LETTERS
TO THE EDITOR

Racism Education is Needed at All Levels of Training

TO THE EDITOR:

The article "Addressing Racism in Medical Education: An Interactive Training Module"[1] describes an innovative way to tackle a very old view: racism. The authors should be applauded for their scholarship and use of this method to address this difficult, emotionally charged issue. Participants in the training were like-minded family medicine faculty who participated in the authors' workshop by choice. Participants were open to discussion and eager to learn new teaching strategies. Even so, the authors facilitated change in participants' attitudes about their ability to teach about racism. Participants in the training set a goal to combat racism and identified specific actions they could take when they returned to their home institution.

The authors' work on racism can be transferred to other aspects of health care beyond the preparation of physicians to care for minority patients. Racism education is needed at every level of academic medicine—from premedical student training to the highest levels of leadership in academic medicine. Racism affects everything from acceptance to medical school,[2] performance on United States Medical Licensing Examinations, residency match results, to promotion in academic departments.[3] It is also a primary driver of underrepresented in medicine faculty from their academic jobs.[4] Indeed, no one is spared from the effects of racism, regardless of their individual racial or ethnic background. We, as medical professionals, have allowed racism to continue to have an influence in virtually every aspect of a medical career.

Recognizing this, Dr White-Davis et al have prepared a toolkit to provide faculty with resources to address racism in their institutions at the curricular level. The toolkit began as a Society of Teachers of Family Medicine Annual Spring Conference workshop constructed and implemented by a multiracial, multidisciplinary team from the Minority and Multicultural Health Collaborative. The toolkit is available for use by all, and can be downloaded at: https://tinyurl.com/y7yel8k4.

Combating the negative effects of racism requires more than a commitment to a goal. It requires the deliberate use of innovative and impactful curricula[1] to facilitate change. Recent political rhetoric in the United States suggests that racism is almost acceptable (again). In this climate, family medicine must identify racism as it is experienced, and actively choose words and actions that foster inclusivity and collaboration. Racism education should be included in faculty development programs to address inequities in faculty. Faculty should welcome and encourage African American, Latino, and Native American youth in our offices, so that when they are old enough to make career choices, they have been inspired to become physicians, scientists, and medical educators. Family medicine leaders in academic medicine have the opportunity to hold deans, department chairs, hospital administrators and other decision makers to a higher standard.

For decades, family medicine has led other medical specialties in the areas of diversity and inclusion.[5] Both in academia and in clinical practice, family medicine is by far the most diverse group. Addressing racism head-on and providing tools for our colleagues in other disciplines will take this leadership role to the next level. Family medicine has always been inclusive, and now we must use our voices to point out and eliminate racism in all its forms.

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Authors' Reply "Racism Education is Needed at All Levels of Training"

TO THE EDITOR:

We would like to thank Drs Washington and Rodríguez for their interest in our brief report, and for their thoughtful and inspirational letter to the editor. We agree that racism affects every level of medical education, which makes it imperative to combat racism in multiple ways. We appreciate that Drs Washington and Rodríguez highlight our toolkit[1] and the importance of having resources available to aid educators in feeling equipped to address the multiple facets of racism that impact their setting and their patient care.

In their letter, Drs Washington and Rodríguez call for the field of family medicine to continue its legacy of being pioneers in promoting diversity and inclusion, and to hold stakeholders and decision makers accountable for change. Further, they humbly acknowledge that "we, as medical professionals, have allowed racism to continue to have an influence in virtually every aspect of a medical career,"[2] and that it is we who have the responsibility to not only hold leadership accountable for change, but also to be the leadership in that change. Each of us can take a step toward change and incite change in others. These changes may require guidance from those of us who study and teach about these principles, and we can embrace that goal by continuing to engage in vigorous, evidence-based scholarship on this topic.

Not everything that is faced can be changed, but nothing can be changed until it is faced.
—James Baldwin

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Collaborative Skills Essential to Leadership

TO THE EDITOR:

First, we would like to acknowledge Dr Mainous for his thoughtful editorial on our validation study of the Foundational Healthcare Leadership Self-assessment (FHLS) published recently in *Family Medicine*.[1,2] We appreciate that he considers this an important topic worthy of attention. His reflection about our conceptual view of leadership education is accurate: that leadership skills include essential teamwork and collaboration, and that in this era of interprofessional practice "the success of

the team is what is of paramount importance." He summarized a key concept well: collaborative skills are essential leadership skills that all of our graduates should demonstrate.

We wholeheartedly agree with Dr Mainous' point that the demonstration of content validity is essential to the validation process. We did include the requested information in the original article, including using eigenvalues >1.0 and factor loadings of 0.3 or greater to reduce items and develop domains.

We appreciate Dr Mainous' editorial reflections on how to measure validity of an assessment, the importance of this work, and the value of collaborative skills for all family medicine residents.

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Letter to the Editor in Response to "Residents' Perspectives on Careers in Academic Medicine: Obstacles and Opportunities"

TO THE EDITOR:

The article "Residents' Perspectives on Careers in Academic Medicine: Obstacles and Opportunities," by Dr Lin and colleagues is an important contribution toward understanding the needs and concerns of future faculty members as we try to identify ways to attract students to family medicine, and transform them into educators in academic family medicine.[1]

The participants in this small study broadly represent family medicine nationally, including the proportion of respondents from groups underrepresented in medicine (URM). While the number of residents from URM backgrounds was small (14), they represented 14.8% of the sample. This is double the national average of African American, Latino, and Native Americans in academic medicine.[2] At a time when faculty recruitment committees grow frustrated in their efforts to recruit URM faculty, the demographics from this article suggest that there are more URM residents interested in academic careers than previously thought, at least in our discipline.

Family medicine continues to be the most diverse of all of the medical specialties, with a higher proportion of URM faculty and residents than any other.[3] This is due in part to our shared goal of providing excellent underserved care, and to our discipline's counterculture history. Family medicine has embraced difference and continues to innovate precisely because of that.

When compared to non-URM faculty, URM faculty have experiences unique to this group.[2] They have identified many issues (lack of mentorship, diversity pressures, isolation, inequitable distribution of clinical responsibilities) as obstacles to their success in academic medicine.[2] Resident participants in the article identified similar obstacles, with lack of mentors topping the list. It was not apparent from the article, however, if participant information regarding racial and ethnic diversity was utilized to guide the development of the grounded theory and qualitative analysis, or if the demographics were simply collected and reported.[4] To collect racial and ethnic demographics and then not analyze for differences in responses between populations makes us question the need to collect and report this information at all, and more importantly, forces us as readers to question what additional themes might have been identified had issues of diversity been considered in the development of the grounded theory. This is a missed opportunity to tap into URM residents identifying actionable items for improvement in URM resident recruitment into academic medicine.

Addressing the changes identified by URM faculty has led to improved faculty retention among all races and ethnicities when implemented.[5] We commend the authors for their scholarly approach to identifying barriers for future family medicine faculty, and for recruiting URM residents to their workshop at double

the national average. It is imperative, however, that in addition to recruiting diverse participants, family medicine researchers and educators actively seek out what those diverse participants might have to say, and use those experiences to inform our program development and diversity efforts.

DISCLOSURES: Drs Figueroa and Rodríguez are past co-chairs of the former STFM Group on Latino Faculty. Dr Figueroa is currently a member of the STFM Program Committee. Dr Rodríguez is a member of the editorial board of *Family Medicine* and a member of the steering committee of the STFM Collaborative on Minority and Multicultural Health. Opinions expressed are the authors' alone.

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