between urban and rural physicians and advanced practice clinicians (APCs) within their Upper Midwest health care system.[1] The article's definitions of rural and urban, while based on the Veteran Health Administration's (VHA) interpretation of the US rural-urban commuting area (RUCA) codes, do accurately stratify urban and rural health clinicians and therefore may misrepresent their respective rates of burnout for each. The authors mention that their findings refute prior claims that practicing in a rural setting may increase burnout compared with an urban setting. Their miscategorized data may steer efforts away from initiatives to decrease rates of physician burnout in rural locations.[2]

The authors coded rurality using the VHA RUCA codes. The VHA uses RUCA code 1 for urban areas, while RUCA codes 2 to 10 correspond to rural areas.[3] Other governmental organizations, such as the US Census Bureau and United States Department of Agriculture's Economic Research Service (USDA-ERS), interpret these codes differently. The US Census Bureau states that "urban areas" contain 50,000 or more people.[4] The USDA-ERS includes detailed descriptions for each of the 10 RUCA codes. Codes 1 to 3 do not refer to population size at all; Code 4 refers to a "micropolitan area core…within an urban cluster of 10,000 to 49,999." [5] US agencies are using RUCA codes differently to define rurality differently. Had the authors used the USDA-ERS categorizations of RUCA codes, for example, they might have found significant results regarding burnout experiences between rural and urban areas. Unfortunately, the authors did not include individual respondents' information, making it impossible to explore alternative groupings of the data which could yield a significant difference in burnout rates between urban and rural clinicians.

While it is tempting to follow the rural-urban classification patterns of a large organization such as the Veterans Health Administration, inaccurately categorizing the data may steer efforts away from initiatives to decrease rates of physician and APC burnout in rural locations. I encourage the authors to reanalyze the data using the interpretation of rural and urban definitions discussed in this letter to determine if a significant difference in burnout exists.

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doi: 10.3122/jabfm.2024.240300R0

Re: Factors Influencing Patient Confidence in Screening Mammography

We read with great interest the article by Jarvis et al., published in the November 2023 issue of the *Journal of the American Board of Family Medicine.*[1] The authors underscore the importance of understanding factors associated with patients' confidence in screening mammography. Their study reveals that while 80% of women trust screening mammography, those with higher education (OR = 0.43; $P = .02$) and dense breast tissue (OR = 0.16; $P = .004$) report lower confidence. Factors such as age, race, and family history were not significant. These findings emphasize the need for enhanced education, particularly for women with dense breast tissue, regarding the efficacy of mammography.

As radiologists, we have observed that mammography and breast cancer detection often provoke negative emotions such as anxiety, discomfort, and worry, potentially impacting adherence to screening protocols and health outcomes. Thus, a patient-centered approach, which addresses emotional responses and prioritizes patient involvement, is essential. Recognizing the emotional impact of breast imaging, particularly in the context of evolving screening recommendations and cultural and socioeconomic barriers, is commendable.

In our practice, empowering patients through active involvement in decision making fosters better communication and ensures that their concerns are promptly addressed. This approach not only enhances the patient experience but can also improve health outcomes and adherence to recommendations. For example, same-day biopsies have been associated with higher satisfaction and reduced anxiety, as patients appreciate the prompt resolution of their concerns.[3]

At our institution, we extend our responsibilities beyond the procedure itself, ensuring the timely communication of pathology results and providing appropriate recommendations. We deliver potentially distressing results in a specialized space designed to reduce stress, ensuring that patients feel supported and heard.

In conclusion, Jarvis et al. present survey results highlighting that confidence in screening mammography is inversely associated with education level and self-reported increased breast density. This underscores the need for strategies to enhance patient-centered care in breast imaging. We recommend approaches such as effective communication, patient education, and creating supportive environments, which align with our experiences and emphasize the importance of a compassionate approach to improving both patient outcomes and overall satisfaction.

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doi: 10.3122/jabfm.2024.240307R0