Letters to the Editor

How Can We Ease the Social Isolation of Underrepresented Minority Students?

To the Editor: In an environment in which there may be a lack of cultural sensitivity, a lack of shared experiences, and a lack of inclusion or like-mindedness, underrepresented minority (URM) students may feel isolated[1,2] and not part of a social network. In our experience, such students may be mistakenly perceived as having a lack of knowledge, being unprofessional, or just not being interested academically and socially. Furthermore, evaluations of clinical rotations have a significant subjective component and are influenced by social interactions of students and faculty and the implicit expectations of both. We have seen the lack of social interaction of some URMs lead to misperceptions of their competencies and to their receiving less-than-deserved evaluations. This translates into lower class rankings, which, in turn, may reduce some URMs' competitive status during the residency selection process.

How can URMs' social isolation in medical school be eased? Although multiple factors including personal choices, biases, and discrimination are all targets for reform, achieving a "critical mass" of URMs in the student body would, we believe, most readily foster the social integration of URMs into the surrounding institutional culture. However, this is unlikely to happen any time soon, as indicated by the laudable but not sufficiently successful efforts of the Association of American Medical Colleges' *Project 3,000 × 2000* initiative and others to increase the number of URMs attending medical schools. Nationally, URMs accounted for 14.1% of first-year matriculants in 2007 and only 7.4% of medical school faculty in 2008,[3,4] resulting in a social environment in which racial discrimination, unconscious biases, or a lack of inclusion may exist.[1]

A feasible solution is curricular change. Part of our role as medical educators is to develop curricula focusing on diversity, professionalism, and cultural competency with the aim of inculcating these qualities into the professional fabric of *all* students, faculty, and staff. Such curricular efforts are already under way in some schools, but much more needs to be done. The ultimate goal is for URMs to be part of the culture of medicine as we develop a health care workforce that provides quality equitable care to a rapidly changing population.

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References

1 Odom KL, Roberts LM, Johnson RL, Cooper L. Exploring obstacles to and opportunities for professional success among ethnic minority medical students. Acad Med. 2007;82:146–153. http://journals.lww.com/academicmedicine/Fulltext/2007/02000/Exploring_Obstacles_to_and_Opportunities_for.6.aspx. Accessed June 15, 2011.

2 Elam CL, Stratton TD, Hafferty FW, Haidet P. Identity, social networks, and relationships: Theoretical underpinnings of critical mass and diversity. Acad Med. 2009;84(10 suppl): S135–S140. http://journals.lww.com/academicmedicine/Fulltext/2009/10001/Identity,_Social_Networks,_and_Relationships_.35.aspx. Accessed June 15, 2011.

3 Association of American Medical Colleges. Diversity in Medical Education: Facts and Figures. Washington, DC: Association of American Medical Colleges; 2008.

4 Sullivan LW, Mittman IS. The state of diversity in the health professions a century after Flexner. Acad Med. 2010;85:246–253. http://journals.lww.com/academicmedicine/Fulltext/2010/02000/The_State_of_Diversity_in_the_Health_Professions_a.21.aspx. Accessed June 15, 2011.

In Reply: Calls to attain a critical mass of underrepresented minority (URM) students, while popular within educational circles, must never be viewed as a stand-alone panacea. Indeed, increased numbers alone may be neither necessary nor sufficient to foster *educationally meaningful* diversity. As we found in our original research,[1] majority faculty had a much different image of what constituted a critical mass of minority students than did minority faculty, including how and where those students were situated within the larger social network. Thus, while the point may be obvious, simply increasing the numbers of URM students without altering the broader social and cultural contexts of educational practices may lead only to continued marginalization and isolation. *Groups* of students can be just as much outliers (in network terms) as individuals can. Moreover, while the term *critical mass* has its origins in the field of physical chemistry, social life is infinitely more complex than a chemical reaction—and thus social groups require far greater, and ongoing, attention to the factors that initiate and activate self-sustaining change than do their chemical counterparts.

