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must be recognized to eliminate social inequities within medical education.^{7,8} We urge PA and medical educators alike to ask themselves, “How might mistreatment manifest itself here for minoritized students?” Conducting institution-wide diversity, equity, and inclusion climate surveys or collecting qualitative data may aid in better understanding the experiences of students who are most likely to be mistreated. We must consider every type of behavior that can marginalize students. The failure to address student mistreatment serves as a barrier to creating genuinely equitable and socially-just medical education environments.

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Reconciling LCME Diversity With Federal Law Mandates for Affirmative Action on the Basis of Disability, Gender, Race/Ethnicity, and Veteran Status

To the Editor: Meeks and colleagues criticize the Liaison Committee on Medical Education (LCME) for defining diversity “with specific references to many marginalized groups” (e.g., racial, ethnic, socioeconomic), “but not to individuals with disabilities.”¹ Golden and Petty similarly call for the “integration of disability into diversity and inclusion initiatives”² and for inclusion of disability into diversity data collection, because measurement is necessary for improvement. The authors would be pleased to learn that academic medical centers (AMCs), as federal contractors, are required “to take affirmative action to employ and advance in employment qualified individuals with disabilities”³ and to collect disability diversity data under Section 503 of the Rehabilitation Act.^{3,4} These and other affirmative action requirements are not currently reflected in the LCME's diversity standard.

The LCME's diversity standard requires AMCs to engage in “recruitment and retention activities, to achieve mission-appropriate diversity outcomes” for faculty and senior administrative staff,⁵ and tells AMCs that they have discretion to choose their own diversity categories “based on the program's mission, goals, and policies.”⁵ In reality, however, AMCs do not have unbridled discretion to choose their own diversity categories for faculty and senior administrative staff recruitment and retention activities.

As federal contractors, AMCs are required to engage in employment affirmative action, collect diversity data, and adopt specific numerical placement/hiring goals for persons with disabilities under Section 503 of the Rehabilitation Act; for women, Blacks, Hispanics, Asians/Pacific Islanders, and American Indians/Alaskan Natives under Executive Order 11246; and for veterans under the Vietnam Era Veterans' Readjustment Assistance Act.⁴ Though AMCs may include additional diversity categories, they may not omit these groups from their lists of

diversity categories for the purposes of recruitment, retention, and other activities to achieve diversity outcomes for faculty and senior administrative staff. The LCME's standards and policies, and the diversity data collection activities of the Association of American Medical Colleges and American Medical Association, should be amended accordingly.

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Leveraging Social Media Analytics for Physicians

To the Editor: We read with great interest the article by Perez and colleagues¹ on developing a physician-led social media training program to address the need for formal instruction on social media use. In addition to the educational objectives proposed by the authors, we recommend incorporating training on basic principles of social media analytics into their toolkit and future Social Media Summit.

By using YouTube analytics features, medical professionals can measure parameters, such as number of views, age and gender of viewers, watch time,

average view duration, and number of likes/comments/subscribes on their own YouTube medical education videos and channels. Drawing from our own experiences exploring the role of YouTube in disseminating medical education to the general public, we demonstrated that YouTube analytics was a useful tool in understanding our audience, as well as their interests.²⁻⁴ For example, YouTube analytics revealed the general public was viewing our geriatric-themed educational videos using mobile devices, and they were sharing the videos using WhatsApp.⁴ We have subsequently incorporated such insights into optimizing our medical education media content for the general public.

There are both benefits and risks associated with social media use. Nevertheless, for physicians who are committed to public health and patient education through social media, leveraging analytics could further improve the quality of health education and promotion.

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Using Podcasts to Study Efficiently and Increase Exposure to Medical Specialties

To the Editor: As medical students and avid podcast listeners, we read with great interest Kelly and colleagues' study, which sought to improve understanding of podcast use in medical education.¹ To speak to the utility of podcasts as accessible and flexible learning tools, below we present empirical observations related to medical student podcast usage.

We agree with Kelly and colleagues that a significant benefit of medical education podcasts is their portability and efficiency.¹ Students often have unproductive periods of time, such as commuting, where traditional study methods may be impractical. Using podcasts to study whenever possible can increase efficiency and free time, leading to an improved work–life balance and decreased stress levels.

At our respective institutions, podcasts were incorporated into our first-year curriculum. Our experiences support Kelly and colleagues' finding that medical education podcasts provide flexible, learner-specific, and entertaining content.¹ Listening to information-dense podcasts, rather than attending in-person lectures, allows us to maximize our time. Because podcasts split information into digestible portions, we find it easier to focus compared with traditional didactic lectures. We observe that many of our peers also value the ability to pause and customize the playback speed of podcasts, allowing for personalized learning.

In addition to functioning as learning tools, podcasts offer exposure to

specialties that are less encountered in medical education. For example, *The Undifferentiated Medical Student* (<https://www.undifferentiatedmedicalstudent.com>) has helped us learn about specialties that are not well represented at our institutions. Podcasts like this one are especially pertinent for medical students who may not experience a robust and diverse clinical curriculum.

We thank Kelly and colleagues for sharing their insights and encourage future studies to similarly assess podcasts featuring medical specialty information. Learning about medical specialties is as important as learning about medical practice. For specialties that are facing shortages of physicians or little exposure from medical students, creating conversations about their scope and culture is necessary to attract potential applicants. We believe that podcasts can help bridge this gap.

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The authors have informed the journal that they agree that both L.K.-P. Wang and P.S. Paidisetty completed the intellectual and other work typical of the first author.

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- 1 Kelly JM, Perseghin A, Dow AW, Trivedi SP, Rodman A, Berk J. Learning through listening: A scoping review of podcast use in medical education. *Acad Med.* 2022;97:1079–1085.