Letters to the Editor

Ways to Guarantee Minority Faculty Will Quit Academic Medicine

To the Editor: In the recent article "Hiring wisdom: Top 10 ways to guarantee your best people will quit," Kleiman[1] discusses major factors leading to employee attrition in business. As we reflected on the academic medical jobs we have had, as well as our research on underrepresented minorities in academic medicine, a striking similarity became apparent: Academic medicine is a business, and faculty members are employees.

Further similarities emerged as we examined some of the top 10 ways to guarantee people will quit:

- "Treat everyone equally" (#10). Employers should instead "strive for treating people fairly."[1] Minority faculty have cited "unfair treatment" as a major reason for leaving.[2]
- "Have dumb rules" (#8). Employees do not want rules that "conflict with the values the company says are important."[1] Minority faculty have observed that stated diversity goals are in direct conflict with some institutional practices.[3]
- "Don't have any fun at work" (#6). Employers should "find ways to make the work environment more relaxed."[1] The climate at some academic medicine institutions has been described as hostile, or even racist.[3] It is also clear that the diversity climate affects longevity of minority faculty.[4]
- "Don't keep your people informed" (#5). Employers need to communicate "not only the good, but the bad and the ugly."[1] In one example of poor communication, minority faculty, and faculty in general, have found the promotions process to be biased, with nonminority faculty promoted more often.[5]
- "Don't develop an employee retention strategy" (#3). Employers should "write down what [they] are doing or will do to ensure [employees stay] engaged."[1] Minority faculty development programs, though still relatively rare, have improved retention rates in this group[6] and could be an effective retention strategy.

Academic medicine engages in 60% of Kleiman's top 10 ways to guarantee the best people will quit. Perhaps it is time for us to learn from our colleagues in human resources and make small changes to reverse the high attrition of minority faculty in our field.

José E. Rodríguez, MD
Associate professor and codirector, Center for Underrepresented Minorities in Academic Medicine, Florida State University College of Medicine, Tallahassee, Florida; jose.rodriguez@med.fsu.edu.

Kendall M. Campbell, MD
Associate professor and codirector, Center for Underrepresented Minorities in Academic Medicine, Florida State University College of Medicine, Tallahassee, Florida.

References

1 Kleiman M. Hiring wisdom: Top 10 ways to guarantee your best people will quit. TLNT. April 8, 2013. http://www.tlnt.com/2013/04/08/hiring-wisdom-top-10-ways-to-guarantee-your-best-people-will-quit/. Accessed July 17, 2013.
2 Cropsey KL, Masho SW, Shiang R, Sikka V, Kornstein SG, Hampton CL; Committee on the Status of Women and Minorities, Virginia Commonwealth University School of Medicine, Medical College of Virginia Campus. Why do faculty leave? Reasons for attrition of women and minority faculty from a medical school: Four-year results. J Womens Health (Larchmt). 2008;17:1111–1118.
3 Pololi L, Cooper LA, Carr P. Race, disadvantage and faculty experiences in academic medicine. J Gen Intern Med. 2010;25:1363–1369.
4 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;20:565–571.
5 Nunez-Smith M, Ciarleglio MM, Sandoval-Schaefer T, et al. Institutional variation in the promotion of racial/ethnic minority faculty at US medical schools. Am J Public Health. 2012;102:852–858.
6 Daley S, Wingard DL, Reznik V. Improving the retention of underrepresented minority faculty in academic medicine. J Natl Med Assoc. 2006;98:1435–1440.

In Reply to Rodríguez and Campbell: Drs. Rodríguez and Campbell should be applauded for their application of scholarship from organizational development to the disadvantages experienced by underrepresented in medicine minority (URMM) faculty in academic medicine. In addition to examining why URMM faculty might leave academic medicine—and to achieve the goal of increasing URMM faculty—I believe we should focus on creating inclusive environments that support the humanity and vitality of all faculty.

Examining faculty attrition is important; in recent C - Change (http://cchange.brandeis.edu) National Faculty Survey studies, over 40% of a nationally representative sample of medical school faculty (including 512 URMM faculty) seriously considered leaving their institutions in the prior year due to dissatisfaction, and over a quarter had seriously considered leaving academic medicine entirely. Data showed no difference between URMM and non-URMM faculty. Certain dimensions of the culture were associated with these disturbing findings.[1] First, lack of relationships, a low sense of belonging and trust, and non-alignment of personal and institutional values predicted leaving one's institution. Additionally, higher levels of ethical moral distress and a sense of being adversely changed by working in medical schools was linked to abandoning academic medicine entirely.[1] Second, when compared with their non-minority counterparts, URMM faculty reported higher leadership aspirations, but lower relational connection and trust, and lower alignment between personal and institutional values.[2]

These trends need to be addressed, but instead of focusing on quitting, let's concentrate on creating environments that empower all faculty to contribute to their fullest ability. The following constructive suggestions[3] can help us move beyond knowing why people leave to make sure that they stay:

1. Facilitate and support relationship formation among faculty, administrators, and learners.
2. Develop opportunities for explicit conversations about personal values to amplify the meaning faculty find in the practice of medicine and in their careers.
3. Encourage positive curiosity when encountering "otherness" and

recognize differences in faculty as benefitting our institutions.

