The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students With Burnout

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Abstract

Purpose
Because of the high prevalence of burnout among medical students and its association with professional and personal consequences, the authors evaluated the help-seeking behaviors of medical students with burnout and compared their stigma perceptions with those of the general U.S. population and age-matched individuals.

Method
The authors surveyed students at six medical schools in 2012. They measured burnout, symptoms of depression, and quality of life using validated instruments and explored help-seeking behaviors, perceived stigma, personal experiences, and attitudes toward seeking mental health treatment.

Results
Of 2,449 invited students, 873 (35.6%) responded. A third of respondents with burnout (154/454; 33.9%) sought help for an emotional/mental health problem in the last 12 months. Respondents with burnout were more likely than those without burnout to agree or strongly agree with 8 of 10 perceived stigma items. Respondents with burnout who sought help in the last 12 months were twice as likely to report having observed supervisors negatively judge students who sought care (odds ratio [OR] 2.06 [95% confidence interval (CI) 1.25–3.39], P < .01). They also were more likely to have observed peers reveal a student’s emotional/mental health problem to others (OR 1.63 [95% CI 1.08–2.47], P = .02). A smaller percentage of respondents would definitely seek professional help for a serious emotional problem (235/872; 26.9%) than of the general population (44.3%) and age-matched individuals (38.8%).

Conclusions

Only a third of medical students with burnout seek help. Perceived stigma, negative personal experiences, and the hidden curriculum may contribute.

Despite matriculating to medical school with mental health profiles similar to their age-matched peers who pursue other careers,1,2 medical students exhibit a substantially higher prevalence of burnout and depression than would be expected on the basis of national norms.3 Because poor mental health may negatively impact students’ competency,4 empathy,5 and professional development6 and may lead to suicidal ideation,7 distress must be promptly recognized and treated.

Studies have reported that few medical students with depression seek help,8–10 primarily because of embarrassment, confidentiality concerns, and fear of stigmatization.5,9,11 Yet, we were unable to find any studies reporting on the help-seeking behaviors of medical students with burnout. Because burnout is more prevalent than depression among medical students and also can lead to potentially serious personal and professional consequences,1,4–7,10,12 we conducted a multi-institutional study to understand the help-seeking behaviors of medical students with burnout and the role of perceived stigma in their decisions to seek help. We also evaluated whether students had personally observed discrimination against other students with mental health problems.11 Finally, we sought to understand whether attitudes toward mental health treatment differed among U.S. medical students, the general U.S. population, and age-matched individuals.

Method
Participants
In the fall of 2012, we invited via e-mail all second- through fourth-year medical students at the Mayo Medical School; University of Washington School of Medicine; University of California, San Diego School of Medicine; Rutgers New Jersey Medical School; and Uniformed Services University of the Health Sciences to complete our Web-based survey. These medical schools were selected because they represent a diverse group of public and private schools geographically distributed, and their students are representative of all medical students in the United States. Participation was elective, and responses were anonymized. The institutional review board at each participating institution approved the study prior to the recruitment of their students.

Study measures
The survey included established instruments to measure dimensions of professional and personal distress (burnout, symptoms of depression, quality of life [QOL]) as well as items exploring help-seeking behaviors, perceived stigma, personal experiences, and attitudes toward seeking mental health treatment.

Burnout, symptoms of depression, and QOL. We used the Maslach Burnout...
We used the two-item Primary Care Evaluation of Mental Disorders28 to measure symptoms of depression. This two-item evaluation performs as well as longer instruments and has a reported positive likelihood ratio of up to 3.42 for the diagnosis of major depression.18,19 Because our was an anonymous survey, we were unable to counsel or refer individual respondents who screened positive for depression. All participating students were sent a thank you letter after completing the survey with a list of school-specific mental health resources.

