COMMENTARY

Addressing the gate blocking of minority faculty

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Abstract: There have been ongoing efforts to increase the presence of underrepresented minorities in medicine (URMM), including faculty development initiatives, mentoring programs and outreach efforts. However, URMM faculty face unique challenges that are crucial for academic institutions and leaders to recognize in order to improve retention of this group and allow for meaningful advancement in the field. This paper introduces the concept of gate blocking, defined as what happens to minority faculty as a result of the consequences of the minority tax and systems designed to advantage some and disadvantage others. In addition to defining gate blocking, the authors make recommendations to address this concern in academic medicine and promote the advancement and retention of URMM faculty.

Keywords: URM ■ URMM ■ Faculty ■ Physician ■ Gate blocking

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There have been ongoing efforts to increase the presence of faculty who are underrepresented minorities in medicine (URMM).[1,2] Groups who are URMM include African-American or Black, Latinx or Native American people. The low numbers of URMM faculty create missed opportunities in innovation, clinical care and education, which negatively impacts the work of academic health centers. Efforts to increase URMM representation have included institution-focused faculty development programs and initiatives that promote mentoring and relationship building.[3,4]

As the literature grows in describing ways to support this group, we are better understanding the specific challenges URMM faculty face, while medical school and other institutional leaders are slowly being equipped with tools to address the disparity.[5,6] Increasing the recognition of disparities allows for these challenges to be addressed along the URMM faculty member's path to promotion and tenure. The minority tax is a unifying concept referring to disparities that impact the recruitment and retention of URMM faculty in academic medicine: including diversity efforts, racism, isolation, mentorship disparities, clinical responsibility disparities, and promotion disparities.[7] Unequal expectations for clinical care and diversity efforts, matched with lower rates of promotion despite meaningful contributions, are components of the minority tax that plague the URMM faculty member.[7,8] Recognizing the interplay of the minority tax with other factors such as imposter syndrome,[5,9,10] distance traveled,[5] power distance[5,11,12] and the gratitude tax,[8] is critical to promote the success of URMM faculty in academic medicine and beyond.[5]

Terminology to better define and characterize challenges disproportionately impacting URMM faculty is essential to building a shared understanding and implementation of solutions. This perspectives article builds on the existing literature addressing factors that impact the recruitment, retention and promotion of URMM faculty. Based on the senior author's (KMC) history of experiences in working with URMM faculty and learners over more than 15 years, this paper seeks to name, characterize and present suggestions to address what is being defined as gate blocking: the consequences that result from the unique trials and barriers URMM faculty face.

Conceptually, gate blocking occurs at career stages when faculty are poised to transition from early to mid-career or mid-career to senior positions. At these times, URMM faculty may find that their progress is blocked by a combination of persistent obstacles encountered since beginning their training (e.g., *distance traveled*, referring to a longer and more difficult path to achieving the initial faculty appointment;[5] and *imposter syndrome*), as well as new obstacles encountered upon entering the faculty role (e.g., *pseudo-leadership*; *reverse imposter syndrome*). A list of these obstacles and suggested institutional actions to address them are presented in Table 1.

Gate blocking can be defined as institutional actions, or institutional negligence, that restrict URMM faculty from achieving tenure and promotion and gaining leadership opportunities. Gate blocking is a manifestation of institutional racism,[13] including both actions and inactions that ultimately hinder the progress of URMM faculty. The

