Statement on Minority Tax

Student National Medical Association

Health Policy and Legislative Affairs Committee

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By:

Schyler Edwards, Region 8 Political Advocacy Liaison

Trisha Chau, Region 1 Political Advocacy Liaison

Kimberly Adu-Gyamfi, HPLA Conference Planning Subcommittee Chairperson

Kayla Holston, MPH, HPLA Policy Statements Director

Justin Anderson, HPLA Committee Chairperson

Eloho E. Akpovi, HPLA Committee Chairperson

Omonivie Agboghidi, MPH, SNMA National President

INTRODUCTION

Founded in 1964 by medical students from Howard University College of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians.

As the population in the United States becomes increasingly racially and ethnically heterogeneous, the need for a more diverse healthcare workforce is evident. However, individuals who identify as Black, Indigenous, and People of Color (BIPOC) continue to be underrepresented in medicine relative to their proportion of the U.S. population.[1] Increasing the racial diversity of the healthcare workforce is essential to addressing disparities in the quality and accessibility of healthcare received by disenfranchised populations, and is a primary goal of the SNMA. In addition to providing culturally humble and socially conscious care, underrepresented minorities bear the burden of the "Minority Tax." Minority Tax describes the undue responsibilities placed upon students and faculty who are underrepresented in medicine (URiM) to increase diversity in medicine through participation in duties other than those that traditionally promote advancement in their careers.[2] These important and necessary duties include—but certainly are not limited to—mentorship of URiM trainees, hosting or speaking with URiM students on the interview trail, and sitting on diversity councils. The purpose of this statement is to demonstrate the SNMA's support for comparable compensation of URiM students and faculty by all academic and medical institutions for undue responsibilities described under the Minority Tax.

BACKGROUND

The BIPOC proportion in the United States has steadily increased since the beginning of the twenty-first century. In 2000, Black/African American, American Indian/Alaskan Natives, and Hispanics/Latinos made up 12.3%, 0.9%, and 12.5% of the United States population, respectively.[3] Last year, those racial categories all increased to 13.4%, 1.3%, and 18.5%,

respectively.[4] By 2060, Black/African Americans, American Indians/Alaskan Natives, and Hispanics/Latinos will increase steadily to 15.0%, 1.4%, and 27.5%, respectively.[5] Though BIPOC has made of at least a quarter of the population and will comprise half of the population by 2060, the BIPOC representation in the healthcare workforce, especially among physicians, has not reflected the proportion in the United States.

The percentage of BIPOC individuals in the physician workforce has largely remained unchanged in the last two decades and still has yet to accurately represent the diversity of our nation's racial/ethnic make-up. In 2006, only 6% of physicians identified as URiM.[6] In that same year, only 14% of medical graduates identified as URiM.[7] Various medical associations, including the National Medical Association (NMA), the American Medical Association (AMA), and the American Association of Medical Colleges (AAMC) have tried to increase the number of URiM students through diversity programs and minority faculty development programs, yet the percentage of URiM students has only increased from 7% to 8% in the last two decades.[8] The proportion of URiM physicians in 2019 is largely disproportionate to the U.S. minority populations, where 13.4%, 18.5%, and 1.3% of the population are Blacks, Latinos, and American Indians/Alaska Natives, respectively.

The disproportion of BIPOC individuals is not limited in the physician workforce, but also exists among medical university faculties. The 2010 United States Census shows that URMs made up anywhere between 2% and 35% of the faculty board with the average at 8.71%.[8] (At historically black colleges and universities, the average was 70%.) Breaking down the percentage based on ethnicity, African American, Native American, and Native Hawaiian represent an average of 3.8% of medical field faculty while Hispanic makes up 4.9% of the faculty. In 2015, the AAMC found there were more URiM in clinical departments compared to basic science departments, but there were less URiM who held high-rank faculty positions compared to the low-rank faculty positions. For example, in the clinical departments, only 9% of associate professors were URM while 5.5% of clinical department professors were URM. The proportion decreases even more in the basic science departments, where 6.5% of associate professors were URM but only 4% of professors were URM.

Overall, while there is an increase in URM among the faculties, White assistant professors and associate professors are being promoted at higher rates compared to non-White

assistant and associate professors. About 46% of White assistant professors were promoted compared to 37% of Asians or Pacific Islanders, 30% of URM, and 43% Hispanics who were promoted that same year. [9] Lastly, after controlling for tenure status, department, sex, and the medical schools, URiM faculty were also less likely to receive a National Institutes of Health research award compared to their White counterparts.[9] The tax is also imposed on URiM students, where they are asked to help recruit URiM students, thus they have less time to do research and to study compared to their White peers.[10] The disparity between all of this is due to URiM faculties spending more time than their White colleagues recruiting URiM students and faculty, caring for patients of low socioeconomic status, and advocating for dismantling of racism and increased resources for URiMs leaving them with less time to do scholarly work, such as research and publications.[11]

