Response to “Parathyroid Surgery: Getting It Right the First Time”: Parathyroid Surgery: Primum Non Nocere

DOI: 10.1177/0194599815619602

In order to have a meaningful debate about the treatment of primary hyperparathyroidism (PHPT), it is essential to define what is meant by “cure.” Unfortunately, the definition that Dr Terris used when he reported his results for 112 patients whom he treated over a 4-year period—normocalcemia at 6 months—is pervasive in the literature. As Drs Terris and Stack point out, our 3 patients who had calcium levels >10 may prove over time to be surgical failures, but according to the standard that they have used to judge their own results, these “normocalcemic” patients would have been regarded as “cured.” We advocate a more rigorous standard that is based on simultaneous calcium and parathyroid hormone (PTH) measurements so that patients with normocalcemic PHPT will not be mistakenly labeled as “cured.”

In addition to dispensing with normocalcemia as the benchmark for defining who has been “cured,” it is also essential to analyze the outcomes for patients subjected to bilateral neck explorations based on IOPTH. Irvin reported that 70% of patients who had an elevated PTH despite a >50% fall in IOPTH would have unnecessary bilateral neck explorations. In those cases, if the remaining 3 glands are found to be grossly normal or equivocal, the surgeon is posed with a dilemma. If the surgeon performs a subtotal parathyroidectomy, he or she may be overtreating a patient who has already been cured—exposing that patient to the possibility of permanent hypoparathyroidism; or, if those glands are left in situ and they prove to be hyperfunctioning—for example, normal-appearing 40-mg glands that were once 20-mg glands—then the surgeon has created a situation where a second operation would be more difficult due to fibrosis that would affect all of the glands left in situ.

Two additional points:

1. We operated on 356 patients (31 cases/year).
2. Drs Terris and Stack’s assertion that a second surgical procedure would have higher complication and lower success rates is not supported by the paper that they cited.

We stand by our position that patients who have persistent PHPT after a directed parathyroidectomy can be safely brought back to the operating room with the knowledge that even if the parathyroid glands look grossly normal, they are in fact hyperfunctioning and ought to be treated accordingly. The injunction against overtreatment—Primum non nocere, which is a cornerstone of medical ethics—should be our guiding principle when it comes to parathyroid surgery.

William I. Kuhel, MD
David I. Kutler, MD
Marc Cohen, MD
Department of Otolaryngology–Head and Neck Surgery, Weill Cornell Medical College / New York Presbyterian Hospital, New York, New York, USA

Thomas Heineman, MD
Department of Otolaryngology–Head and Neck Surgery, University of California–Los Angeles, Los Angeles, California

Disclosures
Competing interests: None.
Sponsorships: None.
Funding source: None.

References

A Beacon of Emotional Resilience in a Storm of Mistreatment?

DOI: 10.1177/0194599815621528

We read with great interest McMains and colleagues’ study of shame in otolaryngology residents and physicians and commend the authors for tackling this complex and underresearched topic. In this letter, we draw attention to 2 notable points related to the study: (1) the importance of distinguishing between shaming and mistreating and (2) the potentially unrecognized presence of resilience in the study results.

The study is built on examples of situations that the authors postulate lead to shame, including being called names, being “banished” from the operating room, and being threatened. These actions constitute forms of mistreatment but may not be inherently shame inducing. To be shamed in response to mistreatment requires that the recipient attribute the mistreatment to an internal deficiency and believe that it is

No sponsorships or competing interests have been disclosed for this article.
deserved. Recipients who attribute the mistreatment to a non-internal cause (ie, an ineffective teacher or suboptimal learning environment) may feel guilt or humiliation but do not necessarily experience shame. Thus, the emotional outcome of the mistreatment must be analyzed to determine if particular treatment is “shaming.”

The ability to receive mistreatment and not experience shame may actually constitute a form of emotional resilience. In the study by McMain et al, residents’ responses to the mistreatment suggest the presence of constructive responses to mistreatment. Over half of residents reported self-improvement and reaching out to others in response to the mistreatment, both of which are associated with constructive, prosocial guilt responses. Conversely, respondents also reported keeping the event a secret, reaching out to colleagues less frequently, feeling professionally isolated, and experiencing depression, each of which implies a damaging shame response.

Thus, the data that McMain et al collected suggest the presence of both damaging shame responses and constructive guilt responses in the face of mistreatment. As such, it is both bleak and encouraging. It is bleak because of the high rate of reported mistreatment, which is consistent with rates previously reported, and its tendency to cause shame. However, the emotional resilience woven into the results is encouraging.

Research is needed to further characterize how learners experience shame, what influences its occurrence, and the outcomes with which it is associated. This should be accompanied by equally important research into what constitutes and influences emotional resilience in the face of learner mistreatment. Eradicating mistreatment in medical education will take time, but characterizing the underlying emotions and promoting resilient responses can and should begin immediately.

William E. Bynum IV, MD
Family Medicine Residency, National Capital Consortium,
Fort Belvoir Community Hospital,
Fort Belvoir, Virginia, USA
Steven J. Durning, MD, PhD
Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA

The views expressed in this letter are those of the authors and do not reflect the official policy of the Department of Defense or the U.S. Government.

Disclosures
Competing interests: None.
Sponsorships: None.
Funding source: None.

References

Response to “A Beacon of Emotional Resilience in a Storm of Mistreatment?”
DOI: 10.1177/0194599815621529

We sincerely appreciate the interest of Drs Bynum and Durning and their thoughtful consideration. They highlight several important aspects of this topic. First, the emotional response experienced by the learner does depend to a degree on his or her own emotional makeup. Tangey and Dearing provide a book-length treatment of features of “guilt-prone” and “shame-prone” personalities. Generally speaking “guilt-proneness” tends toward more adaptive and resilient responses than does “shame-proneness.” The second important aspect is that emotional resilience can be cultivated. The importance of this has been recognized by the US Army, which has initiated the Comprehensive Soldier Fitness program in an effort to maximize resilience among soldiers. These techniques can and should be adopted throughout medical and surgical training to maximize learner experience during residency training.

The work of this research group has aimed to extend the conversation about educational best practices, looking critically at how we, as a community of educators, do business. We serve in a leadership capacity with respect to our trainees. It is clear that there are many behaviors associated with successful leadership. Increasing exposure to and training in effective leadership behaviors represent an opportunity to improve learning environments and unlock potential among our trainees.

For the benefit of our trainees and the strength of our profession, it is incumbent upon each of us to build resilience in our trainees and model professionalism in teaching both for ourselves and for our colleagues.

Kevin Christopher McMain, MD
South Texas Veterans Health Care System, Surgery, San Antonio, Texas, USA