The authors' point about curriculum, while hopeful, also needs further contextualization. Almost 20 years ago, Hafferty and Franks[2] argued that "merely" adding more ethics courses to a medical school's curriculum would do little to halt the ethical erosion of students and physicians widely cited in the medical education literature. Instead, they pointed to a hidden curriculum of ethics instruction that could (and often did) counteract or nullify what was taking place in the classroom.

This is not to suggest that increasing the numbers of URM students and/or courses would be an exercise in futility. Indeed, such actions can serve as markers that a given school is serious about diversity and inclusion. However, enacting any change(s) *in isolation or without regard for the surrounding social or organizational context* is unlikely to be successful—as noted in the authors' reference to the underperforming (at least in terms of expectations) AAMC *Project 3,000 × 2000*. Similarly, significant increases in the number of women in medicine have addressed some, but not all, of the gender inequities and sexism historically pervasive in the profession of medicine.

The social isolation of URM students, then, is a systemic problem that requires bottom-up, emergent, and

relational solutions. Identifying the variety of activation points/targets (e.g., organizational mission and values, recruitment and hiring practices, leadership development, campus climate, student services, research programs, patient interactions, and community involvement) and the synergies that link them is the principle challenge facing us now. Networks link not only people but also social structures and practices.

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References

1 Elam CL, Stratton TD, Hafferty FW, Haidet P. Identity, social networks, and relationships: Theoretical underpinnings of critical mass and diversity. Acad Med. 2009;84(10 suppl):S135–S140. http://journals.lww.com/academicmedicine/Fulltext/2009/10001/Identity,_Social_Networks,_and_Relationships_.35.aspx. Accessed June 26, 2011.

2 Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med. 1994;69:861–871. http://journals.lww.com/academicmedicine/Abstract/1994/11000/The_hidden_curriculum,_ethics_teaching,_and_the.1.aspx. Accessed June 26, 2011.

In Reply: The proposal from Boateng and Thomas to focus on curriculum changes in medical school, emphasizing diversity, professionalism, and cultural competency as strategies to ease the social isolation experienced by some minority medical students, is a positive contribution and should benefit medical education and patient–provider interactions and, at least in the short term, ease the cultural isolation of URM students. Currently, many medical schools have already integrated cultural competency training into their curricula, with some states requiring cultural competency training for medical school, residency, and continuing medical education programs and medical licensure.[1]

However, by itself, developing curricula focusing on diversity, professionalism, and cultural competency in medicine will not rectify the social isolation experienced by minority students. The issue of social isolation is an important one and affects not only the medical school experiences but the career trajectories of URMs in medicine. The low representation of minorities among medical school faculty contributes to an inadequate body of mentors sharing the cultural backgrounds of minority students. These mentors are important as pathfinders, teachers, and the establishment of a medical school climate that is supportive to all of its students. In order for URMs to acquire an equitable role in the "culture of medicine," they should achieve parity in accessing health careers and in professional advancement opportunities.

The long-term goal of increasing the number of physicians and other health professionals from all segments of American society should continue to receive our greatest attention and our greatest efforts. For this is the most effective and most comprehensive way to improve access to health services in our society, to effectively engage our citizens in taking responsibility for helping to manage their own health care, and, ultimately, to curtail the inexorable rise in the costs of health care.

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Reference

1 Betancourt JR, Green AR. Commentary: Linking cultural competence training to improved health outcomes: Perspectives from the field. Acad Med. 2010;85:583–585. http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Commentary__Linking_Cultural_Competence_Training.14.aspx. Accessed June 28, 2011.