We also employed the Medical Outcomes Study Short Form (SF-8) Survey20 to measure mental and physical QOL. For this instrument, norm-based scoring methods are used to calculate mental and physical QOL summary scores.20,21 The mean mental and physical QOL summary scores for the U.S. population are 49.2 (standard deviation [SD] 9.46) and 49.2 (SD 9.07), respectively.20 Previous research has demonstrated acceptable psychometric properties,20,21 and the SF-8 has been used before in samples of medical students.2,22

Help-seeking behaviors and fear of disclosure. Respondents were asked if they had sought help and support for an emotional/mental health problem in the last 12 months, and, if so, from whom (family, friends, dean of student affairs, medical school personnel who are not the dean of student affairs, primary care physician, mental health specialist at a medical center associated/not associated with the medical school, other). Earlier work suggests that self-reported utilization of medical services is accurate when validated against medical records using similar time frames.23 Given what is known about students’ reluctance to seek help, the survey also included items about perceptions of how well confidentiality is protected when students do seek help.

Stigma. Stigma is a multidimensional phenomenon24,25 that includes self-stigma (internalized attitudes held by individuals), public stigma (negative attitudes about mental illness and treatment held by others), treatment stigma (negative attitudes about seeking help), and stigmatizing experiences (perceived and feared discrimination due to emotional/mental health problem) and leads to decreased help-seeking behavior.26,27 We selected items from the existing literature on stigma,14,15,16,22 including validated instruments13,25,27–31 that assessed these dimensions. We modified some items to make them more relevant to medical students.

Attitudes toward seeking mental health treatment. Our survey included three items assessing students’ attitudes toward seeking mental health treatment. These items stemmed from questions on the National Comorbidity Survey-Replication (NCS–R),32,33 which is designed to assess this domain. We used one item verbatim about willingness to seek professional help for a serious emotional problem (scale: would definitely go, probably go, probably not go, or definitely not go for professional help; item V07368). We used publicly available data to obtain responses to this item from the general U.S. population (ages 18–99 years old) and from individuals of a similar age to medical students (ages 22–35 years old).24

Analysis Our primary analysis involved descriptive summary statistics and the chi-square test or Wilcoxon–Mann–Whitney test, as appropriate, for univariate comparisons. All tests were two sided with type I error rates of 0.05. All analyses were done using SAS version 9.3 (Cary, North Carolina).

Results A total of 873 of 2,449 medical students responded to our survey (35.6% response rate). Table 1 includes the demographic characteristics and prevalence and levels of distress (i.e., burnout, QOL, and depressive symptoms) among respondents. Demographic characteristics of respondents were generally similar to those of the overall study population; however, respondents were slightly less likely to be male (442/873 [50.9%] versus 1,369/2,449 [55.9%]) or to be second- or fourth-year students (response rate by year in school: 183/566 [32.3%], 358/956 [37.4%], and 332/927 [35.8%] for second-, third-, and fourth-year students, respectively) than the overall study population. In addition, 50.9% (442/873) of respondents were male compared with 52.0% (9,434/18,154) of graduating medical students nationally in 201335; 29.2% (254/873) were married compared with 32.4% nationally in 1996 (the last time the Association of American Medical Colleges [AAMC] Graduation Questionnaire included a question about marital status); and 11.1% (96/873) had children compared with 12.9% nationally in 1995 (the last time the AAMC Graduation Questionnaire included a question about having children).26,37 The prevalence of burnout (454/861; 52.7%) and depression (330/870; 37.9%) and mean mental (46.6) and physical (53.7) QOL scores were similar to those found in other national studies of medical students, including ones with higher response rates.1,6,7,10,12

Help-seeking behaviors

Overall, 360 (of 830; 43.4%) respondents reported seeking help for an emotional/mental health problem in the last 12 months. Among those with burnout, approximately a third (154/454; 33.9%) reported seeking help for an emotional/mental health problem in the last 12 months. Most of these respondents sought help and support from family (109/154; 70.8%), friends (97/154; 63.0%), or a mental health specialist at a medical center associated with their medical school (105/154; 68.2%). Fewer sought help from a mental health specialist at a medical center not associated with their medical school (38/154; 24.7%), a primary care physician (41/154; 26.6%), or medical school personnel (dean of student affairs: 34/154 [22.1%] or other medical school personnel: 32/154 [20.8%]; percentages add up to more than 100% because respondents could indicate all resources they had used).

