2024, Volume 56, Issue 5, 339-340, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

Authors' Response to Letter About "URiMs and Imposter Syndrome" Commentary

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HOW TO CITE: Carvajal DN, Zambrana RE. Authors' Response to Letter About "URiMs and Imposter Syndrome" Commentary. *Fam Med.* 2024;56(5):339-340.
doi: 10.22454/FamMed.2024.336789

PUBLISHED: 16 April 2024

TO THE EDITOR:

We appreciate Dr Fernandez Montero and colleagues' interest and thoughtful comments about our study. We agree with their major points that those underrepresented in medicine (URiMs) are undervalued and overtaxed due to their minority status and commitments. They raise two important issues regarding the representativeness of the sample and the results that URiMs in our study are less likely to report imposter syndrome (IS).

We first address sampling issues. We agree that alternative explanations for our results are possible due to sample selection—including that variations of IS may exist among Hispanic/Latine physicians whose experiences may vary by race, nativity, and class and that busy URiM faculty with high degrees of IS may have self-excluded themselves. However, the percentage of URiMs who completed our survey was near 20%,[1] which is substantially higher than the total percentage of practicing URiM family physicians (12.5%).[2]Moreover, the percentage of URiM academic family physicians is noted to be even lower.[3,4] Therefore, while we do not claim our results are generalizable to all URiM family medicine faculty across the country, URiMs were overrepresented in the study sample.

Next, we wholeheartedly agree that hostile work environments, disproportionate clinical and administrative work burdens (eg, the "minority tax"),[5] and fewer opportunities for advancement have pushed many URiMs out of academic medicine. Because of the robust body of knowledge on URiMs and barriers to career persistence, the study measured both IS and other institutional variables of discrimination that are known to hinder academic persistence among URiMs. One scale, the Perceived Gender, Race/Ethnicity, and Class Bias scale, measures perceived discrimination in professional advancement and found significant differences between URiMs and non-URiMs. Compared to non-URiMs, URiMs report more experiences of being left out of professional opportunities due to racial/ethnic discrimination. Additionally, our results demonstrated that URiMs are significantly more likely to report perceptions of not belonging, lack of professional integration, and inadequate mentorship compared to non-URiMs. These data suggest that institutional forms of racism and discrimination are a more likely explanation for lack of career persistence than are individual feelings of IS. Further, while evidence is inconsistent, a significant body of literature does *not* support the notion that racial/ethnic minorities, including URiMs, have higher frequencies of IS compared to non-URiMs.[6-8]

Drawing on our data and a strong body of extant evidence, we conclude that systemic, institutional racism persists as a major barrier to URiM persistence in academic family medicine. Experiences of racism and discrimination are omnipresent among URiMs.[9,10]We argue that systemic racism produces significant minority tax experiences, and this disproportionate burden, mainly endured by URiMs, cannot be attributed to individual intrinsic characteristics such as those reflected by imposter syndrome.[11] Individual attribution of IS suggests that individual remediation is needed. Yet, extensive scholarship signals that these manifestations of systemic racism must be addressed by the very health systems, leaders, and institutions who allow for their persistence. As noted in our article, several family medicine scholars have made recommendations for increased recruitment, and especially retention, of URiMs in academic medicine.[8,12,13] We and others echo your suggested strategies for change, including a revamping of traditional promotion and tenure requirements that almost always exclude the important equity, inclusion, and community engagement work that is disproportionately shouldered by URiMs.

Lastly, while no doubt your statement, "We face a shortage of URiM faculty in academia, a definitive crisis" is true, we must note that this is not a *new* crisis and will likely worsen as the US populations of Black/African American and Latine communities increase. Representation in the medical professions will remain stagnant while inequities among underserved communities will continue to rise. The percentage of URiMs in academic medicine has been abysmally low at least since the 1970s.[14] Even worse, the 2023 Supreme Court decision striking down affirmative action—which did not significantly improve URiM representation—is likely to cause further decline in representation of the most historically excluded racial/ethnic groups. History has demonstrated this long-standing problem. We agree that the time to implement policies that promote the change we want and need is now. Therefore, institutions and their leaders must be held accountable for implementation and evaluation of the very strategies brought forth by Dr Fernandez Montero and colleagues, us, and other scholars in our specialty.

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