A Response to Excessive Screening Questions

Recently, JAMA Internal Medicine published a firsthand account of a trauma survivor who had disclosed over a series of years on multiple self-administered screenings that she had experienced trauma, yet none of her health care clinicians had ever followed up with her or provided any support or resources. In reading her account, I wondered how many of her clinicians had even seen the screening questionnaires she completed.

Standardized screening questionnaires allow primary care clinicians to learn important information about patients, especially in psychosocial areas (eg, depression, anxiety, substance use) that can be difficult to assess in short appointments. Adding to their efficiency, they can be completed in the waiting room. But for them to be useful, they have to be read, and the appropriate resources must be available.

Just as “alarm fatigue” can result in not paying attention to important warnings from electronic health records, use of screening questionnaires performed more often than necessary can deluge clinicians with more information than they can incorporate in a visit, decreasing the efficiency of the visit and leading to cynicism on the part of patients (eg, “Why do they keep asking me if I am depressed, when I keep telling them I am not?”) and on the part of primary care clinicians (eg, “Why are my patients repeatedly given these screeners, when I dealt with this issue on the last visit?”).

In this issue of JAMA Internal Medicine, Simon and colleagues estimated the proportion of standardized screenings performed at 24 federally qualified health centers in 2019 that were excessive, defined as performed when not recommended. Six screeners were evaluated (depression, anxiety, smoking status, passive smoke exposure, health literacy, and preferred learning style), all of which were tied to national performance metrics. The authors found that 34.9% of all screenings performed (2,067,152 of 5,917,382) were excessive.

It is likely that excess screenings were driven by fear of missing a targeted metric, combined with challenges in figuring out who was appropriately due for a screening. And while some may think that little harm is done by having patients complete excess questionnaires, patients can hardly be expected to know when their answers matter, and when they will go in a pile of unread papers. If we want patients to respond to sensitive questions, they must know that we are interested in their answers.

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Figure 1. Gender-Based Salary and Representation Disparities in Internal Medicine in 2018 to 2019

A. Median annual salary for women vs men based on faculty position. Median annual salary for women was uniformly lower compared with men across all faculty levels within internal medicine. Female representation was nearly equal at the most junior faculty rank but declined with each rank of faculty promotion. B. Median annual salary for women was lower compared with men across internal medicine specialties but reached higher than 90% of male salaries in 10 of 13 specialties (blue line, right y-axis).

Figure 2. Gender-Based Salary Disparities in Internal Medicine Specialties in 2018 to 2019, by Rank

Median women's salary as a percentage of men's salary, by specialty and faculty rank. Men's salaries surpassed women's salaries in 56 of 62 categories of faculty rank in 13 internal medicine specialties. Equivalence point of women's and men's salaries is displayed as the black line at 100%.
particularly within the higher ranks of cardiology and gastroenterology (Figure 2).

Discussion | Our analysis of the 2018 to 2019 AAMC Faculty Salary Report from 154 US medical schools demonstrates persistent salary differences by gender and representation disparities in IM specialties, despite the increasing number of women in IM. We found that nonprocedural IM specialties exhibited closer parity in both salary and representation, whereas procedural specialties had low female representation with the largest salary disparities.

Within IM, unadjusted salary differences between genders appear to be improving over time. Yet, substantial salary inequities persist at the highest faculty levels and specifically in procedural-based specialties.4 Our findings regarding the disparities in procedural IM specialties align with recent works that examined both academic and nonacademic physician salaries and found that the largest gender differences in salary across multiple medical and surgical specialties existed among specialties and practices with the highest proportion of male physicians.5,6 The reasons for this remain unclear; IM procedural specialties have long been male dominated in composition and leadership, despite increasing gender parity in the preceding training stages. Taken together, these findings suggest that workforce gender parity was associated with salary equity, and further investigation of the disparities in procedural specialties is needed.

Limitations include inability to adjust for additional individual-level factors that may affect salary, including professional service, academic productivity, clinical volume, and ancillary funding sources, and these factors are likely also influenced by gender, race, and geography. Our findings may not be generalizable across all US medical schools given the heterogeneity in IM departmental structures. Despite the influence of potential confounders, these unadjusted gender-disaggregated data provide important insights regarding physician workforce composition and salary.

Our findings suggest that salary disparities persist in US IM specialties and are most pronounced in procedural specialties with fewer women. These findings emphasize the importance of gender diversity to achieving salary parity in IM subspecialties and highlight opportunities to improve representation and salary equity in IM procedural specialties.

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COMMENT & RESPONSE

Efficacy of COVID-19 Vaccines Against Active Comparators or Inert Placebos

To the Editor A recent Viewpoint1 stressed that, although placebos are essential for accurate evaluation of new drugs and strategies, placebo composition is frequently unknown and interpretation of some trials testing COVID-19 vaccines, using at times inert placebo and at other times meningococcal conjugate vaccine in the control arm, is difficult. The authors refer to World Health Organization recommendations that control participants in trials testing unlicensed experimental vaccines should receive either an inert substance or an approved efficacious vaccine.1 We wish to elaborate on the latter.

In the current COVID-19 vaccine trial era, the clinical equipoise of inert placebo vs experimental vaccines should be questioned, given the implications of keeping participants on placebos for long periods.2 This matter, not so relevant a year ago when placebo-controlled trials began and the scientific community still ignored the efficacy of COVID-19 vaccines, is more cogent now, as available data show vaccine protection from infection or severe disease.3 In this context, can we still randomize participants vs inert...