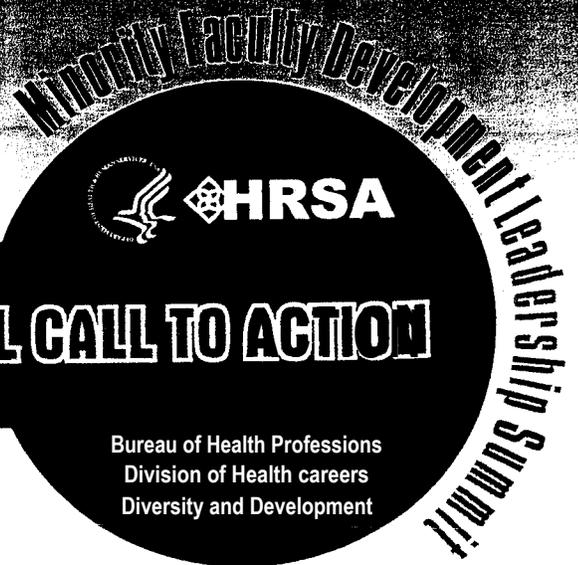




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**A NATIONAL CALL TO ACTION**

Bureau of Health Professions  
Division of Health careers  
Diversity and Development

# Minority Faculty Development Leadership Summit for Health Professions

Chairman

Report of the HRSA Expert Panel

*Prepared by*

Rivera, Sierra & Company, Inc.

for the

Division of Health Careers Diversity and Development

Bureau of Health Professions

Health Resources and Services Administration

Department of Health and Human Services

Rockville, MD

# Minority Faculty Development Model for HRSA Sponsored Health Professions

Third Draft

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Health Resources and Services Administration  
Department of Health and Human Services  
Rockville, Maryland

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## Disclaimer

This third draft of the Minority Faculty Development Model was disseminated to the Expert Panel and the Summit registrants at the same time. This was not formally reviewed by the Expert Panel, due to the author's time constraints. The final report of the Model will be prepared by HRSA, following the Summit. The final report will include feedback from the Summit registrants, and will be reviewed and approved by the Expert Panel, before it is submitted for Agency and Departmental clearance and publication.

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This document is produced by Rivera, Sierra & Ca., Inc. under contract awarded by the Health Resources and Services Administration, U.S. Department of Health and Human Services, 5600 Fisher Lane, Rockville, MD 20857. The contents are solely the responsibility of the contractor and do not necessarily represent the official views of the agency.

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# Minority Faculty Development Model for HRSA Sponsored Health Professions

Third Draft

## Introduction and Overview

The Health Resources and Services Administration (HRSA) is sometimes referred to as the "Access Agency." The mission of HRSA is to provide national leadership, program resources and services needed to improve access to culturally competent, quality health care. In furtherance of that mission, Congress authorized HRSA, through its Bureau of Health Professions (BHP) to establish various programs designed to enhance the caliber and quality of faculty and insures the diversity of the health professions workforce with HRSA's portfolio. Two of these programs are the Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP).

Among the goals set forth in the HRSA's 2005-2010 Strategic Plan is to "Improve Access to Healthcare" by developing programs to "increase recruitment, training, distribution, and retention of under-represented minorities into the health care professions."<sup>1</sup> In keeping with this mandate, and in light of numerous reports which have drawn a correlation between under representation of minorities in health professions with the perpetuation of health disparities, HRSA undertook the leadership role of helping to shape the debate regarding a model that can be readily used and adapted by health professional schools seeking to increase the hiring, retention and promotion of under-represented minority (URM) faculty.

### Centers of Excellence (COE)

The Centers of Excellence (COE) Program provides grants to health professional schools to support educational programs of excellence for underrepresented minority students and faculty (URM). These programs strengthen our national capacity to train URMs in the health professions and to create a more diverse health professions workforce.

Eligible applicants include schools of: allopathic medicine; osteopathic medicine; dentistry; pharmacy; graduate programs in behavioral or mental health and other public or private nonprofit health or educational institutions. This includes programs in clinical and counseling psychology, clinical social work, and marriage and family therapy. All applicants must have URM student enrollments that are at or above the national average.

Historically Black Colleges and Universities (HBCU) COEs are located at four HBCUs designated by statute. They are Meharry Medical College Schools of Medicine and Dentistry, Xavier University of Louisiana College of Pharmacy, and Tuskegee University School of Veterinary Medicine. Hispanic COEs must give priority to activities serving Hispanic Americans. Native American COEs must give priority to activities serving Native Americans; and establish an arrangement with one or more higher education institutions with traditions of significant enrollments of Native Americans. These may be public or nonprofit institutions, and may include schools of nursing. "Other" COEs must be a health professional school that can document a combined enrollment of URMs above the national average.

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<http://www.hrsa.gov/about/strategicplan05-10.htm#goals>

**The legislative purposes of COEs are to:** 1) develop a large, competitive applicant pool and establish an education pipeline for careers in the health professions; 2) establish, strengthen, or expand programs to enhance the academic performance of URM students; **3)improve the capacity of the school to train, recruit, and retain URM faculty,** including payment of stipends and fellowships; 4) improve information resources, clinical education, curricula, and cultural competence about minority health issues for the school's graduates; 5) facilitate research on health issues affecting URM groups; 6) train students to provide health services to a significant number of URMs, at community-based facilities that are remote from the school's main campus; and 7) provide stipends to URMs to enable them to participate in the COE program.

COE was appropriated approximately \$33.8 million in FY 2004 and 2005, to fund 34 projects. These Centers fund approximately 7,000 URM students in health professions schools researching minority health issues and gaining experience in community based health facilities. In addition, these Centers fund 1,900 URM faculty members.

### **Minority Faculty Development Model**

The Minority Faculty Development Model will be used by health professions schools to train, recruit, and retain under-represented minority faculty. The three major areas in this model are clinical training, research, and academic/teaching. A diverse panel of 15 highly qualified expert professionals was recruited in 2003 to provide unbiased guidance on the model. These experts are from allopathic and osteopathic medicine, dentistry, pharmacy, and graduate programs in behavioral and mental health. They include representatives from COE schools, non-COE schools, professional associations, and some professionals chosen because of their ability to lend balance or needed perspective to the deliberations.

To accomplish the goal of creating such a model, HRSA identified three domains or areas of inquiry for the experts: clinical training, research training, and academic/teaching training. Within these domains, 24 questions were structured by HRSA staff for consideration by the expert panel. At the first meeting of the panel, this number was further refined to 14 questions and it is these questions which will be the subject of this report. As seen in this report, these questions are synthesized even further.

The charge to the MFD Expert Panel was to create an omnibus model which might be applied across all health professions and refine that model in order to make it more directly applicable to the specific health professions that are eligible to participate in the COE program.

## The Questions Considered by the Expert Panel

The 14 questions which were considered by the panel are broken up into two groupings: one of general applicability across all areas of training; and another grouping more relevant to specific training areas.

Five questions were asked across all disciplines:

1. How are minority faculty identified and recruited?
2. How are minority faculty trained and developed?
3. How are minority faculty retained?
4. What are the requirements for minority faculty to attain tenure?
5. What information does incoming minority faculty need to know to be effective from the beginning of their assignments?

These questions were then examined within the context of three specific training or work areas: clinical training, research training and academic/teaching training.

In order to examine the concept of an MFD model in the context of clinical training, the panel was asked to consider two additional questions:

6. How much time does minority clinical faculty need to spend in a clinical setting?
7. What skills does minority clinical faculty need to be effective clinical educators?

In the context of research training, three questions were put to the panel:

8. How many publications in peer reviewed journals do minority research faculty need to have published annually?
9. How many presentations does minority research faculty need to be make each year at national, regional, and state conferences?
10. What special research training does minority research faculty need?

Finally, in the context of academic/teaching training, the panel was asked to consider four questions:

11. What does the minority academic/teaching faculty need to know about writing COE and other grant proposals?
12. What does a minority academic/teaching faculty need to know about administering COE and other programs?
13. What pedagogical skills do minority academic/teaching faculty need to be effective in the classroom?
14. How do minority academic/teaching faculty balance their teaching requirements versus their research and other duties?

Ultimately, all 14 questions focused on the two critical issues that represented the charge to the panel: how do you recruit minority faculty and how do you retain them. In order to make a model from this process, the panel was asked to determine how these issues are currently managed. Then, to fulfill the purpose of how should they be managed, what are the best practices?

This Model is the report based on the three meetings of the expert panel as prepared by Rivera, Sierra & Company. This is the contractor hired to facilitate the panel discussions and synthesize their deliberations. This report is in this document which serves as the basis for the National Summit deliberations.

The findings and conclusions are not those of HRSA; nor were they meant to be. Over the past decade or more, numerous organizations and institutions have attempted to articulate what can be basically called principles relevant to minority faculty development. But few have been able to actually conceptualize a model.

This report proposes a model to guide institutions seeking to address this important issue. The report does not attempt to serve as a literature search and analysis of all of the research on the subject of minority faculty development. But it does build upon an initial literature search conducted by HRSA staff in preparation for the deliberations of the panel.

Importantly, the report does not attempt to address all of the issues which impact upon minority faculty development. Societal and institutional racism, economic impediments, lack of availability within the "pipeline" of schools are all important subjects. But they are beyond the scope of this panel.

The panel was asked to assume the existence of these and other barriers and answer the question: what can institutions of higher learning, particularly those receiving support from HRSA, do to change the landscape and create a climate where the issue of minority faculty development can be addressed in a positive way for the benefit of both the institution and society at large.

This report attempts to frame and answer some of the critical questions which any institution must ask in order to address minority faculty development. And, this report offers some recommendations for moving forward with a minority faculty development initiative.

## **Minority Faculty Development Leadership Summit: *A National Call to Action***

The Minority Faculty Development Leadership Summit: A National Call to Action is designed to provide Project Directors of HRSA/BHP grant programs, institutional faculty and administrators, and their representatives in the Federation of Associations of Schools of the Health Professions (FASHP) with a unique opportunity to provide feedback on the proposed Minority Faculty Development Model (MFD). This meeting is also intended to foster dialogue as well as share ideas among potential and current faculty, administrators, and professional organizations, concerning the problems of inadequate minority faculty representation in the health professions.

It is anticipated that approximately 200 participants, including Federal program officials and staff, representatives from health professional schools, as well as two (2) and four (4) year institutions will attend this two day meeting. The meeting will be held in Washington D.C. on March 29-30, 2005.

HRSA expresses its gratitude to the hard work of the dedicated members of the Expert Panel whose names and affiliations are set forth below:

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## Acknowledgments

This project owes its existence, in part, to the HRSA Strategic Plan for FY 2005-2010 which was in the design process during the Expert Panel deliberations and was recently published. In that plan, HRSA Administrator Dr. Elizabeth Duke set forth seven goals which would guide the agency in the next five years:

1. Improve access to health care;
2. Improve health outcomes;
3. Improve the quality of health care;
4. Eliminate health disparities
5. Improve the public health and health care systems;
6. Enhance the ability of the health care system to respond to public health emergencies;  
and
7. Achieve excellence in management practices.

This project responds to many of those strategic goals.

This project acknowledges the unwavering support of DHCDD Division Director, Captain Henry Lopez, Jr. as well as support and guidance, at the operational level, from Diversity Branch Chief Captain Sheila Norris and Federal Project Officer Stuart Weiss. Stuart Weiss is the editor of this document.

# The Academic Triad

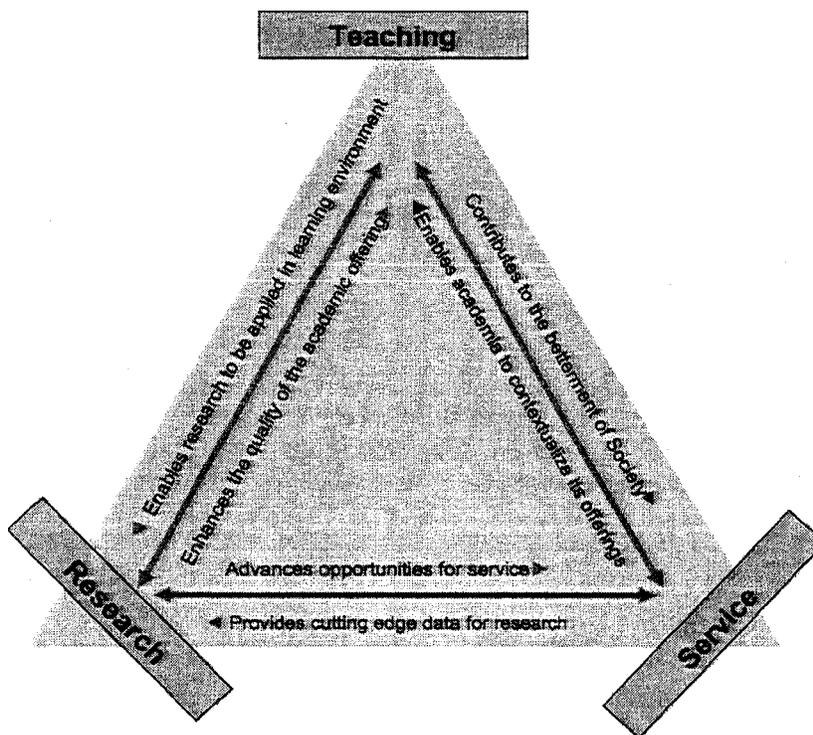
## Background

In the first meeting of the expert panel, it was determined that, in order to focus the discussion around the three dominant domains of clinical training, research training, and academic/teaching training, it would be useful to concentrate on a series of questions relating to recruitment and retention of minority faculty.

Since a significant part of the deliberations outlined here involve an analysis of values, two background considerations need to be mentioned: 1) the existence or reaffirmation of the critical triad of attributes necessary for academic progression; and 2) the recognition of a "new world" where the actions and activities within society are interdependent with those within academia.

The triad looks like this:

# The Faculty Development Triad



This triad concept was a starting point for consensus within the panel. A significant part of the deliberations, however, turned on how each of these elements of the triad are "valued."

A logical extension of the triad leads to the second point. The validity of the diagram rests on the concept of interdependence; that is, each point of the triad is dependent upon the other in order to be integrated or whole. While each can exist in the abstract, in order to exist as a faculty development model, interdependence is necessary.

In his work, "Scholarship Reconsidered: Priorities of the Professoriate,"<sup>2</sup> Ernest Boyer, Past President of the Carnegie Foundation for the Advancement of Teaching noted:

*The nation 's schools, its health care delivery system, and its banking system, for instance, all cry out for the application of knowledge that faculty can provide. New discoveries, rooted in research, can today, as in the past, produce cures for dreaded diseases and improve the quality of life. Other problems that relate, for example, to the environment, to ethical and social issues, to crime and poverty also require more carefully crafted study and, indeed, solutions that rely not only on new knowledge, but on integration, too. And surely the scholarship of teaching will be necessary to produce an informed citizenry capable of the critical thinking that is so needed in America today.*

*The conclusion is clear. We need scholars who not only skillfully explore the frontiers of knowledge, but also integrate ideas, connect thought to action, and inspire students. The very complexity of modern life requires more, not less, information; more, not less, participation. If the nation 's colleges and universities cannot help students see beyond themselves and better understand the interdependent nature of our world, each new generation 's capacity to live responsibly will be dangerously diminished*

## The Universal Model

### Foundation

The following represents the difficult but serious thinking process engaged in by the Expert Panel as they struggled with the creation of the model itself.

One panel member noted: "I think that to be a minority faculty, you not only have to meet the minimum standards, but you actually have to exceed them by quite a bit. In other words, if the, quote/unquote, "standard" is for you to have ten articles in order to be promoted to associate professor, women or minorities may do better to have 15 or 20 because then it looks like you can compete."

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<sup>2</sup> Boyer, Ernest L. *Scholarship Reconsidered: Priorities of the Professoriate*. San Francisco, Jossey-Bass, 1990.

To resolve the dilemma, it was suggested that we need to shift our paradigm from the perspective of "how do we make these Minority faculty fit" to one which "celebrates the differences."

This, in turn, led back to the question of value. "The point of this is to value the scholarship of teaching and value the scholarship of community service. ... This is a way of putting the spotlight more directly on those two aspects, the value/scholarship of teaching, and the value/scholarship of community service. "

This led to the expressed view that "Historically, the concept of "scholarship" has not been attached to community service or teaching. So if you're looking for "value added", the value-added concept is that this is all scholarship."

This, in turn, led back to the skill sets which a minority faculty member brings to the table of academia. Without framing the skills themselves, it was noted that: "If we agree that there's a value-added set of skills that minority faculty bring, but non-minority faculty do not bring; and we agree that they have a role as change agents within our academic medical centers; then we agree that they have a duty to perform service, in terms of mentorship and in terms of service. And then we need to protect their time to do that."

The panel summarized their building blocks for a Minority Faculty Development Model by noting that there are, essentially, are three steps necessary for the advancement of URM faculty:

1. the valuing of scholarship of teaching, and the valuing of community service;
2. the formal structuring, including orientation, that may begin with new-hires but continues on, in terms of faculty development; and
3. addressing the competitive environment.

The panel appeared to find consensus around the term "parity". Parity is defined as an institution recognizing that the scholarship devoted to teaching, research, and service are substantially equivalent, and ought to be considered that way. This should be across the board for all faculty, regardless of race or sex.