In Reply: We agree with Dr. Boateng and Dr. Thomas that social isolation is an important barrier to success among underrepresented minority students (URMs), and we feel for their frustration at the complexity and slow progress on this important issue. Cultural distance for URM students is likely greater than for non-URM students and can affect socialization and interpersonal skills that are valued during medical school such as networking, self-promotion, and reflection. Curricula that foster cultural competency, explore issues of diversity, and promote professionalism are essential to prepare students to care for patients of all backgrounds and circumstances. However, students' problems with interprofessional behavior, social norms, and support mechanisms cannot be fully modified through curricular changes. Nor can medical school curricula overcome, or be responsible to teach methods to overcome, cultural and social barriers due to socioeconomic status, cultural distance, and social norms.

These complex barriers make themselves known through negative social and psychological experiences that students have encountered throughout their lives. Strategies to deal with these barriers are much more specific to the individuals involved and cannot be addressed through melding and generalizing students' experiences in a structured manner. But there are ways that medical schools can help. For example, schools can offer support through increasing the number of URM students, having student activities about diversity, and providing social and cultural outlets. Also, having a place where students feel comfortable discussing their experiences of cultural and social barriers is critically important. And helping students address frustrations with poor clinical evaluations and learn concrete approaches to improve the evaluations is also essential. Other approaches include having well-staffed offices for diversity, having student societies, and encouraging students to use their external support systems, including family and religion.

We encourage medical schools to simultaneously focus on curriculum and "downstream" social factors important for URM students' success. Medical schools are optimally positioned to partner on a long-term basis with local pipeline institutions and form new models for the future. We should not be discouraged and should continue to improve student[1] and faculty diversity[2] and seek innovative strategies to ensure academic success for URM students.

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References

1 Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in U.S. medical schools. JAMA. 2008;300:1135–1145.
2 Mahoney MR, Wilson E, Odom KL, Flowers L, Adler SR. Minority faculty voices on diversity in academic medicine: Perspectives from one school. Acad Med. 2008;83:781–786. http://journals.lww.com/academicmedicine/Fulltext/2008/08000/Minority_Faculty_Voices_on_Diversity_in_Academic.21.aspx. Accessed June 27, 2011.

More Thoughts About Residents' Professionalism Education in Malpractice

To the Editor: Hochberg et al[1] have replaced fear with knowledge in their institution's professionalism seminar about malpractice for surgery residents. I trust that the following suggestions for the course content, and a contrasting analysis of the setting in which technical surgical errors arise, will add to the authors' contribution.

In addition to acquainting trainees with the anatomy of tort suits, a fundamental course precept should be maintenance of the patient–doctor relationship and assurance of good care. Thus, the course should include strategies for (1) communicating with potentially injured patients, (2) maintaining the patient–doctor relationship, and (3) supporting remedial or ongoing care in the original institution or by transfer of care. These principles are as important as, *and more empowering than*, limiting ourselves to discerning whether we have erred and defending ourselves, error or no. When we physicians address only our own pain, patients become commodities at best, adversaries at worst. Institutions that train practitioners using the three principles outlined above experience stronger patient–doctor relationships and institutional trust, better resolution of physicians' feelings of failure or guilt, and substantially improved patient safety.[2]

In their article, the authors' language and analysis were sometimes imprecise, which can exacerbate the anxiety the authors seek to allay. Contrary to their lead statement, *every* doctor is *not* likely to be sued by a patient. They later state that "frivolous" malpractice claims contribute to the growth of liability insurance costs, defense costs, and payouts. Possibly inaccurate and emotionally loaded terms, like "frivolous," can inflame parties and transform caregivers into combatants. As Studdert et al[3] ably demonstrated, and as we realize whenever we analyze closed claims, it is difficult to know whether a claim is valid until substantial investigation or legal discovery occurs. This fact should be emphasized in malpractice education.

The exquisite pain of malpractice litigation is superficially salved if we physicians see ourselves as victims of unsavory attorneys. Rather, I suggest that malpractice curricula stress that reflection, and sober analysis from the perspective of our special relationship to patients and society, can help us make appropriate use of our legal advocates, interact with legal adversaries, or act with balance when we, a colleague, or a family member is a defendant.

