faculty growth among the AAMC member institutions. Furthermore, having a strategic plan for faculty diversity for longer than the past five years was not associated with URM faculty growth. While case studies

provide examples of the efficacy of strategic planning for diversity and inclusion at several U.S. medical schools, the data we present suggests that this method may not be generalizable.

4.2

Essentially, creating a strategic plan for diversity appears to fall short of the efforts to induce the organizational change needed to succeed. Establishing a strategic plan may contribute a false sense of accomplishment while, ultimately, failing to improve organizational culture, policies, and procedures for URM faculty. Studies examining diversity policies in corporate America suggest that diversity efforts may be hurt by these very same policies.^{32,33} Moreover, evidence supports that institutional diversity efforts in academic medicine can potentially contribute to the “responsibility disparity” or “minority tax” for existing URM faculty.^{19,26} Such self-identifying faculty members are disproportionately called on to serve in organizational diversity efforts and working groups, such as strategic planning for diversity.¹⁹ As these responsibilities are often uncompensated or under-valued in terms of career success or promotion, they may actually serve to increase barriers for the URM faculty recruitment, retention, and promotion without yielding appreciable benefits.^{19,26}

4.2.1—This study has several limitations. The data in the *AAMC Faculty Roster* likely overestimates URM faculty presence since instructors may be included as faculty members, while this rank at many institutions is not truly a faculty position. Moreover, while we dichotomized institutions by the degree of their change in URM faculty proportion, this level of improvement overall is small. This highlights the degree to which faculty diversification efforts within academic medicine are failing to achieve greater representation. Another limitation is that our identification of strategic plan presence was limited what could be found on the internet. While the AAMC and other strategic planning literature suggests publically communicating these strategic planning initiatives and the use of technology to do so, some schools may have not chosen to distribute their strategies via public institutional websites.^{13,30} Another important consideration is the fact that strategic planning documents may not accurately represent institutional efforts. Similarly, strategic planning literature suggest that it is not uncommon for strategic plans to change during the course of implementation.^{10,14} However, given the low level of racial/ethnic faculty diversity in virtually all U.S. medical schools, the goal to increase pipeline and workforce diversity would likely persist even if the exact methods for achieving it did change. Lastly, despite identifying a specific goal to increase workforce diversity, the specific content of the strategic plans was not assessed in this study. Such details may relate to a plan’s efficacy and is a topic for ongoing investigation by our group.

Implications

Most AAMC-member institutions have a strategic plan with goals to increase faculty diversity. Having a plan with goals to increase faculty diversity and having a plan for longer than five years was not associated with percent change in URM faculty. Further work is needed to explore if specific elements of strategic plans for diversity are associated with successful URM faculty growth. Understanding how such elements work will set the stage

for subsequent studies to evaluate strategic plan implementation with meaningful diversity and inclusion outcome metrics, such as change in URM presence, promotion rates, and qualitative changes in URM and non-URM faculty experiences. Academic institutions should focus on interventions that accountably and equitably engage URM and non-URM faculty and leadership to overcome organizational barriers and facilitate URM faculty growth.

Acknowledgments

The authors wish to thank Megan Bair-Merritt, MD MSCE of Boston Medical Center & Boston University School of Medicine, Christopher Louis, PhD of Boston University School of Public Health, Victoria Parker, DBA Ed.M. of the Boston University School of Public Health for their aid in the conceptualization of this study.

Funding: Dr. Washington's fellowship is funded by a training grant from the Ruth L. Kirschstein National Research Service Award program (4T32HS022242-03).

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Figure 1. Change in URM faculty from 1998 to 2015 by plan status

Percent Change (%) of URM faculty from 1998 to 2015 for each U.S. medical school (N=118) by institutional presence or absence of a strategic plan with a goal to increase faculty diversity. No significant association ($p=0.13$) between Percent Change and plan presence was found.

(Data Source: *AAMC Faculty Roster*, 1998 & 2015)

Table 1

Medical school characteristics by plan presence & plan type

Characteristics	Plan Present n (%)=86 (72.9)	Plan Absent n (%)=32 (27.1)	p	Diversity-specific Plan n (%)= 32 (37.2)	Integrated Plan n (%)= 54 (62.8)	p
Region			0.65			0.17
Central	23 (74.2)	8 (25.8)		11 (45.8)	13(54.2)	
Northeast	25 (73.5)	9 (26.5)		11 (44.0)	14 (56.0)	

¹URM= underrepresented minority in medicine; IQR= interquartile range

²*= p < 0.05

³Higher Growth and Minimal Growth based on calculations using data from *AAMC Faculty Roster* (1998 & 2015)

Table 2

Medical school characteristics by percent change & plan duration

Characteristics	Higher Growth n (%)= 88 (74.6)	Minimal Growth n (%)= 30 (25.4)	p	Plan Duration 5 Years or Less n (%)= 52 (71.2)	Plan Duration Greater Than 5 Years n (%)= 21 (28.8)	P
Region			0.49			0.61
Central	23 (74.2)	8 (25.8)		13 (65.0)	7 (35.0)	
Northeast	22 (64.7)	12(35.3)		16 (72.7)	6 (27.3)	
Southern	31 (86.1)	5(13.8)		17 (77.2)	5 (22.8)	
Western	12 (70.5)	5 (29.4)		6 (66.6)	3 (33.4)	
Status						
Private	27 (75.0)	18 (25.0)	0.008*	17 (68.0)	8 (32.0)	0.86
Public	61 (83.6)	12 (16.4)	—	35 (60.3)	13 (39.7)	—
Percent URM Faculty, 1998 median (IQR)	4.8% (2.9%)	5.7% (2.6%)	0.03*	5.3% (3.3%)	4.8% (2.0%)	0.19
Percent URM Faculty, 2015 median (IQR)	6.7% (4.3%)	5.1% (2.8%)	0.001*	6.7% (4.6%)	5.6 (1.7%)	0.27

¹ URM= underrepresented minority in medicine; IQR= interquartile range² * = p < 0.05³ Higher Growth and Minimal Growth based on calculations using data from *AAMC Faculty Roster* (1998 & 2015)

Table 3

Summary table by percent change status

	Minimal Growth n (%)	Higher Growth n (%)	p
Plan Status (N=118)	30 (25.4)	88 (74.6)	0.43
Present	24 (27.9)	62 (72.1)	
Absent	6 (18.8)	26 (81.2)	
Plan Type (N=86)	23 (26.7)	63 (73.3)	
Diversity-Specific Plan	12 (37.5)	20 (62.5)	0.14
Integrated Plan	11 (20.4)	43 (79.6)	
Plan Duration (N =73)	22 (30.1)	53 (69.9)	
5 years or less	17 (32.7)	35 (67.3)	0.64
Greater than 5 years	5 (23.8)	16 (76.2)	

¹ Higher Growth and Minimal Growth based on calculations using data from *AAMC Faculty Roster* (1998 & 2015)