Shining a Light on the Dark Side

TO THE EDITOR: As a third-year medical student rotating in labor and delivery, I agree with a recent commentary (1) and urge everybody to consider his point about Laine and colleagues’ editorial (2). As a field, we do need to talk about the good, the bad, and the ugly. However, featuring 2 of these ugly stories about obstetrics and gynecology in an internal medicine journal without input from our colleagues in this field could be counterproductive. If we are ready to talk about the dark side, making a conscious effort to avoid targeting him and to start sharing the secrets of the whole family would probably be more beneficial.

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TO THE EDITOR: I read the anonymous essay (1) and Laine and colleagues’ editorial (2) with interest. Not long ago, my colleagues and I published an editorial on the use of cynical humor by medical staff: implications for professionalism and the development of humanistic qualities in medicine (3). We observed that health workers are almost always overworked, tired, and overwhelmed with the demands and stresses of their profession. Indeed, they are not immune to the numbing effect of the day-to-day clinical grind. Some turn to derogatory humor as a coping mechanism.

We acknowledged that laughter can be therapeutic for patients and physicians alike. Yet, when used in ways that compromise human dignity, humor in the hands of those given the fiduciary duty to care for others becomes palpably dehumanizing and allows little power to truly heal.

In the words of the late Ernest Boyer, the “crisis of our time relates not to technical competence, but to a loss of the social and historical perspective, to the disastrous divorce of competence from conscience” (4). Preparing our future physicians to embrace such humanistic values as kindness, compassion, integrity, respect, and humility is perhaps one of the greatest challenges of medical education in the 21st century. We need to develop pedagogical approaches that not only will prepare clinically competent physicians but are equally as embracing of these values if they are to be transformative.

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References
allow persons to make accusations for which they do not take
credit? We have a grave responsibility as physicians. When I
report abuse to child or adult protective services, I cannot do
so anonymously. I know there will be consequences.
This essay was based on the experience of a faceless
medical student. Please review the decision to print it and
Laine and colleagues’ editorial. I find it egregious, and no-
where do these articles discuss the widely accepted policies
in place to prevent and report such occurrences.

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Forms can be viewed at www.acponline.org/authors/icmje/ConflictOf
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References
26280420] doi:10.7326/M14-2168
2. Laine C, Taichman DB, LaCombe MA. On being a doctor: shining a light on
doi:10.7326/M15-1144

TO THE EDITOR: Soon after the anonymous essay (1) and
Laine and colleagues’ editorial (2) were published, our pro-
gram director fired off an e-mail to our entire residency.
“Would you please read this and tell me what you think?” she
wrote, with an undertone of urgency and a sense that she
wasn’t asking. The essay ricocheted along the corridors of our
3 teaching hospitals, off the whiteboards in our precepting
rooms, and across the benches in our laboratories until it
seemed that no resident or faculty member was left un-
scathed. Responses flooded her inbox, and our secrets
started spilling.
There were accounts of physicians who needed forgive-
ness and of many more who needed to forgive. Many ex-
pressed regrets for complicity in similar situations. “It left me
numb and flushed, and I couldn’t write or speak for a min-
ute. . . . [There are things] I can’t forgive myself for, simply be-
cause I was in that space when they happened.” Others re-
called with embarrassment their own hesitant laughter, 
flamencos missed opportunities to confront impropriety.
The events portrayed in the anonymous essay were
shocking and sobering indeed, but many recognized how lit-
tle it takes to erode our empathy and threaten our patients’
dignity. How we are all one off-color joke, one insensitive la-
bel, one unkind gesture away from inhumanity.
One response stood out for its positivity. An intern re-
marked, “It reminds me of the importance of culture and cul-
ture leaders.” He recalled a particular bariatric surgery intern
who was determined to focus not on his overweight patients’
shortcomings but on their inherent dignity and the struggles
they had faced. “He [showed] that maintaining one’s integrity
through words and actions not only protects against burnout
but could also make you a leader, even as an intern.”
If a single, unifying theme has emerged from this week of
reflection, it is that we should all demand such leadership
even as we search for that same inner strength. Rather than
recoil from this portrayal of “medicine’s dark underbelly” (2),
we applaud the courage of the author and of the editors who
understood the need for this dialogue. It is no longer a secret
that we are all 1 family and that we all have silences to break.

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/authors/icmje/ConflictOfInterestForms.do?msNum=L15-0516.

References
26280420] doi:10.7326/M14-2168
2. Laine C, Taichman DB, LaCombe MA. On being a doctor: shining a light on
doi:10.7326/M15-1144

TO THE EDITOR: We applaud the editors of Annals for pub-
lishing the anonymous essay (1) and Laine and colleagues’
accompanying editorial (2). No one likes to expose the dark
side of their field, but as professionals, we have a solemn
responsibility to acknowledge the darkness within medicine
just as we celebrate its humanity.