Importantly but erroneously, the authors imply that most technical surgical errors are committed by inattentive, experienced surgeons performing routine procedures. In fact, the source they cite found the opposite: The cases were "predominantly … complicated by comorbidity, complex anatomy, repeat surgery, or equipment problems."[4] Technical errors occurred in the context of complexity. This phenomenon is yet one more element that should be discussed in any malpractice curricula for surgery residents.

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References

1 Hochberg MS, Seib CD, Berman RS, Kalet AL, Zabar SR, Pachter HL. Malpractice in an academic medical center: A frequently overlooked aspect of professionalism education. Acad Med. 2011;86:365–368. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Malpractice_in_an_Academic_Medical.27.aspx. Accessed May 30, 2011.
2 Boothman RC, Blackwell AM, Campbell DA, Commiskey E, Anderson S. A better approach to medical malpractice claims? The University of Michigan experience. J Health Life Sci Law. 2009;2:125–159.
3 Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. N Engl J Med. 2006;354:2024–2033.
4 Regenbogen SE, Greenberg CC, Studdert DM, Lipsitz SR, Zinner MJ, Gawande AA. Patterns of technical error among surgical malpractice claims: An analysis of strategies to prevent injury to surgery patients. Ann Surg. 2007;246:705–711.

In Reply: We are grateful to Dr. Akwari for her thoughtful comments about our recent article on resident malpractice professionalism education. As she quite generously commented, replacing fear with knowledge is the primary goal of our professionalism seminar.

We strongly agree with her suggestion that in-depth and ongoing patient–doctor communication is crucial, especially when the possibility of malpractice has occurred. We do discuss patient–doctor communication at length during many of our other professionalism seminar sessions—not just the one on malpractice. Our malpractice session is limited to one hour, so we try to maximize the time discussing "the nuts and bolts" of the litigation process—topics previously quite foreign to surgical residents (as shown by our preseminar survey).

In the research we discussed in our article, our specific focus was a retrospective analysis of over 18,000 surgical procedures from July 2001

through May 2008 at NYU Medical Center, to learn what malpractice actions had been brought against the Department of Surgery during the period studied. Our research made clear to us that surgical malpractice usually comes to light long after the patient leaves the hospital, when maintaining the patient–doctor relationship may be beyond repair and ongoing care has changed to alternate providers.

Our malpractice professionalism seminar focused on the specific causes we identified for surgical malpractice: improper documentation, inadequate informed consent, technical error, and others. Regarding Dr. Akwari's interpretation of Regenbogen and colleagues'[1] findings, while it is clear that most of the technical errors occurred in routine operations with experienced surgeons, as we had said, she is correct to emphasize the issue of complexity, since the errors happened "under conditions of increased patient complexity or systems failure." Upon reflection, we agree with Dr. Akwari that some of our terminology was imprecise. We should have been clearer in stating that most surgeons report being sued—not most doctors. And finally, we certainly agree with her comment that

> reflection, and sober analysis from the perspective of our special relationship to patients and society, can help us make appropriate use of our legal advocates, interact with legal adversaries, or act with balance when we, a colleague, or a family member is a defendant.

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Reference

1 Regenbogen SE, Greenberg CC, Studdert DM, Lipsitz SR, Zinner MJ, Gawande AA. Patterns of technical error among surgical malpractice claims: An analysis of strategies to prevent injury to surgery patients. Ann Surg. 2007;246:705–711.

Simulation Is the Way to Bring Risk Management and Patient Safety Together

To the Editor: Alper and Wachter[1] give a fascinating account of the barriers that exist between risk management and patient safety and why it is important that there be more widespread sharing of and learning from data about critical incidents. While that is undoubtedly true, the question remains: What would be the most effective way of delivering this learning that would encourage doctors to incorporate it into their everyday practices?