Figure 1 shows the percentage of respondents who sought help for an emotional/mental health problem in the last 12 months by the degree of EE and DP. Although respondents with high EE were nearly twice as likely to have sought help as those with low or intermediate EE, only
about 40% (140/365) of respondents with high EE sought help. In comparison, help-seeking behavior only varied slightly by degree of DP as only about 32% (92/289) of respondents with high DP sought help in the last 12 months.

Perceived stigma and fear of discrimination and disclosure

Table 2 includes respondents’ perceptions of stigma. Of respondents, 10.3% (90/870) agreed or strongly agreed that it is a sign of personal weakness or inadequacy to receive treatment for an emotional/mental health problem. Approximately half agreed or strongly agreed that residency program directors, supervisors, peers, and patients held negative attitudes about mental illness and its treatment. For example, 439 (of 873; 50.3%) agreed or strongly agreed that residency program directors would pass over their application if they were aware that the student had an emotional/mental health problem. A similarly high percentage (404/871; 46.4%) agreed or strongly agreed that patients would not want them as their doctor if they were aware that the student had been treated for an emotional/mental health problem.

Respondents also feared disclosure of an emotional/mental health problem. Approximately 1 in 5 (179/866; 20.7%) disagreed or strongly disagreed that the mental health care provided to medical students at their school/affiliated institution was truly confidential. A similar percentage agreed or strongly agreed that the dean (226/872; 25.9%) and residency program directors (179/873; 20.5%) at their institution could access their personal medical record and that seeking care for an emotional/mental health problem may end up in their academic record (172/869; 19.8%).

Responses to only 2 of the 10 stigma items varied by year in school (data not shown). Although fewer fourth-year respondents agreed or strongly agreed that patients would not want them as their doctor if the patient was aware that they had been treated for an emotional/mental health problem (102/182 [56.0%], 164/358 [45.8%], and 138/331 [41.7%] for second-, third-, and fourth-year students, respectively, \( P = .007 \), they were more likely to agree that they would hide it from others if they were to receive treatment (114/183 [62.3%], 205/358 [57.3%], and 221/332 [66.6%]; \( P = .04 \)).

In comparison with respondents without burnout, those with burnout were more likely to agree or strongly agree that receiving treatment for an...
emotional/mental health problem is a sign of personal weakness or inadequacy and to believe that residency program directors, supervisors, and peers hold negative attitudes about mental illness and treatment (all \(P < .05\), see Figure 2). For example, 59.7% (271/454) of respondents with burnout in comparison with 39.6% (161/407) without burnout agreed or strongly agreed that residency program directors would pass over their application if they knew that the student had an emotional/mental health problem. The majority of respondents (341/873; 62.0%) agreed or strongly agreed that if they were to receive treatment for an emotional/mental health problem, they would hide it from others. Responses to this item did not vary by burnout.

Respondents with burnout were less likely to believe that the mental health care provided to medical students at their school/affiliated institution was truly confidential; they were more likely to agree or strongly agree that the dean and residency program directors could access their personal medical record and that seeking care for an emotional/mental health problem might end up in their academic record (all \(P < .05\)).

Confidentiality breaches and other observed behaviors

In the last 12 months, over 10% of respondents reported that they had observed supervisors (e.g., residents, fellows, faculty, and dean’s office staff) reveal students’ emotional problems to others (137/867; 15.8%), give fewer opportunities to students who had emotional problems (100/862; 11.6%), or negatively judge students who sought care for emotional problems (112/868; 12.9%). Few respondents reported seeing supervisors access the medical records of students without their consent (29/879 [3.3%]; see Table 3). Over half of respondents observed fellow students reveal other students’ emotional/mental health problems (485/868; 55.9%). Nearly a third observed fellow students socialize less with students who had emotional/mental health problems (272/863; 31.5%).

