Many of our data are corroborated by those of Shrank and colleagues. Like them, we found that EAs and AAs believe in patient choice, advance directives, and family participation in decisions. Both groups believe that advance directives improve the chances that patient choices will be honored, and want a particular family member as a proxy. Euroamericans tend to trust that health professionals honor patients' wishes and to refuse life support based on quality-of-life considerations (including functional outcome and hospitalization requirements for aggressive care). In contrast, AAs tend not to trust that health professionals honor patients' wishes and to request life support for as long as possible.[2]

But our data differ from those of Shrank and colleagues in important ways. Unlike them, we found that EAs prefer to talk about death beforehand; AAs do not.[4] Euroamericans also tend to believe that they can control treatment and, thus, want to express their wishes to physicians. In contrast, AAs tend to believe that the health care system—not patients—controls treatment and, thus, hesitate to express their wishes to physicians.[2] We also found important gender differences. Specifically, more women than men in both ethnic groups trust the health care system to empower patients and respect their wishes.[3]

Taken together, all four articles[1–4] reveal general (but not necessarily uniform) preferences within ethnic groups and genders. Knowing these preferences gives health professionals a place to start end-of-life care discussions. Yet the greatest challenge is recognizing variation within groups and avoiding harmful stereotyping. We welcome future contributions by Shrank and colleagues and others to this important field.—**Henry S. Perkins, MD, FACP, Emi Ponce De Souza, BS, Josie D. Cortez, MA, Helen P. Hazuda, PhD,** *The University of Texas Health Science Center, San Antonio, TX, USA.*

REFERENCES

1. **Shrank WH, Kutner JS, Richardson T, et al.** Focus group findings about the influence of culture on communication preferences in end-of-life care. J Gen Intern Med. 2005;20:703–9.
2. **Perkins HS, Geppert CMA, Gonzales A, Cortez JD, Hazuda HP.** Cross-cultural similarities and differences in attitudes about advance care planning. J Gen Intern Med. 2002;17:48–57.
3. **Perkins HS, Cortez JD, Hazuda HP.** Advance care planning: does patient gender make a difference? Am J Med Sci. 2004;327:25–32.
4. **Perkins HS, Shepherd KJ, Cortez JD, Hazuda HP.** Exploring chronically ill seniors' attitudes about discussing death and postmortem medical procedures. J Am Geriatr Soc. 2005;53:895–900.

RESEARCH LETTER: Do Physicians Discuss Political Issues with Their Patients?

To the Editor: Politicians have an important influence on the structure and function of our health care system. As a result, it seems likely that physicians and their patients might discuss political issues of consequence to health care. Yet, little is known about physicians' attitudes and activities in this regard or about their level of personal political participation.[1–4] We conducted a survey to examine the political attitudes and activities of physicians and to identify characteristics associated with physician willingness to address political issues with clinic patients. We developed a 23-item, 1-page questionnaire and pilot tested it with 8 physicians. The instrument measured personal political activities, political activities in the clinic, and attitudes about addressing political issues with clinic patients. Excluding demographics, response options were dichotomous (yes/no) or 5-point Likert scales. The University of Pennsylvania Institutional Review Board approved the study, which was conducted after Pennsylvania's voter registration deadline but before Election Day (October 5 to November 1, 2004). All primary care physicians (PCPs) in the Division of General Internal Medicine practicing in the University of Pennsylvania Health System were asked to complete the questionnaire. Six practices in urban and suburban Philadelphia were surveyed. Hospitalists and clinician-researchers were excluded. Participation was optional and consent implied. Questionnaires were self-administered and anonymous. For analyses, Likert responses were dichotomized (agreement/disagreement) and "unsure" responses were excluded. Bivariable associations were examined with χ^2 or Fisher's exact tests as appropriate using STATA 8.0 (Stata Corp., College Station, Tex). Of the 37 eligible PCPs, 36 (97%) participated. Study PCPs practiced clinical medicine for medians of 9 years (25% to 75% interquartile range (IQR) 7 to 15) and 32 hours per week (IQR 20 to 40), and 19 (53%) were male. All PCPs had indigent patients but 6 (17%) primarily served patients with annual household incomes less than $25,000. Table 1 summarizes our survey findings. Overall, 34 PCPs (94%) discussed voting or a politically oriented health care issue with a patient and 20 (56%) initiated such discussions. Twenty-two (63%) were willing to offer voter registration in their clinics, while 30 (83%) were willing to offer information on voter registration. Thirty-one (86%) agreed that political communication with patients, either through brochures or direct discussion, was appropriate. Male PCPs were more likely to contribute money to political campaigns (15 of 19 vs 8 of 17, $P = .05$) and to initiate discussions with patients about politically oriented health care issues (12 of 19 vs 5 of 17, $P = .04$). Physicians who contributed money or volunteered time to political cam-

Table 1. Political Activities and Attitudes of UPHS Clinician Cohort ($N = 36$)

Variables	*N* (%)
Currently registered to vote	36 (100)
Personal political activities in the last decade:	
Voted in a national election	35 (97)
Contributed money to a political campaign	23 (64)
Attended a political campaign event	13 (36)
Volunteered time to a political campaign	7 (19)
Interactions with clinic patients in the last decade:	
Had a discussion about voting	31 (86)
Initiated a discussion about voting	15 (42)
Discussed a politically oriented health care issue	30 (83)
Initiated a discussion about a politically oriented health care issue	17 (47)
Agree these politically oriented activities are appropriate in clinic:	
Remind patients to vote through clinic brochures	30 (83)
Remind patients to vote through direct discussion	21 (58)
Inform patients about politically oriented health care issues through clinic brochures	18 (50)
Discuss politically oriented health care issues with patients	15 (42)

