Perhaps in Dr. Shanafelt's study, the wellness promotion practices of residents with high mental well-being enable them to demonstrate empathic concern while still maintaining their own well-being and averting burnout.

Striking this balance between empathy and self-care may be a critical skill for residents to master and may help to ensure well-being throughout their careers. Further explorations of gender differences in clinical empathy may help elucidate how the risk of burnout or compassion fatigue may differ between female and male physicians. We appreciated the contribution of Dr. Shanafelt and his colleagues to our understanding of these important connections.—**Neda Ratanawongsa, MD, Scott M. Wright, MD, Rachel B. Levine, MD, MPH, Johns Hopkins School of Medicine, Baltimore, MD.**

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Authors' Response

In Reply:—We thank Drs. Ratanawongsa and colleagues for their insightful comments. Larson and Yao's¹ concept of "surface acting" and "deep acting" is a useful method to conceptualize the ways physicians express empathy. In addition to potential effects on the patient's experience, the way physicians respond to patients can positively (enhanced meaning/personal fulfillment) or negatively (burnout, compassion fatigue) impact physician outcomes.

Although we believe surface acting is appropriate in many situations, the motivation behind use of this technique is important. We agree with Larson and Yao's¹ assertion that surface acting motivated by a "value guided commitment to care" can contribute to both patient and physician satisfaction. In contrast, repetitive use of surface acting simply to avoid dealing with patients' emotional concerns is likely to contribute to cynicism.

Deep acting has the potential to create an even greater connection between physicians and patients as well as enhance physicians' sense of meaning in their work. This approach, however, involves physicians altering their own emotional state to identify with the patient's experience and has the potential to create reactive emotions (anger, distress, concern, and grief) for the physician. Physicians who are able to recognize and process such personal reactions are better able to express empathy without experiencing "compassion fatigue." We believe training medical students and residents to calibrate their use of surface and deep acting and identify personal reactions in each patient encounter is an important step in developing physicians who are both empathetic and resilient.^{2–4}

The energy physicians can devote to emotional labor is ultimately a limited resource. We hypothesize that attention to

personal well-being through mindful practice and nurturing of personal interests and relationships allows physicians to renew the energy they have to devote to this work.⁵ This concept holds that empathy and well-being have reciprocal feedback loops. The complexity of these interactions highlights the need for additional studies on the relationship between well-being and empathy and research that provides insight into how physician well-being can be promoted. We hope that support for such studies will grow in the coming years.—**Tait Shanafelt, MD, Colin West, MD, PhD, Joseph Kolars, MD, and Thomas Habermann, MD, Mayo Clinic College of Medicine, Rochester, MN.**

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To the Editor:—Franks et al.'s¹ article entitled "Racial disparities in the content of primary care office visits" observed that African-American (AA) patients are less likely to receive preventive care during office visits to primary care. The authors present an interesting study and do a good job enumerating and addressing the limitations of their dataset and analyses. Still, we feel 2 points merit further discussion:

1. That AA receive more of some preventive services and less of others does not make intuitive sense. If ethnicity were a direct determinant of preventive services, then the relationship should be independent of the type of service in question. In absence of a consistent relationship between ethnicity and the type of services offered, we must consider the existence of an unadjusted confounder. Attempts to explain this phenomenon should consider not only provider characteristics, but also those of the patient and site of care as well.
2. That the disparities observed for one time period do not persist into the following one suggests that, regardless of the mechanism for the disparities, they are waning over time. Rather than focus on the causal mechanism for disparities, we should celebrate that the only remaining significant disparity by 1995 to 2001 was in rectal screening (a procedure not recommended by the U.S. Preventive Services Task Force <http://www.ahcpr.gov/clinic/uspstf/uspstfprca.htm>).

Future research should try to understand what might account for this improvement so as to perpetuate its benefits.—**Maria Silveira, MD, MA, MPH, and Eve Kerr, MD, MPH, Ann Arbor VA Health Services Research and Development Center of Excellence, Ann Arbor, MI.**

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