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http://dx.doi.org/10.1016/j.mayocp.2017.06.018

Defining Physician Burnout, and Differentiating Between Burnout and Depression—I

To the Editor: On the basis of the conclusion that more than 50% of US physicians suffer from burnout, Melnick and Powsner[1] and Shanafelt and Noseworthy[2] underlined the importance of taking systemic action to reduce the risk of the syndrome by improving conditions under which physicians work. To effectively deal with the issue of job stress, we think that a critical step is to understand burnout as a *depressive condition*.

Various definitions of burnout have been proposed since the introduction of the construct in the 1970s. According to the most widely endorsed of these definitions, burnout combines emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment. Many studies, however, have consistently shown that the burnout syndrome, far from being reducible to its 3 definitional dimensions, actually involves the full array of "classical" depressive symptoms (eg, anhedonia, depressed mood, and suicidal ideation). For instance, in a 3-wave, 7-year study of 3255 Finnish dentists, burnout and depressive symptoms have been found to decrease/increase in parallel over time.[3] A disattenuated correlation as high as 0.91 has been observed between burnout and depressive symptoms in a cross-sectional study of 1046 French schoolteachers that standardized the time window of the 2 entities' assessment.[4] The persistent neglect of these accumulating findings is problematic from both a clinical standpoint and a public health standpoint.

In addition, it should be emphasized that the prevalence of burnout cannot be estimated because diagnostic criteria for the syndrome are lacking.[5] The assertion that more than 50% of US physicians suffer from burnout is therefore an empty claim. Depending on how cases of burnout are identified, virtually any estimate can be obtained. As an illustration, in a recent study of intensive care unit professionals,[6] the prevalence of burnout was found to be either 3% or 40% as a function of how burnout was defined. Such dramatic differences in prevalence estimates of burnout are perplexing. Indeed, although a prevalence estimate of 3% suggests that intensive care unit professionals are doing pretty well in managing job stress, a prevalence estimate of 40% conveys an alarming message. The proliferation of arbitrary estimates of burnout's prevalence is confusing for occupational health researchers and practitioners. Importantly, arbitrary estimates undermine the ability of public health policy designers to make informed decisions (eg, for establishing intervention priorities). In the current context of diagnostic and nosological blur, Shanafelt and Noseworthy's recommendation to first "acknowledge and assess the problem [of burnout],"[2(p133)] for instance, appears to be inapplicable.

We plead for a redefinition of burnout as a depressive condition so that the harmful effects of unresolvable job stress can be more accurately and comprehensively assessed. As research compellingly suggests, reducing the harmful effects of unresolvable job stress to the experience of emotional exhaustion, depersonalization, and reduced personal accomplishment is mistaken in that it denies the depressive core of the syndrome referred to as "burnout." Replacing the notion of burnout by the concept of job-induced depression would help us be more effective in the management of occupational adversity. Methods to examine the specific relationship between job stress and depression in research and clinical settings are available.[5]

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http://dx.doi.org/10.1016/j.mayocp.2017.07.007

Defining Physician Burnout, and Differentiating Between Burnout and Depression—II

To the Editor: Shanafelt and Noseworthy[1] in a recent study are to be commended for continuing to raise awareness of physician job stress, but their reliance on fractions of questions from what they indicate to be "potentially standardized instruments" to categorize burnout is unfortunate. Among these, the popular Maslach Burnout Inventory (MBI)[2] is a proprietary test, and

its use in the table titled "Candidate Dimensions of Well-being for Organizations to Access" is flawed. Not only are the 'cutoff' scores proposed by the developers of the MBI wholly arbitrary and devoid of any clinical referent,[2] the inventory's user manual also warns that "neither the coding nor the original numerical scores should be used for diagnostic purposes."[2] Nonetheless, several authors have attempted to take the complexity of physician burnout syndrome down to even single-item measures validated against the MBI[3] and/or to comment on qualitative differences that describe a "sense of calling"[4] in making physician assessments.

Because no diagnostic criteria for burnout have been developed,[5] the methods for identifying cases of burnout have proliferated, resulting in dramatic variations in prevalence estimates, as this article epitomizes in the comparison of burnout rates between 2013 and 2015, reported as the Mayo Clinic experience.[1] Because the likelihood for misattribution error is present at baseline, this alone may invalidate the authors' conclusions regarding the impact of their detailed 9-strategy intervention. Namely, they report that "the absolute burnout rate among Mayo physicians decreased by 7% over 2 years, despite an 11% increase in the absolute burnout rate noted in a national comparison using the same metrics."[1] But again, stated differently, using MBI diagnostically to assess the prevalence of burnout and changes over time leads to findings that are hard to maneuver in medical decision making.

Another concern arises when demographic characteristics of the Mayo physicians' surveyed is considered. Factors such as physician turnover between survey intervals could introduce differences, or quite possibly the retained physicians may have learned to answer more positively in the survey—perhaps to avoid work group scrutiny, stigma associated with being labeled as "burnt out," or termination of their group affiliation—hence, short-term improvements especially without careful characterization have limited utility. Moreover, whether "deliberate, sustained, and comprehensive efforts by the organization to reduce burnout and promote engagement can make a difference"[1] as the authors conclude, I think is open to question and may overstate the result given the time horizon is so short.

Consequently, I am skeptical of the utility that derives from reflecting burnout repercussions as separate hemispheric domains of person or profession. Shanafelt and Noseworthy[1] imply this idea with a 50:50 shading scheme used in Figure 1 of their article. How does responsibility for repercussions of burnout adjust the interactions between clinicians and their supervisory leaders? An even split, as portrayed, ignores the current paradigm shift from blaming an individual physician to blaming the employment environment as the main driver of job stress and the predictable consequences of overwork. This graphic is misleading, and there may be other reasons the institutional leadership and other at-will employers may wish to display a sense of limited liability for burnout. Indeed, there is widespread agreement among clinicians that burnout exists, and the dysfunction of it can be solved.

Finally, despite the authors' self-interested reporting style, and disclosure of potential competing interests, it is clear to me that they personally have an obligation as lead researchers at a vanguard institution to spearhead efforts to determine the binding diagnostic criteria for burnout, and once validated, should move onto examining burnout's prevalence. The need for sound diagnostic criteria cannot be overstated, and clarifying burnout's nosological status (eg, with respect to depression and posttraumatic stress disorder) is a prerequisite to a rigorous assessment of burnout's prevalence. Only then can we go forward confidently with medical intervention and prevention strategies for burnout that truly make a difference. With more than 400 physicians (women > men) committing suicide annually, time is of the essence.[6]

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Editor's Note: When publishing a letter that comments on an article published previously in *Mayo Clinic Proceedings*, it is the journal's policy to invite the author(s) of the referenced article to publish a response. Drs Andrew Jager, Micheal Tutty, and Audiey Kao were invited to respond to the letter by Schears and preferred not to provide a reply.

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http://dx.doi.org/10.1016/j.mayocp.2017.07.006

In Reply—Defining Physician Burnout, and Differentiating Between Burnout and Depression

To the Editor: We appreciate the interest in our articles[1,2] calling for systemic action to reduce physician burnout. We also are grateful for the opportunity to respond to the letters from Bianchi and Schonfeld[3] and from Schears.[4] Following their recent studies reporting overlap between burnout and depression in