Responses to two of these items varied significantly by whether the respondent with burnout personally sought help for an emotional/mental health problem. Compared with those who did not seek help, respondents with burnout who sought help in the last 12 months were twice as likely to have personally observed supervisors negatively judge students who sought care (odds ratio [OR] 2.057 [95% confidence interval (CI) 1.251–3.385], \(P = .0045\)). Additionally, respondents with burnout who sought help were more likely to have personally observed fellow students reveal emotional/mental health problems to others (OR 1.634 [95% CI 1.083–2.466], \(P = .0192\)).

Attitudes toward mental health care among medical students compared with the population

If the need arose to receive professional help for a serious emotional problem, 235 (of 872; 26.9%) respondents would “definitely go,” 408 (of 872; 46.8%) would “probably go,” 207 (of 872; 23.7%) would “probably not go,” and 22 (of 872; 2.5%) would “not go” for professional help. In comparison, 44.3% and 38.8% of U.S. adults and age-matched individuals respectively indicated that they would “definitely go” for professional help, according to findings from the NCS-R. See Supplemental Digital Figure 1 (at http://links.lww.com/ACADMED/A259) for medical students’ attitudes toward seeking mental health treatment in comparison with those of the general U.S. population and age-matched individuals.

Discussion

Findings from this large, multi-institutional study indicate that medical students with burnout infrequently seek help for an emotional/mental health problem—only about 3 of 10 students with burnout sought help within the last year. This rate of help-seeking behavior among medical students with burnout is similar to that previously identified among medical students with depression.63 Students’ rate of help-seeking behavior increased incrementally with increasing levels of EE but not by degree of DP. This finding suggests that students may more readily recognize symptoms of EE (e.g., feeling at the end of one’s rope or frustrated, fatigued, and emotionally drained) than symptoms of DP (e.g., feeling calloused toward patients, emotionally hardened, and detached). It also may suggest that students believe that seeking treatment may help with EE more than
Students with burnout had higher perceived stigma scores and greater fears of discrimination and of confidentiality breaches than students without burnout. This finding aligns with that of Schwenk and colleagues’ single-institution study, in which depressed medical students more frequently expressed depression stigma attitudes, as well as with other data suggesting that those most in need of treatment more often perceived stigma. Although the association between stigma and depression is well recognized, our study is the first, to our knowledge, that demonstrates a relationship between stigma and symptoms of burnout, although we are unable to determine causation. Our finding of increased stigma scores among distressed students (suffering from depression and burnout) points to distorted perceptions that work against the distressed individual’s ability to frame the problem and optimally problem solve. Given the cross-sectional design of our study, we do not know if burnout leads to amplified perceptions of stigma or if those with greater perceptions of stigma and thus less interest in seeking help are more likely to burn out. As the preponderance of evidence suggests, stigma regarding mental health care likely explains why half of Americans in need of such care do not actively seek treatment.

Similarly, perceived stigma likely explains, at least in part, why medical students with burnout do not actively seek help.

As social and cultural factors influence help-seeking behaviors, what medical students observe in their training environment likely influences their willingness to seek help. Fear of discrimination by residency program directors, supervisors, and peers and concerns about confidentiality were common among students in our study. Nearly half believed that residency program directors would pass over their application if they knew the student had an emotional/mental health problem, a belief held even more strongly by students who were burned out. Over 10% of students observed supervisors giving fewer opportunities to students with emotional/mental health problems or judging them negatively. Moreover, 16% observed supervisors breaching the confidentiality of students with an emotional problem. A breach of confidence between students was even more common—over half (56%) observed students revealing the emotional/mental health problems of other students. Students with burnout who sought help were even more likely to have observed confidentiality breaches or discrimination than students without burnout who had not sought help. This finding suggests that confidentiality breaches and discrimination may actually occur, rather than solely being feared as a consequence for students with burnout who seek help.