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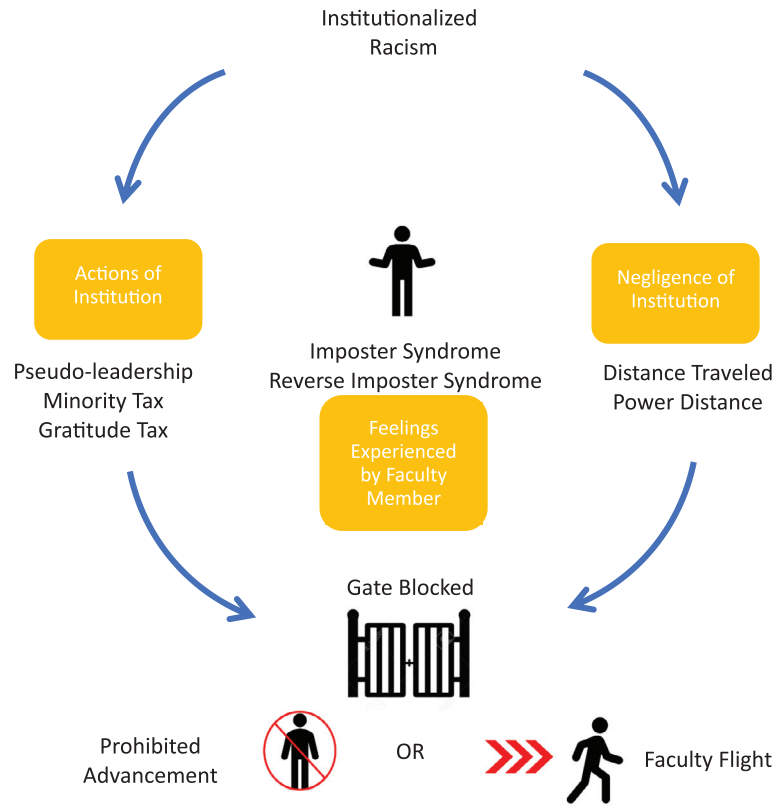
Table 1. Institutional recommendations for dismantling gate blocking URMM faculty.

Factors contributing to gate blocking for URMM faculty	Recommendation for institutional action	Potential outcome
Minority tax[7]	Provide funding and staff support for offices of diversity and inclusion, URMM faculty and URMM leaders. Require senior institutional leaders, faculty and staff to join the effort in addressing these concerns at all levels of the institution.	Improved representation, institutional climate and promotion rates for URMM faculty
Gratitude tax[8]	Appreciate the talents and abilities of URMM faculty and provide interinstitutional mentorship opportunities that will promote their growth and advancement at their home institution and if needed, facilitate their departure if other institutions provide opportunities for advancement and greater academic success as a faculty member or leader.	URMM faculty will appreciate and value their worth and be willing to move to a new institution if needed for promotion or advancement of their career.
Imposter syndrome[5]	Provide faculty development and mentorship opportunities to encourage and reassure URMM faculty of their abilities and their belonging.	URMM faculty will be more confident in their abilities leading to greater contributions to clinical care, teaching and research in the institution.
Reverse imposter syndrome	Seek qualified URMM faculty and leaders for positions in the institution and do not hire diversity for diversity sake without plans for inclusion and development. Be true to URMM faculty, provide faculty development and mentorship early on in their careers to facilitate their advancement and progression in academic medicine.	URMM faculty will be able to give themselves a fair and honest appraisal of their ability for opportunities in the institution.
Pseudo leadership	Eliminate racism and privilege systems in the institution by mandating antiracism trainings, senior level accountability, evaluation and compensation actions for nonadherence and working with human resources to release from employment all who do not comply.	Institutions will ensure that URMM have the training and resources to be successful in their role.
Power distance[5]	Create psychological safe space for URMM faculty to promote their contributions to the field. Create opportunities for URMM faculty to disagree with senior leadership by engaging them in decision making and seeking their opinions. Actively prevent fear and retaliation by making discussions open and welcoming for all.	Institution leadership will involve URMM faculty in meetings and conversation and promote the input of this group in decision making.
Distance travelled[5]	Appropriate resources like funding for faculty development, mentorship and leadership development for URMM faculty as advancement in the field may take more resources and time to account for the distance travelled. Familiarize academic health system leadership with the literature concerning the taxes and how they impact distance travelled.	URMM faculty will become more prominent in leadership roles in the institution

result of the blocked gate is either a blocking of advancement of the URMM faculty member or faculty flight, where the faculty member leaves academic medicine, as depicted in Fig. 1. Therefore, gate blocking can either be an action directly impacting the URMM faculty member, or the result of intentional or unintentional negligence of an act or need that should have been recognized or carried out on behalf of the URMM faculty member. The latter occurs because health system leadership may not recognize the unique challenges URMM faculty face in academic

Fig. 1. Gate blocking of URMM faculty advancement.



medicine,[7] making it impossible to address them, thereby blocking the gate.

Imposter syndrome has been well documented in the literature. It can be described as feelings of inadequacy that faculty may have in their current work environment, when they feel like they do not deserve their job title although they are indeed capable and properly trained.[5,9,10] However, the persistent doubt in their ability, often because of institutional racism and suppression, may create anxiety, feelings of isolation and inadequacy, causing them to miss out on opportunities for advancement. Imposter syndrome can manifest as the gratitude tax[8] for the URMM faculty member, causing them to forego opportunities for advancement due to a fierce loyalty to the institution and gratitude for just having a job. Fatigue from imposter syndrome may cause the URMM faculty member to leave academia altogether (faculty flight), as institutional racism and privilege systems compound feelings of not belonging.[7,14] Imposter syndrome is an illustration of gate blocking for URMM faculty, as this feeling experienced by URMM faculty hinders the retention and progress of this group.