The URiM faculties not only face representation and promotional challenges but also personal health challenges associated with the disparities they encounter at work. Various qualitative studies found URiM faculty feel they have to constantly prove to others the value they bring to the workforce.[12–14] In addition, they are the ones who are responsible to recruit URiM students, as well as mentoring other URiM colleagues.[2] Even then, without a representative diverse workforce, the lack of URiM mentors can lead to poor retention and the feelings of being excluded and isolated.[15] Therefore, the psychological dissatisfactions, discriminations, and lack of URiM representations among medical faculties coupled with the Minority Tax that most URiM faculties are burdened with lead to disparity of URiM faculties across most medical schools.

In addition to the lack of proportional BIPOC representation, the United States Senate has cut 96 million dollars in fundings for various programs to help the BIPOC population interested in the healthcare field.[16] Nevertheless, the Council on Graduate Medical Education (COGME) has continued to push the federal government to financially support schools who can recruit and retain minority faculties.[27]

SCOPE OF THE PROBLEM

Diversity in the healthcare workforce is essential to improving healthcare quality, access, and outcomes for marginalized and BIPOC populations. Black/African American and

Hispanic/Latinx physicians, though underrepresented in the field, together with Asian physicians, actually provide most of the care received by underserved patient populations: 53.5% of racial and ethnic minority and 70.4% of non-English speaking patients.[12–14] This disparity in patients and communities served in clinical practice is one of many facets of the inequalities that exist between URiM faculty and their White counterparts, resulting in undue burdens with long term implications for patients and providers. While medical institutions strive to recruit and retain more URiM students and faculty, programmatic policies need to be put in place to address the impediment of career advancement and success due to the Minority Tax. This Minority Tax has many contributing factors, including the burden of racism and microaggressions, time spent on diversity efforts instead of traditionally career-promoting activities and feelings of isolation and invisibility. For this reason, the Minority Tax leads to a disparity of responsibilities between URiM individuals and their White counterparts resulting in decreased job satisfaction and obstacles during the progression of their careers.[2]

1. Racism in medicine has been documented in numerous studies as a major cause of job dissatisfaction for URiM faculty.[2] Study participants have described racial/ethnic bias that results in advantages or disadvantages in processes like recruitment and promotion.[17] URiM residents reported regular experiences of overt and covert racially motivated behaviors from individuals ranging from patients to attendings and program leadership. These behaviors included being mistaken for nonmedical hospital staff, persistent questions regarding one's ethnic origin and invasion of personal space.[18]
2. URiM faculty report feeling a sense of responsibility to their communities through clinical care and research focused on underserved populations, but these efforts have been undervalued and less rewarded by clinical and academic programs.[13] In addition to these responsibilities, URiM faculty experience pressure from their institutions to participate in diversity efforts. These efforts, such as serving on diversity councils and mentoring minority students in pipeline programs, are necessary, but further detract from the time URiM faculty members spend participating in scholarly work that is conventionally required for career advancement.
3. Feelings of isolation result from a combination of difficulty in cross cultural communication and forming relationships with nonminority faculty, lack of faculty diversity and lack of role models or mentors.[13] Feelings of belonging and support in an

institution are essential for career success and satisfaction, but URiM faculty members have few, if any, individuals in their department who look like them. This isolation further decreases the likelihood of URiM faculty collaborating together on scholarly projects, due to the limited number of URiM faculty.[2]

Pursuing a medical degree is an arduous process. Research studies estimate the percentage of students in their first four years of medical school exhibiting moderate levels of burnout to be 34%.[19] URiM students face additional stress and anxiety that their non-URiM peers do not face. URiM students describe the impact of racial microaggressions and bias as negatively impacting their learning, academic performance and wellbeing overall.[20] When researchers surveyed medical students to assess burnout, depression and quality of life, URiM medical students were more likely to report that their race/ethnicity had negatively impacted their education due to racial prejudice, discrimination and feelings of isolation.[21] This attests to the reality that the Minority Tax is not solely an issue for URiM faculty at medical institutions. URiM medical students are also faced with the additional responsibility of helping future trainees with similar backgrounds through pipeline programs through recruitment and hosting URiM applicants in the homes and working on URiM advocacy within their schools. Anecdotal evidence supports the assertion that URiM trainees advocate for diversity in their respective programs, work against health disparities, oversee pipeline programs and serve as mentors and recruiters for future URiM trainees.[22] More scholarly research is needed on the impact this Minority Tax has on URiM student's academic success, mental health and quality of life, as will be discussed further in the next section.