Organized medicine has shown a high tolerance for the
kinds of appalling behavior that were the subject of the essay.
Unfortunately, these are not isolated incidents. Last month,
when The Washington Post reported on the essay, it hit a re-
sponsive chord (3). The story garnered more than 290 com-
ments, many from physicians and nurses with their own horror
stories of medical disrespect. Reading through those com-
ments, we question Laine and colleagues’ inference that these
behaviors in medicine are uncommon.

We have allowed a code of silence to pervade the prac-
tice of medicine, which is especially inhibiting for students
and residents. Our acquiescence has spawned one of the
most insidious aspects of the “hidden curriculum.” According
to Liao and associates, “a strong desire to ‘fit in with the team’
and fear of repercussions can trump the moral courage re-
quired to speak up about safety concerns and unprofessional
behavior. While educators focus on formal resident patient
safety curricula, the hidden curriculum may be a more power-
ful ‘teacher,’ suppressing speaking up, and shaping residents’
attitudes and behaviors” (4).

A third-year medical student at Harvard wrote a compel-
ling essay last year about what she termed the “culture of
disrespect” (5). “Many in medicine actively protect the culture
of disrespect because they hold a fundamentally flawed idea:
that harshness creates competence,” she stated.
LETTERS

Having worked in academic medicine all of our careers, we can state emphatically just the opposite: that mutual respect, empathy, and excellent communication among all members of the medical team are critical success factors. At The Arnold P. Gold Foundation, we have been working for almost 3 decades to recenter the practice of medicine around the patient and to advocate for more humanism in our increasingly fragmented health care system.

We hope the editors of *Annals* will not hesitate the next time a clinician decides to “break the silence” and speaks out against the bullying subculture of medicine. That act alone will elevate the culture of relational medicine and humanitarian practice.

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**References**

**TO THE EDITOR:** Thank you for shining this light. As a family physician, I hear stories weekly of physicians who discount the lived experiences of women. Reading Laine and colleagues’ editorial (1) and the anonymous article (2), I am inspired to reflect also on my own practice, now and in the past, and to pledge to do better, to listen more deeply, to honor all stories, but especially to find room in my heart to understand those who live their lives differently than I do, who make choices I would not, to see myself in “others” and “those people.” We can do better. This will help. Thank you.

Elizabeth Allemann, MD
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**Disclosures:** Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L15-0513.

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**IN RESPONSE:** We appreciate the attention that the On Being a Doctor essay “Family Secrets” has garnered. Whether readers appreciated or were appalled by our decision to publish it, the essay has clearly generated dialogue about an important issue. Prompting such discourse was exactly why we published it.

Mr. Vargas Pelaez believes that it was inappropriate for an internal medicine journal to publish an essay about an incident that occurred in an obstetrics and gynecology setting. We believe that the issues raised in this essay transcend specialty divisions. Unfortunately, this sort of inappropriate behavior is not confined to a single specialty—nor is it confined to male doctors or solely directed at female patients. We cannot say how common this type of behavior is, but that it happens at any frequency means it happens too often. Physicians should never act this way toward patients. Doing so in front of students and residents they are supposed to be teaching is especially abhorrent.

As Dr. Dharamsi suggests, although humor can be healing, the patient should never be the brunt of the joke. When we become physicians, we take an oath, and part of that oath is to treat patients with warmth, sympathy, and understanding. The ability to heal does not negate the importance of treating our patients with respect.

We applaud Dr. Ray for never hesitating to speak up when she witnesses inappropriate behavior and emphasize that anonymous publication was a decision made by the editors. It was not intended to protect the physicians but rather to prevent a patient who may have received care at an institution where the author worked from worrying that she might have been one of the patients discussed in the essay.

Dr. Sgro and colleagues’ experience reflects our goal in publishing this disturbing essay—to prompt thoughtful discussion about professionalism among medical students, physician trainees, and their senior colleagues so that all are prepared to speak up should they find themselves in situations such as those described in the essay.

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**CORRECTION**

**Correction:** Ultrasonography Screening for Abdominal Aortic Aneurysms

**TO THE EDITOR:** In our article, “Ultrasonography Screening for Abdominal Aortic Aneurysms: A Systematic Evidence Review for the U.S. Preventive Services Task Force” (1), we state that...
neither the individual population-based abdominal aortic aneurysm (AAA) screening trials, nor our pooled analysis of these trials, showed a statistically significant reduction in all-cause mortality. However, a careful reader, Frank Lederle, pointed out that the authors of MASS (Multicentre Aneurysm Screening Study), a large, good-quality trial, reported their hazard ratio (HR) for all-cause mortality to be statistically significant at 13-year follow-up (HR, 0.97 [95% CI, 0.95 to 0.99]) (2); these data are shown in Table 2 of the manuscript and seem to contradict our statement. Dr. Lederle also questioned whether pooled results for all-cause mortality with upper CIs of 1.00 may in some cases be statistically significant if carried to 3 decimal places. We would like to walk Annals readers through these issues and our series of analyses to clarify what may appear to be discrepancies in our results and conclusions.