### **Institutional Considerations**

In order to give focus to the discussion about structure, the panel began a discussion about institutional considerations that present in order to advance minority faculty. What must an institution do in order to bring itself to the point noted by one Panel member, when, for example, mentoring occurs naturally. Among the elements determined to be critical by the panel were:

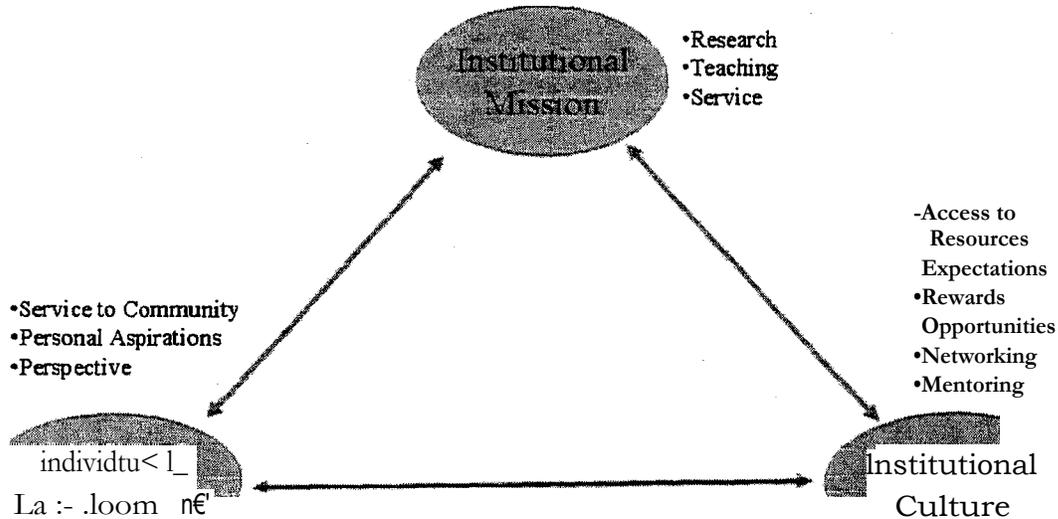
- Institutions must value the contributions and perspectives of potential and hired minority faculty;
- Institutions must demonstrate their commitment to minority faculty development by creating a formal structure and incentives for participation;

- Institutions must recognize the linkage between the scholarship associated with Teaching, Research and Service (at the academic, clinical and community based levels), and their underlying qualifications;
- If institutions have articulated a commitment to minority faculty development, then they must be held accountable to its fulfillment. One way to do this would be supporting grant-based activities after expiration of a grant that addresses diversity issues.

### Conceptualizing the Structure

This is the structure of the model that the Panel conceptualized for Minority faculty development:

### The Minority Faculty Development Model



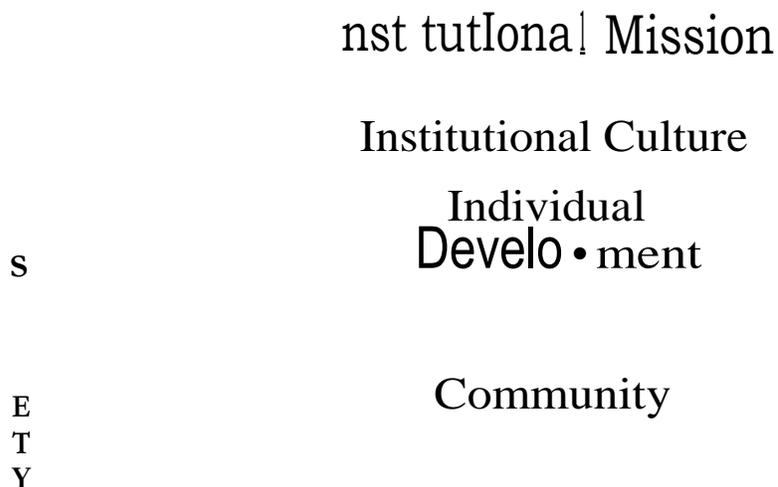
This diagram is the overview and framework, including the necessary components. It is the structure for the Minority Faculty Development Model. The Panel agreed that this structure requires two improvements: 1) adding a role for community; and 2) a non-linear structure to show the value of each component, and their interdependency.

The following diagram represents the author's interpretation of these changes. In the prior diagram, adopted by the Panel, the roles Institutional Mission, Institutional Culture and Individual Development are interrelated in what appears to be a bidirectional compact.

The figure below accomplishes the same goal. But in addition, the community is given a central role within complementary concentric circles of greater and greater involvement. By putting

community in the center, the contributions of minority faculty or candidates are automatically validated. It is validated because in order to engage in "individual development," it is critical that one address the needs of the community. The individual faculty member is both part of and wrapped by Institutional Culture, which in turn are part of and wrapped by the Institutional Mission. Finally, all three are contextualized by the word Society.

### Making the Model Operational



The following contributions were made regarding the process necessary for making the model operational.

- In order to make the model work, "you need incentives in each of those areas [the circles]."
- "You have to find out what is being done in order to say what changes need to be done."
- "We [need to] formalize recognition for faculty development."
- "We need to make certain that all faculty can take advantage of what is there."
- "Even when they do [consider diversity as part of their mission], do they go from that step to the next step, which is making it operational, making it happen."

- "Someone has to be in charge, and someone has to be monitoring the activities of those faculty members."
- "[I]f you talk about institutions that learn, or leaning organizations, what you're trying to develop is an institution that would do a self assessment."
- "If we're going into the needs assessment, as part of continuous process improvement, then you need to have some benchmarks of your progress."
- The process would be "continuous diversity improvement."

The concept of Continuous Diversity Improvement (CDI) was created by the panel in order to signify the dynamic process of the business improvement model. Through CDI, the challenge of diversity is not met by artificial goals or objectives. Instead, CDI requires principled activities aimed at creating parity of equal opportunity for minority and non-minority faculty.

CDI, for this purpose, was focused on achieving the Institutional Mission of the academic institution. The panel identified the following elements as being relevant to CDI analysis:

- needs and self assessment;
- SWOT<sup>3</sup> analysis;
- strategic planning;
- benchmarking;
- accountability mechanisms;
- and process/outcome evaluations.

In reality, however, CDI needs to be applied with respect to each of the three functions of the model: Institutional Mission, Individual Development, and Institutional Culture.

The concept of CDI is derived from the business concept of Continuous Process Improvement and itself is a subset of Total Quality Management (TQM). As defined by searchcio.techtarget.com, TQM is a comprehensive and structured approach to organizational management that seeks to improve the quality of products and services through ongoing refinements in response to continuous feedback.

Utilizing CDI in the context of minority faculty development, the following steps would have to be undertaken:

1. **Define** diversity improvement as a key institutional process;
2. **Identify** those parts of the institution where deficiencies exist;
3. **Select** an approach or methodology for moving forward;
4. **Analyze** the process and activity chosen;
5. **Outline** current process and procedures;
6. **Recommend** improvement changes;
7. **Implement** with a structured and time limited plan;

---

Strengths, Weaknesses, Opportunities and Threats.

8. **Evaluate** for process and outcomes and accountability;
9. Correct the process based upon evaluative findings; and
10. **Renew** the process of improvement.

The Panel reduced this process to 4 steps, with the acronym AVID. AVI means that, in order to implement a program of Continuous Diversity Improvement, one must:

- **Assess** where the institution is and where it should be;
- **Value** the contributions of its minority candidates and faculty;
- **Implement** the strategies that maximize minority representation; and
- **Disseminate** the policy in way that is both informative and supportive.

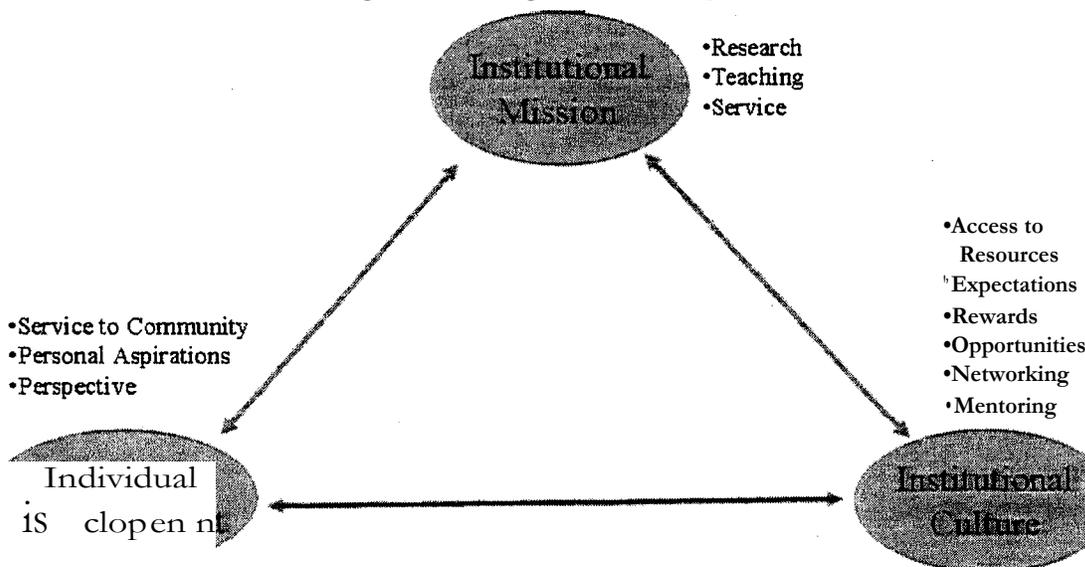
In the arena of Institutional Culture, the panel indicated that a successful model would have to "reflect the communities on all levels of modeling." As an institution makes this operational, it needs to value and respect differing perspectives.

At the level of the Individual Development, the panel concluded that, in addition to community service and personal aspirations, this referred to the "value-added of the individual perspective."

## Implications for a Minority Faculty Development Model

Based upon the proceedings of the Expert Panel meetings, the following two models represent complementary models for Minority faculty development:

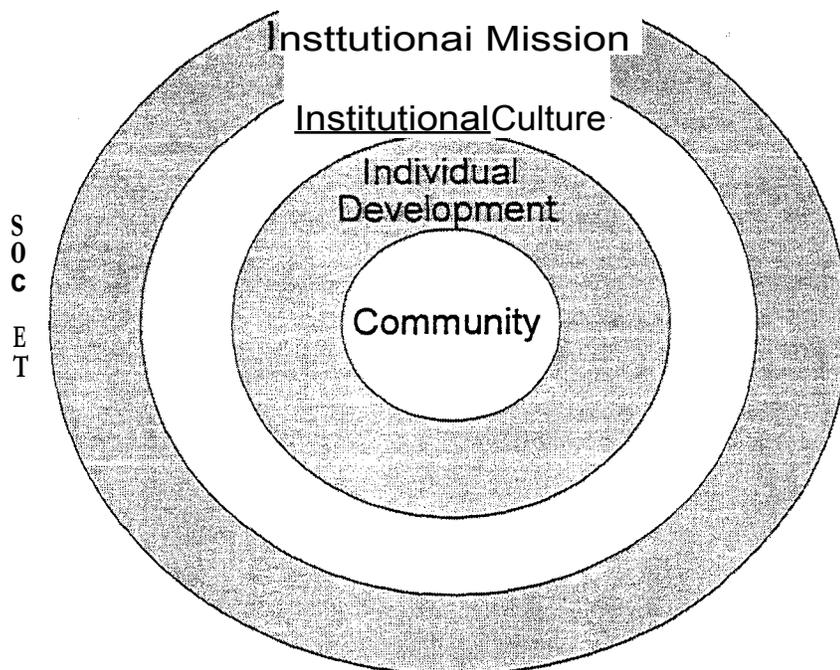
### The Minority Faculty Development Model



The above diagram advances the quest for a workable model for Minority faculty development considerably. Extrapolating from the work of the expert panel, this model is both non-linear and interdependent. Its non-linear aspect is simple but important - there is no beginning and no end. Each activity is related to the other, feeds off the other, and makes the model circular, not linear. At the same time, each aspect is interdependent and reliant on the other for its existence. For example, one cannot individually develop within academia if there is no institutional mission supporting that development and if the institutional culture does not support it as well. But, at the same time, an institutional mission or institutional culture that attempts to ignore individual development fails. In this relationship, there is no one core value. Rather, each of the elements is core for the remaining elements.

Several panel members stated that the ideal system for minority faculty development is very close in both form and substance to the ideal system for faculty development generally. That is not to say that minority faculty do not have special needs, interests and views. They do. But, it recognizes that, in the final analysis, minority faculty generally seek nothing more than assimilation into the academic family as scholars and contributors while maintaining their connection to an outside reality.

In the second model outlined below, the relationship between individual development, institutional culture and institutional mission is framed as a series of concentric circles with community at its heart and society as its boundary. This non-linear conceptualization allows for a clearer recognition of the interdependency between the three aspects and serves to underscore the primary role played by community and society.



Minority Faculty Development Model - Alternate

This contextualized model would help institutions to overcome past inability to assimilate URM faculty by recognizing their presence as critical to the existence of either culture or mission.

With this lens, and using the insights of the expert panel, the model starts to take on new dimensions as reflected below:

| Model Aspect                  | Components  | Operational Considerations  |
|-------------------------------|---|---|
| <b>Institutional Mission</b>  | <ul style="list-style-type: none"> <li>• Teaching</li> <li>• Research</li> <li>• Service</li> </ul>   | <ol style="list-style-type: none"> <li>1. Formal recognition of MFD as part of core mission</li> <li>2. Institutional commitment to "continuous diversity improvement"</li> <li>3. Creation of mechanism for monitoring and accountability</li> <li>4. Creation of institutional incentive which supports minority faculty development</li> </ol>   |
| <b>Institutional Culture</b>  | <ul style="list-style-type: none"> <li>• Access to</li> <li>• Resources</li> <li>• Expectations</li> <li>• Rewards</li> <li>• Opportunities</li> <li>• Networking</li> <li>• Mentoring</li> </ul> | <ol style="list-style-type: none"> <li>5. Creation of formal vehicles for valuing non-traditional contributions</li> <li>6. Integrating the value of differences into academic life as opposed to just social life</li> <li>7. Recognizing the role of mentoring as a vehicle for advancement by making it operational</li> <li>8. Creating incentives/rewards which value the contributions associated with diversity</li> <li>9. Creating an environment that allows equal access to resources for exploration of issues related to diversity, community and service</li> </ol> |
| <b>Individual Development</b> | <ul style="list-style-type: none"> <li>• Service to</li> <li>• Community</li> <li>• Personal</li> <li>• Aspirations</li> <li>• Perspective</li> </ul>   | <ol style="list-style-type: none"> <li>10. Creation of new standards for evaluating diversity contribution</li> <li>11. Creation of mechanism for giving parity to service, especially prior service</li> <li>12. Recognizing the duality of aspirations which flow from minority status within a society</li> <li>13. Recognition of the inherent values associated with a differing lens or perspective</li> </ol>  |

What were previously described as "the outlines of an omnibus model" now serve as operational guidelines with respect to implementation of the adopted model. But, for the most part, the concepts remain unchanged:

**Faculty Identification.** In order to effectively identify potential URM faculty members for the COE and non-COE health professional schools, a proactive outreach mechanism which reaches potential minority applicants at earlier stages in the pipeline must be developed. At a minimum, health professional schools should reach collegians at the point that they are making decisions about declaring majors and considering professional schools. This is even more important for schools of osteopathy since they, more than others, suffer a lack of awareness within the minority community from lack of awareness, i.e. the community does not really understand osteopathy and its origins.

**Faculty Recruitment.** Schools interested in recruiting minority faculty need to consider new alliances that make it clear to potential minority candidates that the institution is a friendly one for the junior minority faculty. This can be done by joining with minority student organizations to engage in recruitment campaigns. It can also be done by assigning a pre-hire mentor to informally answer questions regarding the challenges of navigating the system.

**Faculty Development.** In order to properly develop minority faculty, small group counseling needs to take place that is designed to help the minority faculty member translate what may be their community-based interests into academic, peer-reviewable, scholarly activity.

Junior minority faculty need to be given the opportunity to earn a "second seat" on a peer-reviewed article so that they can learn and understand the rigors associated with scholarly writing. Obtaining this opportunity is dependent upon being on a research team or having a research/writing mentor. If on a team, individuals have multiple changes for authorship at varying levels. Most peer-reviewed journals want to know the contribution that each individual made.

Regardless of area of interest, minority faculty need to know how to navigate the world of grant writing. Because most minority faculty spend significant amounts of their time serving as role models, the concept of modeling and mentoring is very easy to accommodate, it serves as a good vehicle for senior faculty members to coach a junior minority faculty. Colloquia where minority faculty members can test their concepts and approaches and be subject to collegial critique are also helpful.

**Faculty Retention, Tenure and Promotion.** Schools need to make junior faculty, particularly minority faculty who often feel socially and professionally isolated, aware of both the formal and the informal rules regarding retention. These rules can be as obscure as two second authorships equal one prime authorship, or serving on more than three committees is subject to the law of diminishing returns. The chair of the department or section should coordinate with the Chair(s) of the Promotion/Tenure Committee to provide minority faculty with a semi-annual briefing on the current state of the standards for promotion and tenure. Retention of minority faculty would be enhanced greatly by a program that clearly values the service participation of minority faculty when they join minority-focused committees and spend an inordinate amount of time counseling minority students.

Faculty Effectiveness. For a minority faculty member to be effective, certain attributes need to be established from the very beginning of employment for minority and non-minority faculty alike. In most cases, minority faculty members without tenure will be working with non-minority faculty too. Faculty without tenure cannot be perceived as "having a chip on their shoulder" or being "racially isolationist." Faculty should study carefully the meaning of the word "collegiality" and apply it within the constructs and constraints of one's own personality so that collegiality is neither strained nor forced. The minority faculty member must exhibit a positive attitude and be perceived as available to non-minority students as to minority students.

