regularly tested on the medical decisions they would hypothetically make, they should be assessed on how they would convey and execute those choices. Theoretical frameworks like MEET could help students build a more reality-rooted confidence in their abilities, improve their communication skills, and assimilate techniques to implement in their future clinical practice.

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Yuri Yin-Moe Aung
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; yuri.aung15@imperial.ac.uk; ORCID: http://orcid.org/0000-0002-3138-5797.

Eri Yin-Soe Aung
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; ORCID: http://orcid.org/0000-0003-4113-3881.

Rishabh Hariharan
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; ORCID: http://orcid.org/0000-0003-3230-006X.

In Reply to Aung et al:

Receiving the comments from Aung and colleagues was a moment of joy and reinforced our trust in Medical Education Empowered by Theater (MEET) as a meaningful pedagogy. We wanted to seize the opportunity to expand on some of the authors' reflections.

The transition to practice is indeed a moment of profound discomfort. Early-career doctors often feel ashamed, awkward, and abandoned when facing suffering and death in real-world situations in which they are responsible for clinical decisions.[1] The cursed words "what if" when pointing to the past are terrible: "What if I had done *this* instead of *that*?" The resulting intense emotional reactions often drive early-career doctors away from engaging in meaningful reflections about their performance. Reflections should be focused on preparing for future experiences and not on finding who was guilty of a bad outcome. On the stage, early-career doctors and medical students not only have the opportunity to revive and reflect on the experience, modulate and relive their emotions, but they can also help supervisors become aware of their struggles.

Moral, racial, and sexual harassment by supervisors is inadmissible, but there are other ways of sabotaging the good spirit of novices. Some (well-intentioned) supervisors believe that they are preparing the newcomers for the reality of practice by pointing out the downsides of the medical profession. These supervisors work in a complaining mode, repeating ad libitum how miserable a doctor's life can be, and how difficult patients are, draining the soul out of early-career doctors and medical students. The stage may become a place to reenergize and learn that although doctors encounter sad situations, the profession itself is not sad. Having the means and opportunity to help others may be a source of joy and fulfillment.

Finally, as the authors stated, several modern medical schools count on professional actors in various simulated activities, from training to assessment. However, these actors often do not participate in devising the learning goals—actors do not have space to bring their learning tradition and culture to the medical education table. We have been working with this question in mind: How can we empower actors as autonomous medical teachers? MEET invites Aung and colleagues and *Academic Medicine* readers to join this conversation.

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Marco Antonio de Carvalho Filho, MD, PhD
Associate professor, emergency medicine, Life and Health Sciences Research Institute (ICVS), University of Minho, Braga, Portugal, and Senior Researcher in Medical Education, University Medical Center Groningen, The Netherlands; macarvalhofilho@med.uminho.pt and m.a.de.carvalho.filho@umcg.nl; ORCID: https://orcid.org/0000-0001-7008-4092.

Debbie Jaarsma, PhD
Full professor of medical education, director, Center for Education Development and Research in Health Professions, and research leader of LEARN (Lifelong Learning, Education & Assessment Research Network), University Medical Center Groningen, Groningen, The Netherlands; ORCID: https://orcid.org/0000-0003-1668-2002.

Marcia Strazzacappa, PhD
Actress, clown, and associate professor of education, and Laborarte coordinator, University of Campinas, São Paulo, Brazil; ORCID: https://orcid.org/0000-0002-4118-6572.

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A Wider Use for the Uncertainty Communication Checklist

To the Editor: We would like to commend the authors of "Development of the Uncertainty Communication Checklist: A Patient-Centered Approach to Patient Discharge From the Emergency Department."[1] Not only do Rising and colleagues address the important issue of how we can support doctors to develop the skills to communicate diagnostic uncertainty to patients, but they also offer a rare example of how to involve patients in teaching and in learner assessment. We were also pleased to see that the checklist will continue to be refined based on the experience of its use in teaching emergency department residents. However, we would have appreciated some further detail on the refinement process the authors plan to use.

It strikes us—a psychiatrist completing a PhD in the field of ambiguity tolerance, and a professor of medical education—that such a checklist could have far wider use. As the authors indicate, diagnostic uncertainty is common within medicine, and this issue is not unique to the discharge process within the emergency department. For example, there is limited evidence regarding the best way to support and train clinicians in communicating to patients the challenging concept of medically unexplained (i.e., persistent physical) symptoms. Within the United Kingdom, this is a huge challenge within both the community (primary care) and the acute hospital (secondary care) settings.

We are in complete agreement that involving patients to improve the doctor–patient interaction approach is the "next frontier" for public engagement. Involving patients would