Such practices, embraced and encouraged by leaders, faculty, and trainees, could help create a culture in academic medicine that would be more inclusive, relational, and collaborative; enhance faculty engagement and productivity regardless of race, ethnicity, or gender; and secure the relational trust of URMM faculty. Thus, we might achieve the goal of a more diverse and values-based leadership of academic medicine.

Linda Pololi, MBBS

Senior scientist, Brandeis University, and director, C - Change: National Initiative on Gender, Culture and Leadership in Medicine, Waltham, Massachusetts; lpololi@brandeis.edu.

References

1 Pololi, LH, Krupat E, Civian JT, Ash AS, Brennan RT. Why are a quarter of faculty considering leaving academic medicine? A study of their perceptions of institutional culture and intention to leave in 26 representative medical schools. Academic Medicine. 2012;87:859–869.
2 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. Academic Medicine. 2013;88:1308–1314.
3 Pololi LH. Changing the Culture of Academic Medicine. Lebanon, NH: Dartmouth College Press; 2010.

In Support of Medical Student Research

To the Editor: In recent years, it has become increasingly important for medical students to gain familiarity and facility with research methods due to growing emphasis on evidence-based medicine. As a result, more medical students are choosing to pursue research projects through an independent scholarly year. Despite this trend, two of the largest national programs that supported medical student research were discontinued this year—the Doris Duke Charitable Foundation's Clinical Research Fellowship and the Howard Hughes Medical Institute's Research Scholars Program. Having participated in the Doris Duke program, we want to briefly reflect on the value of medical student research and call for future support of this cause.

Nothing prepares a young physician to tackle a career in academics more than independent research. A scholarly year provides students protected time to focus on a subject of interest and work under the mentorship of a senior investigator. These experiences provide insight into the practice of academic medicine, intensive training in research methods, and refinement of core skills needed to effectively communicate and present scientific findings.[1] Students' accomplishments often make them competitive candidates for research-based residencies and prepare them to incorporate research into their future practices. Perhaps most important, a research year can cultivate a passion for being at the forefront of discovery through generating meaningful questions based on clinical experiences, confirming (and rejecting) hypotheses, and sharing findings with peers.

Medical schools have addressed students' desires to participate in research through various mechanisms. In the Mount Sinai Class of 2012, 23% of medical students not pursuing a PhD participated in an additional scholarly year. Students received funding from national programs or institutional support to pursue research in medical oncology, cardiology, epidemiology, and other specialties. Other schools mandate participation in research as part of the medical school curriculum.[2] For example, Duke University requires that all medical students spend their third year immersed in a mentored research experience. Stanford University takes a different approach, requiring a longitudinal research experience that spans the four years of medical school as an adjunct to didactic sessions on research methods. These schools recognize that many students will ultimately pursue primarily clinical careers, but believe that the skills students acquire in statistics, evidence-based medicine, and the scientific basis for clinical decision making merit the continued investment in medical student research.

Going forward, it is the responsibility of mentors, schools, government, and private organizations to commit to the next generation of physician investigators. We urge the community to facilitate independent scholarly research years for qualified students, and we encourage our peers to seek out research opportunities with enthusiasm and courage. These experiences can be the highlights of medical education. They were for us.

Alexander C. Small, MD

Urology resident, Columbia University Medical Center, New York, New York, and 2012 alumnus, Doris Duke Clinical Research Fellowship Program; as3913@columbia.edu.

Lauren L. Levy, MD

Intern, Memorial Sloan Kettering Cancer Center, New York, New York, and 2012 alumna, Doris Duke Clinical Research Fellowship Program.

References

1 Parsonnet J, Gruppuso PA, Kanter SL, Boninger M. Required vs. elective research and in-depth scholarship programs in the medical student curriculum. Acad Med. 2010;85:405–408.
2 Laskowitz DT, Drucker RP, Parsonnet J, Cross PC, Gesundheit N. Engaging students in dedicated research and scholarship during medical school: The long-term experiences at Duke and Stanford. Acad Med. 2010;85: 419–428.

The Importance of Real-Time Feedback in Undergraduate Assessments

To the Editor: As undergraduates, students face a barrage of formal assessments in many forms, including single-best-answer questions, extended matching, short answer questions, and OSCEs. Preparing for these assessments is no easy task, and the relief that comes from completing them successfully is certainly hard to describe. Although learners may progress to the next stage after passing an assessment, it is quite clear that they often receive very little actual feedback about their performance. Passing an assessment does not necessarily mean full attainment of knowledge, so shouldn't students be informed of the questions they answered incorrectly or the OSCE stations in which they did less well? After all, when it comes to patient care, we must encourage students to learn from their mistakes even if they have managed to "tick the box" for that year. Feedback should be actively encouraged and should be provided to learners in real time to enhance clinical care.

So, what exactly is feedback? Carless et al[1] define feedback as "Dialogic processes and activities which can support and inform the student on the current task, whilst also developing the ability to self-regulate performance on future