This latter point is critical since the likely colleague in the profession will be non-minority. But the converse is true for non-minority faculty working with minority students. Learning how to work side-by-side and in a collegial atmosphere is critical to a perception that the minority faculty member seeks advancement within the institution. But it would be an unfair burden to assume that the onus for working side-by-side effectively and collegially should be placed entirely on minority faculty.

**Faculty Balance.** Often minority faculty members have requirements that other faculty members do not share. These are: 1) counsel all minority students; 2) serve on all minority-focused committees; and 3) teach cross-cultural competence. Therefore, it is important that a minority faculty member develop a sense of balance between the three requirements of teaching, research and service. Yielding to the pressure of providing an inordinate amount of service at the expense of either teaching or research is the death knell for minority promotion and tenure.

## Applying the Model to Specific Health Professions

### Allopathic/Osteopathic Medicine<sup>4</sup>

One member of the Expert Panel made the following assessment:

"The environment of healthcare is changing; therefore, academia and its environment are changing, as well, even if there is resistance to change. This, in part, is economically and philosophically driven. If one looks at the early history of medical education, it was community-based, with a heavy emphasis on public health and prevention. With the introduction of teaching hospitals, there was a slow and steady chasm between the science and technology and public health of medicine, which was more profitable. Hospital-based healthcare moved academia further away from the communities that they served. Now, hospital-based is deemphasized because of cost, and medical academia finds itself struggling to move towards, again, a community-based model.

Yet we, in the process of the healthcare professions education, have sometimes lost the trust of our communities. Developing a pipeline of minority faculty is an opportunity to develop the necessary bridge between academia and the communities that we serve. It is an opportunity to

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<sup>4</sup> By determination of the expert panel, the fields of allopathic and osteopathic medicine were joined and, in this analysis, are considered together.

develop paradigms for the definition of faculty, tenure, and promotion, and what is, and should be, valued; community-based research and service and interdisciplinary work. It is also an opportunity to increase recruitment into research trials; assurance of culturally and linguistically appropriate research; and the telescoping of the time between scientific discovery and practice at the bedside of new research findings. This may require change in the values and beliefs of academia."

Medicine is both blessed and burdened with being a "high prestige" profession. For almost all cultures, medicine is considered a field which is most desirable with one notable exception. In the American Indian, Native Alaskan and Native Hawaiian cultures, the medical professional, in addition, has spiritual overtones reflective of a cultural perspective that made the "traditional healer" a special person in relation to the Creator. This prestigious position held by medicine, however, is also its burden. In relation to other professions, it is one which has suffered from under-representation of those minorities. Many of those minorities are also economically disadvantaged too. This seemingly euphemistic distinction recognizes, for example, that, while Asians are minorities or people of color, people from six countries in Asia are not under-represented in the medical profession. Generally, for this analysis, minorities would refer to African Americans, Latinos and American Indians, Native Alaskans or Native Hawaiians.

This is not a deficit model. The model is moving forward.

Because of the gap between the requirements for medical academia and the available pool of qualified applicants for positions is so wide, the medical profession should look at some of the following special considerations in order to implement an effective Minority faculty development model:

- Opportunities must be extended to "community based practitioners" to lecture at medical schools on subjects that directly relate to the cultural reality of the school's minority constituency.<sup>5</sup>
- Rather than just advertise for faculty positions, schools should actively recruit within community and rural health centers of the type funded by HRSA and other agencies for practitioners who combine the ability to obtain grants and administer meaningful public health programs while providing the kind of supervisory guidance that is often associated with quality teaching.
- In the special case of osteopathic medicine, the profession needs to recognize that the very principles of osteopathic medicine, while obscure to some, resonate well within certain minority communities which have traditionally relied upon osteopathic approaches albeit under more traditional and indigenous names.
- Medical schools need to incorporate cultural competence as a valued and mandatory curricular offering, in addition to the traditional view of "infusing" cultural competence throughout the curriculum. This would create opportunities for minority faculty to fulfill the need for teaching in this area.

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<sup>5</sup> While many schools consider themselves to have a national constituency for purposes of admission, the fact is that they have, in the final analysis, a local constituency represented by their surrounding community.

The Expert Panel mad the following findings and recommendations:

In the recruitment phase for the faculty, public schools have scholarship funds available for students if they go back to rural communities. That can be increased.

Some students choose to come into academia as a way to obtain a payback requirement. That has helped students, especially minority students who have had those scholarships, to be able to pay back by coming into the academic institution.

Compensation is an advantage for COEs. COEs do not have a problem recruiting minority faculty. The chairs are recruiting people who inquire about how they can qualify for the COE program. COE management has an opportunity to sit on the committees, to take recruits out to lunch, etc. These are things that the institutions could do.

If diversity in the faculty could be added, from the top, to the LCME requirements, then the university would see it with more seriously e.g., if cultural competence would be an LCME requirement.

This is an accreditation issue. If you tie this directly to accreditation, then the university will see it as something that they not only will benefit from, but that they will be held accountable for and measured by.

The health professions associations should take a leadership role on faculty development. We need to determine where this stands now with the AAMC. This would be a proactive development program which reaches into the not-too-far pipeline. Early identification would start within medical school, so that the school is actually grooming people along that process.

An idea that needs to be supported with the AAMC and the AASPH, is that minority faculty development is important and proactive. This is a different way of looking at developing faculty early,prior to becoming faculty. This requires identification in residency, fellowships, and starting to groom people early for that role.

There needs to be that institutional will from senior leadership who are willing to be out to make it truly a senior leadership issue. This becomes a factor that gets reflected in terms of how that chancellor or dean reviews its department chairs and section chiefs.

We need to create incentives for individuals and institutions, in dealing with the financial obligations. This is particularly important for students, who are often incurring six-figure debt to complete a health professions education. When we get into the salary and equities, having some types of cancellation programs that are more advanced becoming available in areas where there is true need would certainly be beneficial.

This one is in the federal realm. For example, when primary care became an issue, programs were developed. I recommend that we look at something similar, where there would be a cancellation benefit to reduce the obligation that would help out the faculty dealing with 20 and 30 years of debt repayment. Then the salary issue may not be as serious.

Create incentives for the institutions. If there's a way, create them, at public schools at the state level. The states would also make a commitment to some type of benefit for faculty.

If we're looking at research in specific areas, they could target those specific areas. This may not be only for medical school. Depending upon the discipline, look at creating those types of entitlement programs that would be beneficial, and would provide incentives for students and institutions to take a step forward.

In the recruitment and retention aspects of faculty development, we need to have each site focus on growing their own, however far down the pipeline that may be developed. We need to consider developing individuals in our own institutions, and not looking elsewhere. That would be a whole different approach.

In line with that is the portfolio helping students, starting with undergraduates, and continuing on to health professions students. Helping them develop a portfolio with the idea and the sense that that they need to teach, do research, and do service. That's the individual development.

There are three phases to this process: 1) the institution needs to develop; 2) we help the individual understand the development; and 3) we have focus groups with some of our junior and senior faculty.

If faculty members, early on, do not have about 30 percent of their time set aside for research, they are not going to make it. In order to support that, they have to have support for their research. Fellowships certainly are a part of that. But the reality of the institutions is unless they have research done, they are not going to get there.

At some medical schools, promotion and tenure are disentangled. Therefore, tenure becomes something distinct that you apply for, versus promotion.

Also, there is not an "up and out going forward" after five or six years. That creates a very different criteria of how things are weighted, in that there is not equal weight on three components or having one dominating. It's more like two out of three, whatever the choice is. This very different approach is one which schools may look at, as it has some flexibility.

Someone may never decide to go forward for tenure. There is nothing forcing them to. If someone chooses to stay as an assistant professor for a long period of time, they would not be told after six years, that they either get promoted or are forced out.

### **Allopathic and Osteopathic Medical Aptitudes**

The six scores mentioned earlier, with no necessary differences between the two in general. However, research has shown that general internists are Specialists and specialists in a given field who work extensively with others on a team are Generalists. This is from research in 1983 by the Human Engineering Laboratory, Tech Report 1983-6.

## Dentistry

Until recently, dentistry suffered somewhat from being a second tier option to medicine. Much of that has changed. But, so has the profession of dentistry. Managed care has, in many respects, leveled the playing field and has given dentistry a form of parity with medicine.

Dentistry has always had a special role in society which, in many ways, is founded on the principles of osteopathy. The disease model of medical practice starts with the Hippocratic Oath, "First, do no harm" but lives with the principle of "wait until the harm occurs."

Dentistry is proactively involved in preventive public health. But there is not an equal amount of energy spent on prevention and treatment. Although most efforts are devoted to treatment, there is much to be done in prevention and health promotion. That presents dentistry with unique opportunities for advancing minority faculty development.

Therefore, the following considerations are appropriate for dentistry as one considers implementing an effective minority faculty development model:

- Capitalizing on the significant role that dentistry plays in preventive medicine, the dentistry profession and its schools of dentistry need to become more proactively involved in the image which it portrays in the minority community - an image exemplified in television advertising, and product advertising.
- Schools of dentistry need to appreciate the special role that practitioners play in referring and encouraging young people (the pipeline) to consider dentistry as a possible field.
- Schools of dentistry should educate the community about the economic opportunities associated with the profession of dentistry. Accommodations should be made to encourage it.
- Schools of dentistry need to develop better alliances with the industry that supports dentistry in order to insure that there is not just product penetration in minority communities but, as well, the development of an image that minorities can and should be an active part of the profession.
- Because of the special role of preventive dentistry in public health, schools of dentistry should engage in significant academic-private sector partnerships. These partnerships can or should be grant funded in order to create an alternative recruitment mechanism for minority faculty.

The Expert Panel made the following findings and recommendations:

- Make dental schools presumptive Health Professional Shortage Areas (HPSAs) to allow for National Health Service Corps (NHSC) scholarship recipients to fulfill their obligation by teaching, and therefore bring under-represented minority (URM) faculty into the pipeline.

- Have the national association, American Dental Education Association (ADEA), support developing an initiative to engage in ACTIVE recruitment and development of URM faculty, in contrast to placing an ad and seeing who applies, which is a passive system. This initiative would be supported by foundation resources or DHCDD.
- Recommendation: Develop HRSA supported Minority Faculty Fellowship Program (MFFP) for training and development prior to entering the academy, in effect creating a pool of faculty for recruitment.
- The current MFFP, which is underfunded in terms of level of support and reaches only a very few individuals and institutions, expects training to occur while the individual is a new junior faculty member. In effect, this creates a double burden.
- Engage in a dual-track education process in the community to increase awareness of dentistry, as a health profession choice and its rewards, and the prestige of being a member of the academy (c.f. China model).
- For years, dentistry was considered a technical-mechanical occupation. It is now well recognized that oral health is an essential component of general health; consequently, dentists are required to have extensive knowledge of scientific matters as well as dexterity for provision of sophisticated treatment procedures. Dental schools are in an outstanding position for improving the image of dentistry and stimulate students at an early age to pursue this career path that will contribute to improving community health and well being.
- Representation of minority faculty in dentistry is insufficient to effectively provide students with cultural knowledge applicable to the growing number of minority populations that are known to disproportionately suffer from oral health disparities. Dental schools should commit to recruit and hire additional minority faculty and upon hiring, their interests, strengths and/or weaknesses should be identified. A properly structured faculty development program should be instituted; their teaching responsibilities in pre-clinical courses or the dental clinic should be balanced to allow for participation in dental research and/or service activities and their progress should be monitored.
- Inequalities in salary compensation between minority and non-minority faculty are known to occur. Dental schools should assure that salaries are paid commensurate to individual qualification, responsibilities, and length of service. Efforts should also be made for appointing additional minority faculty to administrative positions.

**Dentist Aptitudes:**

Low Idea Productivity, average Classification Ability and Concept Organization, high Spatial Relationships Visualization and very high Manual Speed and Accuracy, probably a Specialist orientation.

## Pharmacy

What is so very unique about the profession of pharmacy is its roots in private enterprise and entrepreneurship. The pharmacist traditionally was both a health professional and a storekeeper.

This duality has led to the highest level of community based penetration of all the healthcare professions. In short, where there is a drug store, there is likely to be a pharmacist and, unlike other institutions which may not see the "return on investment" from location in minority communities, the pharmacy is omnipresent. This traditional role presents unique opportunities to the profession to make major strides in advancing minority faculty development.

But the majority of pharmacists do not work in community pharmacies anymore. The entire paradigm is shifting to having the pharmacist focus on being a drug expert and less attached to the product. Most pharmacists do not practice in drugstores anymore, and are no longer small business owners or entrepreneurs.

However, the potential for minority pharmacists is expanding greatly beyond this single dimension. They are also needed in hospital pharmacies, nursing homes and similar facilities. Significant demand for pharmacists exists in pharmaceutical and industrial research companies, and the federal government.

To meet demand from these sectors, there will be employment opportunities for minority faculty who can train pharmacologists, and related specialties including toxicology, subspecialties in biomedical pharmacology, and veterinary pharmacology.

Some of the considerations relevant to advancing minority faculty development within the profession of pharmacy are the following:

- While pharmacy is one of the leaders in minority enrollment, the profession continues to lag with respect to minority faculty enrollment due in part to the inability to capitalize on the significant presence that pharmacy has in the minority communities.
- Pharmacy schools need to value the very special role that the pharmacist plays in the minority community and, in valuing that role, consider candidates from minority communities because of the very special qualifications they bring from their respective communities.
- Pharmacy schools need to consider the entrepreneurship aspect of pharmacy as a potential avenue for recruiting minority faculty who one year could teach a course in cultural competence and ethical practice and thereafter be recruited to teach a more traditional pharmacology offering.
- As medical schools have had to come to grips with acupuncture and other non-Western medical interventions, pharmacy schools should embrace openly the non-traditional pharmaceutical approaches used by indigenous communities and, in so doing, embrace the knowledge of communities that surpasses some western concepts by thousands of years.

- Perhaps, more than any other profession, a concerted effort should be made to integrate cultural competence into pharmacy education thus providing an opportunity for the recruitment and retention of minority pharmacists who bring innate knowledge and skills to the academic arena.
- Schools of pharmacy should consider training academies which "teach the teachers" by helping practitioners to learn, in a continuing education environment, the skills necessary, for example, to teach a course in cultural competence.

The Expert Panel made the following findings and recommendations:

In an ideal world, all institutions would adopt some sort of formal faculty mentoring program. It may be unique to the institution. We suggest that accreditation bodies look at this. As part of pharmacy accreditation, there is a faculty-development component. But it doesn't necessarily address mentoring.

A second, but related, issue is on promotion and tenure. There has been a dramatic shift in sort of the role of the promotion and tenure committee in recent years. Different institutions treat the promotion and tenure processes differently.

Previously, the committee was seen in a gatekeeper type of role; we let you in, we do not let you out. A current model is that if somebody is brought onto the faculty, they need to receive guidance from the committee, especially during the reappointment, about what they need to do to achieve promotion and tenure.

This is related to the mentoring role, but from a committee perspective, in reviewing a portfolio for reappointment. For example, a committee's review could say, "These are things you've done great, these are things that probably you may need some additional help, and here are some resources you may want to utilize."

Tenure is going through a transition. Pharmacy schools are looking at where we were, and what are the purpose and role of tenure, in general. But as long there is tenure, schools and committees need to take a look at what their role is in the process. There should be credit given for mentoring in the tenure and promotion process.

A frequent barrier identified by faculty is a lack of time, or credit for an activity, that would count towards promotion or tenure. Therefore, it is not necessarily valued that mentoring could be subsumed under teaching.

### **Pharmacist Aptitudes**

A high score in Concept Organization, quite low in Classification Ability, very low in Idea Productivity, not a strong Generalist. Two of the tests have both a speed and an accuracy measure, and a pharmacist should be especially high in both accuracy measures.

## Behavioral and Mental Health

Behavioral and mental health consists of many different health professions. For the purposes of our Expert Panel, we included representatives from psychiatry, psychology, and aptitude testing. Other behavioral and mental health professions, such as social work and clinical counseling (licensed and unlicensed), were not included in the development of this model.

Each of those professions would have their own unique facet that they would put on this Model.

The Panel recommends dividing this model into psychiatry and psychology issues. We understand that these are very broad categories. But they would be consistent.

Working with community and embracing diversity is a key component for the model for behavioral and mental health.

The field of behavioral health has, for a long time, been dominated by Arts and Sciences Schools with majors and degrees in psychology. For many decades, the decision to become a psychologist was made almost spontaneously in reaction to board scores or graduate school acceptance/rejection letters. Unlike pre-med majors, or other health professions, it was considered rare for someone to want to be a psychologist in their first, second, or even third year of college. Thus, for this profession, the pipeline issue is significantly different.

Yet, at the same time, the field of behavioral health has seen a change that is, by all reports monumental. The field of counseling was born and it did not come from the psychology department necessarily. Counselors have come from the education field. Counselors have come from social work. And most importantly, counselors have come from the field of advocacy, treatment and recovery.

Thus, the behavioral health field is well situated to take advantage of the fact that, from these diverse counselor fields, there is a rich crop of diverse candidates who are just waiting for the next opportunity.

With that in mind, schools that specialize in psychology and other areas of behavioral and mental health should consider the following elements as they move forward towards the creation of a minority faculty development model:

- Schools should look at the creation of a more identifiable pipeline for the behavioral health professions by focusing on the emerging pool of pipeline candidates from the field of peer counselors, licensed behavioral health counselors, counselor advocates and the like.
- Schools should create innovative academic-community partnerships which link schools of psychology with community-based services such as substance abuse counseling, domestic violence counseling and the like.
- Schools should expand their clinical offerings in order to more effectively embrace the growing counselor field.

