Facilitating Identity Compatibility in Mentorships: Implications for Diversity in Medicine

Journal of Medical Education and Curricular Development
Volume 8: 1–2
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DOI: 10.1177/23821205211006412

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ABSTRACT: Despite intentional efforts to improve diversity in medicine, there is pronounced underrepresentation of minority groups and non-disclosure of minority identities by medical students due to societal stigmas and fears of acceptance. One way that medical schools address this challenge in supporting diverse student backgrounds is by facilitating faculty mentorship programs with underrepresented minority (URM) students. These efforts are valuable, but they are unfortunately not available at all institutions and do not always allow URM students to engage in the process of choosing a mentor confidentially. Medical schools largely do not make self-reported information from faculty about their various identities and allyships available to medical students, which limits the resources that students have to independently forge these connections. Helping students form their own mentor-mentee relationships by making faculty demographics available can lead students to find individualized support across their medical training. Identity compatibility between students and their role models has shown to correlate with academic achievement and senses of belonging. Enforcing that all medical schools share the identities of faculty who choose to disclose this information with students will thus be helpful to further diversity as a continuous commitment in medical education.

KEYWORDS: medical education, diversity, minority, inclusion

RECEIVED: February 21, 2021. **ACCEPTED:** March 2, 2021.

TYPE: Perspective

FUNDING: The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The author received financial support from the Northwestern Open Access fund for publication of this article.

DECLARATION OF CONFLICTING INTERESTS: The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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In the medical profession, we iteratively reflect on the value of a diverse network of providers and the ways that embracing the diversity in provider identities enriches our practice of medicine, provision of care, and collaborative growth. The main source of growth of diversity in this community comes from intentional selection and support of a diverse pool of medical students. Despite this intentionality, the pipeline of diversity in medical school cohorts shows to be fairly stagnant in the US by several metrics.

A JAMA study showed that from 2002 to 2017, the number of Black, Hispanic, American Indian, and Alaskan Native students who graduated medical school increased but this increase was slower than their White and Asian counterparts.[1] A study in 2016 found that only 2.7% of medical students in allopathic American medical schools reported disabilities, and a follow-up study in 2019 found that the percentage was around 4.7%.[2,3] This percentage significantly differs from the percentage of Americans with disabilities, which the Center for Disease Control (CDC) reports is about 25%.[4]

In addition to racial disparities in recruitment, the discomfort of accepted medical students in disclosing their underrepresented identities is pronounced. The percentages reported by institutions in the 2016 study ranged from 0% to 12%, with anecdotal evidence that the degree of disclosure was dependent on the openness of the program regarding disabilities in trainees. In a 2015 study, it was found that 40% of non-heterosexual medical students were afraid of discrimination and about 30% of sexual minority students did not disclose their sexual orientation during the admissions process or medical school due to fear of a lack of support.[5]

As the US continues to grow into a "majority-minority" nation, the low representation of minority groups in medical school is concerning because of the established value in having providers who match their patients' identities for both building longitudinal relationships and improving patients' health outcomes.[6,7] A provider who is an active wheelchair user would unequivocally better empathize with the clinical concerns of their patients who use wheelchairs than a provider who never operated a wheelchair, for example.

The lack of comfort that accepted students with minority identities feel among their peers and medical school community is also concerning as it can exacerbate their longitudinal battles with imposter syndrome as well as their long-term retention in academic medicine.[8,9]

One area which may contribute to our limitations in supporting diverse cohorts is the accessibility of faculty identities and experiences to students. Current medical school diversity efforts often rely on the existing diversity in faculty—utilization of this resource consists of role models with underrepresented backgrounds connecting with students with similar backgrounds and developing longitudinal mentor-mentee relationships with them.[10] These programs, such as the Diversity Mentorship Program at Oregon Health and Science University Medical School, greatly minimize the barriers that students face in reaching out.

But such formal programs do not exist at every institution and they also may require students to disclose their identities to more audiences than they are comfortable with to benefit from the matching process. Students of underrepresented identities

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in medicine may instead wish to privately seek out mentors who share specific identities at their own pace. But the availability of voluntarily-reported faculty identities is limited: A preliminary web search corroborates that the self-reported sexual orientation, gender pronouns, ability status, and race of medical faculty as well as allyship of these identities is largely unavailable on institutional websites. “Out Lists” and lesbian, gay, bisexual, transgender, and queer (LGBTQ) allyship lists of faculty in particular have gained traction by medical schools, but their prevalence remains low.[11] The scarcity of this resource may be rationalized by the aforementioned focus and resource allocation toward faculty-driven programming.

Making faculty identities easily available to medical students will facilitate their process of finding specific mentors who can most positively affect their experiences, support, and training in medicine. Several studies have analyzed the psychosocial effects of identity-matched role models on groups that are also underrepresented in medicine. One study identified that African-American role models were helpful in coaching at-risk African-American youth with identity development.[12] Another analyzed the value of LGBTQ role models in helping non-heterosexual individuals feel more comfortable to come out.[13] A third study showed that having non-white and non-male role models in science, technology, engineering, and mathematics (STEM) allowed non-white and non-male STEM students to find a greater sense of belonging.[14]

Identity compatibility between individuals and their role models has also shown to be a determinant of academic performance and interests. A study of young students, both white and of color, showed that those with at least one role model who matched their race and gender scored better than those without an identity-matched role model.[15] In medicine, a correlation has been identified between interest in medicine for undergraduate women and exposure to successful female physician role models.[16]

We can maximize the support that existing role models in medicine can provide to diverse future generations of physicians by requiring all Liaison Committee on Medical Education (LCME)-accredited medical schools to query faculty on their preferences for sharing identities with trainees and share the permitted data. Much of this data is already available for practicing providers in institutional databases, so the communication of this data to students should not significantly burden medical education teams.

A possible challenge in this initiative is protecting the confidentiality of faculty identities for those who do not want it to be on a public website. This can be mitigated by requiring institutional login credentials to access the information and publishing privacy guidelines.

Academic medical institutions should continue to strengthen their commitment to diversity in a sustainable way with greater transparency in sharing the intersectional identities of their faculty who elect to disclose this information.

Author Contribution

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