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Dear Editor

We thank Schonfeld et al (1) for their comments on our letter (2) on the degree to which depression and burnout overlap in ICU staff. However, although we agree that these two forms of distress are associated, that does not mean they are the same thing—correlation is not the same as overlap.

In our survey of 218 staff (3), only five met criteria for burnout and depression, whereas 62 met burnout criteria without meeting depression criteria and two met depression criteria without meeting burnout criteria. We inferred from this that high-risk burnout symptoms are significantly more common in ICU staff than symptoms of clinical depression and that burnout and depression are not the same thing. Interestingly, another recent study of 5,897 practicing physicians (4), using different measures of depression and burnout, has reported that burnout was five times as common as depression, suggesting that this finding may be more widely applicable to health professionals who are functioning well enough to be at work.

The definition we used for burnout was not “arbitrary.” It was based on research by Schaufeli et al (5) which shows that emotional exhaustion and depersonalization are most strongly associated with a clinical diagnosis of burnout and is consistent with previous research practice in this field (6). However, we agree that there needs to be greater evidence-based consensus on the dichotomous classification of burnout. We would also support the idea that it might be useful to screen staff with high rates of burnout symptoms for depression, as well as anxiety and posttraumatic stress (which were both more prevalent in our sample than depression) and moral distress, which we did not measure.

Even if, for argument’s sake, burnout is viewed as a “sub-clinical” form of depression, that is not the same thing as saying there is no point measuring it. There is now a huge literature supporting the construct of burnout and demonstrating its dose-related association with the serious risks of suicidality and medical error. In addition, there is evidence that burnout levels in doctors are higher than that of the general population and deteriorating (6). The concept of burnout is also useful for an important pragmatic reason, in that, it resonates with health professionals, who are notoriously reluctant to seek help and poor at estimating their own distress (7). Hopefully by increasing awareness of these symptoms and encouraging staff to self-calibrate (7), the likelihood of more timely intervention at the individual and organizational level will be increased.

In conclusion, although we welcome the commitment by Schonfeld et al (1) to furthering the understanding of work-related stress, we fear that in their efforts to conflate burnout with depression, they are “throwing the baby out with the bathwater.” In our view, in dismissing this construct, they risk failing to identify staff at risk of developing more serious mental health problems. We have a duty of care, as a society, toward health professionals, and we need a better understanding of the nature of the pressures they are regularly placed under at work, for their sakes and those of their patients.

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