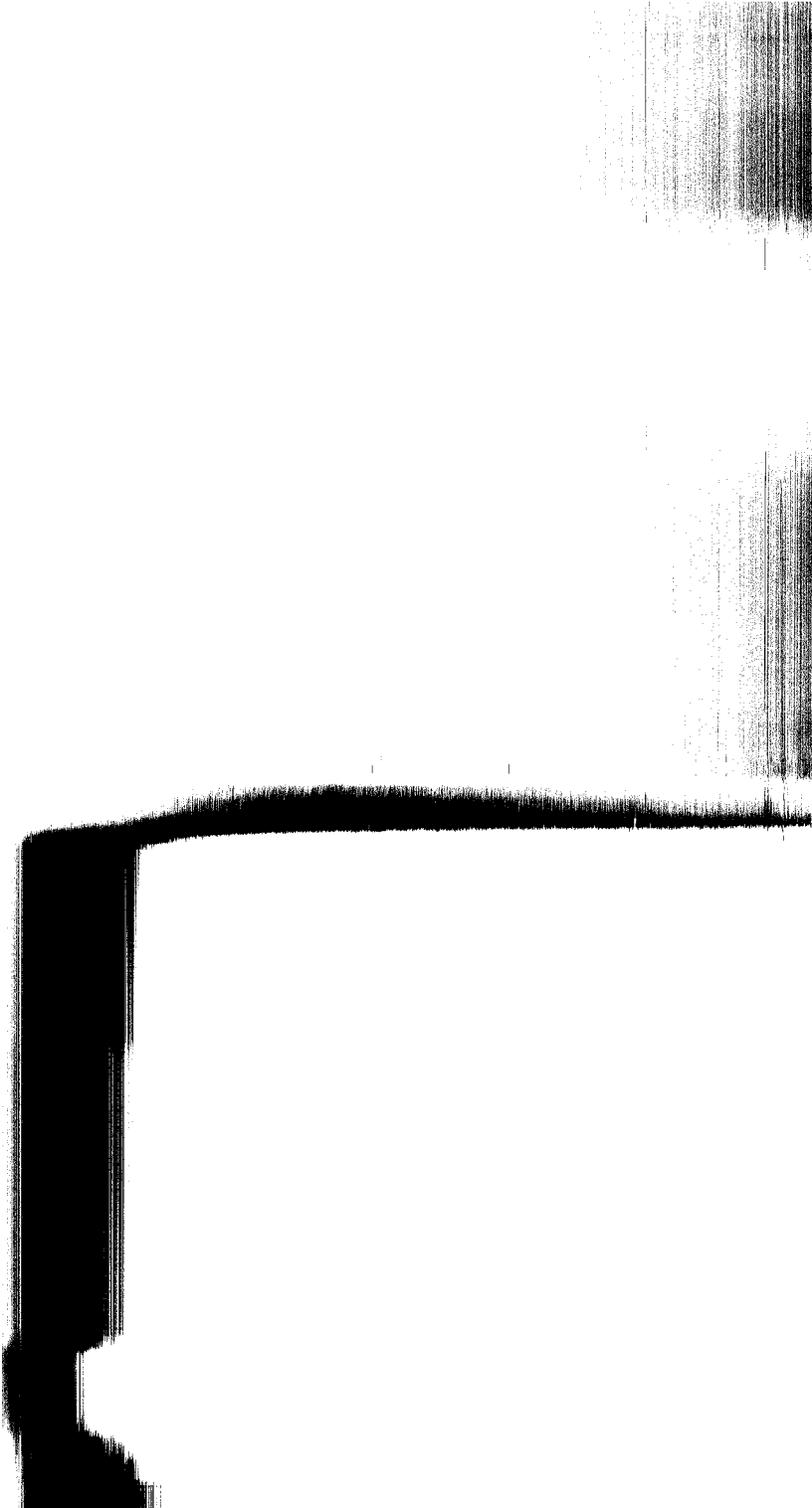
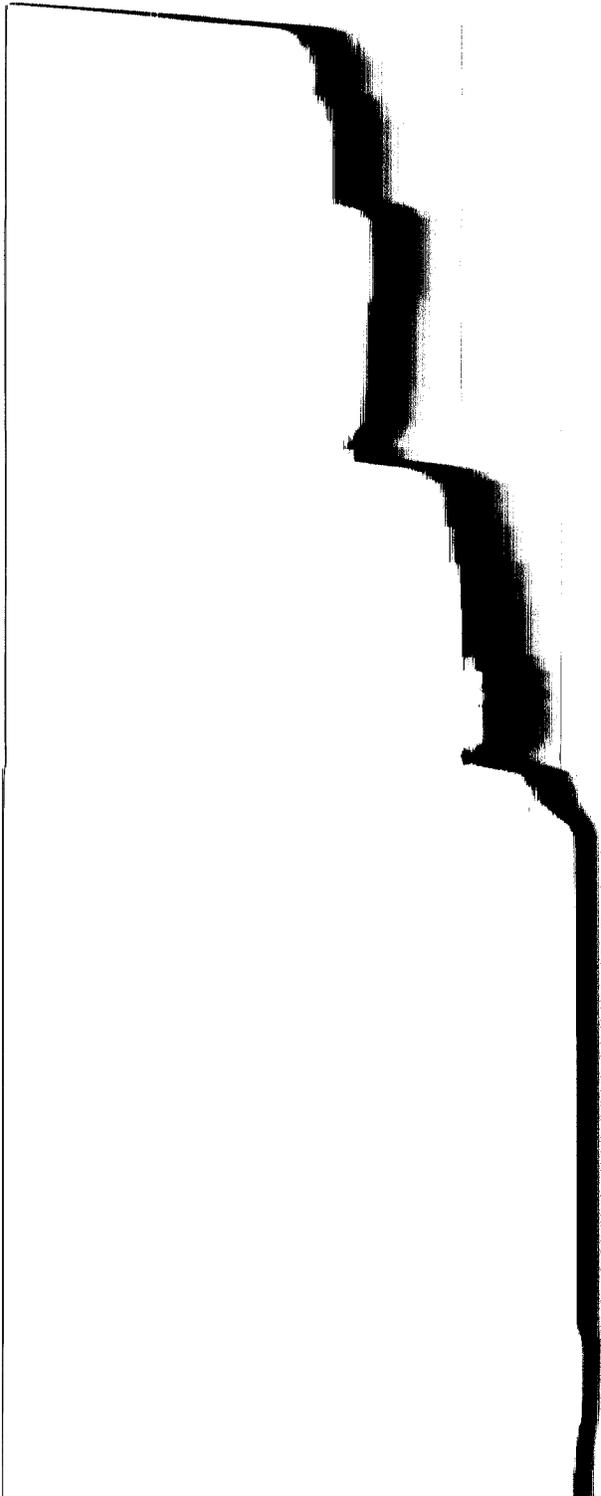














- Perhaps more than any other field, the issue of cultural competence has proven to be a critical component of breaking down denial and, thus, the field of cultural competence training represents an exciting and important entry point for minority faculty into the field of behavioral health.

The Expert Panel made the following findings and recommendations:

It is important to expand the definition of teaching, research, and service.

We need to address the issue of life beyond the profession for a minority faculty. Many medical schools are based in urban areas. Departments of psychology, however, can exist in places like Ames, Iowa, and Ithaca, New York. In many instances, in these smaller communities, minorities are nonexistent. At times, it's very difficult to attract faculty to this type of town. I think that taking a look at improving the services within the community; making the campus an attractive place to be; and also addressing issues of institutional racism or campus racism, may be important. This has come up at a number of institutions. This involves making the campus community a larger community.

It is common in psychology programs for under-represented minorities to be the conscience of the faculty. It is important that the rest of the faculty in counseling and psychology departments should be trained to improve their skills and attitudes with regard to diversity. This would lift the problem of having minority faculty seen as being "out there" from the rest of the faculty.

### **Behavioral and Mental Health Professional Aptitudes**

For the *clinical worker* in the more three-dimensional fields one would expect: Specialist, average Classification Ability, high Concept Organization, low to low-average Idea Productivity, and average or high Observation. If diagnostics is a major issue given a particular speciality, the higher Classification Ability might be required.

For the *psychotherapist/counselor*: Generalist, average Idea Productivity and Classification Ability, low Spatial Relationships Visualization, other scores relatively unimportant.

## **Historical Context for the Project**

Programs such as the Centers of Excellence are not created as an abstract principle. Jordan Cohen, M.D., President of the Association of American Medical Colleges, wrote in *The Journal of the American Medical Association* (JAMA) what medical schools and other health care higher education institutions had gleaned over decades:

*We all know that several sizable subgroups of the American population—principally African Americans, Native Americans, Mexican Americans, and mainland Puerto Ricans—remain severely underrepresented in the medical profession. Although they comprise almost a quarter of our countrymen and women, these subgroups of our population constitute less than 8% of practicing*

*physicians. For academic medicine, the figures are even more disconcerting. Individuals from these underrepresented minority groups make up barely 3% of full-time faculty members in US medical schools (excluding historically black and Puerto Rican medical schools).<sup>6</sup>*

Dr. Cohen also spoke eloquently about the cost of failure:

*A racially and ethnically diverse faculty, fully empowered by the equitable presence of minorities within all ranks of the academy, is the only conceivable bridge to the diverse physician workforce and the culturally competent health care system that the full spectrum of the American public deserves. As long as our medical school faculties have little more than token representation from many sectors of the richly diverse American culture, and as long as faculty advancement, for whatever reason, is grossly distorted by race and ethnicity, the medical profession cannot truly lay claim to the ethical and moral high ground it professes to occupy.*

This disparity, recognized by the profession and Congress alike resulted in passage of the Health Professions Education Partnerships Act, Public Law 105-392 in 1998. Specifically, Congress authorized expenditures for the following purposes:

- (1) to develop a large competitive applicant pool through linkages with institutions of higher education, local school districts, and other community-based entities and establish an education pipeline for health professions careers;*
- (2) to establish, strengthen, or expand programs to enhance the academic performance of under-represented minority students attending the school;*
- (3) to improve the capacity of such school to train, recruit, and retain under-represented minority faculty including the payment of such stipends and fellowships as the Secretary may determine appropriate;*
- (4) to carry out activities to improve the information resources, clinical education, curricula and cultural competence of the graduates of the school, as it relates to minority health issues;*
- (5) to facilitate faculty and student research on health issues particularly affecting under-represented minority groups, including research on issues relating to the delivery of health care;*
- (6) to carry out a program to train students of the school in providing health services to a significant number of under-represented minority individuals*

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<sup>6</sup> Cohen, J.J. (1998). *Time to Shatter the Glass Ceiling for Minority Faculty*. The Journal of the American Medical Association. 280:821-822.

*through training provided to such students at community-based health facilities that--*

*(A) provide such health services; and*

*(B) are located at a site remote from the main site of the teaching facilities of the school; and*

*(7) to provide stipends as the Secretary determines appropriate, in amounts as the Secretary determines appropriate.*

These statutory provisions became the cornerstone for the HRSA Centers of Excellence (COE) program. As HRSA implemented the COE program, it became apparent that the clarity of statutory purpose did not mean that there was either clarity or uniformity in the ways that COEs should achieve diversity in the health professional workforce covered by the program.

To forge positive solutions, one could not avoid some of the negative realities. As noted by the American Psychological Association:

*Barriers to ethnic minority faculty recruitment and retention arise from the lack of a clear understanding and appreciation of the value of diversity for the discipline and the significant contributions of ethnic minority faculty. Existing attitudes and practices within the discipline often convey the idea that academe is inhospitable to ethnic minorities both as a place to receive training and as a setting for pursuing a career. These attitudes and practices often fail to respect, value, and reward ethnic minority faculty for their ability to expand psychological knowledge, enrich psychology's curricula, and prepare ethnic minority and non-minority students for meeting the scientific and applied needs of our ethnically diverse society. The under representation of ethnic minority faculty will continue until psychology programs reexamine and transform their existing attitudes and practices related to faculty recruitment, retention, and tenure and promotion standards.*

## **Issues Not Considered by the Expert Panel**

It was not within the scope of the Expert Panel's mandate to consider each and every issue which impacts upon minority faculty development. There are issues such as overt and institutional racism, structural and intergenerational poverty, economic disparity, historical trauma. Although these are relevant and important, they were beyond the focus of the deliberations. It was assumed, for purposes of moving forward, that these issues are barriers to increasing the number of URM faculty in health professional schools and institutions. The panel focused on how to solve the problem rather than merely attempting to define the problem.

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<http://www.apa.org/ops/char/e3.html>

Additionally, the Expert Panel did not address the issues of building the pipeline. Building the pipeline is defined as those activities necessary to create candidates capable of ultimately serving as faculty.

Finally, cultural competence was not explicitly addressed. There are important questions here for health professions schools. Is cultural competency meaningful unless it is related to patient care? How can they incorporate cultural competence as a valued and mandatory curricular offering? Should this be done with a unique course on cultural competence? Or is it better to infuse cultural competence throughout the curriculum? Are minorities the proper ones to teach these courses, since not all under-represented minorities come from economically disadvantaged backgrounds? How do cultural competence issues vary between minority groups?

Building the pipeline and cultural competence were understood to be "overarching" considerations. These issues permeate all discussions regarding the under-representation of minority faculty within America's health professional schools.

## Minority Faculty Recruitment

Recruitment does not have one set definition in the health professional schools. For some, recruitment, when tied to the work "minority" reflects, as much a desire for diversity, as it does a pragmatic reflection of the changing demographics within country's population and therefore the patient caseload. Many universities adopt language similar to that used by the University of Kansas:

*University of Kansas is committed to increasing the diversity of the student body, faculty and staff. Each search conducted for a university position should include affirmative strategies for increasing diversity.*<sup>8</sup>

Other institutions recognize that diversity enhances the quality of education being provided to students and the service provided to society. For example, the University of Minnesota provides this rationale for its efforts:

*The need to address diversity issues at the University of Minnesota reflects the increasing national concerns about how higher education institutions address broader societal issues, and is reflected in attention to diversity within undergraduate, graduate and professional student populations, diversity within the faculty and staff, as well as issues of diversity with the curriculum and the classroom.*<sup>9</sup>

Finally, some experts, such as Wong, et al. noted in the context of the recruitment of women into academic medicine, that the issue of recruitment is directly related to quality care:

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<sup>8</sup> See <http://www.ku.edu/~eualoD/recruitment/Minority.shtml>.

<sup>9</sup> See [http://www.academic.umn.edu/DIannino/accredltc\\_institutional/self/chapt\\_20.html](http://www.academic.umn.edu/DIannino/accredltc_institutional/self/chapt_20.html).

*Leaders in the medical community have long recognized that diversity among health professionals is critical to excellence in the delivery of clinical services. Reasons cited include representation from different cultural perspectives, social equity, and improved access and health outcomes in underserved communities. As the U.S. population grows even more racially and culturally diverse, we enhance our ability to meet the sociocultural needs of all patients.*<sup>10</sup>

It is within this rationale of meeting the needs of a demographically changing patient base that recruitment of minority faculty for the health care professions receives its most cogent foundation. Recognizing that recruitment for diversity is directly related to the provision of quality health care is consistent with the rationale behind the IRIS efforts to eliminate racial and ethnic disparities in health care.

### **Recruitment Challenges**

There are numerous challenges in the area of minority faculty recruitment which have been identified by academic institutions. Perhaps the most discouraging, albeit candid, analysis came from the minority recruitment effort instituted at Brown University during the 2001-2002 academic year. A Committee on Minority Faculty Recruitment met over a period of one year and issued its report in April, 2002. Their analysis<sup>11</sup> concluded:

*The committee has spent a lot of time strategizing about attracting more Minority candidates to apply to positions...*

*The committee has come to the conclusion (and I have come to the conclusion, after serving on the committee for 3 years) that our efforts are frustratingly slow- the difficulty comes not so much in getting information out and identifying candidates as getting them hired. I have proposed to the committee (and to the Dean of the Faculty) that we meet late in the Spring with Dr. Simmons and the Affirmative Action Monitoring Committee to talk about new strategies for hiring and retaining minority professors. We have concluded that this particular cause needs a strong push from the administration- perhaps raising money for special post-doc fellowships to draw young scholars, especially in the sciences, as well as a couple of endowed chairs that could attract more mature scholars. In addition, we hope that Dr. Simmons can help us generate a list of contact people in diverse fields to identify candidates, and also use her considerable power and influence to attract promising minority scholars to Brown.*

So even in the face of the best efforts of an institution, minority faculty are not necessarily going to apply or otherwise make themselves available for opportunity. This underscores the underlying premise of the Expert Panel, which is that something needs to be done which allows the minority faculty candidate or member to feel "valued" not for the color of their skin or background but rather for their substantive potential and actual contributions to the Academy. Without a proactive effort, we risk disappointing results for future recruiting efforts.

<sup>10</sup> Wong, E.Y., Bigby, J., Kleinpeter, M., Mitchell, j., Camacho, D., Dan, A., Sarto, G. (2001). *Promoting the Advancement of Minority Women Faculty in Academic Medicine: The National Centers of Excellence in Women's Health*. *Journal of Women's Health & Gender-Based Medicine*, 10:541.

<sup>11</sup> [http://www.brown.edu/Faculty/Faculty Governance/Faculty Meeting/040202/CMFR.html](http://www.brown.edu/Faculty/Faculty%20Governance/Faculty%20Meeting/040202/CMFR.html).