UPHS, University of Pennsylvania Health System.

paigns were more likely to support voter registration in the clinic (18 of 23 vs 4 of 12, $P = .02$). PCPs who primarily served low-income patients were less likely to regard discussions about politically oriented health care issues as appropriate (0 of 5 vs 13 of 22, $P = .04$). In conclusion, the majority of our study PCPs discussed voting or health care politics with their patients. To our knowledge, this is the first study to demonstrate that the personal political activities of physicians are associated with their willingness to address political issues with clinic patients. Moreover, we found that gender was associated with political activity inside and outside the clinic, a finding consistent with a study of English PCPs.[5] Our study was limited by the small sample size, the single health care system source of our cohort, unadjusted analyses, and self-report. Future studies should continue to explore the political attitudes and activities of physicians in different populations and settings, in addition to addressing the influence of such activities on the patients they serve. Moreover, we believe that a debate on the ethical issues surrounding political discourse in the practice setting is warranted.—**Craig A. Umscheid, MD, Bruce Y. Lee, MD, MBA,** *Division of General Internal Medicine; (DGIM) and Center for Clinical Epidemiology and Biostatistics (CCEB);* **Robert Gross, MD, MSCE,** *Division of Infectious Disease and CCEB; and* **Barbara Turner, MD, MSEd, DGIM,** *University of Pennsylvania School of Medicine, Philadelphia, Pa, USA.*

REFERENCES

1. **Jameson MG.** Physicians and American political leadership. JAMA. 1983;249:929–30.
2. **Frank E.** Political self-characterization of US women physicians. Soc Sci Med. 1999;48:1475–81.
3. **Myllykangas M, Ryynanen OP, Kinnunen J, Takala J.** Comparison of doctors', nurses', politicians' and public attitudes to health care priorities. J Health Serv Res Policy. 1996;1:212–6.
4. **Wakeford RE, Allery L.** Doctors' attitudes, medical philosophy, and political views. Br Med J (Clin Res Ed). 1986;292:1025–7.
5. **Cooke M, Ronalds C.** Women doctors in urban general practice: the doctors. Br Med J (Clin Res Ed). 1985;290:755–8.

Mortality Associated with Hormone Replacement Therapy in Younger and Older Women

In Reply:—I appreciate the opportunity to respond to Dr. Grant's letter concerning our meta-analysis on mortality associated with hormone replacement. It is true that no single trial of younger women has shown a significant reduction in mortality with hormone use. In fact, no trial of hormone replacement has shown a decrease or increase in mortality. Death is a very rare event, especially in younger postmenopausal women, and it would require a very large trial to provide the statistical power necessary to produce significant results. A more precise estimate can be made by pooling the results of many smaller trials in the form of a meta-analysis.

In the analysis of younger women, approximately one half of the deaths were from one trial with ovarian cancer survivors that provided 40% of the weight. However, as described in the article, when this trial was excluded from the analysis there still was a significant reduction in mortality for the younger age group, with an odds ratio of 0.56 (confidence interval [CI], 0.31 to 0.99). Since our analysis was published, the Women's Health Initiative estrogen-only trial has shown a hazard ratio for total mortality of 0.73 (CI, 0.47 to 1.13) in those 50 to 59 years old.[1] If these data were added to our meta-analysis, it would provide 50% of the weight, with a revised odds ratio for mortality in the younger age group of 0.67 (CI, 0.49 to 0.92).

It is not possible to completely control for previous exposure to hormone replacement in clinical trials, but randomized trials help to reduce baseline differences between the treatment and control groups. In this meta-analysis, the women in the younger age group had a mean age of 53.7 years and had no recent exposure to hormone replacement, which indicates that their previous exposure to hormone replacement was probably minimal. Longer trials of hormone replacement will be needed in the future to assess whether this mortality benefit seen in younger women persists over the years.—**Shelley Salpeter, MD, FACP,** *Santa Clara Valley Medical Center, San Jose, CA.*

REFERENCE

1. **Anderson GL, Limacher M, Assaf AR, et al.** Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. JAMA. 2004;291:1701–12.

To the Editor:—We commend Dr. Shanafelt et al.[1] on their recent study noting an association between higher mental well-being and residents' capacity for empathy, comprising the "cognitive" capacity for insight into others' experiences and the "emotive" capacity to respond to these experiences. Although the use of the SF-8 to measure well-being only presents a limited assessment of aspects of physical and mental health, their findings support the need for further empiric work about the nature and promotion of resident well-being. In this study sample, female residents had higher emotive and cognitive empathy scores compared with men, but a lower proportion of female residents possessed "high mental well-being." This intriguing finding raises further questions about the interactions between empathy and well-being and the implications for future research.

A recent review described clinical empathy toward patients as emotional labor.[2] Physicians may use 2 different modes of acting to express empathy: (1) "surface acting"—displaying behaviors unmatched by underlying emotional content and (2) "deep acting"—modifying their underlying emotions to create congruency with these behaviors. Larson and Yao argue that recurrent surface acting by physicians may actually lead to cynicism and burnout, although there is a lack of empiric studies to support this belief. If this conjecture is true, residents who possess a high capacity for empathy may have decreased mental well-being over time because of this persistent dissonance between their underlying emotional state and their performance as empathic physicians.

Another concern is that too much empathy for patients could lead physicians to sacrifice aspects of their own well-being. Some physicians with high empathy may be unable to set the necessary boundaries to protect their own well-being. Huggard[3] describes the phenomenon of "compassion fatigue," whereby physicians who engage empathically with their patients develop burnout because of secondary traumatic stress.