Part of the problem in answering this question is that learners often become afraid, embarrassed, and defensive when discussing critical incidents; such feelings do not create a good educational climate. How can we do better? It is possible that simulation may be one way of squaring this circle. In simulation, small groups of doctors learn to train and test their skills in environments that are close to their real-life practices. Because the learning is done in teams, there is less of a spotlight on individual doctors. Whilst rich and immersive simulation environments are increasingly available, the essential components of simulations are the scenarios on which they are based. In the United Kingdom, simulation scenarios are often modeled on real-life critical incidents that have recently occurred in the learners' hospitals.

The simulation environment does not have to be state-of-the-art in terms of technology—low-technology solutions are likely to be both effective and cost-effective.[2] Also, expense need not always be a barrier, for although a hidden cost of simulation is creating the scenarios, if they are based on real-life events, then the scenario-writing job will be largely done.

Clearly, simulation is the way to bring risk management and patient safety together. What better way to help doctors learn how to avoid error than by enabling them to educate themselves in environments where they feel safe and engaged and where patients cannot be harmed?

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References

1 Alper EJ, Wachter RM. Commentary: Medical malpractice and patient safety: Tear down that wall! Acad Med. 2011;86:282–284. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Commentary_Medical_Malpractice_and_Patient.12.aspx. Accessed May 30, 2011.

2 Ker J, Hogg G, Mann N. Cost effective simulation. In: Walsh K, ed. Cost Effectiveness in Medical Education. Abingdon, UK: Radcliffe; 2010.

In Reply: We wholeheartedly agree with Dr. Walsh that simulation—particularly using model scenarios—can be effective in teaching about critical events. However, simulation may not be effective or appropriate for certain kinds of medical errors, such as some failure-to-diagnose cases, operative errors, or system-specific miscommunications. Also, simulation has the relative disadvantages of being relatively costly and time intensive and being difficult to deliver to large numbers of learners simultaneously.

While simulation should clearly have a role in a robust patient-safety training environment, it will not replace directly engaging learners in discussions about malpractice issues and thoughtfully reviewing the most common types of cases. Given the influence of such issues on medical practice, we believe this type of dialogue about malpractice should also be part of the core curriculum for all learners. Further research findings, like those reported by Hochberg et al,[1] should help us learn what other methods of patient safety training are most effective, which present the fewest obstacles, and in what combinations they should be used.

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Reference

1 Hochberg MS, Seib CD, Berman RS, Kalet AL, Zabar SR, Pachter HL. Perspective: Malpractice

in an academic medical center: A frequently overlooked aspect of professionalism education. Acad Med. 2011;86:365–368. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective__Malpractice_in_an_Academic_Medical.27.aspx. Accessed August 10, 2011.

Assessing Physicians' Competence

To the Editor: The study reported by Korinek et al[1] addressed an important topic. But we have some serious concerns about its generalizability.

First, the study relied heavily on the use of MicroCog screening.[2] An older physician may not do well on the MicroCog test. It is computer based, and an older physician is more likely to suffer from cyberphobia and/or incompetence. We are concerned that the study findings could be inadvertently used to discriminate against older physicians and perhaps even prematurely terminate their careers.

Second, the exclusion criteria for both groups that were studied excluded all international medical graduates (IMGs). The authors acknowledge that this limits the generalizability of their findings and that the MicroCog has not been validated for any foreign-born group.

With these limitations in mind, we suggest the SLUMS (Saint Louis University Mental Status) Examination[3] for screening IMGs and computer-challenged older physicians. It is a simple, practical, cheap, face-to-face test.

Third, we do not think the control group accurately represented the physician population who are practicing in the United States. The authors addressed the same concern.

Fourth, the authors mention that the participants in the two study groups were "tested under different personal circumstances" that could have affected their performance on the test. In our view, a study of this kind would probably be most accurate if a random sample without any bias were selected to represent the entire population.

Our goal in pointing out the above problems is to urge readers to be cautious in using the study findings because, in our opinion, they do not accurately represent the nation's physicians regarding the issue of competency and underlying cognitive problems.