### Overcoming the Challenges

The American Association of University Professors (AAUP) created a *Guidebook for Search Committees* and identified the following twelve steps as necessary for developing a proactive recruitment process:

1. Communicating the Educational Rationale for Diversifying the Faculty;
2. Aligning Departmental and Institutional Commitments;
3. Creating a Welcoming Environment;
4. Securing Financial Resources;
5. Countering Segregated Networks;
6. Establishing a Successful Search Committee;
7. Educating the Search Committee;
8. Debunking Myths about Minorities;
9. Constructing a Position Description;
10. Reexamining and Changing Hiring Biases;
11. Hosting the Campus Visit;
12. Making the Offer

While these twelve steps were conceived in the context of general university education, they also apply to health care professional institutions. What stands out from the twelve steps is the need for proactive involvement in a successful recruitment process. As was noted by the Indiana University's Office of Strategic Hiring and Support in a 2003 report:

[A] successful program designed to recruit and retain ... faculty of color requires that faculty, as well as administrators, be fully committed to its objectives and be extensively involved in its implementation. Faculty, especially those protected by having achieved tenure, must take a leadership role.

The American Psychological Association (APA) created a Commission on Ethnic Minority Recruitment, Retention, and Training in Psychology to look at the issue of recruitment and retention and this resulted in a report in 1997 entitled *Visions and Transformations: The Final Report*. In that report, the Commission broke down the process of recruiting more Minority faculty into two steps:

1. The decision to recruit diverse faculty. Prior to initiating minority recruitment activities, the program would actively assess itself and its climate. Based on this assessment, faculty would have a clear understanding of their values of diversity, their expectations for diversification, their vision of how diversity fits within and

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<sup>72</sup> Viemes Turner, C.S. (2002). *Looking at Diversity*. Panel Presentation for the American Association of University Professors Governance Conference, October 19, 2002. Retrieved December 12, 2002 at <http://www.aaup.org/allissues/AffirmativeAction/Articles/aalookinaat.htm>.

" Author unknown (2003). *Facing the Challenge of Achieving Minority Equity in Faculty Representation*. Accessed December 10, 2003 from <http://www.indiana.edu/~shslimaaesireport1.0df..>

contributes to the program mission, and of how the contributions of ethnic minority faculty will be assessed and rewarded.

2. The recruitment process. The program would recognize that the methods used in recruiting mainstream faculty may not work for ethnic minority faculty. Consequently, the program would write a position announcement that clearly identifies its commitment to diversity, its view as to how diversity intersects with its educational mission, and its efforts to create an environment conducive to success for all faculty.

Search committees would be sensitive to the fact that ethnic minority individuals may differ from mainstream faculty in a number of ways (e. g., less traditional career paths, more varied potential contributions, etc.), and seek to make the job qualifications as inclusive as possible. The search committee would work to develop innovative personalized strategies and sources for attracting candidates. The screening process would not eliminate ethnic minority candidates based on nontraditional work experiences and publications in ethnic minority journals.

In the selection process, the search committee would view diversity as a positive contribution to the field and to the faculty. Consequently, in addition to the elements of a good faculty interview, program faculty would attend to those aspects of the visit that express attention to the candidate's ethnic/racial background and the expression of this background in the candidate's personal, social, and professional interests.

Negotiations would be approached with an emphasis on attracting the ethnic minority candidate to the institution, maximizing opportunities for the ethnic minority faculty member's scientific work and teaching, and building in incentives for retaining faculty over the long term and promoting their careers.<sup>14</sup>

In summarizing its recommendations, the APA made clear that any model seeking to address this issue of recruitment must:

1. ensure that all future psychologists develop some minimal competence in multicultural issues by infusing or integrating ethnic minority issues into all required coursework at the undergraduate and graduate and professional levels;
2. seek to prepare professionals to provide services to linguistically diverse populations by improving the quality of related training and professional development and increasing the number of psychologists who can provide such services. For example, a program could provide its students opportunities to learn a second language and provide field training in settings that serve linguistic minorities. In addition, such programs could promote the development in multiple languages of both glossaries of psychological terminology, and

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<sup>14</sup> Holliday, B.G., Suinn, R.M., et al. (1997). *Visions and Transformations: The Final Report of the Commission on Ethnic Minority Recruitment, Retention, and Training in Psychology*. Retrieved September 9, 2003 at <http://www.apa.org/om/visions/visionsichame4.html>.

guidelines on the conduct of therapy and the application of psychological procedures with linguistically diverse populations;

3. value ethnic minority professionals and communities by utilizing ethnic minority psychologists as mentors and supervisors, by providing educational training and experiences in ethnic minority communities and clinical settings, and by encouraging psychologists of color to engage in academic and research careers;
4. promote specialized competence in multicultural issues by providing an organized, coherent body of coursework and field or research experience on multicultural issues that are sufficient to constitute a major emphasis or "track" within a major field of graduate or professional study in psychology;
5. emphasize applied and community-based research in ethnic minority communities, including interdisciplinary and inter-organizational collaboration and consultation, neighborhood and community sampling and assessment, and systemic interventions.

## Minority Faculty Retention

Cohen, in his Glass Ceiling article for JAMA summarized three compelling issues relative to Minority retention in the health care professions:

1. Minority faculty, by virtue of their small numbers in a given medical school, are disadvantaged by comparative isolation within the academic community. Those of us who have not experienced such isolation take for granted the ease with which our professional networks, lubricated by social familiarity, expand throughout our careers.  
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2. Minority faculty often feel disproportionately obliged to serve on time-consuming committees, to mentor students with complicated nonacademic problems, and to engage in community service activities that are not typically career advancing.  
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3. Attainment of senior faculty rank by minority faculty is tantamount to crashing a long-running party at which a relatively circumscribed group of invitees has had privileged access to the trappings of power. In this regard academic medicine is no doubt similar to many other complex social enterprises, such as big business. Many subtle, largely unconscious social conventions, falling far short of overt discrimination, have evolved over time to protect the turf of those who, for whatever reason, already occupy high-status positions.

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<sup>iS</sup> Cohen, J.J. (1998). *Time to Shatter the Glass Ceiling for Minority Faculty*. *The Journal of the American Medical Association*. 280:821-822.

The challenge in retention is to create policies that reverse these three barriers and recognize that these barriers are, in large part, unrelated to the core qualifications for retaining good faculty.

In a program co-sponsored by HRSA and the Society for Academic Emergency Medicine, the conference report concluded as follows:

*The availability of a critical mass of minority faculty in health professions schools has come to be recognized as a major factor in the recruitment and retention of minorities in health professions schools, as well as an elemental factor in the ultimate improvement of minority health status in this country. Minority faculty provide leadership, serve as role models, provide perspective on dealing with minority patients, and promote culturally competent approaches to enhance the effectiveness of health service delivery to minority populations. Moreover, with the presence of larger numbers of minority faculty in health professions schools, there is a heightened awareness of minority health issues and an increased capacity for research and development of new initiatives that further help in improving minority health.*<sup>16</sup>

It was, with this backdrop, that the Minority Faculty Development Model Expert Panel began its work.

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<sup>16</sup> <http://www.saem.omffacdev/Mainpaaes/Minorityfd.htm>.

## Deliberations of the Expert Panel

### Question 1.

#### How are minority faculty identified and recruited?

One of the threshold questions raised repeatedly and often rhetorically by the Expert Panel was this: why is minority faculty development, including identification and recruitment, different from development, identification or recruitment of any faculty. Why isn't the process of identification and recruitment merely a search for excellence? Another way to phrase the inquiry is this: What distinguishes the minority faculty candidate or member from the non-minority population?

In a 2001 NIMH study conducted by Dovidio, et al<sup>7</sup>, the following findings were made that bear directly on this inquiry:

"Within academic institutions, people of color - both faculty and students - are typically numerically distinctive and feel stigmatized."

"In general, minority faculty members report that they are very conscious of their race or ethnicity and feel stigmatized. In part, as a consequence, satisfaction with the job and quality of life at predominantly white institutions is significantly lower for faculty of color than for white faculty members."

"We found evidence of a direct link between numerical representation, feelings of racial/ethnic stigmatization, and job satisfaction among racial and ethnic minorities in psychology departments at colleges and universities across North America."

Other scholars have attributed the above feelings to activities which reflect directly on the role of institutional mission and institutional culture. Trower in 2002<sup>8</sup> made some poignant observations regarding the culture that exists in academia which help put the stigma and marginalization issue into clearer focus. And, from the perspective of the expert panel, Ms. Trower's analysis speaks to the issue of the lens used to see a problem.

Both women and people of color are adversely affected by the traditional academic model, designed by and for white males, as well as an academic culture that says there is only one way of knowing (through conquering, providing or disproving, and competition rather than cooperation), one way to conduct research (independently, in a disciplinary silo, undistracted by teaching or service activities that take time away from traditional scholarship), one way to "fit" into a department and be a good colleague (by assimilating to the dominant culture and sacrificing family or other personal obligations), one way to prove oneself in the

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<sup>7</sup> Dovidio, John F., Gaertner, Samuel L, Niemann, Yolanda Flores, Snider, Kevin. 2001. Racial Ethnic and Cultural Differences in Responding to Distinctiveness and Discrimination on Campus Stigma and Common Group Identity. *Journal of Social Issues*, Vol. 57, No. 1, 2001, pp. 167-168.

<sup>8</sup> Trower, Cathy. 2002. Why So Few Minority Faculty and What to Do: Diversifying the *Region's Professoriate*. Connection, Fall 2002: New England Board of Higher Education.

academy (by peer review among mostly white males), one way to earn tenure (by publishing in the "appropriate" academic journals, which are usually refereed by white males), and one way to achieve full professorship (through the approval of tenured colleagues).

For people of color, especially women of color who face both race and gender issues, the white male model is especially troublesome. A 1998 study by Professors Linda K. Johnsrud of the University of Hawaii, Manoa and Kathleen C. Sabao of the University of the Pacific found that "White faculty developed mechanisms that reinforced their dominant values and their power to define who is to be included and who is to be excluded from - or remain peripheral to - the academy."

For the Expert Panel, these considerations translated into a word which became an undercurrent for multiple discussions. The word is **value**. Briefly summarized, Panel members raised these value questions:

- How are contributions which minority candidates have made valued in the identification and recruitment process;
- How is service to the community, an essential requirement for most educated minorities, valued in the identification and recruitment process;
- How is the unique role that minorities play as models and mentors for students valued in the identification and recruitment process.

The Panel found that the current recruitment model utilized by many institutions is, in essence, a deficit model focused on the underachievement of minorities and their lack of capacity to meet a presumed higher standard. This deficit model serves only to underscore the stigmatization which many minorities already feel and reinforces the view, as expressed by one Panel member that academic institutions are not "welcoming to minority faculty."

And the failure to value the contributions or gifts of minority candidates results in a subtle selection process, as described by one Panel member:

"active recruitment for white faculty ... [means] recruitment for the distinguished professor, the endowed chair, the high level associate or professorial or deanship."

"In our experience, I think that for minority faculty positions, they may occur at a lower level for the instructor and the assistant professor."

Unfortunately, failure to engage in effective minority identification, recruitment development often results in the most adverse impact on the minority faculty than any other part of the institution.

A critical corollary to the concept of value was the Panel's view that minority faculty recruitment should not be looked at from the perspective of imposing the onus of this issue upon the minority faculty. Often minority faculty, who were not involved in creating the exclusion that resulted in under-representation of minorities, were forced to overcome the legacy of exclusion. They did this by having enhanced credentials and then participating with the institution in helping it to clean its own house, in order to eliminate the exclusionary practices. This burden of being required to be more qualified and more willing to battle the institution's own history puts the minority candidate at an unfair advantage to the non-minority candidate. The non-minority would not be similarly required to engage in such activities or exhibit added credentials. Therefore, recruitment of minority candidates carries with it, as one Panel member noted, the tacit requirement that "they must serve on almost every committee that's out there so that you can have a minority presence." In a November, 2002 article in the American Association of Medical Colleges' *Reporter*, Dr. Lynne Richardson noted, on the one hand, that "[t]here are obstacles for Minority faculty that make advancement more difficult,"<sup>19</sup> but that, on the other hand, "[m]inority faculty have to refute the presumption of inferiority."

Panel members also spoke about the onus issue in the context of academic or institutional expectations. Minority faculty are often expected to provide service to the underserved, by teaching the multicultural psychology course or about cross-cultural issues. Non-minority faculty would not normally be expected to do this.

One unique solution to the recruitment dilemma for minority candidates is the creation of a portfolio requirement. This allows a candidate for the faculty to properly record their contributions to society, community, or academia in a manner that can be fairly judged and equitably valued.

In an August 2004 article in *Academic Medicine*, Dr. Deborah Simpson, Dr. Janet Hafler, Diane Brown, and Dr. LuAnn Wilkerson explored the state and use of teaching portfolios and tenure in U.S. medical schools. They concluded that "the number of medical schools whose portfolio packets include portfolio-like documentation associated with a faculty member's excellence in education has increased by more than 400% in just over ten years."<sup>20</sup>

This portfolio concept is used elsewhere in academia. In the fine arts world, the portfolio concept is vital to understanding one's artistic development over time. Similarly, a portfolio for a minority candidate in the healthcare field could detail and illustrate his or her contributions to society, community, institution, or family. It could demonstrate what the candidate values.

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<sup>19</sup> Proctor, j. (2002). *Despite Growth in Ranks, Minority Faculty Promotions Lag*. American Association of Medical Colleges Reporter. 109:2. Retrieved December 10, 2003 from <http://www.aamc.org/newsroom/reporter/nov2000/drowth.htm>.

<sup>20</sup> Simpson, D; Hafler, J; Brown, D; and Wilkerson, L., Documentation Systems for Educators Seeking Academic Promotion in U.S. Medical Schools, *Academic Medicine*. 2004,79:8.783-790.

## Aptitudes for Health Professions Faculty

A primary issue in identifying and recruiting health professions faculty is whether a candidate has aptitude(s) for success in this field. This is true for all faculty. Appendix B presents an overview of aptitude testing.

In looking for basic "health sciences" experts, *a typical* beginning, ideal, aptitude profile would contain high scores in six aptitudes: Classification Ability, Concept Organization, Spatial Relationships Theory, Spatial Relationships Visualization, Design Memory, Observation. Since the two last aptitudes are similar, one can often substitute for the other, so that a low-average score in Design Memory would be adequate if one had high Observation. There are other situations in which *high* scores in all six previously-named aptitudes would not be necessary. Example: Spatial Relationships could be average except for the Epidemiologist (who should be high); the Spatial Relationships Visualization is not important for the psychiatrist, but critical for the dentist who specializes in orthodontics, etc. Classification Ability would be more important in the diagnostician or researcher than in a pharmacist.

**One problem, however, is that this project is focusing not on the practitioners of health sciences, but rather on *teachers* (faculty).** That changes the picture considerably. To the extent the faculty member spends time in meetings, on budget duties, as a mentor/advisor to students, as a "stand-up instructor" and the like, then other aptitude combinations are called for. The teacher would be low in Visualization unless that person were using extensive tools, materials, and tangible objects (such as teaching anatomy or laboratory chemistry, or the microscopic identification of materials). The faculty member who spends much time with students in a counseling/advising capacity should be either a mixed Generalist/Specialist or a Generalist, whereas the practitioner of surgery would typically be a strong Specialist. But the teacher who must advance through publications ("publish or perish") is more likely to be a self-directed Specialist, not a Generalist who enjoys interacting with others more than undertaking a solitary research project. Thus, to some extent, a contradiction exists.

Given the above, it would be necessary to identify not just the speciality (how does a psychotherapist differ from an osteopath and from an allopathic physician), but also the *roles involved in the daily work* of the person in question.

While it is possible to create basic guides for each of the five health professions of interest (allopathic, osteopathic, dentistry, pharmacy, behavioral/mental), these would each have to be modified by the role the person is filling. This produces a matrix-like table, when we consider three roles (clinical, research, academic/teaching) by five professions. Such a table could be developed, should the discussion underway during the model development require it.

The consensus of the panel is summarized in the following points:

- On the surface, minority faculty appear to be recruited in the same ways as non-minority faculty;
- Minority faculty who are recruited from the practice field may not be adequately socialized or prepared for academic life;
- Minority faculty are often subject to an assumption that they will be willing to fulfill the university's diversity needs by serving as a role model, member of minority-focused committees, teacher of cross-cultural courses, and mentor to all minority students. This is a burden that often falls unequally on the minority faculty member;
- Minority faculty are more often recruited because of the change in how the institution may be perceived in the minority community while white faculty are recruited because of the change in how the institution may be perceived in the academic and professional community;
- Actions need to be undertaken that allow the contributions, both actual and potential, of minority candidates to be properly recorded and valued. To do so, institutions need to take visible steps which regularly and routinely place value on contributions of the type and nature that may emanate from the minority community;
- Minority candidates, in particular, but all candidates in general, should be required to create and prepare a portfolio that illustrates the contributions which they have made, or potentially may make, to the institution that are not distinct or unique.

## **Question 2.**

### **How are minority faculty trained and developed?**

## **Question 3.**

### **How are minority faculty retained?**

## **Question 4.**

### **What are the requirements for minority faculty to attain tenure?**

The discussion of these three questions was taken together. The dilemma regarding training and development is summarized in this quote from one of the Panel Member:

"There were a lot of institutions that didn't have a formal faculty development program. In those institutions, a white or a majority faculty person was more likely to get mentoring because a senior faculty person took a liking to them, or

had similar interest, or saw something in the background that related to them... whereas a minority junior faculty person, at the same institution with the same lack of resources, may not get mentoring because someone hasn't taken them under their wing. Where there isn't a formal program, everybody is sink or swim but you're more likely to get more mentoring if you're white."

Looking at a model for how faculty should be trained and developed, the following characteristics were described as part and parcel of an active MFD program: mentoring; protecting the time of the mentor; advocacy, training and skills development; dissemination of the tenure navigation process; role modeling; individual career plans; and institutional commitment.

