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On the "Bubble" of Burnout's Prevalence Estimates

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CORRESPONDENCE

On the "bubble" of burnout's prevalence estimates

Discussion on: Psychological burnout and critical care medicine: big threat, big opportunity

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Initial correspondence from Drs. Laurent, Schonfeld and Bianchi

Dear Editor,

Hawryluck and Brindley [1] recently addressed the issue of burnout—a syndrome thought to be induced by job stress—among critical care medicine (CCM) practitioners. Although we agree that the practice of CCM can be stressful, relying on burnout as an indicator of the practitioners' response to occupational adversity is unwarranted.

Despite its popularity, burnout remains poorly defined [2]. Disconcertingly, investigators have widely relied on the Maslach Burnout Inventory (MBI) for "diagnosing" burnout in spite of the fact that the MBI is *not* a diagnostic instrument [2, 3]. Experiencing fatigue or distancing oneself from one' work—what burnout is about—is not a sign of ill-being in itself [2]. Unfortunately, the MBI does not allow investigators to determine *when* fatigue and distancing reach clinically relevant levels. The nosological blur surrounding burnout leads to endless speculations regarding the prevalence of the phenomenon and the "threat" it may represent, a state of affairs that bears on interventional resource allocation and public health policy-making [2, 3]. In many respects, current research on burnout's prevalence looks like a "bubble," in which ever-increasing estimates are spotlighted in the absence of any clear link to clinical reality.

Instead of speculating on the prevalence of burnout, we recommend that occupational health specialists focus on depressive disorders, that is to say, on diagnosable stress-related afflictions [2]. A close follow-up of CCM practitioners would be crucial in order to identify improvements or deteriorations in CCM practitioners' health status over time as a function of working conditions.

Reply from Drs. Hawryluck and Brindley

We wish to thank Drs. Laurent, Schonfeld and Bianchi for their response to our article on psychological burnout (1). We agree the Maslach Burnout Inventory is not diagnostic and does not permit identification of when psychological and physical symptoms affect professional performance. However, we do feel that the inventory can be a useful warning tool for professionals who rarely take the time to discuss their own feelings or recognize their own stress, which too many seem to view as either private or as a sign of weakness.

We also agree that many of us will have times when we experience fatigue and need to distance ourselves from work as we seek to re-equilibrate the work-life balance. These moments are not necessarily problematic. Yet profound disengagement, disenchantment, disrespect, a lack of empathy and understanding are serious problems when patients and families need to connect to the person within the professional, to feel the humanity within the science and technology. The signs and symptoms of burnout cannot be completely encompassed in existing depressive and stress—related disorders. While we absolutely agree that critical care professionals are not immune to mental illness and more attention must be paid to such issues, we would argue that failure to acknowledge burnout as distinct does CCM a disservice by: (1) seeking to medicalize all challenges of clinical

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practice and (2) by undermining much needed efforts at its prevention which must encompass both self-care, and address leadership, bullying, gender related issues and intra-team conflicts within group clinical practice.

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None.

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