Re: Early-Career Compensation Trends Among Family Physicians

To the Editor: We applaud the authors on their comparative analysis of income trends of family physicians nationwide, an important topic, well-timed amid the rising cost of living and skyrocketing debts across the primary care workforce.[1] With increasing shortage in primary care physicians, a key driver that may be exacerbating this shortage is the lower income of primary care specialties when compared with the earnings of subspecialists. The article further explains these trends, most notably, gender differences in compensation, but there seems to be opportunity to delve deeper into the data presented to gain a clearer picture as it pertains to both race and gender.

Secondary analysis of the data collected on race and ethnicity depicted a small but insignificant difference with White family physicians associated with higher income than Black or Asian family physicians. This is in contrast to findings from the existing literature cited by the authors, of the significant associations documented between race, ethnicity, and gender on income differences.[1] It is important to emphasize the limitation in the methods and analysis in this study: there was 1-year worth of missing data on race and ethnicity, survey questions on race/ethnicity were limited to a "select best" option, and this data were not included in the primary statistical analysis. Given the methodological limitations on how the data on race and ethnicity were collected and analyzed, the categorization of race/ethnicity and sampling size may not have been sufficient or accurate to detect a difference between race/ethnicity and income. Admittedly, research involving accurate categorization of race and ethnicity data has historically been cumbersome, inconsistent across institutions and systematically flawed.[2] Accurately capturing and categorizing race and ethnicity data are necessary to demonstrate the diversity in the field of family medicine. Although the workforce of family medicine is proudly and necessarily diverse, the article does not consider the intersectionality of race/ethnicity and gender, which hinders the external validity of these findings, given the reality of our diverse workforce.[3] In 2012, nearly half of underrepresented minorities (URM) in medicine practiced in primary care, although the proportion of URM in primary care compared with all primary care physicians remains low.[4,5] Nonetheless, with the ongoing institutional interest in promoting diversity, equity and inclusion, the diversity of the family physician workforce is increasing.[4,5] This highlights the importance of accurately depicting race and ethnic information as it will aid with the interpretation of findings relevant to the growing proportion of URM physicians.

In essence, we may not be capturing the true disparities of earned compensation or experiences of those with intersecting sociodemographic variables, such as Black or Latinx women family physicians practicing in rural area. This calls for conduction of more culturally rigorous research using methodology that considers the intersectionality of race and gender and its impact on income trends. We hope that future studies would help to assess additional contributory factors that may lead to the phenomenon of URM women faculty physicians, for example, receiving disproportionately less pay, and may be a nidus to investigate ways of mediating and preventing it from negatively impacting our current and future workforce.

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Re: Why Do Physicians Depart Their Practice? A Qualitative Study of Attrition in a Multispecialty Ambulatory Practice Network

To the Editor: We read with great interest the article from O'Connell and colleagues on drivers of departure for physicians from a multispecialty ambulatory practice.[1] Physician turnover can be attributed to both push and pull factors.[2] Push factors are typically negative that drive a person to leave their current position, and pull factors are typically attractive that pull toward a new opportunity. Authors used a qualitative methodology to assess determinants of physician attrition from their current practice. This was achieved by interviews that were analyzed to identify major domains for departure, including: the health care business model, practice characteristics/culture, and personal considerations.[1] Although a broad set of themes were revealed, the themes with negative connotations were isolation/burnout, corporatization of medicine, and the COVID-19 pandemic and inbox burden. An important contribution of this study is that it is not based

on physicians' self-reported intent to leave - which can be a proxy for job satisfaction – but rather on physicians who had already left. Studying this population highlights the unique drivers of actual turnover as opposed to modeling job dissatisfaction. We believe identification of these factors and their impact on attrition are an important step in implementing interventions that promote retention.

Although O'Connell and colleagues addressed factors for turnover, few specifics on interventions were addressed. One consideration for turnover is the literature on belonging. Belonging is not a new topic in Psychology research but is being more readily addressed in the medical field. Current publications have begun to publish on attrition in health care settings. A survey study by Schaechter and colleagues investigated the association between workplace belonging and the likelihood of women health care professionals leaving their institutions.[2] The results revealed a significant link between greater workplace belonging and a reduced likelihood of leaving an institution within the next 2 years. Another publication by Silver and colleagues looked at the field of Rehabilitation Medicine – where there are significant workforce shortages - and addresses these challenges discussing push and pull factors contributing to attrition.[3] To enhance retention, emphasis should be placed on stay factors, achieved through the establishment of a culture that nurtures a sense of belonging as well as addressing the push and pull factors.

We agree with the authors that their work uniquely highlights the actual factors of physicians who left a large, multispecialty ambulatory practice network, and feel there must still be a focus on intent to leave and prioritization of efforts to mitigate job dissatisfaction. Proactively studying and addressing these aspects contributes to employee well-being and fosters belonging in the workplace environment. Allan et al. identifies 5 strategies that can be implemented by leaders in medicine to enhance gender equity.[4] The strategies include conducting stay interviews, analyzing department/division metrics, implement best practices for parental leave and return policies, inviting midcareer women faculty to publish with senior faculty, and avoiding bias in evaluations. Given that the majority of the physicians that left the ambulatory practice were women, these strategies are imperative to implement across an organization.

As O'Connell et al. suggest, efforts to improve retention in clinical medicine are critically important and must be evidence-based. The qualitative approach of these authors is helpful to identify factors quantifiable and modifiable for intervention for physicians who have actually departed their institution. Proactive initiatives, rooted in belonging, are essential for implementing targeted interventions that promote retention and contribute to the overall well-being of health care professionals.

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Response: Re: Why Do Physicians Depart Their Practice? A Qualitative Study of Attrition in a Multispecialty Ambulatory Practice Network

To the Editor: We appreciate the letter[1] from Muir and colleagues on our qualitative analysis[2] of physician departure from a large, multispecialty ambulatory practice network.

A criticism raised was the lack of detail on possible interventions, suggesting that interventions seeking to mitigate physician attrition should try to increase a sense of belonging. Camargo[3] has proposed that "retention efforts should always follow recruitment strategies" and specifically mentioned efforts like sponsorship and mentorship in the workplace. A survey study of 366 women health care professionals performed by Schaechter[4] and colleagues found that greater workplace belonging was associated with lower likelihood of attrition (OR 0.68, CI 0.63 to 0.74; $P < .0001$). Survey respondents further expressed the importance of open communication and empowering professional thriving.

Muir[1] et al emphasized the strength of our analysis only including physicians who had already left the practice, indicating that our findings reveal factors that actually contributed to attrition, not just factors related to physician dissatisfaction. In future studies, we plan to examine factors associated with physician attrition in specialties with significantly higher burnout rates, like emergency medicine.

Emergency medicine was found to have one of the highest female attrition rates at 8.6% in a study done by