Just as concerning is our finding that the prevalence of stigma regarding the treatment of mental health problems appears to be higher among the medical students in our cohort than among national samples of U.S. adults and age-matched individuals. In comparison with data from the NCS-R, medical students in our study were substantially less likely than the general population to have observed confidentiality breaches and discrimination.
to indicate that they would seek professional help if they developed a serious emotional problem (27% versus 44%). Similarly, in comparison with a random sample of 2,782 graduate and undergraduate university students at a large, public Midwestern university,29 undergraduate university students at a random sample of 2,782 graduate and 44%). Similarly, in comparison with a random sample of 2,782 graduate and undergraduate university students at a large, public Midwestern university,29 medical students in our study were more likely to report that they would conceal treatment for an emotional/mental health problem (62% versus 30%). Most students indicated that they do not view seeking help as a sign of personal weakness, suggesting that they accept the biopsychosocial model of mental health problems. Our data suggest, then, that students are concerned that having a mental health problem and seeking help will negatively impact their future career as a physician, which may be the main reason students with emotional/mental health problems do not access help.

How should medical schools respond to these findings? A high degree of self-stigma does not appear to be a primary hindrance to seeking help as few students endorsed such behavior as a sign of personal weakness or inadequacy. This finding suggests that including additional curricula on the biopsychosocial model is unlikely to be a successful solution on its own. Instead, medical schools must address students’ perceptions of public and treatment stigma as well as feared and experienced stigmatizing experiences. A successful intervention, then, should address the learning environment. For example, residents36 and physicians37 beliefs and behaviors may perpetuate stigma and students’ fears of the negative repercussions of help-seeking behavior. The traditional medical culture also discourages the admission of personal vulnerabilities,42 does not prioritize physicians’ health,43,44 and promotes the principle that work should always come before personal needs.45–47 In an attempt to induce a culture shift, some have suggested promoting personal mental health within core competencies48,49 as the Royal College of Physicians and Surgeons of Canada49 and the United Kingdom’s General Medical Council already have done.50 Curricula to educate students about confidentiality, the hidden curriculum, medical culture, how to support their peers, and when to personally intervene, including informing medical school staff or other relevant authorities when a student is impaired from a mental health problem, also may be useful.

Such initiatives need to be part of broader work to address the high prevalence of burnout and other forms of mental health problems among medical students as well as part of leadership-sponsored initiatives to support a culture change. Unfortunately, little is known about how best to reduce burnout and promote positive mental health despite the Liaison Committee on Medical Education requiring medical schools to provide student wellness programs.46 Curricular reform efforts, including a reduction in contact hours, pass–fail grading, and embedded mindfulness experiences, also may help curb distress and promote well-
In the last 12 months, how many times have you observed the following behaviors among your supervisors (e.g., residents, fellows, faculty, dean’s office staff) at your institution?

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Once</th>
<th>2–3 times</th>
<th>4 or more times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reveal students’ emotional problems to others</td>
<td>731 (84.2)</td>
<td>74 (8.5)</td>
<td>46 (5.3)</td>
<td>17 (1.9)</td>
</tr>
<tr>
<td>Give fewer opportunities to students who have emotional problems</td>
<td>761 (88.4)</td>
<td>50 (5.8)</td>
<td>31 (3.6)</td>
<td>19 (2.2)</td>
</tr>
<tr>
<td>Access medical records of students without their consent (e.g., without being directly involved in the student’s medical care)</td>
<td>838 (96.7)</td>
<td>11 (1.3)</td>
<td>8 (0.9)</td>
<td>10 (1.2)</td>
</tr>
<tr>
<td>Judge students negatively who have sought care for emotional problems</td>
<td>754 (87.1)</td>
<td>53 (6.1)</td>
<td>38 (4.4)</td>
<td>21 (2.4)</td>
</tr>
</tbody>
</table>

In the last 12 months, how many times have you observed the following behaviors among fellow students at your institution?