The panel highlighted some of the unique issues that minorities encounter when entering academic life:

- Minority faculty are brought "in for many reasons, many of them good reasons, [but] with less preparedness than white faculty;"
- "They [minority faculty] are often asked to play roles that focus on their minority status."
- "The minority faculty member is expected to be a counselor and an advisor for students, on top of everything else they have to do..."
- "Socio-cultural and economic disadvantages."
- "The lack of role models..."
- "Social isolation..."

The consensus<sup>21</sup> of the panel revolved the following points:

1. Where there is no faculty training or development process, minority faculty suffer at multiple levels ranging from lack of foreknowledge or preparation for life in academia (e.g. not know what questions to ask or to whom one should address a question) to social isolation caused by lack of role models, value and cultural differences, and the added burden of being the guardian of all minority issues and people;
2. Where there is a faculty development program in place, non-minorities are more likely to utilize the services because more of the mentors or advisors in such programs look and sound like the non-minority professor. The absence of such identification produces a chilling effect within the junior minority faculty member;

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<sup>21</sup> Though pipeline issues related to minority faculty were not part of the focus of the panel's discussion, some of the subgroups emphasized the importance of schools identifying and working with minority health professions students about becoming faculty. Such a proactive approach would allow students to begin acquiring the types of skills and experiences necessary to become successful faculty.

3. To be effective, a training/development program must be a proactive activity like a literacy program, meaning that it must seek out the minority faculty and solicit participation;
4. Minority faculty need to be allocated legitimate credit for the work that they do in supporting a school's credibility in the community by serving on minority program committees and cross-cultural programs;
5. Institutions need to understand the value that a minority faculty member has as an individual and as a member of the academic community. Institutions then must nurture, support, encourage, compensate and move that value forward.

### **Question 5.**

### **What information does incoming minority faculty need to know to be effective from the beginning of their assignments?**

The Panel reached quick consensus regarding the information which minority faculty need to know in order to be effective including:

- The rules of the institution, both formal and informal;
- Knowledge that the promotion and tenure processes begin on their first day of employment;
- An understanding of how the peer evaluation and student evaluation processes play a role in promotion and tenure.
- An understanding of the institutional culture that shapes how people are treated and perceived;
- A positive attitude;
- Networking skills; and
- Advocates or mentors within the non-minority faculty.

In order for Minority faculty to be effective from the beginning of their assignments, the faculty member must understand his or her personal assets and be sufficiently attuned to the outside world to be able to seize upon an opportunity. This may be through understanding and navigating the rules; networking; understanding the culture; or understanding the players. In effect the panel recommended the use of the SWOT concept of analyzing Strengths, Weaknesses (an internal analysis) plus Opportunities and Threats (an external analysis) in order to make strategic determinations that will lead to success in the academic setting.

## Clinical Training

### Question 6.

**How much time do minority clinical faculty need to spend in a clinical setting?**

### Question 7.

**What skills do minority clinical faculty need to be effective clinical educators?**

There is no consensus regarding the answers to these two questions because of the varying needs and philosophies of the represented healthcare professions. For example, one Panel representing the osteopathic profession stated emphatically: "Don't let them [minority faculty] get into clinical practice if you want them to go into academic practice ... [because]"our colleges do not pay a competitive wage that compares with clinical practice." Another state that this is true for everyone.

On the other hand, outside of osteopathy, it was noted that "there are students who are looking more at academic medicine because of the problems in clinical practice."

In the behavioral and mental health field, it was noted that clinical practice was more often the source for publication but that not valued as highly within academic circles because it came from practice rather than academic study.

In the pharmacy, the trend was "to provide new faculty members with fellowships and stipends and grants to initiate research projects. Because one of the big problems is while you're in school you are focused on a clinical career. Unless somebody took you by the hand or you identified yourself as being interested in research, you don't get the grant writing skills."

In some cases, clinical experience is a devalued commodity in today's competitive academic marketplace. But it often represents one of the more significant assets of the minority application. This is not uniform across the health professions. If one pursues a true clinical practice after training, whether the individual is minority or not, the transition into academic life can be more difficult.

One panelist said that in dentistry "There is the concept of clinical track versus tenure track." The appointment, promotion, and tenure considerations may vary depending on which track you are on. Therefore, if a minority faculty has clinical skills from serving in the community, that very skill that may not be valued as highly as someone on a tenure track.

There are multiple issues happening simultaneously. In medicine and dentistry, there has been development of multiple faculty tracks, (e.g., clinical educator, the "standard triple threat", clinician researcher). Some, but not all, of these tracks have tenure associated with them. Many institutions do not have tenure or are eliminating tenure.

In some institutions, promotion and tenure are two distinct and unrelated issues. If advancement is not contingent on tenure, then there is no "up and out" rule. The movement to the newer type of tracks may be advantageous since it allows faculty to hone in on their strengths.

But one issue that still remains is educating the promotion and tenure committees that there are different standards. Problems and contradictions may occur as people grow accustomed to the changing nature of what it means to be faculty. Problems will arise when people enter an institution with misaligned expectations (e.g., the individual is on a more traditional faculty track and is really behaving more in the clinical educator role.)

The issue for the panel appeared to be not how long one should do clinical teaching but rather whether there is substantial value to a track that is effectively "second tier." This is not just a minority faculty issue. People who are clinician educators are different than those doing research. That depends on an institution's mission. Therefore, neither the promotion nor the tenure processes are tied to people excelling in all three. Neither the promotion nor the tenure process is tied to being a "triple threat". Rather, people must meet the requirements for the various tracks and ranks.

In some cases it was difficult to draw a consensus from the panel discussion. Some salient points and questions arose, that merit further research and inquiry:

1. Is clinical experience, defined as experience from the field or the community, more often found on the minority resume than theoretical academic preparation? Is the reverse true for the non-minority resume? Do the answers to these two questions vary by health profession?
2. Is clinical teaching, defined as clinic, community-based or service oriented activity, being increasingly devalued by academic institutions? With respect to tenure, are these activities valued significantly less than academic preparation? If this is true, then how does that reconcile with the changing role of tenure in these institutions? How much does this problem vary by institution and by health profession?

## Research Training

### Question 8.

**How many publications in peer reviewed journals do minority research faculty need to have published annually?**

### Question 9.

**How many presentations do minority research faculty need to be make each year at national, regional, and state conferences?**

### Question 10.

**What special research training do minority research faculty need?**

### Question 11.

**What does the minority academic/teaching faculty need to know about writing CUE and other grant proposals?**

A central point, around which most panel members concurred, was made by a Panelist who stated:

*There 's nothing unique about a lot of these questions, such as research presentation or research training, that are different for minorities than any other race.*

*If we think about research training, one of the big issues is trying to make your area of research interest a legitimate avenue of inquiry, particularly if it is community based or priority populations.*

In medicine, bench research or traditional clinical research is often valued higher because it is the normative type of research. In a medical school where this is the standard, health services research, for example, would be of lesser value, regardless of whether the faculty is minority or not. Because so many minority faculty go into medicine because they care about social problems affecting their communities, they want to research and study these issues. But many of these issues do not lend themselves to randomized clinical controlled trials, which is a barrier to obtaining institutional support and research funding.

Similarly, the number of publications was perceived to be race-neutral. There were no significant or perceived differences between the requirements imposed on minority and non-minority faculty. Therefore, the issue of the number and quality of publications turned, not on minority versus non-minority status, but rather on the formal and informal requirements of the academic institution.

Again, no distinction is made along racial lines. The Panel's analysis of the skills within the minority faculty population suggests that in addition to their other responsibilities, they are also required to be members of the inner sanctum of grant writers in order to be successful as faculty. Grantsmanship is valued, regardless of color.

Several subgroups did speak about the need to maintain a favorable balance between teaching, research and service but no sub-group was prepared to assign a formula.

What appeared to be a recurring theme is pre-hire preparation of minority faculty for the rigors of balancing the teaching, research and service commitment. The special research training minority research faculty need is that special knowledge known to those with mentors and counselors that allows them to submit research grant proposals that are successful in bringing money to the institution.

## [Academic Training

### **Question 12.**

**What does minority academic/teaching faculty need to know about administering COE and other programs?**

### **Question 14.**

**How do minority academic/teaching faculty balance their teaching requirements versus their research and other duties?**

This section is divided into those skills necessary to be effective outside the classroom (i.e., administration and time management) and inside the classroom.

COE applications and administration were a matter of some controversy. Some panel members felt strongly that minority COE proposals, even if funded, are generally marginalized within academic institutions.

However, several Panel members noted again that there is an informal administrative track that can be successfully navigated by minority faculty members who work within the COE structure and use that structure to bring in the million dollar grant to the institution. The difficulty pointed out by them is that the reward may often be a non-tenure track position that is effectively keyed

to the continuing grant. Depending on the rank of an individual when they begin, a COE (or HCOP) grant can become a barrier that hinders obtaining a traditional faculty appointment. For the same reason, taking on some administrative roles early in an academic track can be problematic regardless of whether the faculty is minority or not. How much of a problem can be very dependent on the institution.

The overwhelming consensus was that minority faculty have the greatest difficulty balancing their teaching requirements with their research and service requirements because of the unfair burden placed upon minority faculty to serve as role models, mentors and counselors to minority students and to participate as the "minority representative" on all activities having to do with people of color. In the final analysis, however, the panel was very clear that pedagogical skills are race-neutral and minority faculty need the same skills as all other faculty, the ability to analyze, synthesize, research and present.

### **Question 13.**

### **What pedagogical skills do minority academic! teaching faculty need to be effective in the classroom?**

Health professions faculty are often required to teach students. Because of the many years of required study to attain this level, they usually are not trained to be educators. This is true for many other professions as well. Therefore, the risk is that while they have superior levels of technical knowledge and skills, they often do not know how to effectively communicate this to their students in a classroom setting.

The purpose for this section of the minority faculty development model is to provide a brief set of skills necessary for faculty to know in order to become more effective, without having to invest time in taking education courses. The section has two parts. The first part focuses on what faculty need to do to teach effectively. The second part focuses on what the students they teach need to do. However, the faculty would be responsible for sharing these principles with their students.

#### **What Faculty Need to Do To Teach Effectively**

1. In developing curriculum, a faculty member needs to be able to identify an area for instruction.
2. Faculty need the skills and experience to search the literature to find best practices related to that area.
3. Faculty need to be able to write accurate and precise objectives, as a starting point. Those objectives need to be tied to a relevant skill or knowledge set (e.g., teaching, research).

4. Faculty need to devise some sort of assessment to ascertain whether the objectives were met.
5. Faculty need to incorporate some form of program change to improve student and program performance on reaching the objectives.
6. The new faculty member must also be able, with the new approaches to education, be able to give coherent and succinct lectures.
7. Lead small group discussions, and create relevant cases for Problem Based Learning (PBL) sessions as well as to facilitate the PBL sessions too.
8. Faculty members benefit if they are able to work as part of an instructional team with other professionals as well as students in reaching the objectives for the area of instruction.

### **What Students Need to Do To Learn Effectively**

UCLA/Charles R. Drew Schools of Medicine Center of Excellence has developed a model for faculty of enrichment programs targeting underrepresented minority students in the sciences. It presents a curriculum to develop study and test taking skills needed to succeed in medical school. Its major sections include the curriculum, study skills for students, and using evaluation for change. This model can be accessed at <http://www.medsch.ucla.edu/coe/projectsite/home.htm>.

Educators' effectiveness can be increased if their students perform better. Please see Appendix A to learn how faculty can help students improve performance.

## Panel Recommendations

Based upon the deliberations of the Expert Panel, the following recommendations are offered for consideration:

1. The Model should be submitted for critical peer review and presented to conferences and journals in order to obtain the widest dissemination and feedback.
2. The Model should be presented at the annual meetings of the professional associations in order to obtain critical feedback.
3. The Model should be tested at approximately 10 schools.
4. The Model should be examined in the light of other health professions, including nursing, public health, social work, allied health, optometry and podiatry.
5. The Federation of Associations of Schools of the Health Professions should be called upon to recommend integration of the Model within their member schools.
6. Centers of Excellence should be required under their grant to test the Model in order to generate reliable longitudinal data.

## Conclusion

What has been said consistently throughout the deliberations needs to be restated here. In an ideal world, there would be no need for minority faculty development as such. Faculty development is exactly that faculty development - regardless of color. But, we do not live in an ideal world. Thus, like women who for so long were excluded from the upper echelons of academia, the time has come for minorities to obtain the equal opportunity that the law requires and society deserves.

The analysis reflected herein is not the original insight of the author. Rather, it is an attempt to crystallize the insights and expertise of a panel of experts who have considered the matter and have collectively shared their insights.

Recommendations flowing from this panel are not meant to solve all of the problems associated with under-representation of minorities. What is offered here is a template for moving forward with a closing caveat that there is much more work to do.

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## Appendix B: Aptitude Testing

### I. Aptitudes explained.

Aptitudes are those inborn characteristics or abilities that make it easier for one to learn or to do certain things. True aptitude testing consists of a series of independent work samples or tasks, each one tapping a different innate aptitude. The current battery contains sixteen statistically independent work samples relevant to the discussion underway.

Every occupation uses certain aptitudes, and the profile of aptitudes required for different careers has been extensively studied for over eighty years. Practical experience with thousands of clients has demonstrated that most people are unhappy with their jobs for predictable reasons — reasons that can be elucidated by the aptitude profile. Most often the reason is unused aptitudes, aptitudes that interfere with the given task or career direction. As an example, a high score in Idea Productivity (described below) creates a problem of boredom and lack of concentration which interferes with such professions as law or accounting. It could lead to problems for a researcher who must attend to small details, quite routine in nature, over a period of time of more than two hours. Less often than having unused aptitudes is the problem of not having the proper aptitudes, which makes the work difficult and unpleasant.

### II. Relevant Aptitudes Defined.

**A. Idea Productivity.** This is a measure of the number of ideas generated over time. Not the *quality* of the ideas, only the *quantity*. The quality is determined by training and experience within a given area. When Idea Productivity is too high for the work being done, one tends to become bored, distracted, find it hard to concentrate, begin daydreaming, etc. There may be tendencies to forget details, leave things unfinished, march off in a new direction, and disrupt on-going projects in favor of new ones. In terms of jobs, a strong score in Idea Productivity suggests the need for variety. This variety can be across tasks, people, issues, problems, places, content — the vital factor is variety *per se*. Faced with "same old, same old", boredom increases and productivity and satisfaction decrease. Teaching, especially at lower levels, uses Idea Productivity well.

**B. Classification Ability.** This is a very powerful aptitude that demands usage and is often a source of difficulty for people high in it. It is actually the problem-solving, critical, diagnostic thinking aptitude. It allows one to see commonalities in separate events or data, to separate the important from the irrelevant in any situation, to "shoot from the hip" and come up with right answers even when guessing or going on a hunch. A high score generally indicates a restless mind that becomes bored — particularly in a repetitious or static field. This is a demanding aptitude that enjoys problem-solving and trouble-shooting tasks, research, or investigative activities. It has both good and bad aspects to it, as do many aptitudes. On the negative side, when it is not used well it may lead to various problems, including job-drifting, unwillingness to handle details, procrastination, rebellious thoughts or actions, indecisiveness about personal issues, argumentativeness, obsessive "over-review" of situations, and quick frustration with others who are slower to "catch on".

On the positive note, Classification Ability is an excellent talent for jobs or tasks that require quick responses, or looking beyond the obvious and seeing connections. It is used well in roles such as advice-giving, counseling, teaching, consulting, investigating or researching, diagnosing situations or people, editing, and directing and developing new programs or processes. When one critically analyzes or evaluates a project or proposal one uses Classification Ability. It is also used to point out various alternatives and counterpoints in an argument or debate. Thus, it is used in law and investigative fields as well as counseling, teaching, and consulting fields. It is a primary diagnostic aptitude.

**C. Concept Organization** is sometimes defined as the logical and analytical thinking talent, or the organizational gift. It represents a talent for seeing how all of the pieces of a project fit together to make a coherent whole, or seeing how the various facts can be combined into a compelling argument or presentation. People who work with the logical analysis of data, or time, or space might work in such areas as the following : journalism or other writing jobs (facts and words are organized logically); logistics and meeting planning: (materials, products, and space); teaching and training of various types: (facts and logical connections); most of the sciences (observations and data); law (precedents, facts, arguments).

**D. Spatial Relationships Theory** is an ability to handle mathematical systems, a talent for manipulating symbolic relationships, and a gift for understanding abstract "force" fields. People high in this can see relationships within and among forces that do not have a three-dimensional quality. Wind, tides, gravity, electron movement at the sub-atomic level, *qi* (chi), electricity, magnetism — all of these are non-tangible forces. Spatial Relationships Theory thus plays a role in such fields as astronomy, quantum mechanics, photonics, optics, seismology, atmospheric, physics, and pure mathematics. In the financial arena, it is used for statistical analysis, budget duties, trend analysis, math modeling tasks, demographic studies, and the like. It is also a primary aptitude for an epidemiologist, in the field of public health.

**E. Spatial Relationships Visualization** represents a talent for seeing in three dimensions, given only two. An X-ray, for example, is a two-dimensional depiction of an actual three-dimensional object. The person with this aptitude can imagine or visualize the object mentally as being three-dimensional.

People with this gift are called structural, and the appropriate fields for them are those that involve "real answers", concrete objects, tools, and a "truth" that can be weighed, measured and demonstrated. These fields include: engineering of all types; design fields such as architecture, interior design, stage set design, movie set design, etc.; applied sciences and technologies, such as mining, medicine, forestry, agriculture, aviation, cartography, archeology; three-dimensional sciences such as crystallography or molecular biology.