In addition to the mental and emotional toll of the Minority Tax, URiM students face the financial burden of championing diversity efforts at their medical institutions, including cost of coffee meetings, travel to URiM recruitment conferences, travel to local URiM mixers for upperclassmen to help underclass URiMs feel welcome, and more. Attendance at a medical school is an expensive investment in one's future as medical students graduate with a median debt of $180,000 and over 40% of them have borrowed $200,000 or more in student loans.[23] Affordability can be a major determining factor in choosing a medical institution, especially for URiM students, and previous debts from other educational endeavors must be accounted for. According to the AMA Journal of Ethics, in 2011, 60.5 percent of African Americans, 45.7 percent of Hispanics, and 42.1 percent of American Indians or Alaska Natives in the entering

medical class already had debt.[23] While members of marginalized groups disproportionally affected by the wealth gap, the additional financial costs associated with participation in diversity efforts increases the burden on URiM students.[24]

The aforementioned factors contributing to the Minority Tax can ultimately lead to physician and student burnout, a triad of emotional exhaustion, depersonalization and lowered sense of personal achievement, which has been linked to an increased risk to patient safety as well as poorer quality of care and decreased satisfaction with care.[25] In a 2008 study of over 7,000 members of the American College of Surgeons, major medical errors reported by surgeons were identified as strongly related to burnout and mental health.[26] This further exacerbates the current state of health disparities experienced by minority populations in underserved areas. As such, medical institutions will need to implement broad policies to foster an environment that is welcoming to and supportive of URiM students and faculty if their goal is to increase recruitment and retention. Such an environment would not only mitigate the detrimental effects the Minority Tax has on the mental well-being of physicians and trainees, but also act as an important patient safety intervention.

STATEMENT OF POSITION AND RECOMMENDATIONS

The SNMA strongly supports comparable compensation of URiM students and faculty by all academic and medical institutions for undue responsibilities described under the Minority Tax. URiM students and faculty must be compensated for their work to increase diversity in medicine. Furthermore, medical school administrations should collectively value and take responsibility for URiM recruitment and advocacy to prevent the onus from falling solely on URiM students and faculty. In other words, URiM recruitment and advocacy should become entrenched in the culture, values, and endeavors of the higher administration of these institutions so that there is collective responsibility. The SNMA recommends the following:

1. URiM students and faculty should be compensated through an hourly wage for the time spent towards URiM recruitment initiatives, given per diem for food during meals with prospective students/faculty during interview days and admission recruitment initiatives, and reimbursed for travel and lodging expenses for activities geared towards URiM

recruitment and advocacy (e.g., SNMA Regional and Annual Medical Education Conferences).

2. In order to create a diverse physician workforce, URiM students must have the best possible environment to succeed. We propose that the AAMC conduct research on the negative impact of the Minority Tax and recruitment strategies on URiM students by investigating the impact that it has on the student's class performance, United States Medical Licensing Examination scores, mental health, quality of life, levels of burnout and stress, and the amount of time these students are able to dedicate to required scholarly work and conducting research (e.g., publications, non-URiM recruitment related leadership titles).
3. We also propose the AAMC create resources and guidelines that describe how to lessen the burden of the Minority Tax for institutions and students that describe what forms of participation can be compensated, such as assistance with URiM recruitment, increasing resources for URiM students, and advocacy for dismantling racism through service on advisory councils and meetings with school administration and how the participation of URiM is compensated through the creation of scholarships, wages, and stipends.
4. Lastly, the AMA should adopt a policy that protects URiM students from unfair recruitment practices such as asking URiM students to dedicate a disproportionate amount of time to medical school admission initiatives compared to their non-URiM counterparts and placing the burden of URiM recruitment on URiM student volunteers. The ideal policy implemented by the AMA would ensure proper compensation for URiM students' and faculty's advocacy and recruitment efforts through wages, stipends, and scholarships.