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References

1 Korinek LL, Thompson LL, McRae C, Korinek E. Do physicians referred for competency evaluation have underlying cognitive problems? Acad Med. 2009;84:1015–1021. http://journals.lww.com/academicmedicine/Fulltext/2009/08000/Do_Physicians_Referred_for_Competency_Evaluations.13.aspx. Accessed May 24, 2011.

2 Elwood RW. MicroCog: Assessment of cognitive functioning. Neuropsychol Rev. 2001;11:89–100.

3 Tariq SH, Tumosa N, Chibnall JT, Perry MH, Morley JE. Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder—A pilot study. Am J Geriatric Psychiatry. 2006; 14:900–910.

In Reply: We appreciate the comments by Dr. Dastgeer and Mr. Ebadi and agree that one should proceed with care when addressing an issue as serious as physician competence. As we noted in our article, we would not recommend using MicroCog[1] alone to make critical decisions about competence to practice but, rather, as an initial screening tool to assess the need for further neuropsychological evaluation.

We respectfully disagree with the suggestion that MicroCog may discriminate against older physicians. The test interface is simple, with responses entered using only the number keypad and three other keys. Also, one of us (L.L.K.) compared physicians reporting less computer experience with those with high levels of experience (all physicians reported some computer experience) and found that there was no significant difference between the two groups on the MicroCog Global Cognitive Proficiency Score [$t(66) = .913$, $P = .364$].[2]

Further, the MicroCog normative groups are stratified by age and education level, with the highest level being more than 12 years of education. Thus, an 83-year-old physician is compared with a group of the general population, aged 80–89, with more than 12 years of education. We do not find that this would place an older physician at any unfair disadvantage.

Other tools are available to screen for cognitive difficulty, such as the Saint Louis University Mental Status (SLUMS) Examination.[3] However, we opine that the MicroCog is a more appropriate and sensitive instrument for use in physician competence assessments. As noted, the MicroCog uses age- and education-adjusted reference groups. It assesses processing speed, which is the measurement most sensitive to brain impairment.

Dastgeer and Ebadi point out some limitations of our study, which were acknowledged in the article. We agree that the results of a cognitive examination that is not normed on foreign-born individuals must be interpreted with caution when administered to such individuals. CPEP, the Center for Personalized Education for Physicians, has a neuropsychologist interpret the results, including whether language and cultural issues may have influenced the findings. While a stratified sample of randomly selected physicians would be a better control group, we believe that the volunteer control group provided an adequate comparison.

As cited in our article, there is a growing body of research that is consistent with the findings of our study. We stand by the results of this and other studies that suggest that an assessment of neuropsychological functioning should be an integral part of any evaluation of physician competence.

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References

1 Elwood RW. MicroCog: Assessment of cognitive functioning. Neuropsychol Rev. 2001;11:89–100.
2 Korinek L. Neuropsychological differences between physicians referred for competency evaluations and a control group of physicians. Diss Abstr Int. 2001;66:2824.
3 Tariq SH, Tumosa N, Chibnall JT, Perry MH, Morley JE. Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder—A pilot study. Am J Geriatric Psychiatry. 2006; 14:900–910.

What Is the Value of an Honor Society?

To the Editor: I congratulate Rosenthal et al[1] on designing what appears to be a valuable contribution to efforts to preserve empathy in third-year medical students. I was especially intrigued by their finding that in the Robert Wood Johnson Medical School class of 2010, students' knowledge that they had been selected for the Gold Humanism Honor Society (GHHS) seemed to significantly raise their scores on the Jefferson Scale of Physician Empathy Medical Student Version (JSPE-MS). Those students, following the completion of clerkships but prior to notification of GHHS selection, had scored nearly identically on the JSPE-MS as the non-GHHS students, and their empathy levels had, in fact, eroded much more over the course of the year than had those of the non-GHHS students. We are therefore left to conclude that GHHS selection in and of itself increased empathy.