**F. Design Memory.** The ability to recall and reproduce sketches, drawings, and visual patterns. Used in various fields that require visual depictions or working with visual materials in a somewhat technical fashion. Design Memory can be used for creating maps and charts, technical diagrams, graphs and other such materials to use with presentations. Design Memory enhances and supports all technical and scientific fields as well as many art-related design functions. It is additionally useful in memorizing material which is or can be depicted visually. In memorizing

the bones or nervous system of the body one can use strong Design Memory. Such a task is far easier for the person who can keep the basic pattern and lines in his head and must only attach the names to what he "sees" in his mind.

**G. Observation.** An ability to recall small visual details or changes in a visual field. It is important in inspection or art-related tasks as well as in medical or laboratory technology. With the minimum amount of training a person high in Observation can look through a microscope and notice small changes in cells over time, or variations from the normal cell. This is also valuable in identifying birds or plants, so it is used in the botanical, horticultural, and biological research areas.

**H. Verbal Memory.** This is the ability to remember a great deal of what is read, or to learn through associative methods. People high in Verbal Memory are usually good students in classes (such as Latin or anatomy) where they must read and memorize a new jargon. Important in most professional programs that require extensive learning through "reading and memorizing" activities.

**I. Tonal Memory,** The most basic of the music-related aptitudes. It might be called the memory for melodies and harmonies, or the ability to recall with precision fine details of sound production. The presence of this aptitude is valuable in a range of jobs besides music. It would be an asset in all recording and broadcasting industry positions, as well as in learning languages by ear, speech therapy, dramatics, translating and interpreting, even court reporting. In a more generalized capacity a high score in Tonal Memory indicates one can recall conversations, and this is useful in any job that requires one to remember and then act upon instructions presented during meetings or telephone conversations.

**J. Rhythm Memory.** Used in remembering rhythm patterns and in the percussion areas of music. It also measures the need for large-muscle movement. Rhythm Memory is used when one is engaging in dancing, hiking, biking, swimming, and other exercises or sports areas. For these purposes, people high in Rhythm Memory have difficulty being sedentary for more than a few hours at a time, and become restless and distracted when in extensive meetings. Successful and happy physicians sampled by the Human Engineering Laboratory study in 1983 were found to be significantly higher in Rhythm Memory (and in Tonal Memory) than the general population.

**K. Pitch Discrimination.** A measure of overall "fineness of perception". It indicates a sensitivity to small shades of differences, or a subtlety in areas ranging from smell to taste to texture. People who work with precision tools and materials that require exact measurements need good Pitch Discrimination.

**L. Manual Speed and Accuracy** is simply finger dexterity.

**M. Number Memory** is a measure of the ability to recall not only numbers but other miscellaneous material. Many people who are high in Number Memory seem to store a great many facts in their heads – facts that may or may not be related to anything special. This can be an advantage in fields that require one to have statistical information at the fingertips.

N. Time Frame Orientation refers to the short or far-sightedness one tends to display. People in the long-range area have an ability to see the advantages of time spent in preparation phases. They are good at strategic planning and working toward goals that require some initial sacrifice, such as professional training. This could also be necessary for those needing to conduct extensive research to publish enough for advancement to higher academic levels.

**O. Generalist/Specialist Orientation.**

This may be a very important factor (perhaps the single most important factor) for the purpose of predicting the retention of health faculty at professional schools. The language needs to be more precisely defined. Sometimes this factor is termed Objective versus Subjective personality.

1. **The Generalist** prefers a situation that contains a diversity of tasks and interactions throughout the day, with perhaps some delegating or sharing as a part of the work. Generalists have an intuitive understanding of and interest in others. They are natural team players, willing to submerge their own needs into those of a larger community.
2. **Specialists** long to be the expert or authority within a well-defined area. Specialists, with proper, solid training, have clear ideas about how things should be done, and prefer to actually do the work themselves as opposed to delegating it. Specialists have much more need for autonomy and independence of action than the Generalists. Specialists need to *work from the heart*, in the sense that their work must be personally important to them — they must have some passion for it. It is this intense interest or passion that then leads to having sufficient dedication to becoming an expert in an area. Additionally, Specialists need to see a direct link between their own efforts and the outcomes or rewards. They do not enjoy having others take credit for that which they feel they did on their own.

## **Appendix C: How Faculty Can Help Students Improve Performance**

In addition to making the faculty aware of these principles, we encourage the faculty to share these principles with their students in an orientation or in the first day of class. The concept is that if students know how to effectively study, learn, and prepare for class by learning this material, then they will have an increased chance of understanding and retaining the information which the faculty is teaching.

The following material is excerpted from a presentation by Dr. Lawrence (Hy) Doyle at the 2003 National Health Careers Exploring Exposition in Bethesda Maryland. Dr. Doyle's doctorate is in Educational Leadership. He serves as the Assistant Director for the UCLA and Charles Drew Schools of Medicine. In this capacity, he develops and presents learning skills counseling and programming to medical students and residents.

### **How People Learn**

People learn three ways: 1) aurally, by what they hear; 2) visually, by what they see; and 3) kinesthetically, by what they touch. Note taking is actually kinesthetic, because the words are recorded by touching the pen and paper.

Unfortunately, many health professions schools are based on the first medical school, established in 1100. In that case, a room was designed to seat as many people as possible to view a professor and a cadaver at the front of the classroom.

To remedy this, a new model is advocated for health professions education: 1) lectures are limited to two hours per day; 2) students study in small groups; 3) students have patient interaction; and 4) problem solving with people is the way to learn. Students are happier and perform better in this arrangement.

### **Study Skills and Taking Notes**

Facts from the field of cognitive psychology state that for students taking notes in a class, 25%-35% of knowledge from the class is forgotten within 1-2 hours, and an additional 25% -35% is forgotten within 24 hours. After 24 hours, the curve flattens. But that is a loss of 50%-60% of what students know if they do not review.

To prevent this: 1) at the end of every class, they should do a quick review of their notes, and that evening, they should review the notes and write a one or two sentence summary of their notes. The review and summary should answer the questions: What did I just read? What did it mean.

This review and summary process is the opposite of cramming. People who cram for a test forget what they learned when the test is over.

## **Take Care of Yourself**

To perform well in the rigorous environment of health professional education, students need to remember to take care of themselves as they are learning how to care for others. Specifically, this means that students cannot afford to cut corners on their sleep, nutrition, or exercise.

People need an average of 8 hours per day of sleep. REM sleep, when dreams occur, happens every 90 minutes. REM sleep consolidates the memory from the day.

Barriers to sleep should be overcome. The sleep environment should be dark. Snoring may be a symptom of sleep apnea, which would need to be confirmed and treated.

Nutrition for good performance includes a diet of protein and complex carbohydrates, including fruits, vegetables, and whole grains. Drink enough water. Take a daily multivitamin with minerals as a supplement.

Be careful in limiting foods with caffeine, alcohol, and sugar. Try to limit coffee to one cup a day. If you eat a breakfast that is high in simple carbohydrates, you will be asleep in an hour.

Finally, exercise. For busy students who do not have time, using a pedometer with the new 10,000 steps a day programs offer a good option.

## **Outline your notes**

This is important because a student's brain works approximately 4 times faster than faculty person talks, which is 60-70 words per minute. A student needs to study from notes which are focused on the main ideas.

The guidelines we recommend are: 1) have the title, date and subject in the upper right corner of each page; 2) listen and condense; have 1 idea per line; distinguish between major and minor ideas by indenting the minor ideas; and leave room for the 1 or 2 sentence summary at the end of each day's notes.

## **Memory**

The brain likes to see things over time instead of all at once. Therefore, regular study is more effective. Spaced learning is more effective than massed learning. Attention diminishes after approximately one hour of concentrated study.

When there is a list of terms that people have to memorize, people tend to remember the items at the beginning and the end of the list. This is known as the primacy and recency effects. Therefore, when memorizing lists of items, people should use mnemonic devices to aid them.

## **Summary**

Your students will be very good at testing and studying to have arrived at the point where they are in health professions schools. However, it is a higher level of education, where higher levels of performance are required.

Like professional athletics, performing well at studying and testing are skills that improve over time with practice. As shown in the field of sports psychology, some tension is required to enhance performance. However, just as too much relaxation would be counterproductive, so would too much tension. These techniques and methods are suggested to enable students to relax so that they can concentrate, to perform effectively.

## Appendix D: A Model of Comprehensive Faculty Development: The Case of Ben-Gurion University

**Author's Note:** *This model is presented to reflect that the issue of faculty development is not just a domestic issue but international in scope. It also reflects the lack of actual multi phase models in the United States. It is specifically offered as a potential template for implementing a Minority Faculty Development Model in the U.S. There are models in the United States, as shown in the next Appendix. But this is a comprehensive approach taken by one University seeking to diversify and support new faculty.*

The Ben-Gurion University (BGU) faculty development program constitutes four phases (Figure 1) (Benor & Mahler, 1989; Benor, 1998). The first aims at enhancing the identification of the new teacher with the institution, its philosophy and educational approaches. This Orientation phase is a two-day workshop based on small-group activity. Each of several such groups consists of four to six physicians, scientists, nurses and other professionals of variable seniority, educational experience and clinical or scientific backgrounds, who are new in the faculty. Each such small group tries to identify health needs and delineates in rough outlines an ideal medical school that may meet these needs. This imaginary scheme is then confronted with the 'traditional' medical school on the one hand, and with BGU philosophy, history, structure and curriculum on the other. The workshop then provides information on every aspect of the school's life, from an overview of the curriculum to promotion and tenure policies. Within this framework the participants meet the dean and key faculty members, as well as students. The expected outcome of this phase is an attitudinal change. The new teachers discover that the institutional objectives are not arbitrary, and that the curriculum is indeed an understandable solution to defined health needs. Further, the new teachers find that their involvement is sincerely welcomed, and that they have the power to influence the curriculum. Participation in this phase is conditional for further promotion.

The second phase, entitled Basic Instructional Skills, is an intensive three-day workshop. It also hosts a multidisciplinary and multiprofessional assemblage of teachers, working again in small groups. The workshop is modular. Each module relates to a single major educational concept, such as defining and formulating educational objectives, selecting an appropriate teaching method from a wide-ranging menu, preparing teaching materials and, finally, evaluating attainment of the objectives. Each module starts with a written simulation that triggers discussion and requires fulfilment of a group task, which is later presented to the plenary and criticized. Then each group produces its own product, which is again scrutinized by the plenary. Each module ends with a short lecture on the matter. This workshop, therefore, guides the participants into systematic course design step by step.

The third phase, designed for more experienced teachers, offers a variety of activities in all aspects of the educational program. Among these are improving lecturing skills, raising the cognitive level of instruction, writing test items, designing clinical evaluation, activating student

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a Senor, Dan E. *Faculty Development, Teacher Training and Teacher Accreditation in Medical Education: Twenty Years from Now. Medical Teacher, 22(5):503-513 (2000).*

participation in learning, preparing audio-visual aids, teaching physical diagnosis, teaching communication skills, tutoring problem-based self-learning groups and more. Some are offered on a regular basis, usually several times a year; some others are a response to an expressed need, and therefore much less frequent. Different formats are utilized. Some are one- to three-day workshops; in some others participants have to complete a task between the two parts of the workshop; in yet others on-the-job coaching follows a workshop. In some workshops participants practice on real students who provide a real-life flavor; in still others a microteaching technique is employed, providing the teacher with an 'armchair' opportunity to discuss his or her own performance in a non-threatening environment. Finally, an educational expert is available to interested teachers in between workshops for counseling and support.

The fourth phase offers experienced teachers several theoretical educational courses, such as a course on evaluation in education, research design and other major issues of medical and health professions education. These courses will, in the future, become an academic program towards the degree of Master in Medical Education. This phase is explicitly targeted toward a small group of educational leaders, who are, or will be, in decision-making positions such as members of curriculum committees, coordinators of major courses, and vice deans.

## **Appendix E: Faculty Recruitment, Development and Retention Programs University of Texas Health Science Center at San Antonio Medical Hispanic Center of Excellence**

The University of Texas Health Science Center at San Antonio (UTHSCSA) is a Hispanic Serving Institution and a Hispanic Serving Health Professions School. The medical school has more Hispanic faculty than any other in the continental U.S. Most of the Hispanic Faculty at the UTHSCSA is Mexican American. The Medical Hispanic Center of Excellence has been a component of the Medical Dean's Office since 1991 and has established faculty recruitment, development and retention efforts that have been a model of success. The UTHSCSA has not only increased the number of Hispanic faculty since 1997 from 9% to 11% currently but has also increased the number of Tenured Faculty (14 in 1997 to 22 in 2001) and faculty in administrative positions (0 in 1997 to 3 currently). The UTHSCSA can serve as a model of success in creating an institutional environment that supports the increase in representation of Hispanics among its faculty. This has been accomplished by a multilevel approach via an established faculty development program and educating institutional administrators about its importance. The concentration of future efforts will be to further decrease the disparity gap amongst UTHSCSA faculty at all levels, in particular of Latina faculty.

### **INTRODUCTION**

**The University of Texas Health Science Center at San Antonio** (UTHSCSA) was established at its present campus in 1969. It has five professional schools. Approximately 10% of the faculty at the UTHSCSA is Hispanic. The UTHSCSA has been a Hispanic Serving Institution from its inception. The Medical School has more Hispanic faculty than any other Medical School in the continental U.S. Most of the Hispanic Faculty is Mexican American. The UTHSCSA Administration has key personnel that are Hispanic. These individuals are as follows: 1). President of UTHSCSA, the first Hispanic President of a Health Science Center in the continental United States. 2). Vice-President of UTHSCSA that oversees all of the programs in South Texas. 3). Dean of the Regional Academic Health Center. (This center is an extension campus of the UTHSCSA serving four counties in the Lower Rio Grande Valley and the Dean is a native of South Texas.) 4). Assistant Dean in the Medical School. 5). Assistant Vice-President for the Office of University Relations. With these key individuals in place, the UTHSCSA is better able to meet its strategic plan goal for education which is to recruit, develop and retain a diverse faculty and student body and respond to the local, regional, and national health professions workforce needs in medicine.

The UTHSCSA Medical Hispanic Center of Excellence is funded by HRSA. Dr. Martha Medrano is the Director and Dr. Juan Parra is the Associate Director.

### **METHODS**

The objectives of the MHCOE faculty development program are to enhance the research, administrative, and teaching skills of junior Hispanic medical faculty and therefore increase the number of those who are promoted, tenured and retained at our institution. The objectives are accomplished via the Junior Faculty Fellowship and the Hispanic Faculty Association.

## **Junior Faculty Fellowship**

### **Background**

Junior Hispanic faculty members (Assistant Professors) who are new or established in the institution, that have a large clinical service responsibility and thus do not have sufficient time to become involved in teaching or research, are identified to be Faculty Fellows. All Hispanic faculty selected for this program are Assistant Professors appointed full time to the Medical School. The application for the Faculty Fellows consists of a Curriculum Vitae and a letter of support from their Departmental Chair. The exclusion criteria are Hispanic faculty that: 1). Are involved in a research project at 50% time or greater or 2). Are listed as the Principal Investigator on a research grant. A committee composed of the MHCOE Program and Associate Directors, and the Director of Research selects the fellows.

As part of the agreement to participate, the Faculty Fellows are provided with 25% protected time for a period of two years to engage in research, teaching or administrative service that will enhance their chance for promotion and tenure. All of the identified participants have had some research experience, but this experience has been insufficient to prepare them to obtain grant funding and publish consistently in peer reviewed journals.

### **Mentorship Matching**

Each Faculty Fellow identifies an internal and external mentor. The internal mentor is a faculty from the fellow's home department, who can assist the fellow in identifying and securing institutional or departmental resources. The external mentor is a faculty member within or outside of their home department or the institution. The external mentor should have an established track record in the selected areas of clinical service, teaching and research interests of the Faculty Fellow. The internal and external mentors agree to have contact with the Faculty Fellow at a minimum of once a month via e-mail, meeting or phone. The internal mentor agrees to have a face-to-face meeting once a quarter and the external mentor agrees to have such a meeting once a year, preferably during a national meeting. A Mentorship Orientation Manual is given to the fellow and mentor and defines the mentoring relationships and the expectations that both the mentor and the Faculty Fellow.

### **Individual Career Planning**

Each Faculty Fellow meets with the MHCOE Associate Director to review the UTHSCSA Promotion and Tenure Guidelines. The Faculty Fellow selects two of three areas of concentration for promotion and tenure. The concentration areas are research, teaching and clinical and administrative responsibilities. The Faculty Fellow is required to review his or her curriculum vita with the MHCOE Program Director and their Departmental Promotion and Tenure Committee Chair at the beginning of each academic year. The Program Director will assist each fellow in developing an individual career plan with annual goals for each of the three areas of concentration as well as a strategic plan on how to accomplish these goals (See Appendix A). An individual career plan review meeting is set with the Chairperson of the Fellow's Department, the MHCOE Director and the internal mentor annually. Fellows also develop an evaluation portfolio to document improvement in research, teaching and administrative skills. This portfolio assists them in creating a list of individuals from whom they will request letters of support for their Promotion and Tenure packet.

### Enhancement of Research Skills

The Faculty Fellows have structured activities related to research. The activities range from attending a grant-writing workshop to personal consultation and technical assistance in submitting grant applications. All of the funds required for the development of their research are provided through their department or other sources, such as the National Institutes of Health Minority Supplements to RO-1 grants, Health Resources and Services Administration Minority Faculty Fellows Program and the South Texas Health Research Center Faculty Development Funding. The MHCOE will serve as an information resource center for specific funding organizations, as well as foundation, state, and federal program funding opportunities.

