Effect of Favoritism on Junior and Mid-Level Faculty

Favoritism is defined as "showing of special favor or partiality and the state or fact of being a favorite" [1]. While it is human to connect better or feel more comfortable with one individual compared to the others but obvious display and/or conduct of favoritism by those in administrative position has been shown to hamper team work and organizational growth. At an individual level, it appears to breed dissatisfaction in those who are not the so called chosen ones and negatively impact their overall performance [2,3]. As in other fields, medicine is also not untouched by favoritism. There is limited data on its impact on professional performance and satisfaction in the medical fraternity. Therefore, we created an online survey to ascertain the perceived prevalence of favoritism.

A survey was created on the SurveyMonkey-platform, and shared with assistant professors to professors or junior and senior consultants in government and private teaching hospitals, who had at least one senior person supervising them directly (head of department, or unit head).

The survey was shared with 100 medical professionals among the author's contacts, and 93 responded Of these, 62 (66.7%) were women, and 58 (62.4%) were from government teaching hospitals. Nearly three-fourth (72.3%) participants were junior-to-middle level medical professionals (**Table I**).

Table I Baseline Characteristics of the Respondents (*N*=93)

Characterstics	*Value*
Age (y)	41 (4.83)
Qualification	
MBBS (graduation)	11 (11.8)
MBBS and MD/DNB (post graduation)	48 (51.6)
MBBS, MD/DNB and Super specialty training	34 (36.6)
Specialty	
Pediatrics	31 (33.3)
Medicine	18 (19.3)
Surgery	13 (14)
Orthopedics	11 (11.8)
Other clinical specialities	9 (9.7)
Paraclinical specialities	11 (11.8)
Professional level	
Junior consultant	9 (9.6)
Consultant	17 (18.2)
Senior consultant	8 (8.6)
Assistant professor	21 (22.6)
Associate professor	24 (25.8)
Professor	14 (15.0)

Values in no. (%) or [a]mean (SD).

Among the respondents, 82 (88.5%) believed that they had been at the receiving at the end of favoritism sometime or the other. Thirty four (36.6%) participants reported that favoritism had impacted their professional satisfaction, 66 (71.2%) felt the impact of favoritism on their performance and that it influenced/ impacted their career. The results are summarized in **Web Table I**.

Favoritism by leaders at any level creates an environment of partiality and inequality, which is detrimental to the performance outcomes and working of any organization as a whole [2,3]. However, very little has been said about favoritism in medical institutes, especially among faculty, and its impact on their career progression, future choices and professional satisfaction [4,5]. This may possibly be a result of organizational silence or even cultural censorship. Such a work environment is sure to promote cynicism adding to personal stress in an already stressful environment. It may also result in loss of quality and productivity as reported in our survey, and also in previous studies [6].

An obvious limitation of our study is that the survey participants answered queries regarding favoritism by their senior colleagues as perceived by them, and the seniors' viewpoint was not studied. The views of many others being considered to be favorites may be different, and not solicited. Another limitation may be the relatively small number of survey participants, and the highly selective nature of the sample, which may lead to some skewing of results.

We feel that this small study raises important issues, and further studies with larger number of faculty may give a clearer picture.

Note: Additional material related to this study is available with the online version at *www.indianpediatrics.net*

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Iron Overload in an Infant With Rh-Isoimmunization

A late preterm (gestational age-36 wk) baby girl weighing 2.1 kg was born to a 30-year-old, G4A2L1 mother delivered through cesarean section. Mother had Rh-ve blood group, had a living child with Rh+ve blood group in G1 pregnancy; and G2 and G3 were aborted in first trimester. She did not receive anti-D prophylaxis during initial three pregnancies. In the current pregnancy (G4), fetal hydrops fetalis was detected in 24-week antenatal scan, indirect coombs test (ICT) was 1:256 titre positive. She was managed with five intra uterine transfusions (IUT) between 25-34 weeks of pregnancy. Baby had received phototherapy and exchange transfusion for severe hyper-bilirubinemia during first postnatal week.

At one-month of age, baby presented with moderate anemia (hemoglobin - 8.3 gm/dL), without icterus and organomegaly. She was afebrile, active, and with appropriate weight gain. Her blood group was O positive (due to multiple IUTs). Her reticulocyte count was 3.5%, mean corpuscular volume MCV- 74 fL, negative direct Coombs test (DCT) and microcytic normo-chromic red blood cells (absence of hemolysis) found in peripheral smear. She had hyperferritinemia (755, 655 ng/mL) with raised serum iron (138,129 g/dL) and transferrin saturation (76.7%, 56.6%) with low TIBC (180,228 mcg/dL) on day 29 and 63 of age, respectively. On follow up at age of 3 month and 6 month, she had only raised hyperferritinemia (322, 225 ng/mL), with normal hemoglobin (12 g/dL) at 6 month. Baby was managed conservatively with routine supplementation of vitamin D, without any iron chelation therapy.

This neonate presented with asymptomatic anemia and was found to have iron overload. The presence of hyperferritinemia in our case was similar to previous case studies following multiple IUTs [1-3]. The possible differential diagnosis could be common causes of anemia or either existing hemolysis due to Rh-isoimmunization, or suppression of erythropoiesis due to iron overload, or excessive nadir of physiological anemia of infancy [2].

The burden of Rh-isoimmunization is more prevalent in developing countries like India. It causes hydrops fetalis and increases neonatal morbidity [4]. IUT is the management option for severe fetal anemia, guided by antenatal middle cerebral artery Doppler. Currently, the facility for IUT is available only in few referral tertiary care centers of India, and the infants are subsequently followed by pediatricians. We suggest that pedia-tricians should be cautious in prescribing iron supplementation to such infant, who have received multiple intrauterine transfusions.

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Web Table I Survey Findings on Impact of Favoritism (*N*=93)

Your position in your hospital/institute	Junior consultant Consultant Senior consultant Assistant professor Associate professor Professor	9.6% 18.2% 8.60% 22.58% 25.81% 15.05%
Are you involved in teaching and research apart from your clinical work	Yes No	83.70% 16.30%
Have you ever felt that your senior in the department or organization is playing favorites	Always Usually Sometimes Rarely Never	21.51% 37.63% 30.11% 3.23% 7.53%
Have you been able to understand or figure out the reason why your senior has been favoring someone	Always Usually Sometimes Rarely Never	13.98% 36.56% 33.33% 8.60% 7.53%
Has the reason for favoritism something that you feel you could influence/change or generally in your hands	Always Usually Sometimes Rarely Never	.60% 7.53% 16.13% 49.46% 18.28%
Do you think that the favoritism has impacted your performance at work	Always Usually Sometimes Rarely Never	10.87% 10 19.57% 18 42.39% 39 14.13% 13 11.96% 11 1.09%
Has the favoritism influenced/impacted your career in terms of promotions/getting grants/better position in your organization	Yes No	68.82% 31.18%
How much would you say that favoritism has impacted your professional satisfaction	A great deal A lot A moderate amount A little None at all	13.98% 22.58% 24.73% 27.96% 10.75%