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Once</th>
<th>2–3 times</th>
<th>4 or more times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socialize less with students who have emotional/mental health problems</td>
<td>591 (68.5)</td>
<td>73 (8.5)</td>
<td>124 (14.4)</td>
<td>75 (8.6)</td>
</tr>
<tr>
<td>Reveal students’ emotional/mental health problems to others</td>
<td>383 (44.1)</td>
<td>144 (16.6)</td>
<td>245 (28.2)</td>
<td>96 (11)</td>
</tr>
</tbody>
</table>

*Percentages take into account missing values.

Our study has several limitations. First, although similar to that of other national surveys of physicians and medical students,1,3,9,46 our response rate was 35.6%, making our results potentially susceptible to nonresponse bias. To assess for nonresponse bias,29 we compared the demographics of our respondents with those of our entire sample and with those of the full population of medical students. We found few differences between respondents and nonrespondents, with the exception of our sample being slightly biased toward female medical students and second-year medical students. In comparison with medical students nationally, respondents reported similar sex and marital and parental status demographics. We also compared burnout and depression rates and QOL scores and found them to be quite similar to those in other national studies of medical students, including ones with higher response rates.1,3,7,10,12 Additionally, the prevalence of stigma reported by our respondents was similar to that in other studies of medical students.35 For example, 10% of students in our study versus 9% of students in the study by Schwenk and colleagues38 agreed with the personal stigma item (emotional/mental health problems are a sign of personal weakness). The students in both cohorts also held similar beliefs about (1) the detrimental impact of having an emotional/mental health problem on the competitiveness of one’s residency application, (2) public stigma (i.e., stigma beliefs of other students), and (3) the need to conceal treatment of an emotional/mental health problem. Together these findings suggest that our respondents likely are representative of today’s medical students.

Second, ours was a cross-sectional study; thus, we cannot infer causal relationships. Third, we used a 12-month reference period for help-seeking behavior while measuring current burnout and perceived stigma. A longitudinal study that examines in greater detail the timing of recent help-seeking behavior and the perceived benefit of treatment is needed to better determine the factors influencing help-seeking behavior among medical students with burnout. Fourth, as we conducted our study in the fall, we did not include first-year students. We chose not to invite them as we were interested in students’ help-seeking behaviors and personal experiences during medical school. Finally, we asked about a limited number of factors thought to influence help-seeking behaviors and may have missed other determinants.

Despite these limitations, our study has several strengths. To our knowledge, it is the first multicenter study to comprehensively evaluate help-seeking behaviors among medical students with burnout and to compare medical students’ attitudes toward mental health treatment (an important predictor of actual use)35 with those of the general U.S. population and age-matched individuals. We obtained responses from a large, diverse sample of students from six public and private institutions located in different geographic areas of the United States. By using an anonymous survey, we believe that bias related to social desirability was less likely in responses. Finally, the survey included items that were well grounded in the existing literature on stigma8,10,11,13,25,27–31 and that covered multiple dimensions of the construct.

Few students with symptoms of burnout seek help, and perceived stigma, negative personal experiences, and the culture in which they are learning may contribute to this inaction. Unrecognized and untreated distress can continue unresolved for many years,65 ultimately affecting the quality of care an individual provides.51–54 In 2003, the President’s New Freedom Commission on Mental Health called for a national campaign to reduce mental illness stigma.65 A decade later, the medical education community still needs to look inward—to address a medical culture that may contribute to perceptions of stigma regarding mental...
health problems in medical students and physicians. Doing so will not only benefit future physicians but also will benefit the patients for whom they ultimately will provide care.

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