REFERENCES

1. Merchant JL, Omary MB. Underrepresentation of Underrepresented Minorities in Academic Medicine: The Need to Enhance the Pipeline and the Pipe. *Gastroenterology*. 2010;138(1):19-26.e3. doi:10.1053/j.gastro.2009.11.017
2. Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? *BMC Med Educ*. 2015;15(1):6. doi:10.1186/s12909-015-0290-9
3. US Census Bureau. Overview of Race and Hispanic Origin: 2000. Published 2000. Accessed July 1, 2020. https://www.census.gov/prod/2001pubs/cenbr01-1.pdf
4. U.S. Census Bureau QuickFacts: United States. US Census Bureau. Published 2020. Accessed August 15, 2020. https://www.census.gov/quickfacts/fact/table/US/IPE120218
5. Vespa J, Medina L, Armstrong DM. Population Estimates and Projections. *US Census Bur*. Published online 2018:15.
6. Thomson WA, Ferry PG, King JE, Martinez-Wedig C, Michael LH. Increasing access to medical education for students from medically underserved communities: one program's success. *Acad Med J Assoc Am Med Coll*. 2003;78(5):454-459. doi:10.1097/00001888-200305000-00006
7. Blakely AW, Broussard LG. Blueprint for establishing an effective Postbaccalaureate medical school pre-entry program for educationally disadvantaged students. *Acad Med J Assoc Am Med Coll*. 2003;78(5):437-447. doi:10.1097/00001888-200305000-00004
8. Guevara JP, Adanga E, Avakame E, Carthon MB. Minority Faculty Development Programs and Underrepresented Minority Faculty Representation at US Medical Schools. *JAMA*. 2013;310(21):2297-2304. doi:10.1001/jama.2013.282116
9. Fang D, Moy E, Colburn L, Hurley J. Racial and ethnic disparities in faculty promotion in academic medicine. *JAMA*. 2000;284(9):1085-1092. doi:10.1001/jama.284.9.1085
10. Rumala BB, Cason FD. Recruitment of underrepresented minority students to medical school: minority medical student organizations, an untapped resource. *J Natl Med Assoc*. 2007;99(9):1000-1009.
11. Richert A, Campbell K, Rodríguez J, Borowsky IW, Parikh R, Colwell A. ACU workforce column: expanding and supporting the health care workforce. *J Health Care Poor Underserved*. 2013;24(4):1423-1431. doi:10.1353/hpu.2013.0162
12. Carr PL, Palepu A, Szalacha L, Caswell C, Inui T. "Flying below the radar": a qualitative study of minority experience and management of discrimination in academic medicine. *Med Educ*. 2007;41(6):601-609. doi:10.1111/j.1365-2923.2007.02771.x
13. Pololi L, Cooper L, Carr P. Race, Disadvantage and Faculty Experiences in Academic Medicine. *J Gen Intern Med*. 2010;25:1363-1369. doi:10.1007/s11606-010-1478-7
14. Pololi LH, Evans AT, Gibbs BK, Krupat E, Brennan RT, Civian JT. The experience of minority faculty who are underrepresented in medicine, at 26 representative U.S. medical schools. *Acad Med J Assoc Am Med Coll*. 2013;88(9):1308-1314. doi:10.1097/ACM.0b013e31829eefff
15. Elliott BA, Dorscher J, Kosobuski AW, Hill DL. Staying connected: Native American women faculty members on experiencing success. *Acad Med*. 2010;85(4):675-679. doi:10.1097/ACM.0b013e3181d28101
16. Crittenden F. Congress slashes funding for diversifying medicine. Yale Daily News. Published November 15, 2019. Accessed August 15, 2020. https://yaledailynews.com/blog/2019/11/15/159092/
17. Price EG, Gozu A, Kern DE, et al. The role of cultural diversity climate in recruitment, promotion, and retention of faculty in academic medicine. *J Gen Intern Med*. 2005;20(7):565-571. doi:10.1111/j.1525-1497.2005.0127.x

18. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. *JAMA Netw Open*. 2018;1(5):e182723-e182723. doi:10.1001/jamanetworkopen.2018.2723
19. Boni RADS, Paiva CE, de Oliveira MA, Lucchetti G, Fregnani JHTG, Paiva BSR. Burnout among medical students during the first years of undergraduate school: Prevalence and associated factors. *PloS One*. 2018;13(3):e0191746. doi:10.1371/journal.pone.0191746
20. Ackerman-Barger K, Boatright D, Gonzalez-Colaso R, Orozco R, Latimore D. Seeking Inclusion Excellence: Understanding Racial Microaggressions as Experienced by Underrepresented Medical and Nursing Students. *Acad Med J Assoc Am Med Coll*. 2020;95(5):758-763. doi:10.1097/ACM.0000000000003077
21. Dyrbye LN, Thomas MR, Eacker A, et al. Race, ethnicity, and medical student well-being in the United States. *Arch Intern Med*. 2007;167(19):2103-2109. doi:10.1001/archinte.167.19.2103
22. Johnson T. The Minority Tax: An Unseen Plight of Diversity in Medical Education. in-Training. Published December 12, 2017. Accessed August 15, 2020. https://in-training.org/minority-tax-unseen-plight-diversity-medical-education-intern-piece-features-15570
23. The Culture of Medicine. *AMA J Ethics*. 2015;17(2):105-189.
24. Oliver M, Shapiro T. Disrupting the Racial Wealth Gap. American Sociological Association. Published March 8, 2019. Accessed August 15, 2020. https://www.asanet.org/news-events/asa-news/disrupting-racial-wealth-gap
25. Silver JK, Bean AC, Slocum C, et al. Physician Workforce Disparities and Patient Care: A Narrative Review. *Health Equity*. 2019;3(1):360-377. doi:10.1089/heq.2019.0040
26. Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251(6):995-1000. doi:10.1097/SLA.0b013e3181bfdab3
27. Council on Graduate Medical Education. 2002 Summary Report. Health Resources and Services Administration.