If that's the case, it's rather ironic; one would hope that in order to inculcate empathy in medical students, we wouldn't have to tell them that they're better than their peers in some way. Yet that's essentially what the exclusivity of honor societies does.

It seems to me that having any kind of honor society to recognize and promote humanism runs counter to the ideals enshrined in the concept. When I think of humanism, I think of inclusiveness and an appreciation of each individual's unique strengths and abilities, not a questionnaire-based selection process of peers whom one may or may not actually know or have observed working with patients. What this study tells me is that labeling some medical students as "humanists" and others as not engenders empathy in the chosen few but has unknown effects on the undistinguished many. Yet the few and the many will together graduate as physicians, so we need to leave honor societies behind as we advance empathy for all.

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Reference

1 Rosenthal S, Howard B, Schlussel YR, et al. Humanism at heart: Preserving empathy in third-year medical students. Acad Med. 2011; 86:350–358. http://journals.lww.com/academicmedicine/Abstract/2011/03000/Humanism_at_Heart_Preserving_Empathy_in.24.aspx. Accessed June 8, 2011.

In Reply: Ms. Ramer's argument centers on the value of an honor society—maybe of any kind. The literature is replete with both pros and cons of honor societies that bring recognition to some and not to others. It was not our intent to engage in that debate but simply to bring our data to the attention of others. Ms. Ramer misses the point that societies like the Gold Humanism Honor Society (GHHS) recognize outstanding contributions to community service, which fosters important attributes such as altruism among physicians-in-training[1] and sustains and nurtures humanism in the communities in which chapters exist and members practice. By recognizing and rewarding desirable but difficult-to-teach traits in settings where efficiency is emphasized, we hope to inspire all students—not just GHHS awardees—to adopt humanistic values.

Our study focused on preserving empathy through educational intervention, which we believe was successfully demonstrated. The Humanism and Professionalism (H&P) program in our third-year curriculum was partly built on our long-standing involvement with humanism programs of the Arnold P. Gold Foundation, including the GHHS. Given our knowledge of the impact of these programs on our students, our hypothesis was that the H&P program would make a difference in helping our students preserve their empathy.

Membership in the GHHS does not indicate that some students are humanistic and others not. Instead, attributes, including humanism, tend to be present along a continuum. As a corollary to the GHHS, for over 100 years, students have been accorded recognition for excellence in academics through membership in the Alpha Omega Alpha Medical Honor Society. Until the GHHS was formed in 2002, no national recognition for excellence in humanistic traits existed. We believe that GHHS selection allows students to honor colleagues who exemplify these traits. (Research on a peer nomination tool affirms that students can identify medical student exemplars in clinical competence, caring, and community service among their colleagues.[2]) Furthermore, the GHHS exists to enlist these exemplars as lifelong role models and advocates for patient-centered care.

As part of our assessment of the H&P program, we decided to see if there was any difference between those students chosen for the GHHS and the students who were not, and we were surprised to find that it did matter. It was not an assumption that we made going into the assessment. Clearly, recognition for excellence in any area brings confidence to those accorded the honor and, we hope, inspiration to those around them.

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References

1 Blue AV, Geesey ME, Sheridan MEB, Basco WT Jr. Performance outcomes associated with medical school community service. Acad Med. 2006;81(10 suppl):S79–S82. http://journals.lww.com/academicmedicine/Fulltext/2006/10001/Performance_Outcomes_Associated_with_Medical.20.aspx. Accessed June 24, 2011.
2 McCormack WT, Lazarus C, Stern D, Small PA Jr. Peer nomination: A tool for identifying medical student exemplars in clinical competence and caring, evaluated at three medical schools. Acad Med. 2007;82: 1033–1039. http://journals.lww.com/academicmedicine/Fulltext/2007/11000/Peer_Nomination__A_Tool_for_Identifying_Medical.6.aspx. Accessed June 24, 2011.