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 and to start sharing the secrets of the whole family would probably be more beneficial.

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References

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 about the use of cynical humor in medical practice and the related implications for professionalism, empathy, 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.

Yes, humorless pedagogy is dull; nevertheless, the use of humor marks the distinction between learning and healing on the one hand and distancing and destructiveness on the other. Medical educators and role models must enable our next generation of physicians to develop the capacity to reflect deeply and ensure careful use of words that can bring hope in tragedy and compassionate laughter in the face of the otherwise overwhelming exposure to the sorrow of others.

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References

TO THE EDITOR: A local reporter tweeted me about the anonymous essay “Family Secrets” (1). My copy of Annals was still sitting on the kitchen table, and I immediately read the essay as well as Laine and colleagues’ editorial that reviewed the journal’s decision to print it (2). I hope that someone at the American College of Physicians understands the consequences of printing an anonymous report of what is likely more about the embarrassment of someone who did not stand up when he or she should have (and still is not doing so because of the anonymous nature of the essay) than it is a revelation of a secret tolerance of unacceptable behavior.

The media are going to pick this up as news, not self-examination. Despite being in practice for decades, I have never witnessed inappropriate behavior in the operating room. However, I certainly have in other areas and have no problem saying something. I do not know any nursing staff who would witness such an incident without reporting it, and they should.

I do not appreciate Annals’ actions, which promote to the public what they already perceive as a trust issue with physicians in an area where a patient feels most vulnerable. The critics waiting for these kinds of comments, which are viewed as credible, will eat this up as validation of the belief that the medical profession demeans women.

What is wrong with the author of this essay is that he or she did not speak up. Medical education should be training leaders, not followers. I appreciate that the author wants to come forward, but by doing it this way, he or she seems to wish to implicate others as though the behavior were commonplace. I 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.

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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 nowhere do these articles discuss the widely accepted policies in place to prevent and report such occurrences.

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References

TO THE EDITOR: Soon after the anonymous essay (1) and Laine and colleagues’ editorial (2) were published, our program 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 unscathed. Responses flooded her inbox, and our secrets started spilling.

There were accounts of physicians who needed forgiveness and of many more who needed to forgive. Many expressed regrets for complicity in similar situations. “It left me numb and flushed, and I couldn’t write or speak for a minute. . . . [There are things] I can’t forgive myself for, simply because I was in that space when they happened.” Others recalled with embarrassment their own hesitant laughter, lamenting missed opportunities to confront impropriety.

The events portrayed in the anonymous essay were shocking and sobering indeed, but many recognized how little it takes to erode our empathy and threaten our patients’ dignity. How we are all one off-color joke, one insensitive laugh away from inhumanity.

One response stood out for its positivity. An intern remarked, “It reminds me of the importance of culture and culture 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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References

TO THE EDITOR: We applaud the editors of Annals for publishing 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 responsive chord (3). The story garnered more than 290 comments, many from physicians and nurses with their own horror stories of medical disrespect. Reading through those comments, we question Laine and colleagues’ inference that these behaviors in medicine are uncommon.

We have allowed a code of silence to pervade the practice 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 required 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 powerful ‘teacher,’ suppressing speaking up, and shaping residents’ attitudes and behaviors” (4).

A third-year medical student at Harvard wrote a compelling 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.

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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 subculuture of medicine. That act alone will elevate the culture of relational medicine and humanitarian practice.

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Disclosures: Authors have disclosed no conflicts of interest.

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.

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

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, “Ultrasound 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 0.998]). 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>
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<th>Time Point</th>
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<td>13-15 years (3 trials)</td>
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<td>0.985 (0.971-0.999)</td>
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<tr>
<td>Longest follow-up (4 trials)</td>
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<td>0.986 (0.972-0.999)</td>
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