The MHCOE serves as an information repository and actively alerts Faculty Fellows on funding opportunities and strongly encourages them to apply. The MHCOE continues to seek out future research and program funding opportunities as a designated Minority Serving Institution and Hispanic Serving Institution for the UTHSCSA faculty and students.

### Grant Funding Resources

The UTHSCSA Grants Management Office meets with each Faculty Fellow to review funding resources through the Internet and registers them into a grant resources Internet search engine called "Smart Administration." This search engine selects grant sources found on the Internet and sends these electronically to the Faculty Fellows.

### Grant Writing Workshops

The UTHSCSA Division of Educational Research and Development enrolls Faculty Fellows in the annual UTHSCSA "Writing Grant Applications" workshop held in the Spring Semester of each year. By the end of the first year of the fellowship, the Faculty Fellow is required to submit at least one grant proposal to an established ongoing research group in Family and Community Medicine. The Faculty Fellow receives a fundability score and written critique for the proposal submitted.

### Enhancement of Teaching Skills

The MHCOE Faculty Fellows participate in the UTHSCSA Teaching Excellence Course (UTEC), which, for 27 years, has been conducted for UTHSCSA faculty by the Division of Educational Research and Development. The objectives for faculty attending UTEC are to: a) explore their attitudes toward various facets of teaching, b) develop or refine basic teaching skills and c) become acquainted with alternative methods for designing learning activities. The course is conducted in workshop format to encourage exchange of perspectives about educational issues and techniques. The format allows participants to practice teaching strategies and receive feedback from their peers. The participants of the course acquire experience with important teacher tasks such as evaluating student performance, planning a course, teaching a psychomotor skill, intervening with a challenging student and/or using educational software. A highlight of UTEC are four micro-teaching sessions during which participants present a mini-lecture, provide one-on-one clinical teaching, lead a small group seminar and intervene with a challenging student. After each teaching experience, participants receive peer feedback from other participants and from course instructors.

### **Enhancement of Administrative Skills**

The Faculty Fellow's administrative skills are addressed by attending programs such as the Association of American Medical Colleges Minority Faculty Development Program, Robert Wood Johnson Minority Leadership Program or the National Hispanic Medical Association Physician Leadership Program. The MHCOE Director conducts monthly leadership workshops. The fellows are provided a seminar series on leadership and administrative skills that includes training in: a) Time management skills, b) Leadership opportunities in medicine, c) Understanding organizational structures and psychology, d) Effective administration skills and d) Motivational skills in leadership.

### **Hispanic Faculty Association**

#### **Background**

The UTHSCSA has a relatively large number of Hispanic faculty and only a few of them will be impacted by the MHCOE Faculty Fellowship. The MHCOE established the Hispanic Faculty Association (HFA) in 1996. All full and part time tenure and non-tenure track Hispanic Faculty are eligible for membership. The HFA's current membership is 85 faculty representing all five health profession schools at the UTHSCSA.

The MHCOE has developed HFA Faculty Development activities that are offered to all members and are very similar to those of the Faculty Fellowship. The difference is that these are accessed upon request of the faculty member, whereas in the Fellowship, participation in all activities is required. The MHCOE also provides the following additional activities to HFA members:

#### **New Faculty Orientation**

The MHCOE request a list of new UTHSCSA faculty from the Personnel Office in April and October of each year. The Associate Director schedules a meeting with all incoming Hispanic faculty. During this meeting the Associate Director provides new faculty with information about the MHCOE Faculty Development activities. The new faculty are asked to fill out a Faculty Profile Form that outlines the faculty's areas of research, teaching and clinical interests. This information is kept on file at the MHCOE and incorporated into the next revision of the HFA Directory. Faculty interested in research endeavors are referred to the MHCOE Director. The new faculty member is invited to participate in all the above named MHCOE programs.

#### **HFA Picture and Profile Directory**

The MHCOE maintains a HFA Directory. This is revised on an annual basis. The directory is used as a Speakers Bureau and Consultants Bureau. Faculty are asked to identify their research, teaching and clinical areas of interest, which are included in the directory along with their educational and contact information (See Appendix B). The MHCOE also serves as a publication and presentation repository by collecting summaries of publications and presentations done by Hispanic Faculty. The information will be kept on file and updated annually. The directory and publication/presentation repository are shared with the UTHSCSA Office of Public Relations as well as the Deans and Chairs of Departments. This allows the MHCOE to recommend HFA members for invited lectureships, institutional, local, state and national committee memberships, and awards. A copy of the UTHSCSA HFA directory is also sent to National Hispanic Medical

Association and the HSPHS for inclusion of UTHSCSA Hispanic Faculty in their programs and activities.

**RESULTS**

**Table 1  
Summary of Accomplishments for UTHSCSA MHCOE Faculty Fellows**

| Fellowship Years | Number of Fellows | Current Faculty | Promotion Tenure | Funded Grants | Degrees      | Papers    | Presentations     | Courses   |
|------------------|-------------------|-----------------|------------------|---------------|--------------|-----------|-------------------|-----------|
| <b>1999-02</b>   | 3                 | 3               | 1                | <b>5</b>      | <b>1 MPH</b> | <b>5</b>  | <b>31 (5 GR)</b>  | <b>5</b>  |
| <b>1996-99</b>   | 3                 | 3               | 1                | 18            | <b>1 MPH</b> | <b>20</b> | 69(46GR)          | <b>29</b> |
| <b>1993-96</b>   | 3                 | <b>2</b>        | <b>2</b>         | <b>20</b>     | <b>2 MPH</b> | 18        | 141(8GR)          | 19        |
| Total            | <b>9</b>          | <b>8</b>        | <b>4</b>         | <b>43</b>     | <b>4 MPH</b> | <b>43</b> | <b>241 (59GR)</b> | <b>53</b> |

The MHCOE has had three groups of faculty fellows complete the program (Table 1). We continue to follow the Faculty Fellows. The MHCOE has retained two of its three original 1999-02 Faculty Fellows at the UTHSCSA. One petitioned for promotion and tenure last year and received promotion to Associate Professor and will be petitioning for tenure in 2002-2003. All of these fellows have submitted a total of 7 grants.

The following is a summary of accomplishments for the 1999-02 Faculty Fellows:

- They have successfully gained research funding for 5 grant projects.
- One fellow successfully completed the Masters in Public Health Program.
- One Faculty Fellow gained board subspecialty.
- The Faculty Fellows have published 5 papers, and 4 additional papers have been submitted and have 31 presentations at national and regional scientific meetings, eight of which were Grand Rounds and five in major courses at UTHSCSA.

The 1996-99 Faculty Fellow group consisted of three fellows who completed all three years and all continue as UTHSCSA faculty. They have published 20 papers and 13 abstracts and have given 69 lectures (46 Grand Rounds) and taught in 29 medical school courses. They have been funded for 18 grants proposals.

The 1993-96 group consisted of three fellows who completed all three years and two of the three continue as UTHSCSA faculty. They have published 18 papers and 7 abstracts and have given 141 lectures (8 Grand Rounds) and taught in 19 medical school courses. They have been funded for 20 grants proposals.

Dr. Javier Kane, Associate Professor of Pediatrics in Hematology-Oncology, was a Faculty Fellow from 1999-2002. He writes the following summary of his experience as a Faculty Fellow:

The following objectives were met during my fellowship:

1. **Establishment of career goals and development of a directed approach towards achievement.**
2. **Mentorship towards faculty promotion and tenure.**
3. **Support for program development.**

I was hired as an Assistant Professor on the tenure track for the division of Pediatric Hematology Oncology. During the first three to four years with the University I was required to perform the duties of a clinical faculty member and worked primarily in the care of patients in a busy Oncology program. During my early years I was naïve about what was needed for promotion in an academic center and I did not work towards the goal of promotion. What was expected of me was to develop an academic career, but the demand was to take care of a clinical service. This infrastructure did not allow me to focus on my career development. The impossibility of developing educational or research initiatives led to a poor review on my mid-promotion evaluation. The University was demanding academic work but my time and energy were consumed in the care of patients. In order to be promoted I needed to make a drastic change.

As a Faculty Fellow I was counseled in the development of career goals and a strategy for achieving these goals. I understood that promotion would not come without a guided effort towards achievable goals. I set a few clear academic goals related to education and program development. I met with my Division Chief and my Department Chair to make the request of limiting my clinical work. I reduced my clinical time from four to five months a year to two months a year. This allowed me to dedicate more time to the academic activities that I had planned, such as preparing lectures, writing papers and developing projects. In addition, my department allowed me to invest the savings that came from having salary covered by the MHCOE. I hired a part time patient care coordinator who worked with me in the development of a program and freed my time to focus on career goals. Moreover, during this time I realized the importance of getting involved with national organizations and outside collaborators. Encouraged by Dr. Medrano, I became an active participant on a variety of national committees related to my academic and research interests.

During the two years of my fellowship with the Hispanic Center of Excellence I was able to negotiate time to focus on specific career goals and build my Curriculum Vitae with significant academic achievements. On 2002 I was promoted to Associate Professor on the basis of these achievements.

## **DISCUSSION**

In 1997 the MHCOE Director reported to an Associate Dean at the Medical School. Since 2001, the MHCOE Director reports to the Dean of the Medical School. In 2000, the UTHSCSA was awarded a Dental Hispanic Center of Excellence and in 2002 the equivalent of a Nursing Hispanic Center of Excellence was funded. With the combined concerted efforts of all three centers, the UTHSCSA will serve as a model for the nation in Hispanic Health Professions Education.

The faculty development activities have been a long-term achievement. Initially the process was slow and tentative. Initially the major activities were through the Hispanic Faculty Association, which was established in 1996. With every success in planning through the association, there was increasing interest in faculty development activities from the Department Chairs and then the UTHSCSA Administration. This was accomplished with the first release of the HFA Directory in 1997. Since 1999, there has been a concerted effort to educate the UTHSCSA Administration about the institutions' designations as a Hispanic Serving Health Professions School and Hispanic Serving Institution. In 1996, a new Vice-President was recruited who had been at the Hispanic Associations at Colleges and Universities who were well versed in the HSI designation. With the appointment of Dr. Francisco Cigarroa as the UTHSCSA President in 2001, the Vice-President began to work with the MHCOE director to assist the President in creating an institutional Hispanic Health Initiative. The first event, The Hispanic Health Summit, was held in October 2001. The purpose of the summit was to educate the UTHSCSA faculty about the institutions designations and Dr. David Satcher's Race Ethnic Health Disparities Initiative. Dr. Cigarroa subsequently named a Health Disparities Task Force to explore and recommend the infrastructure that would house this institutional initiative. Dr. Martha Medrano, Director of the MHCOE was appointed Chair of this important task force.

The UTHSCSA has a large number of Hispanic faculty (N=177), which represents 12 percent of all faculty. These numbers do not include unpaid adjunct faculty. Our Hispanic faculty total has increased substantially since 1996, primarily in the School of Medicine (SOM). The UTHSCSA and SOM Hispanic faculty increased 50 percent from 1996 to 2003. Table 2 reflects faculty information for complete calendar years. Information is not yet available about overall UTHSCSA faculty recruitment in 2004, but 27 additional Hispanic faculty were recruited to the SOM increasing number (and percentage) of Hispanic faculty to 151 (16%).

**Table 2**  
**UTHSCSA Faculty Profiles: Percent of Increase Between 1996-2003**

| Faculty Profile      | 1996-1999*                   | 2000-20113*                  | 1996-2003*                    |
|----------------------|------------------------------|------------------------------|-------------------------------|
| Faculty              | 5% increase<br>(N=1242→1301) | 2% increase<br>(N=1395→1423) | 15% increase<br>(N=1242→1423) |
| Hispanic Faculty     | 4% increase<br>(N=118→123)   | 23% increase<br>(N=144→177)  | 50% increase<br>(N=118→177)   |
| SOM Faculty          | 6% increase<br>(N=675→720)   | 3% increase<br>(N=788→813)   | 20% increase<br>(N=675→813)   |
| SOM Hispanic Faculty | 2% increase<br>(N=83→85)     | 23% increase<br>(N=101→124)  | 50% increase<br>(N=83→124)    |

Part of the duties of the Task Force on Health Disparities was to gather information and report on the history of promotion and tenure at the UTHSCSA. The UTHSCSA has successfully increased the total number of Hispanic faculty as well as increased the number of faculty promoted and tenured and those in administrative positions (Table 2).

Despite these accomplishments over the years, observations were made that merit attention to address Health Disparities in our community, which are:

- 1. The majority of UTHSCSA faculty is male. The majority of tenured faculty is also male. There has been no appreciable change in the number of female faculty at UTHSCSA from 1997-2001.**
- 2. The number of UTHSCSA faculty that are as designated as White far outnumber minority groups in respect to the total number of faculty, as well as in each category of academic rank. The number of minority faculty listed year to year has not appreciably changed over time, leading to the suggestion that it would be difficult to increase the number of minority Professors and Associate Professors if there is a relative shortage of faculty to promote. The rate of promotion of faculty has also not changed for minority groups or for female faculty over the last five years.**
- 3. The above observations did not vary for the different schools at UTHSCSA.**

Table 2 shows the accomplishment of an increase in total Hispanic Faculty from 1997 to 2003 and an increase in the number of Clinical Faculty as well as Tenured Associate Professors. This makes the Faculty Fellowship an even more important project for the future. With a relatively smaller pool of faculty at our institution at the Assistant Professor level, every effort will be needed to identify and recruit these faculty members into the Faculty Fellowship program—especially female faculty. The MHCOE is also in a unique position to give guidance to the Hispanic Centers of Excellence at our Dental and Nursing schools.

It is apparent that we must increase our pool of prospective faculty by various means. Another project that the MHCOE coordinates is the Medical Student Summer Research Program. This research program assists Hispanic freshman and sophomore medical students that are interested in medical research to identify a research mentor who is then provided with stipends for those students. Hispanic health research topics are identified through the Healthy People 2001 Health Disparities project and other Hispanic Health Initiatives. Aside from their research duties, the students participate in a Summer Research Program Seminar Series implemented by the MHCOE Associate Director and the Medical School Associate Dean for Research.

A major goal of this student research program is to encourage the Hispanic medical students to consider an academic career in Medicine. Some of these students will continue their research as senior medical students in a research selective. In order to be well prepared for an academic career, students interested in academic careers will be assisted by the MHCOE associate director during their junior and senior years in medical school, to develop their career plans and identify residency programs that will foster their research goals and promote fellowship training. The MHCOE associate director and research mentors will provide these students with letters of reference for their residency applications. The MHCOE plans to track these medical students to monitor their progress toward an academic career. The activities of the Medical Student Summer Research Program are designed to reinforce a student's interest in research, direct the student toward Hispanic health related research and provide guidance to the student regarding an academic and research career.

## **SUMMARY**

The UTHSCSA can serve as a model of success in creating an institutional environment that supports the increase in representation of Hispanics among its faculty. This has been accomplished by a multilevel approach via an established faculty development program and educating institutional administrators about its importance. The concentration of our future efforts will be to further decrease the disparity gap between the numbers of our minority—particularly Latina faculty—and white male faculty at all levels.

### **Example of a Faculty Individualized Career Plan**

Goals for a two-year fellowship with the Medical Hispanic Center of Excellence (MHCOE), in conjunction with the role as faculty in the UTHSCSA Regional Academic Health Center (RAHC) Pediatric Residency Training Program:

#### **I. Academic Development**

##### A. Track academic achievements.

1. Develop a system for documenting academic achievements (YR 1).
2. Prioritize areas of concentration in academic development in the areas of service, teaching, and research (YR 1).
3. Participate in HCOE tenure and promotion workshops (YR 2).
4. Revise curriculum vitae (YR 1).

##### B. Establish mentorship.

1. Identify one internal (within the UTHSCSA Department of Pediatrics) to assist with career path and details about negotiating Departmental resources.
2. Identify one external mentor who can provide guidance in the areas of professional interest, i.e. research.
3. Meet and/or communicate with each mentor at least quarterly.

#### **II. RAHC Pediatric Residency Training Program**

##### A. Develop subspecialty or general pediatrics rotation.

1. Conduct literature review (YR. 1).
2. Observe at least two other model programs (YR1).
3. In collaboration with the Pediatric RAHC Program Director, modify model(s) to meet needs of current environment (YR 1,2).
  - a. Develop curriculum/learning goals and objectives for inclusion in the program information form (PIF) for program accreditation (YR 1).
  - b. Establish schedule for training 3<sup>rd</sup> and 4<sup>th</sup> year medical student clerkships (YR 1).
  - c. Adapt current physical environment to accommodate needs for program (YR 2).  
With the assistance of VBMC practice management resources, develop the practice.

B. Advance clinical teaching skills.

1. Conduct literature review (YR 1).
2. Participate in clinical teaching skills training workshops offered through the UTHSCSA Office of Educational Resources (YR 1,2).
3. With support from HCOE, attend at least one regional or national conference on clinical teaching skills (YR 2).
4. Evaluate teaching skills during medical student clerkships (YR 2).

**III. Research**

A. Conduct and/or participate in clinical and educational research.

1. Explore research opportunities in collaboration with the UTHSCSA grants for faculty development and interdisciplinary curriculum development (YR 1).
2. Explore other research opportunities associated with the RAHC.

B. Plan research activities based on assessment of research opportunities.

**IV. Evaluation**

A. Participate in on-going evaluation of HCOE fellowship and RAHC activities.

1. Prepare quarterly reports detailing activities supporting the Pediatric Residency Training Program, academic development, and skill development (YR 1,2).
2. Review and act upon results of evaluations by supervisors, peers, and students (YR 1,2).

B. Develop long-range plans for continuous quality improvement (YR 2).