In Reply to Fochtmann: Dr. Fochtmann raises an interesting point, although it is somewhat tangential to the goals of my original Commentary.[1] Physicians of all types are spending enormous amounts of time completing charts through electronic medical record (EMR) systems. For research physicians, this work is generally time spent away from their research. Is the root problem the EMR per se? No, it is not—a point about which I agree with Dr. Fochtmann. The problem is that the U.S. medical system bases clinical payments mostly on how extensively physicians document. Generically, EMR systems could have been optimized for the purpose of clinical care, but they are, instead, optimized to justify billing codes. Combining this regrettable use of a potentially labor-saving tool, which instead *increases* work load, with productivity measures like relative value units (RVUs) has created a difficult milieu for physician–investigators who are trying to balance clinical and research obligations. The primary driver of the conflict is the expectation that faculty physicians will do enough work (i.e., generate sufficient RVUs) to cover the clinical part of their salary, and a difficult aspect of that expectation is that clinical work has become increasingly inefficient. The EMR is simply one element of a difficult clinical work environment in which the incentives for better care are not well aligned with the requirements for higher reimbursement. It was never easy to combine being a clinician and an investigator, especially an investigator with a lab, but modern clinical practice has made this dual role particularly difficult.

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Addressing Uncertainty in Burnout Assessment

To the Editor: We are grateful to Dr. Eckleberry-Hunt and colleagues for raising the challenges with burnout measurement.[1] While burnout has been reliably and validly measured for nearly 40 years, there is confusion in how it is described. Burnout is a continuum with graduation in severity, analogous to hypertension. Incremental increases in symptoms are associated with adverse outcomes, and the worst outcomes accompany the highest degrees of burnout. For explanatory purposes, researchers both describe measures across the continuum and use dichotomizations. As with hypertension, dichotomizations for burnout that are anchored to the risk of adverse outcome are used to simplify description of populations—even while researchers recognize that there is heterogeneity in risk above and below the threshold.

Dr. Eckleberry-Hunt and colleagues suggest (based on convention) that burnout requires high scores on both the emotional exhaustion and depersonalization scales of the Maslach Burnout Inventory[1]; however, high scores on *either* scale have been shown to predict adverse outcomes (e.g., perception of medical errors, suicidal ideation, reducing professional work effort).[2] This research suggests that a more liberal approach does not overinflate burnout; rather, it allows early identification of those at risk for adverse outcomes.[2] Regardless of the approach used to categorize burnout among physicians, the data indicate a large problem.[3]

We and others have also studied the positive side (satisfaction, well-being, thriving) in physicians for years. Recently, investigators have identified interventions that improve physicians' work lives and well-being.[4] Despite these findings, burnout remains consistently linked with the greatest risk of adverse personal and professional outcomes[2,3]; therefore, we advise against measuring only the positive end of the continuum. While positive psychology approaches can benefit individuals suffering from burnout, they may not change the factors that drive them there. Thus, while we agree with the authors' call to incorporate positive approaches focused on individuals, these should be supplementary to changes at the institutional and system levels to prevent burnout and support physician well-being.

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A Neglected Problem in Burnout Research

To the Editor: Eckleberry-Hunt and colleagues examined problems associated with burnout research.[1] We share some of the criticisms reiterated by these authors regarding the conceptualization and measurement of burnout and agree with the idea that the burnout construct is so problematic that the medical education community "risk[s] not having a valid construct." We are perplexed, however, by the authors' silence regarding burnout–depression overlap, which is arguably the most troubling problem attached to the burnout construct.[2,3]

The extensive research on burnout that we have conducted over the years has led us to suggest that this syndrome is nothing other than *a combination of depressive responses.*[2,3] The emotional exhaustion component of burnout involves fatigue and depressed mood, two diagnostic criteria for depressive disorders. The symptoms covered by the depersonalization component of burnout, such as loss of emotional involvement, irritability, and disengagement, are commonly found in depressed individuals; depressed mood and

anhedonia are directly involved in such disinvestment processes. Diminished personal accomplishment, the third component of burnout, similarly reflects well-known depressive manifestations—namely, negative self-evaluation and feelings of failure.

Maslach and colleagues, well-known contributors to burnout research, themselves wrote that there is "a predominance of dysphoric symptoms" in burnout.[4(p404)] As a reminder, dysphoric symptoms lie at the core of depression. Surprisingly, this observation did not lead these authors to explicitly include dysphoria in their formal definition of burnout or to acknowledge that burnout problematically overlaps with depression.

Importantly, burnout–depression overlap is not limited to symptomatology. Burnout–depression overlap is also etiological. Depressive symptoms, either clinical or subclinical, do not appear out of nowhere. Research evidence from neuroscience, behavioral psychology, and psychiatry indicates that depressive symptoms constitute basic responses to unresolvable (e.g., job) stress—the putative cause of burnout—in individuals *with no noticeable susceptibility to depression.*[2,3] These findings have also been overlooked in burnout research, perhaps because the initial development of the burnout construct was not clinically grounded, theory driven, or informed by the above-mentioned disciplines.[3]

Overall, it is regrettable that Eckleberry-Hunt et al[1] ignored the problem of burnout–depression overlap given the centrality of this problem in burnout research.

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In Reply to Palamara and colleagues and to Bianchi and colleagues:

In Reply to Palamara and colleagues and to Bianchi and colleagues: First, we would like to thank both sets of authors for their comments regarding our article.

We agree that some physicians may, in response to "unresolvable (e.g., job) stress," develop depression; however, in our experience, many physicians may feel fatigued and not enjoy seeing patients yet still enjoy other activities and describe themselves as happy. In contrast, anhedonia in depression is not selective. Factor analyses of surveys both for burnout and for depressive disorder indicate that the two constructs are distinct.[1] Much of the research regarding physician burnout indicates that it is job related. We believe that physician burnout reflects caregiver distress that is unique to the physician–patient relationship (i.e., distress that, as Maslach and Leiter contend, includes cynicism towards patients).[2] Although emotional distress is involved in reduced physician wellness, other factors such as career meaning and cognitive flexibility are also involved.[3] The idea that at some point burnout ends and depression begins seems tenable, although causality is unclear.

Although researchers describe burnout dichotomously to simplify explanation, reporting data in a continuous way may be better, especially in the absence of standardized cutoffs to categorize individuals. The suggestion that burnout requires high scores on both emotional exhaustion and depersonalization is not based on convention but, rather, the Maslach Burnout Inventory Manual.[4] Establishing a physician normative group will identify a commonly accepted rubric.

We agree that burnout is related to negative outcomes. A focus on the measurement of positive indicators of wellness need not require an abandonment of burnout-related research. Medicine often recommends prevention of disease as well as amelioration. Both are needed. The unique physician–patient relationship as a common stressor that influences burnout is likely to persist; strategies are available to promote positive individual psychological growth that help buffer those stresses.

Finally, we wholeheartedly agree that changes at the system and organizational levels are needed.

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A Different View on Political Activism

To the Editor: Kudos to Levinson and for their recent Commentary on the need for political activism.[1] That it was written by medical students is noteworthy; however, it was a bit slanted. True advocates must inform their opinions from both sides before drawing a conclusion. The United States was founded on divergent opinions, and freedoms are codified in the Bill of Rights. Yet, in this hyperpartisan environment, those who do not agree with the more vocal are demeaned, harassed, and attacked—regardless of truth.