Compounding experiences of imposter syndrome, power distance refers to hierarchical relationships in which a URMM faculty member with lower perceived power due to a lower academic rank defers to White faculty members with higher perceived power due to a higher academic rank.[5] As an example, a URMM faculty member might always defer to the opinion of a department chair or dean because of their more senior position in the organization and not because of agreement. Power distances can cause fear and intimidation for the URMM faculty member.

In addition to imposter syndrome and power distance, pseudo-leadership, being the opposite of inclusive leadership, is a factor that contributes to gate blocking. Inclusive leadership is leadership that seeks to engage all strata across an organization.[15] Such leadership models create a psychological safe space, promote diversity and seek differing opinions.[16,17] The literature has increasingly shown the value in diverse leadership, including in academic medicine. URMM faculty are at times sequestered from meaningful leadership development,[3,18] yet the institution recognizes the need to diversify, and therefore may give them a position they have not been trained for or supported to properly execute.

Diversity hires, as such, may lead to URMM faculty manipulation by the institution due to the URMM faculty member having limited knowledge and preparation for the work role. This leads to pseudo-leadership, or unqualified URMM leadership, meaning the faculty member is placed

in a role for the sake of increasing institutional diversity, without commensurably increasing tangible mechanisms for inclusion or ability to make truly impactful decisions. Unqualified leadership is based on phenotype, gender or class, and may operate as a means to control through inexperience, inadequate training, lack of preparation, and lack of support.[19,20] The institution can unknowingly play on this ignorance and coerce the URMM leader to act against his or her own professional interest, blocking the gate to true advancement. Furthermore, URMM faculty leaders who have experienced institutionally driven pseudo-leadership rarely have had the ability to adequately mentor URMM junior faculty, reinforcing the gate blocking of this already underrepresented group.[6,7,21]

Creating pseudo leaders is what the institution does *to* the URMM faculty member, while reverse imposter syndrome is the *feeling* the URMM faculty member experiences once placed in a pseudo leader position. Reverse imposter syndrome is another factor contributing to gate blocking. In reverse imposter syndrome, the minority tax underlies the faculty member's lack of qualification, as they have often not had meaningful faculty development or mentorship, and have served in positions with large clinical or community assignments, leaving little time for scholarship or professional growth.[7] As with pseudo leadership, reverse imposter syndrome blocks the gate for actual advancement for the URMM early career faculty member who is seeking to advance in the field.

Before recommendations are provided to address the gate blocking of minority faculty, it is important to contextualize the factors involved and describe their relationships to each other. Reverse imposter syndrome is related to pseudo-leadership in that URMM faculty are stretched beyond their ability when the institution makes them a pseudo-leader. Power distance is related to imposter syndrome in that URMM faculty can feel like imposters because of the institutional hierarchy of leadership at the medical school. Distance travelled and the gratitude tax are related in that URMM faculty are just glad to have a job because it was such a long road to arrive at their career. All factors of gate blocking trace back to institutional obstacles for URMM faculty physicians rather than any individual faculty physician's perception (Fig. 1).

Recommendations to address the gate blocking of URMM faculty start with senior leadership training on the existence of the gate,[22] and the impact of gate blocking on URMM faculty retention and advancement. This first step has added significance due to limited racial and ethnic diversity in academic medicine leadership.[23] Ways to promote recognizing the gate include reviewing the published literature on URMM faculty and their challenges in academic medicine, training on how to identify and eradicate institutional racism in the academic environment, and creating accountability standards for senior leaders that are tied to evaluations and compensation. Other suggestions on how to address gate blocking URMM faculty are outlined in Table 1.

In this perspectives manuscript, we have introduced the gate blocking concept as it relates to URMM faculty in academic medicine. The impact of gate blocking URMM faculty growth directly impacts the recruitment, retention and meaningful advancement of a necessary diverse body of talent within our field. As academic medicine continues to look for ways to facilitate the success of this group, recognizing and addressing gate blocking must be a priority for all institutional leaders across academic medicine settings.

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