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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]

Renzo Bianchi, PhD
University of Neuchâtel, Institute of Work and Organizational Psychology
Neuchâtel, NE, Switzerland

Irvin Sam Schonfeld, PhD, MPH
The City College of the City University of New York, Department of Psychology
New York, NY

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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