The overarching issues involved with seemingly contradictory interpretations of the evidence reflect the complexity of analysis for all-cause mortality, whereby the overall effect on this outcome is very small, and statistical significance of pooled results is highly dependent on analytic approaches and decisions. Further, readers should be aware that different risk measures (i.e., HR vs. relative risk [RR]) may affect results. Primarily due to study-level reporting, we focused our synthesis on RR measures to maximize data availability across trials.

To harmonize reported outcome measures across trials, we recalculated study-level data to produce an RR for the 13 year timepoint in MASS (RR, 0.985 [CI 0.949 to 0.999]). We rounded this RR point estimate and 95% CI to 2 digits beyond the decimal, as is our convention. As a result, the 95% CI included 1.00 and was not considered statistically significant, in contrast to the study-reported HR. Our use of no more than 2 significant digits is long-standing and we believe appropriate, given that few studies report effect size measures beyond 2 digits, and study-level data are our primary data source. Although we stand by our rounding approach, we acknowledge that different approaches could lead people to somewhat different conclusions, particularly if one adheres to conventional indicators of statistical significance as their primary focus.

In summarizing data across trials, we focused on 2 different time points commonly reported by trials to indicate short- and longer-term clinical impact: the initial 3- to 5-year end point available from all 4 trials (3–6), and the 13- to 15-year time frame available from only 3 of the 4 trials (2, 7, 8). Like others in the field, we pooled the longest available follow-up for all 4 included trials; this included the 3.6-year West Australian trial (6). In our original analysis for the U.S. Preventive Services Task Force, we presented pooled results using a random-effects model with the DerSimonian—Laird estimation method, with a sensitivity analysis examining a fixed-effects model, to provide comparisons to the work of previous reviewers in this area. Due to emerging consensus that this model can underestimate the 95% CI when a small number of trials are combined (9), we expanded our meta-analytic approach when developing our Annals manuscript. We also shifted our primary interpretation to emphasize the qualitative synthesis of the data, and to emphasize the more conservative profile likelihood estimation method for any pooled results.

As shown in the Table below, the choice of statistical model as well as rounding approach makes subtle differences in the final interpretation of long-term mortality results as “statistically significant” or not. The DerSimonian—Laird random-effects models for all-cause mortality at either 13 to 15 years or longest follow-up do not cross 1.00 at the upper 95% CI bound (RR, 0.986 [CI, 0.972 to 0.999]); however, after rounding to 2 significant digits we concluded a lack of statistical significance at this longest time point. When the profile likelihood random effects model is used, point estimates are quite similar, but the upper bound of the 95% CI crosses 1.00, regardless of rounding. Since we agreed that this approach was most appropriate, we emphasized it as our “bottom line,” best estimate of a pooled result for this outcome.

Although details of the analytic approaches can be important to appreciate, we believe that there are other, perhaps more important, considerations when interpreting whether AAA screening is associated with an effect on all-cause mortality. These include the consistency of findings (across analytic approaches), as well as the size and clinical significance of any effect. We believe that these 2 perspectives suggest that any effect of AAA screening on all-cause mortality is slight, if present, and depends on the analytic approach taken and the time point considered. Any uncertainty is offset by a clearly beneficial effect on AAA-related mortality, which has been sufficient for evidence-based policy makers to recommend this screening service (10).

To avoid any confusion, we appreciate the opportunity to issue an erratum for Table 2, in order to clarify the source of the data in that table as representing those reported by the trials’ authors. The title of Table 2 has been changed to the following: “All-Cause and AAA-Related Mortality Data for 1-Time Screening Trials at the Initial and Longest Follow-up as Reported in the Trials.”

We have also amended our text reflecting the summary findings to clarify our results. On page 324, the word “consistent” has been added to the first sentence of the first full paragraph. The sentence now reads as follows: “An invitation to AAA screening was not associated with a consistent statistically significant all-cause mortality benefit in any of the individual trials or in the pooled random-effects analysis at any time point up to 15 years...”

These corrections have been made in the online version.

### Table. Relative Risk, All-Cause Mortality Effect of Abdominal Aortic Aneurysm Screening, Using 2 Random-Effects Models

<table>
<thead>
<tr>
<th>Time Point</th>
<th>DerSimonian-Laird</th>
<th>Profile Likelihood</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2 Significant Figures</td>
<td>3 Significant Figures</td>
</tr>
<tr>
<td>13-15 years (3 trials)</td>
<td>0.98 (0.97-1.00)</td>
<td>0.985 (0.971-0.999)</td>
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<tr>
<td>Longest follow-up (4 trials)</td>
<td>0.98 (0.97-1.00)</td>
<td>0.986 (0.972-0.999)</td>
</tr>
</tbody>
</table>

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References

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